

Booster SmartCover

Policy Document

BSC01072024

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1. Welcome to Booster

Thank you for choosing Booster Assurance Limited to be your trusted life insurance provider.

Booster Assurance is part of the Booster Financial Services Limited group of companies. Booster Financial Services Limited is fully owned and operated here in New Zealand and aims to boost New Zealanders' financial confidence while helping to grow and secure their families' income and money.

Booster Assurance is licensed by the Reserve Bank of New Zealand to provide insurance.

Booster Assurance Limited is not required to have a financial strength rating because its annual gross premium income for the financial year of 1 July 2023 to 30 June 2024 was less than \$1.5million.

2. Take time to understand your Policy

Carefully read all the Policy documents. They form the basis of your contract with us. If you have questions about any of these documents, please talk to your Financial Adviser, or get in contact with us.

The Policy consists of:

1. The Policy Schedule
2. This Policy document
3. The Policy application
4. Any Personal or Supplementary Statements
5. Any endorsement schedules or notices
6. Any other written communication between us that we identify as applying to your Policy.

Headings used are for reference only. They do not form part of the Policy.

3. Privacy

Our Privacy Statement can be found [here](#). It may be updated from time to time.

It is important that the Insured Person understands that, by taking out this Policy, they consent to share personal information (including medical information which they authorise us to collect) with the Policyowners and us.

4. Common and Defined Terms

We've set these out in section 20. It is important that you read these so that you understand your Policy.

In this Policy, we refer to:

- Booster Assurance Limited (Booster, we, our, us)
- The Policyowner(s) (you, your)
- The Insured Person – the person whose life (or other risk) is covered under the Policy. The Insured Person may also be a Policyowner.

5. Who Benefits from a Policy?

All Benefits will be paid to you (the Policyowner(s)) or your Estate(s).

Where there is more than one Policyowner, all Policyowners will be recorded by us jointly. We may require the approval of all Policyowners prior to you exercising any of your rights under this Policy, and all Policyowners will be entitled to Benefits under this Policy jointly. If a Policyowner dies, the interest in the Policy will pass to the remaining Policyowners.

6. When does your Policy start?

Cover commences on confirmation by us. The date we do this is referred to as the Policy Start Date.

7. Duty to disclose

You and the Insured Person must be truthful and honest with us.

We rely on the information provided to us by you, the Insured Person, or anyone else on your behalf, to enable us to issue the Policy and assess claims. If any information provided is false, incomplete, or misleading, or relevant information is not disclosed to us, we can terminate, void, or change the terms of your Policy. We can also reassess Cover or decline a claim. We will only do so in accordance with the law.

It is important that the Insured Person provides us with full and accurate information about the Insured Person's health and lifestyle as questions relating to these aspects of their life are assessed or reassessed upon each application or where applicable to reinstatements or amendments to the Policy. This includes information about all medical conditions the Insured Person currently suffers from, has suffered from in the past, including ones for which the Insured Person has received treatment and has since recovered from, even if the Insured Person has disclosed these to us on a previous occasion. Even a slight change in circumstances may affect the Cover you receive and the premiums to be paid.

False or incomplete information provided to us may impact claim decisions and we may terminate the Policy. If, after we pay any claim, we find out that you or the Insured Person provided us with false or incomplete information, you may have to pay us back all claim payments made to you.

8. Premiums

The Policy Schedule shows the amount of each premium and how often premiums must be paid.

All payments are in New Zealand dollars and will include goods and services tax (where applicable).

Premiums are based on the Cover and the Insured Person's age, gender, smoking habits, health, lifestyle, family history, occupation, and pastimes (at the time of application and where applicable when you or the Insured Person request changes to your Policy).

Other than due to law changes or if you change your Cover, we will only change premiums at the annual renewal.

Reasons premiums change include, but are not limited to:

- The Insured Person getting older
- Changes in Cover (including due to any annual inflation increase)
- Law changes
- Our claims experience being different than expected
- We change the way premiums are determined
- The Insured Person's smoking status has changed from smoker to non-smoker.

First Premium

If we do not get the full first premium payment within 14 Days of the Policy Start Date, Cover is suspended until it is received. If an Insured Event occurs after Day 14 (and before the premium payment has been received by us) the event will not be covered.

If no premium is paid within 30 Days of the Policy Start Date, the Policy will be terminated and cannot be reinstated.

Missed premiums

If any premium payments are missed, Booster will attempt to collect the outstanding premiums. You must pay arrears as soon as possible. Booster will notify you of any arrears so that you can arrange to get the Policy up to date. If the first premium is not received within 30 Days of the Policy Start Date, or if subsequent premiums are three months in arrears, we will terminate your Policy.

How premiums are paid

You can choose to pay your premiums weekly, fortnightly, monthly, or annually.

You can pay by direct debit (from a New Zealand bank account), or internet banking.

9. Annual renewal

Your Policy will renew annually until the Policy ends, is cancelled, or is terminated. The Renewal Date is the same day and month as the first Regular Premium Payable Date. At each annual renewal (which will occur on the Renewal Date), the annual inflation increase will be applied (unless you have elected that it not be applied or be removed from the Policy), and the premium recalculated. The premium will typically increase with the age of the Insured Person.

Prior to each renewal you will be provided with a renewal notice with the new premium(s) and Sum(s) Insured. This will be provided at least 20 Days prior to the Renewal Date.

10. Annual inflation increase

An annual inflation increase is provided with your Policy. Your new limits and premium will be shown in your renewal notice. The renewal notice will also show your premium should you choose to decline the increase.

Each year you may choose to decline the annual inflation increase. If you choose to decline the increase two years in succession, this option won't be included in future renewals.

At any time, you can choose to remove the annual inflation increase, but once it's removed it can't be reinstated.

The annual inflation increase we use at each Renewal Date is the percentage change in the Statistics New Zealand annual Consumers Price Index in the 12 month period to the most recent September quarter, capped at 5%. The updated amount of cover remains subject to the maximum Cover limits set out in the Policy Schedule.

If the Statistics New Zealand Consumers Price Index isn't available, we may select a proxy that we believe reasonably reflects inflation for New Zealand households.

