Claiming Total and Permanent Disablement (TPD) insurance guide

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We understand this can be a difficult time. Our aim is to make the process of making a claim as easy as possible.

This guide will help you understand the process of applying for a Total and Permanent Disablement (TPD) insurance benefit. Please read this guide along with the *Claiming TPD insurance: Frequently Asked Questions*. You can access this document at **virginmoney.com.au/super-insurance**.

What is TPD cover?

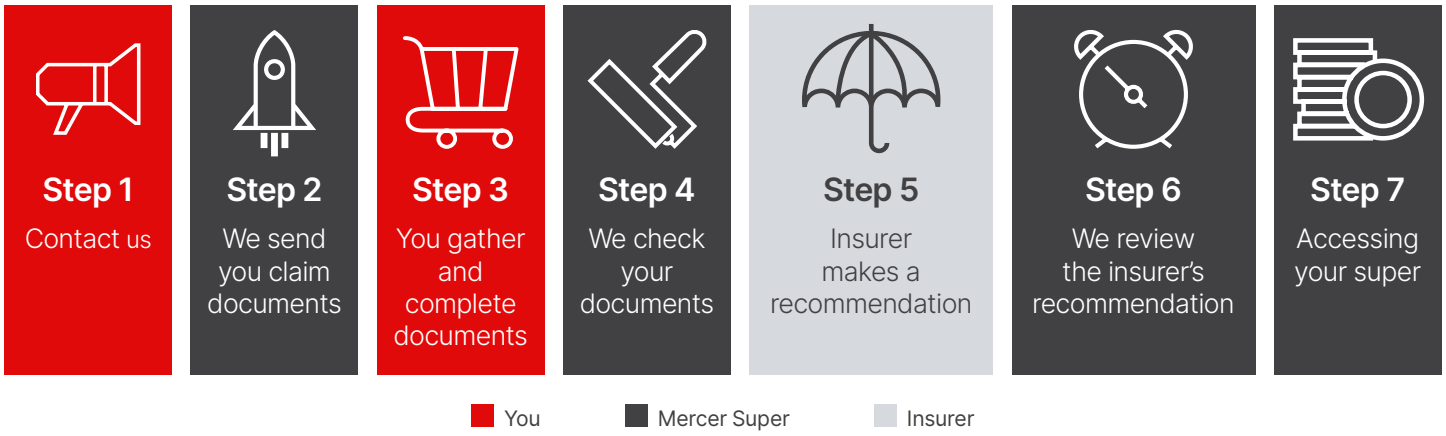
Generally, Total and Permanent Disablement (TPD) insurance provides a lump sum benefit payment if you become permanently disabled due to illness or injury, and solely because of that illness or injury you're unlikely to ever work again.

Accessing a TPD benefit and your super balance

To access your superannuation account balance, which includes any TPD payment from the insurer, you must meet a condition of release called Permanent Incapacity.

For further information on any of the above, please refer to the FAQs.

Steps to claim a TPD insurance benefit



Processing times

TPD benefit processing times can vary. We aim to complete the claims process (including payment) within six months from the date you notify us of your decision to claim.

While we aim to keep the process as smooth as possible, some factors may affect processing times and could potentially extend it to over 12 months or more, such as:

- The time it takes for you to send us all the required documentation
- Any additional medical information required and the time it takes to receive the reports
- The complexity of your claim

Step 1: Contact us

To start the claims process, call us on **1300 217 430**, Monday to Friday 9am-5pm (AEST/AEDT), or email us at **virgininsurance@mercer.com**. If you're calling from overseas, please call us on **+61 3 9192 4419**.

If a claims specialist isn't available when you call, we'll return your call within one business day.

Information to have ready

When you call, please have the following things with you:

- Full name
- Address
- Date of birth
- The date you stopped working due to your medical condition
- Customer number (if you know it)

If you choose to email us, we'll need the same information and a contact phone number.

What to expect

During the call, we may ask you further questions. This ensures we provide you with the correct information and forms for your situation.

How to stay in touch

Tell us how you'd like us to contact you – by email, phone or post. We'll check in every 20 business days using your preferred method, unless you let us know something different.

Step 2: We send claim documents

This step will be completed within five business days after we receive enough information to confirm your eligibility to claim.

Your Case Manager will be your main contact to help you start your claim. They'll send you a set of documents within **five business days** using your preferred contact method.

If your Case Manager is unavailable, our dedicated Claims team will help you.

Step 3: You gather and complete the documents

Now that you've received the claims documents, it's time to gather the information and complete the necessary forms. Please call your Case Manager if you need help.

Here's what you need to do:

1. Read the instructions: Carefully read through all the documents you received. Make sure you understand what is required for each
2. Complete the forms
3. Collect supporting documents
4. Prepare your ID

Here's a list of some of the documents you may need:

- Insurer Claim forms
- Medical Practitioner form (to be completed by your treating doctor)*
- Any medical reports to support your claim*
- Employer statement (to be completed by your last employer)
- Original certified copies of your ID**
- Authority to access medical information
- Information about your employment history. Sometimes we need a copy of your job description, pay and leave records from your last employer

Everyone's situation is different, so some of these documents may not apply to you.

Important information

* You will need to pay any costs associated with obtaining documents from your doctor as part of making a claim. If you do not have some or all of the documents we need, please get in touch as incomplete documents could delay your claim.