11. Smoking

If the Insured Person has used any products containing nicotine or tobacco, or used e-cigarettes or vapes in the 12 months prior to application for a Policy they must tell us, and are considered to be a smoker. If the Insured Person was a smoker but has not used any of these products for 12 consecutive months, and they do not have a disease or disorder which could in our opinion have been caused or exacerbated by smoking, they should tell us and we can change their status to non-smoker. Any reduction in premiums will only take place from notification of the changed smoking status.

12. Changing your Policy

It's important to regularly review your insurance to make sure you have the right types and amounts of Cover.

We recommend that you speak to your Financial Adviser about any change you want to make, so that they can help make sure your Cover remains appropriate. If you make changes directly with us, we will tell your Financial Adviser.

All Policyowners must agree to any changes to this Policy. If you request a change, any other Policyowners will be contacted for confirmation of the change, unless the change relates to a Policyowner's or Insured Person's address, contact details, or the Insured Person's smoking status.

What changes can be made by you?

1. The Sums Insured:
 - a. Sums Insured can be decreased at any time. Premiums might not be reduced by the same proportion as the reduction in the Sums Insured.
 - b. Sums Insured can be increased using the Special Events Increase Benefit (see section 15) without additional medical underwriting – although we will ask about changes in lifestyle, activities or occupation. You or the Insured Person may need to provide evidence of such changes.
 - c. To apply to increase the Sums Insured or add optional Benefits, contact your Financial Adviser.

2. Addresses and contact details.
3. Policy ownership can be changed.
4. The Policy or Benefits can be cancelled at any time. We recommend talking to your Financial Adviser prior to cancellation.

What changes can be made by the Insured Person?

1. Addresses and contact details.
2. Smoking status - if the Insured Person was a smoker but has not used any products containing nicotine or tobacco, and not used e-cigarettes or vapes for 12 consecutive months, and they do not have a disease or disorder which could in our opinion have been caused or exacerbated by smoking, we can change their status to non-smoker (also called ex-smoker). Any reduction in premiums will only take place from notification of the changed smoking status. See section 11.

What changes can be made by the Premium Payer?

If the premium payer is a different person, they may amend premium payment details.

13. Temporary cover suspension

If you have been made redundant or are suffering significant financial hardship, provided your Policy has been continuously in force for a minimum of 12 months you can suspend Cover for up to six months. The advantage of this is that once the period expires, you can resume Cover without needing to arrange a health declaration or for new underwriting to be obtained. Booster will determine, acting reasonably, whether you are suffering from significant financial hardship by using the definition of that term in KiwiSaver legislation. If you've been made redundant, Booster may need to confirm this.

You choose how long the suspension will be when you apply for one and it is set for that period. The suspension period cannot be ended early. No premium is due for the period that the Policy is suspended, however there is also no Insurance Cover – no Benefit payment will be made if the Insured Person dies or becomes terminally ill, or is diagnosed with, or has symptoms of, a Trauma or Critical Illness, or is Totally and Permanently Disabled while the Cover is suspended. You will not be able to claim for any illness, injury or condition that arises during the suspension period.

You can only suspend your Policy once and you will need to give us acceptable evidence of significant financial hardship or redundancy.

14. Ending your Policy

You can cancel your Policy at any time.

If you pay your premiums every:

- Week, fortnight or month, we won't refund any premiums.
- If you pay annually we will refund the share of premiums for remaining Cover from the cancellation date of the Policy.

Your Policy will end:

1. On the day the Insured Person turns 99 (other than for TPD or Trauma and Critical Illness Cover).
2. When you are eligible for payment of the full Life Cover amount.
3. When you are eligible for a Trauma and Critical Illness and/or Temporary and Permanent Disability payment equal to the Life Cover amount
4. When you ask us to cancel your Policy,
5. On termination for non-payment of premiums.
6. On the death of the Insured Person, whether or not you are eligible for a Benefit payment.

Cover for TPD ends on the Insured Person's 65th birthday. It will also end on payment of a TPD claim or Life Cover Claim.

Cover for Trauma and Critical Illness ends on the Insured Person's 70th birthday. It will also end on payment of a Trauma and Critical Illness or Life Cover claim.

Termination for non-payment

If the first premium is not received within 30 Days of the Policy Start Date, or if subsequent premiums are three months in arrears, we will terminate your Policy

If your Policy is terminated for non-payment, we will notify you of the termination using the last known contact details we have for you. Your Cover stops from the date of notification of termination (whether or not we have been able to contact you). There are no refunds for premium payments made to the date of termination.

You can apply to reinstate your Policy if it has been terminated

If your Policy is terminated for non-payment, you may be able to reinstate it. This is only available within 179 Days of the date of termination. We may require you to give us additional information relating to the Insured Person's health and lifestyle.

You will also need to pay any missing premiums before the Policy terminated, and premiums that would have been due between the termination date and the Reinstatement Date.

No Benefit will be paid if suicide, attempted suicide, or intentional self-injury contributes to or causes the death or Terminal Illness (whether directly or indirectly) within 13 months of the Reinstatement Date.

Please contact your Financial Adviser for assistance if you want to reinstate the Policy.

If the Policy is terminated for non-payment of the first premium within 30 Days of the Policy Start Date, it cannot be reinstated.

Free Look Period

- 30-Day free look: We offer a 30-Day Free Look Period. If you cancel the Policy within 30 Days of the Policy Start Date (and have not made a claim on the Policy), any premium payments will be refunded and the Policy cancelled from the Policy Start Date.
- The 30-Day Free Look Period does not apply to Policy reinstatements.

No cash value

This Policy has no cash value if terminated or cancelled.

Cancellation due to sanctions

We will not provide Cover and will not be liable to pay any claim or pay any Benefit to the extent that the provision of such Cover, payment of such claim or provision of such Benefit would be in respect of a person who is the subject of any sanction, prohibition or restriction under United Nations resolutions or trade or economic sanctions, laws or regulations of New Zealand, the European Union, United Kingdom or United States of America, or any of its states and/or any other applicable economic or trade sanction laws or regulations. This provision applies not only to the Policyowner, but to the Insured Person and any other related party or beneficiary of the Policy. Should we determine that the above is applicable, we may at our sole discretion terminate the Policy with immediate effect.

15. Understanding the Benefits that your Policy includes

Cover under this Policy is only provided for Insured Persons who, at the time the Policy application is received by us are permanently residing in New Zealand, at least 16 years old, and

1. Are New Zealand citizens, or
2. Hold a New Zealand permanent residency visa, or
3. Hold a New Zealand residency visa allowing the Insured Person to live permanently in New Zealand, or
4. Are Australian citizens.

Additional application criteria

	Minimum Entry Age	Maximum Entry Age	Expiry Age	Minimum Limit	Maximum Limit
Life and Terminal Illness	16	69	99	\$200,000	\$2,000,000
Total and Permanent Disability	16	60	65	\$25,000	\$500,000
Trauma and Critical Illness	16	60	70	\$25,000	\$500,000

1. Applications must be prior to the Maximum Entry Age.
2. The Cover will expire on the Insured Person's Expiry Age birthday.
3. The Maximum and Minimum Limits are the maximum and minimum Sums Insured available for each Benefit. The Minimum limit only applies if the optional Cover is selected.
4. The sum of the Sums Insured for the Total and Permanent Disability Cover and Trauma and Critical Illness Cover must be no greater than the smaller of \$500,000 and the Life and Terminal Illness Cover.

Other Insurance

The total Sum Insured under all policies, issued by us and other insurers, for an Insured Person must not exceed \$5,000,000 for death cover and \$1,500,000 combined Sum Insured for the optional Benefits of Total and Permanent Disability and Trauma and Critical Illness. The combined Sum Insured for optional Benefits cannot exceed the Sum Insured for death. If we discover the Cover exceeds these limits when handling a claim we will pay our pro-rata share of these limits.

a. Life and Terminal Illness Benefits

Life and Terminal Illness Benefit

You will be eligible to claim the Life Cover – amount of Cover - from the Policy Schedule (less the amount of any claim that has already been paid under this Policy) if the Insured Person dies or is diagnosed with a Terminal Illness (where a Medical Specialist considers that even with available treatment, the Insured Person has 12 months or less to live).

When we will not pay the Life and Terminal Illness Benefit

No Life and Terminal Illness Benefit will be paid if

1. Suicide, attempted suicide, or intentional self-injury contributes to or causes the death or Terminal Illness (whether directly or indirectly) within 13 months of the Policy Start Date, or reinstatement of the Cover after termination.
2. Any specific underwriting exclusions, limits or other special acceptance terms apply.
3. The illness, injury or condition on which you are claiming arose during the suspension period.
4. Refer to Section 18 for Exclusions that apply to all Benefits.

Additional Benefits

1. **Advance Terminal Illness Benefit:** If the Insured Person is diagnosed by a Medical Specialist and the diagnosis meets the definition of any of the Advance Terminal Illness Benefit conditions listed below, we will make one payment to you of 30% of the Life Cover - amount of Cover (capped at \$300,000). The Life Cover amount will reduce by the amount paid under this Benefit. The Trauma and Total and Permanent Disability Cover amounts will also be reduced by the amount paid under this Benefit.

List of Advance Terminal Illness Benefit conditions (current at the date of this Policy):

- a. Motor Neurone Disease
- b. Stage 4 Congestive Heart Failure
- c. Stage 4 Exocrine Pancreatic Cancer
- d. Stage 4 Distal Esophageal Cancer
- e. Stage 4 Liver Cancer
- f. Stage 4 Stomach Cancer
- g. Stage 4 Non-small Cell Lung Cancer

See section 17 (Advance Terminal Illness condition definitions) for further definition of these conditions.

Booster may amend the list of Advance Terminal Illness Benefit conditions from time to time if, based on medical advice, the medical outlook for the relevant condition has improved. We will give you 30 Days' notice before this change takes effect. Any change will not apply if you have already made a claim to Booster for an Advance Terminal Illness Benefit.

2. **Advanced Funeral Benefit:** If the Insured Person dies, we may provide an advance of one payment of \$15,000 from the Life Cover Benefit shared across the Policyowner(s) (or their Estate(s)) on production of evidence (acceptable to us) that a Life Cover claim can be made. The total amount of Cover will be reduced by the amount of this payment. If Life Cover is subsequently declined by Booster, the Advanced Funeral Benefit must be repaid.
3. **Grief Counselling Benefit:** If the full Life Cover Benefit is paid (on death or Terminal Illness diagnosis of the Insured Person) we will pay up to \$2,500 on production of evidence (acceptable to us) to reimburse you for the cost of specialist grief counselling provided to you, the Insured Person's partner or other dependents. The \$2,500 value will only be paid once, is in addition to the Life Cover, is shared across all Policyowners, and must be applied for and paid within 12 months of the main Benefit payment being made.
4. **Insured Person's Child's Funeral Benefit:** If the Insured Person's child dies, on production of evidence (acceptable to us), we will pay:
 - a. \$2,000 if the Insured Person's Child is aged from birth to under 10. This includes still births, provided a death certificate is produced.
 - b. \$5,000 if the Insured Person's Child is aged between 10 and 18 (prior to the Insured Person's Child turning 19)

If parents have more than one Policy with Booster we will only pay one Benefit per Insured Person's Child, shared across the Policyowner(s).

If the death is a result of a condition known at the Policy Start Date or if it occurs within three months of the Policy Start Date, no Benefit payment will be made.

We will not pay a Child's Funeral Benefit if the child's death directly or indirectly arises from an injury caused by you, the Insured Person or the child's parents or guardian(s).