** There are alternative methods to confirm your identity. Your Case Manager will be able to help you with other options to identify yourself. For more information about certified identification, including how to get your documents certified, please read the *Completing proof of identity factsheet*. You can find this at: **virginmoney.com.au/super/proof-of-identity**.

Returning the documents

Once you've gathered and completed all necessary documents, you'll need to send them back to us. If you require assistance in returning your documents, please contact your Case Manager.

Step 4: We check your documents

This step may take up to ten business days.

When we receive your completed documents, we'll review them to ensure you've provided everything we need within ten business days. If anything is missing, or unclear, we'll contact you.

Insurance checks

We'll verify that you had insurance cover available to claim on the date of your disablement.

Here's what we'll check

1. Premiums were paid on time, and cover hadn't stopped because the balance in the account was too low to pay the premiums.
2. Cover wasn't cancelled by you or under superannuation law. This includes after 16 months of inactivity without your instructions to continue the insurance.
3. Any other terms and conditions that may have caused the cover to stop or prevent the claim being paid.

If you're not eligible to make an insurance claim, we'll let you know and explain why. You'll have the opportunity to provide more information if needed.

Sending the claim to the insurer

Once we've received the minimum insurance requirements as outlined in the letter from your Case Manager, completed all the insurance checks, and confirmed the insurance was current at your date of disablement, we'll send your claim to the insurer.

Step 5: Insurer makes a recommendation

This step may take the insurer up to two months, unless there are circumstances beyond their control*

The insurer will assess your claim and determine if you meet their definition of Total and Permanent Disablement.

Check for exclusions

There may be limitations and exclusions that apply to your cover. If this is the case, the insurer will let you know.

Request for more information

The insurer might ask for more information from you or us. If they request further medical information from your doctors, the insurer will cover these costs.

It's important to note that this could extend the time it takes for the insurer to make their recommendation.

Recommendation by the insurer

Once the insurer is satisfied they have all the information, they'll recommend to either:

- Accept (pay the claim) or
- Decline (not pay the claim).

They will inform us of their recommendation.

* Circumstances Beyond the Insurer's Control, as defined in the Life Insurance Code of Practice. For example:
  - The insurer has been unable to contact you about your claim.
  - You have not responded to the insurer's reasonable enquiries or requests for documents in a reasonable timeframe.

The code ensures a consistently high level of product and service standards for life insurers to abide by for life insurance policies issued within Australia.

Step 6: We review the insurer's recommendation

This step should take up to 15 business days.

If your claim is accepted

If the claim is accepted, we'll let you know within five business days. At this time we'll also allocate the insurance benefit into your super account.

If your claim is declined

If the insurer's recommendation is to decline the claim, we'll review their recommendation within **15 business days**. If exceptional circumstances apply and we need more time, we'll write to you to explain why.

Advocating for you

If we disagree with the insurer's recommendation to decline the claim, we have a legal obligation to advocate on your behalf if there is a reasonable prospect of the insurance claim being successful.

We'll keep you updated as we work through our review with the insurer.

If we agree with the insurer's recommendation to decline

If we agree with the insurer's recommendation to decline the claim, we'll let you know our reasons within **five business days** of completing our review. This will also include an explanation of the insurer's reasons for not paying the benefit.

Next steps for you

If your claim is declined, we'll provide you with the following options:

- The opportunity to provide further information and request a review of the insurer's decision
- Information about the complaints process

Important information

If your claim is declined for TPD cover you may be eligible for a Permanent Incapacity payment (which is your super account balance only).

Step 7: Accessing your super

This step should take five business days after all documents are received and reviewed, and provided the trustee is satisfied that you meet the condition of release.

If your TPD claim is approved by the insurer, any payment will go into your super and form part of your account balance.

Withdrawing from your super account

To withdraw any funds from your super account the trustee must be satisfied that you meet the condition of Permanent Incapacity. This means they must determine that you're unlikely to engage in a job for which you're reasonably qualified (by education, training or experience) because of physical or mental ill health.

If you withdraw your entire super benefit, you will lose any remaining insurance you currently have. If you want your remaining insurance to continue you will need to leave a sufficient balance in your account to fund future premiums.

This information is intended as a guide only and does not constitute advice. Before making a withdrawal, you should speak to a licensed financial adviser about the impacts this could have on your remaining insurance entitlements.

Documents we may need from you

To finalise your payment, we might need you to provide the following documents. We'll let you know if these are required:

- Original certified copy of your ID (this must be by post)*
- A completed Permanent Incapacity form (by post or email). This form will include a request for:
  - Your personal details
  - Payment instructions
  - Your banking details
  - Two completed statements from legally registered medical practitioners (for example your local GP/doctor) that we sent you in the initial claim pack

* For more information about certified identification, including how to get your documents certified, please read the *Completing proof of identity factsheet*. You can find this at: **virginmoney.com.au/super/proof-of-identity**.

Important information

You will need to pay any costs associated with obtaining documents from your doctors.

Receiving your payment

Once we confirm that you meet the condition of release, we'll process your payment as per your instructions.

Advice options

There may be financial or tax implications you should consider when accessing your benefit. Advice from a licensed professional, such as a financial adviser, may be helpful to decide the best option for you when it comes to your superannuation benefits.

If you're experiencing financial hardship, you may be able to access some of your super to meet reasonable and immediate living expenses.

We're here to help

Speak with one of our Claims consultants on **1300 217 430**, Monday to Friday 9am-5pm (AEST/AEDT). If you're calling from overseas, please call us on **+61 3 9192 4419**.

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