5. **Financial Advice and Other Support:** If a Life Cover claim is paid (including a Terminal Illness claim), your Financial Adviser has agreed to provide reasonable support throughout the process, and advice for you or your family, including financial advice and investment advice services relating to the claim and proceeds.
6. **Special Events Increase - Life:** If the Insured Person is under 50, has a personal risk loading of less than 50% as recorded on the Policy Schedule, has no Policy exclusions or other risk-related terms (called per mille loadings), hasn't been diagnosed with a Terminal Illness, hasn't received (or isn't eligible for) the Advance Terminal Illness Benefit, or claimed, or is eligible for a claim for Total and

Permanent Disability or Trauma and Critical Illness (whether or not Total and Permanent Disability or Trauma and Critical Illness Cover is listed on the Policy Schedule), and any of the following events apply to the Insured Person:

- a. The birth or legal adoption of the Insured Person's Child,
- b. Marrying or entering a civil union,
- c. Dissolution of their marriage or civil union, or being subject to a separation agreement, or the death of a spouse or de facto partner, or
- d. Purchasing a New Home (including a bare block of residential land for the purpose of building a New Home),

you may be able to increase your Life Cover by up to 25% of the Life Underwritten Sum Insured, 25% of the current Life Cover amount, or \$250,000, whichever is lower, without additional medical underwriting. We will ask for additional information from you relating to the Insured Person's lifestyle and occupation and we reserve the right to decline increased Cover, or to adjust it, based on that information.

Any terms and loadings that applied to the Sum Insured (as set out in the Policy Schedule) will apply to the increased Cover. If different parts of the Sum Insured have different loadings and exclusions (as set out in the Policy Schedule) we will apply the increased limit to the part with the lowest loading first.

Other conditions of the Special Events Increase:

- a. If the event is buying a New Home, the increase can be no more than the amount of any loan obtained by the Insured Person to purchase the home.
- b. The Special Events Increase can be applied for once in any 12-month period and only three times over the life of the Policy.
- c. The amount of cover is subject to the maximum Sum Insured limit set out in the Policy Schedule over all policies with Booster.
- d. The increase in Cover must be requested within two months of the event, other than for the New Home purchase, where it must be within one month of the date of you purchasing the home. Evidence of the event is also required within this time (copies of the Insured Person's Child's birth certificate or adoption details, copies of the title to the home and loan details, copies of marriage documents etc). Booster will review and advise if the evidence is acceptable.
- e. If the evidence does not meet our requirements, the Special Events Increase will not be approved.
- f. The Special Events Increase won't be paid if suicide, attempted suicide, or intentional self-injury contributes to or causes the death or Terminal Illness (whether directly or indirectly) within 13 months of the date of the increase. In that case, the Sum Insured prior to this Special Event Increase will apply.

b. Optional Total and Permanent Disability Benefits

Total and Permanent Disability Benefits

This Benefit only applies if there is a Total and Permanent Disability (TPD) Benefit shown on the Policy Schedule.

You will be eligible to claim the TPD – amount of Cover - from the Policy Schedule if, due to illness or injury, as diagnosed by a Medical Specialist, the Insured Person:

- a. Has been unable to work for the prior 6 months and is unlikely to ever be able to work in any gainful occupation for which they are suited (based on their education, training or experience, or future rehabilitation), or
- b. Is totally and permanently unable to perform at least two of the Activities of Daily Living without the assistance of an adult

Cover under the TPD Benefit will end on the Insured Person's 65th birthday.

Cover under the TPD Benefit will end when the TPD Cover Benefit has been paid.

The combined value of Trauma and Critical Illness and TPD amount of Cover cannot exceed the total Life Cover amount or \$500,000, whichever is lower.

When we will not pay Total and Permanent Disability Benefits

No Total and Permanent Disability Benefit will be paid if

1. The Insured Person's Total and Permanent Disability is caused by, or made worse by, their criminal activity
2. The Insured Person's Total and Permanent Disability is a result of self-inflicted harm (including failure to participate in reasonable rehabilitation)
3. You or the Insured Person haven't provided all the information to support the claim, the Insured Person refuses to undergo a medical examination or other tests we consider reasonably necessary to confirm the diagnosis and determine whether the claim can be accepted, or refuses to participate in any rehabilitation
4. Any specific underwriting exclusions, limits or other special acceptance terms apply.
5. The Policy is within a suspension period
6. The illness, injury or condition on which you are claiming arose during the suspension period.
7. Refer to Section 18 for Exclusions that apply to all Benefits.

Accelerated Benefit

Any payment of a TPD Benefit reduces the Life Cover - amount of Cover - by the amount paid.

We'll adjust the premiums for the remaining Life Cover amount to reflect the reduced Cover.

Additional Benefits

1. **Special Events Increase – TPD:** If the Insured Person is under 50, has a personal TPD loading of less than 50% (as shown on the Policy Schedule), has no Policy exclusions or other risk-related terms (called per mille loadings) and doesn't meet the criteria for a Terminal Illness Benefit, the Advance

Terminal Illness Benefit, the Trauma and Critical Illness or TPD benefit (whether or not Trauma and Critical Illness Cover is listed on the Policy Schedule), then a Special Events Increase may be available.

The availability of this Benefit is the same and subject to the same conditions as under the Life Cover Special Events Increase (Section 15 A), and also the following conditions:

- a. The TPD Cover can be increased by up to 25% of the TPD Underwritten Sum Insured, 25% of the current TPD Cover amount, or \$100,000, whichever is lower
- b. The amount of cover is subject to the maximum Sum Insured limit for TPD Cover of \$500,000 (or the maximum Sum Insured limit declared at initial underwriting, whichever is lower).
- c. The combined value of Trauma and Critical Illness and TPD amount of Cover cannot exceed the total Life Cover amount or \$500,000, whichever is lower.

2. **Claims:** Claims for the TPD Benefit require an assessment of medical evidence and/or written opinion from a Medical Specialist confirming:

- a. The Insured Person is unlikely to ever work again, from when the Insured Person has been unable to work, and details of the reason the Insured Person is unlikely to ever work again, or
- b. The Insured Person is totally and permanently unable to perform at least two of the Activities of Daily Living without the assistance of an adult.

We may request that the Insured Person obtain a second medical opinion that we will pay for if needed.

Claims can only be assessed for payment once all information has been received.

c. Optional Trauma and Critical Illness Benefits

Trauma and Critical Illness Benefits

This Benefit only applies if there is a Trauma and Critical Illness Benefit shown on the Policy Schedule.

You will be eligible to claim the Trauma and Critical Illness – amount of Cover - from the Policy Schedule if the Insured Person is diagnosed by a Medical Specialist as having one of the Trauma and Critical Illness conditions, or undergoes one of the defined Trauma and Critical Illness procedures.

Cover under the Trauma and Critical Illness Benefit will end on the insured's 70th birthday.

Cover under the Trauma and Critical Illness Benefit will end when the Trauma and Critical Illness Cover Benefit has been paid.

The combined value of Trauma and Critical Illness and TPD amount of Cover cannot exceed the Life Cover amount, or \$500,000, whichever is lower.

Cover Deferral – Trauma and Critical Illness

Trauma and Critical Illness Cover is subject to a three month stand-down. No Cover is provided if the Insured Person is diagnosed with, has symptoms of, or requires treatment for or by, Cancer, Chronic kidney (renal) failure, Heart Attack, Stroke, Major Organ Transplant, Coronary Artery Bypass Graft Surgery, Triple Vessel Angioplasty, Heart Valve Surgery, or Repair to the Thoracic or Abdominal Aorta within three months of the Policy Start Date (or Reinstatement Date). This deferral period will also apply to the amount of any increase in Cover, where we have agreed to an increase. Premiums are payable during the stand-down period.

The Cover Deferral (the stand-down period) will be waived by us if this Cover is replacing cover under another policy of the Insured Person that we determine to have equivalent Trauma and Critical Illness cover to Cover under this Policy – during the three-month Cover Deferral we will provide Cover up to the same level as the original policy (but not greater than Cover under this Policy). Proof of the other policy must be provided within 30 Days of the Policy Start Date so that we can confirm equivalence, and any stand down period under the other policy must have already been fully served and the original policy must be cancelled.

When we will not pay Trauma and Critical Illness Benefits

No Trauma and Critical Illness Benefit will be paid if

- a. The illness, condition or need for procedure is caused by, or made worse by, involvement in criminal activity.
- b. The illness, condition or the need for procedure is a result of self-inflicted harm (including but not limited to drug or alcohol abuse).
- c. If treatment isn't necessary.
- d. You or the Insured Person hasn't provided all the information to support the claim, the Insured Person refuses to undergo a medical examination or other tests we consider necessary to confirm the diagnosis and assess a claim and determine the claim can be accepted.
- e. Any specific underwriting exclusions, limits or other special acceptance terms apply.
- f. Your Policy is within the suspension period.
- g. The illness, injury or condition on which you are claiming arose during the suspension period.
- h. The illness, injury or condition on which you are claiming arose during the Cover Deferral period, and is one of the illnesses, injuries to which the Cover Deferral applies.
- i. Refer to Section 18 for Exclusions that apply to all Benefits.

Accelerated Benefit

The payment of the Trauma and Critical Illness Benefit will reduce the Life Cover by the amount paid.

We'll adjust the premiums for the remaining Life Cover amount to reflect the reduced Cover.

Additional Benefits

1. **Special Events Increase – Trauma and Critical Illness:** If the Insured Person is under 50, has a personal Trauma and Critical Illness loading of less than 50% (as shown on the Policy Schedule), has no Policy exclusions or other risk-related terms (called per mille loadings) doesn't meet the criteria for the Advance Terminal Illness Benefit, the Trauma and Critical Illness or TPD Benefit (whether or not TPD Cover is listed on the Policy Schedule), then a Special Events Increase may be available.

The availability of this Benefit is the same and subject to the same conditions as under the Life Cover Special Events Increase 15 A, and also the following conditions:

- a. The Trauma and Critical Illness Cover can be increased by up to 25% of the underwritten Trauma and Critical Illness Sum Insured, the 25% of the current Trauma and Critical Illness amount of Cover, or \$100,000 whichever is lower
- b. The amount of cover is subject to the maximum Sum Insured limit for Trauma or Critical Illness Cover of \$500,000 (or the maximum Sum Insured limit declared at initial underwriting, whichever is lower).
- c. The combined value of Trauma and Critical Illness and TPD amount of Cover cannot exceed the total Life Cover amount or \$500,000, whichever is lower.

2. **Claims:** Claims for the Trauma and Critical Illness Benefit require an assessment of medical evidence and/or written opinion from a Medical Specialist confirming that the Trauma and Critical Illness condition has been satisfied as per the Trauma and Critical Illness definitions in Section 16 (List of Trauma and Critical Illness conditions covered by the Policy).

16. List of Trauma and Critical Illness conditions covered by the Policy

Triple Vessel Angioplasty:

Means undergoing medically necessary coronary artery angioplasty to correct or treat a narrowing or blockage of three or more different coronary arteries within the same procedure or by multiple procedures within a 60-Day period.

Advanced Dementia (including Alzheimer's disease) of specified severity:

Means the unequivocal diagnosis by an appropriate Medical Specialist of advanced dementia (significant cognitive impairment, abnormal behaviour, or deterioration of intellectual capacity) as measured by a recognised cognitive assessment tool such as a Mini-Mental State Examination (MMSE) with a score of 20 or less out of 30, or other appropriate cognitive assessment tool with equivalent level of severity and that results in the person requiring permanent supervision to ensure their safety.

Repair to the Thoracic or Abdominal Aorta (excluding its branches) – with specified treatment:

Means the repair or correction of any narrowing, dissection, rupture or aneurysm of the thoracic or abdominal aorta (but not any of its branches) either through open thoracic or abdominal surgery or Endovascular Aneurysm Repair (EVAR).

Angioplasty and other non-surgical techniques are excluded.

Aplastic Anaemia:

Means irreversible bone marrow failure resulting in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of:

- Marrow stimulating agents;
- Bone marrow transplant;
- Peripheral blood stem cell transplantation;
- Blood product transfusions; or
- Immunosuppressive agents.

Benign brain or spinal cord tumour (with permanent neurological impairment or requiring specified treatment):

Means a non-cancerous tumour of the brain or spinal cord that results in:

- Neurological damage and functional impairment which an appropriate Medical Specialist considers permanent, or
- The medically necessary surgical removal of the tumour.

The tumour must be confirmed by imaging studies such as a computed tomography (CT) or magnetic resonance imaging (MRI) scan.

The following are excluded:

- Pituitary Neuroendocrine Tumours (PitNETs).
- Cysts, granulomas and cerebral abscesses.
- Cholesteatomas.
- Malformations in or of the arteries or veins of the brain or spinal cord.
- Haematomas.

Loss of sight in Both Eyes (severe and permanent):

Means irreversible loss of sight in both eyes to the extent that:

- Visual acuity is 6/60 or less in both eyes after correction, or
- Field of vision is restricted to 20 degrees or less in both eyes, or
- A combination of visual defects resulting in the same degree of visual impairment.

Blindness due to cataracts is excluded.

The loss of sight must be confirmed by an appropriate Medical Specialist.

Coronary Artery Bypass Graft Surgery:

Means the actual undergoing of bypass graft surgery, either through an open-heart operation or through a 'key-hole' surgical technique, to one or more blocked coronary arteries.

The procedure should be considered medically necessary by a cardiologist.

Cancer - excluding specified early-stage cancers:

Means the confirmed diagnosis of the presence of one or more malignant tumours characterised by the uncontrolled growth and spread of malignant cells, and the invasion and destruction of normal tissue beyond the basement membrane as confirmed histologically by a pathologist.

The term malignant tumour also includes sarcoma, leukaemia, lymphoma, multiple myeloma, and inaccessible brain tumours described as malignant on neuroimaging.

The following are specifically excluded:

- Tumours which are histologically classified as 'pre-malignant', 'non-invasive', 'high-grade dysplasia', 'borderline' or 'having low malignant potential'.
- All carcinoma in situ except carcinoma in situ of the breast where a total mastectomy was performed and was considered to be the appropriate and necessary treatment.
- All cancers of the prostate unless histologically classified as having a Gleason score of 7 or above; or having progressed to at least clinical stage T2 on the TNM clinical staging system; or where a total prostatectomy has been undertaken and was considered to be the appropriate and necessary treatment.
- All cancers of the thyroid unless having progressed to at least TNM classification T2N0M0, or where a total thyroidectomy has been undertaken and was considered to be the appropriate and necessary treatment.
- All cancers of the bladder unless having progressed to at least TNM classification T1N0M0.
- Cutaneous lymphoma confined to the skin.
- Chronic lymphocytic leukaemia unless having progressed to at least Rai stage I.
- All non-melanoma skin cancers unless greater than 4cm or having invaded perineural tissue or beyond the subcutaneous fat, or where there is evidence of spread to bone, lymph nodes or other distant organs.
- All melanomas less than 1mm thickness as determined by histological examination and which is also less than Clark Level 3 depth of invasion.
- Pituitary Neuroendocrine Tumours (PitNETs) unless invasion of surrounding structures or metastasis is unequivocally proven histologically and/or radiologically by Magnetic Resonance Imaging (MRI).
- Dermatofibrosarcoma protuberans confined to the skin and that has not spread to the lymph nodes or distant sites.
- Polycythemia Rubra Vera, unless requiring cytoreductive therapy and/or surgery.
- Essential thrombocythemia, unless requiring cytoreductive therapy or surgery.
- Thymoma gland tumours without evidence of invasion and destruction of surrounding tissue

Cardiomyopathy- severe and permanent:

Means an unequivocal diagnosis, by an appropriate Medical Specialist of impaired ventricular function of variable aetiology resulting in:

- Permanent and irreversible physical impairments to at least Class 3 of the New York Heart Association classification of cardiac impairment, or
- A persistent left ventricular ejection fraction of less than or equal to 35% despite optimal medical therapy.

Chronic kidney (renal) failure – with specified treatment:

Means end stage kidney disease presenting as chronic irreversible failure of both kidneys to function, requiring either regular renal dialysis or kidney transplantation.

The definition will also be met if, despite the need for regular renal dialysis or a kidney transplant as confirmed by a nephrologist, the insured chooses renal supportive care.

Chronic (decompensated) liver failure – of specified severity:

Means end stage irreversible liver failure with one of the following symptoms:

- Permanent jaundice;
- Chronic ascites; or
- Hepatic encephalopathy.

Chronic lung failure – of specified severity:

Means chronic irreversible lung disease that has progressed to an advanced stage with either a PaO₂ consistently less than 55mmHg or requiring long term oxygen therapy of at least 15 hours per Day, as certified by an appropriate Medical Specialist.

Coma - with specified severity:

Means a prolonged state of unconsciousness characterised by abnormal response to external stimuli, with a Glasgow Coma Score (GCS) of six or less and requiring mechanical ventilation for a continuous period of at least 72 hours.

The diagnosis of coma must be made by an appropriate Medical Specialist.

Excluded from this definition is coma as a result of excessive alcohol use or illicit substance use.

Deafness in Both Ears (profound and permanent, or requiring cochlear implant):

Means a confirmed diagnosis of profound, irreversible hearing loss in both ears with any one of the following:

- Best corrected hearing threshold of 91 decibels or greater in the better ear, averaged at frequencies from 500 hertz to 3,000 hertz, or
- Requiring or undergoing cochlear implant due to profound loss of hearing in both ears.

The diagnosis must be made by an appropriate Medical Specialist.

Heart Attack:

Means the death of a portion of the heart muscle because of inadequate blood supply to the relevant area. The diagnosis must be supported by diagnostic rise and/or fall of cardiac biomarkers with at least one value above the

99th percentile of the upper reference limit and at least one of the following:

- Signs and symptoms of ischaemia consistent with a heart attack;
- ECG changes indicative of new ischaemia (new ST-T changes or new left bundle branch block);
- Development of pathological Q waves on the ECG;
- Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality; or
- Identification of a coronary thrombus by angiography or other intracoronary imaging.

We will consider other appropriate and medically recognised tests where the above evidence is inconclusive or superseded by technological advances.

The following are excluded:

- A rise in biological markers because of an elective percutaneous procedure (such as coronary stent insertion) for coronary artery disease.
- Other acute coronary syndromes including but not limited to angina pectoris.
- Other causes of increased troponin levels in non-obstructive coronary arteries including myocarditis or coronary spasm where there is no evidence of infarction.
- Any cardiomyopathy including Takotsubo cardiomyopathy (Takotsubo Syndrome).

Heart valve surgery:

Means surgery to replace or repair heart valves because of heart valve defects or abnormalities. This excludes angioplasty, intra-arterial procedures or non-surgical techniques.

Loss of Independent Existence - total and permanent:

Means any illness or injury that results in the Insured being permanently unable to perform 2 or more of the Activities of Daily Living without total dependence on another person.

Major burns of the skin (of specified severity and requiring specified treatment)

Means deep partial-thickness burns or full thickness burns to the skin requiring surgical debridement and skin grafting or flap reconstruction.

The burns must involve one of the following:

- 20% of the total body surface area as measured by the Lund-Browder Chart or 'Rule of Nines';
- 50% of the total combined area of both hands;
- 50% of the total combined area of both feet; or
- 25% of the face.

The diagnosis must be confirmed by a relevant appropriate Medical Specialist.

Major organ transplant:

Means has undergone, or been placed on a recognized organ transplant waiting list in New Zealand or Australia for transplant from a human donor of one or more of the following complete organs:

- Kidney
- Heart
- Lung
- Liver (including partial liver transplants)
- Pancreas
- Small bowel, or
- Bone marrow.

Motor neurone disease:

Means the unequivocal diagnosis of motor neurone disease by a neurologist and confirmed by neurological investigation.

Muscular dystrophy:

Means the unequivocal diagnosis of muscular dystrophy by an appropriate Medical Specialist.

Multiple Sclerosis – with specified severity:

Means the unequivocal diagnosis by a neurologist of multiple sclerosis that has resulted in persistent neurological impairment resulting in one of the following:

- An Expanded Disability Status Scale (EDSS) of 7.5 or more; or
- Permanent inability to perform at least one of the Activities of Daily Living without total dependence on another person.

Clinically isolated syndromes are excluded.

Idiopathic Parkinson's Disease:

Means the unequivocal diagnosis of idiopathic Parkinson's Disease as confirmed by a neurologist.

Loss of limbs – total and permanent:

Means the total and permanent loss of use of two or more limbs caused by an illness or injury. In this case, limb is a whole hand or whole foot.

For the purpose of this definition 'loss of use' means the inability to use the affected limb in a meaningful or practical way, such as holding, grasping, typing, carrying, standing or walking.

Stroke:

Means an acute cerebrovascular event resulting in death of brain tissue and neurological deficit lasting more than 24 hours and caused by one of the following:

- Focal ischaemia (infarction) of brain tissue; or
- Haemorrhage (intracerebral, intraventricular or subarachnoid)

Findings on MRI, CT, or other reliable neuroimaging evidence must be consistent with the diagnosis of a new stroke.

The following are excluded:

- Transient ischaemic attacks.
- Brain damage due to accident, injury, infection, demyelination or non-vasculitic inflammatory disease.
- Any vascular disease affecting the vestibular system, eye, retina or optic nerve (including retinal artery and venous occlusive events).
- Migraine.
- Subdural and/or epidural haematoma.

17. Advance Terminal Illness condition definitions

- Motor Neurone Disease - the unequivocal diagnosis of any of the following types of motor neurone disease, made by a neurologist and supported with appropriate tests:
 - Amyotrophic lateral sclerosis (ALS);
 - Progressive muscular atrophy (PMA);
 - Primary lateral sclerosis (PLS);
 - Progressive bulbar palsy (PBP);
 - Flail arm (or leg) syndrome; or
 - ALS-plus syndrome.
- Stage 4 Congestive Heart Failure – an unequivocal diagnosis by a cardiologist of advanced, refractory heart failure resulting in both of the following despite optimal medical therapy:
 - Permanent and irreversible physical impairments to at least Class 4 of the New York Heart Association classification of cardiac impairment, and
 - A persistent left ventricular ejection fraction of less than or equal to 30%.
- Stage 4 Exocrine Pancreatic Cancer - the confirmed diagnosis the cancer has progressed to Stage 4 using the AJCC TNM classification
- Stage 4 Distal Esophageal Cancer - the confirmed diagnosis the cancer has progressed to Stage 4 using the AJCC TNM classification
- Stage 4 Liver Cancer - the confirmed diagnosis the cancer has progressed to Stage 4 using the AJCC TNM classification
- Stage 4 Stomach Cancer - the confirmed diagnosis the cancer has progressed to Stage 4 using the AJCC TNM classification
- Stage 4 Non-small Cell Lung Cancer - the confirmed diagnosis the cancer has progressed to Stage 4 using the AJCC TNM classification

18. Exclusions that apply to all Benefits

We will not pay any Benefit under this Policy if the claim is due, directly, or indirectly to, any of the following:

- War (whether declared or not), invasion or any act of war
- Terrorism or any acts of terrorism
- Act of a foreign enemy
- Hostilities, strike, riot or civil commotion
- Civil war, rebellion, revolution or insurrection

19. Making a Claim

If you need to make a claim, contact the Financial Adviser linked to this Policy, as soon as possible and they can provide you with the correct claim forms and help guide you through the process. The Financial Adviser is there to help you. You may contact us directly if you wish. If there is more than one Policyowner, the claim form must be completed and signed by all Policyowners unless we agree otherwise at our discretion. The claim form will contain the bank account to which we will pay the proceeds.

Any medical information needed to support the claims must be provided by an appropriately qualified Medical Practitioner registered in New Zealand or Australia. Expenses incurred in evaluating your claim are paid for by you. We may request that the Insured Person obtain a second medical opinion that we will pay for if needed.

If in certain circumstances, it is not possible to pay the Policyowner, Booster will follow an applicable court directed action or other legal process as applicable.

You and the Insured Person must tell us honestly and truthfully everything either of you knows that could affect how we consider your claim. Providing information that is untrue, incorrect, or incomplete may result in us not paying a claim.

You and the Insured Person may need to send us supporting documents giving us the information we need to assess your claim.

We can request further tests, examinations or evidence beyond these documents to assess the claim. This could include but is not limited to:

- examination by a Medical Specialist that we choose,
- capacity and occupational assessments.

We can only assess a claim for payment once we receive all required information.

Claims will be paid to New Zealand bank accounts only, in New Zealand dollars.

20. Definitions

Activities of Daily Living:

1. **Personal hygiene** - Needs help in all areas of bathing or showering (including washing of face, trunk, extremities and perineum), maintaining dental hygiene, nail and hair care, and would be unsafe if left alone.
2. **Dressing** - Needs help in all areas of getting dressed (including selecting appropriate clothes and putting them on as well as putting on socks/stockings and shoes).
3. **Feeding** - Needs help in most areas of feeding and drinking or requires parenteral nutrition. It does not include being unable to prepare the food.
4. **Toileting** - Needs help with transferring to the toilet and cleaning him/herself, or uses a bedpan or commode
5. **Continence** - Has lost all physical or mental ability to use the toilet and needs help in all areas relating to toileting including any of the following:

- a. Requiring a permanent urinary catheter, or
- b. Requiring a permanent colostomy, or
- c. Being totally incontinent (having total loss of control over their bowel or bladder)

6. **Mobility in bed or chair** - Needs help in all areas of mobility (including shifting from one seat to another or transferring from bed to chair) or is bedridden.

Advance Terminal Illness: An illness which, under this Policy, entitles an advance payment of Life Cover

Benefit: An entitlement you have or a payment we make based on the circumstances described in section 15. Your Cover has both built-in and optional benefits. Built-in benefits are part of the Cover. Optional benefits are ones that you can choose to add.

Cover: The type and amount of insurance you have selected in your Policy. There are several different types of insurance available under this Policy. You may have selected some of these but not others.

Cover Deferral: In the case of Trauma and Critical Illness, the three-month stand-down period from Policy/Benefit inception, reinstatements and increases, where listed conditions will not be covered, unless proof of existing and equivalent cover is provided and approved by Booster.

Days: Calendar days.

Estate: The legal personal representatives of a person who has died.

Expiry Age: The Cover will expire on the Insured Person's Expiry Age birthday.

Financial Adviser: The Booster affiliated financial adviser who provides ongoing support for this Policy.

Free Look Period: The period of 30 Days from the Policy Start Date (other than at reinstatement) during which the Policyowner can cancel the Policy and receive a refund of premiums paid.

Insured Event: An event covered by the Policy, being death, Terminal Illness, diagnosis of certain other illnesses or conditions, some defined treatments, and Total and Permanent Disability.

Insured Person: The person whose life (or other Insured Event) is covered under a Policy.

Insured Person's Child: Biological or legally adopted child of the Insured Person, up to the age of 18.

Life Cover: The Cover under Part A of section 15 of this Policy.

Maximum Entry Age: The oldest age a person may be when applying for a policy or benefit.

Minimum Entry Age: The youngest age a person may be when applying for a policy or benefit.

Medical Practitioner: A health practitioner, approved by us, who is registered with the Medical Council of New Zealand as a practitioner of the profession of medicine. That person cannot be You or the Insured Person, or the spouse or partner or business partner of You or the Insured Person, or anyone who is related to or closely associated with You or the Insured Person in any way.

Medical Specialist: A practising medical specialist, approved by us, registered to practise their medical specialty within New Zealand, and whose specialty qualifies them to make a diagnosis, recommend a treatment, or make a prognosis (related to an Insured Event). That person cannot be You or the Insured Person, or the spouse or partner or business partner of You or the Insured Person, or anyone who is related to or closely associated with You or the Insured Person in any way.

New Home: A dwelling purchased and used as primary residence of the Insured Person, including a block of residential land for the purpose of building a new home.

Personal or Supplementary Statements: Any information provided by the Insured Person or Policyowner during the application process, reinstatement process, or where a change to Policy is requested by you or the Insured Person.

Policy: The policy as described in section 2.

Policyowner: The owner of the Policy (who may be different from the Insured Person).

Policy Schedule: The schedule issued with this Policy, and any replacement schedules issued to you throughout the term of this Policy. New schedules will be issued when the Cover provided under your Policy changes.

Policy Start Date: The date on which Booster has confirmed Cover will commence from, which includes reinstatement Cover.

Regular Premium Payable Date: The date on which regular premiums will be made for the life of the Policy, selected at application. If this date is more than 14 Days from the Policy Start Date, an initial first premium payment, which may include a prorated payment, will need to be made too.

Renewal Date: The date on which the Policy will automatically renew. It is the same Day and month annually of the first Regular Premium Payable Date.

Reinstatement Date: The date we reinstate the Policy. This only applies if the Policy has been terminated for non-payment and we accept the reinstatement.

Special Events Increase: An increase in the Sum Insured based on certain conditions, where no new medical underwriting is required.

Sum Insured: The Benefit amount that will be paid (to you, or your Estate) for the type of insurance selected (if an Insured Event occurs).

Terminal Illness: A Medical Specialist considers that even with available treatment, the Insured Person has 12 months or less to live.

Total and Permanent Disability / TPD: An illness or injury which results in the Insured Person meeting the definition as stated in Section 15 Part B - Total and Permanent Disability Benefit.

Trauma and Critical Illness / T&CI: A condition as listed in Section 16 – List of Trauma and Critical Illness conditions covered by the Policy.

Underwritten Sum Insured: The original Sum Insured when Cover was applied for without any subsequent Special Events Increase or inflation increase.

21. Contacting us

Call us on **0800 336 338**, Monday to Friday 8am – 8pm.

If you're overseas, call **+64 4 894 4300**.

Email us at **insurance@booster.co.nz**

All written correspondence will be sent to the email address or addresses provided in the application, or as updated from time to time.

Through the application process, we will correspond with the Insured Person. From the Policy Start Date, we will generally correspond with the Insured Person and Policyowner(s) (and, if different, the person paying premiums).

The Financial Adviser linked to this Policy may also contact us on your behalf during the course of them providing financial advisory services to you. In some instances, we may need to get your (and any other Policyowner's) direct authorisation before we may respond.

22. Jurisdiction

The Policy is governed by New Zealand law.

23. Complaints

If you have a complaint, we are happy to discuss it. Please contact us in the first instance, our customer care centre will do our best to resolve your issue.

We are a member of the Financial Dispute Resolution Service, a free and independent service which can help settle any dispute you are unable to resolve with us.

Financial Dispute Resolution Service contact details are:

Post: Freepost 231075, PO Box 2272,
Wellington 6140.

Phone: 0508 337 337.

Email: enquiries@fdrs.org.nz.

Website: www.fdrs.org.nz.



We're here to help.

To find out more about
Booster SmartCover, talk to your
financial adviser, visit our website,
or call us on **0800 336 338**.

booster.co.nz

Booster Investment Management
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