MLC MasterKey Super Fundamentals

Claims Guide

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Issued by The Trustee
NULIS Nominees (Australia) Limited
ABN 80 008 515 633 **AFSL** 236465

The Fund
MLC Super Fund
ABN 70 732 426 024

Contents

The information in this document forms part of the **MLC MasterKey Super and Pension Fundamentals Product Disclosure Statement (PDS)** dated 1 April 2020

Together with the **Fee Brochure, Investment Menu, Pension Guide, Investment Protection Guide** and **Claims Guide**, these documents should be considered before making a decision to invest. They are available at **mlc.com.au/pds/mkspf**

Insurance is offered to members under insurance policies issued to the Trustee by the insurer. The insurance cover provided is subject to the terms and conditions contained in the insurance policies issued to the Trustee by the Insurer. The terms and conditions of the policies prevail over any inconsistent information in the **PDS, the Insurance Guide** or this **Claims Guide**. The insurance information provided in the **PDS**, the **Insurance Guide** and this **Claims Guide** is based on the policies issued by the Insurer, and information provided by the Insurer about the operation of the policies. **Insurance benefits will only become payable if the insurer accepts the relevant claim**. Payment of any approved claim will be made by the insurer to the Trustee and any insured benefit and any account balance can only be paid to you by the Trustee when a condition of release under the Superannuation Industry (Supervision) Act 1993 is met. The insurer is not a part of the NAB Group of Companies.

The information in this guide is general information only and doesn't take into account your personal objectives, financial situation or needs. Because of this, before acting on this information, you should consider its appropriateness having regard to your personal objectives, financial situation and needs. We recommend you obtain financial advice tailored to your own personal circumstance.

The information in this document may change from time to time. Any updates that aren't materially adverse will be available on **mlc.com.au/pds/mkspf** You can obtain a paper copy of any of these changes at no additional cost by contacting us.

References within this guide to 'we', 'us' or 'our' are references to the Trustee, unless otherwise stated.

For more information please contact us or speak with your financial adviser. An online copy of this document is also available on **mlc.com.au/pds/mkspf**

Support when you need it most

This **Claims Guide** will help you understand the process required to finalise your claim as simply and quickly as possible so it can be assessed by the insurer.

Our **Claims Philosophy** is to:

- make prompt payments
- communicate the process clearly
- treat our claimants, members and their beneficiaries with the utmost respect and empathy at all times, and
- pursue claims on the member's behalf that we consider both reasonable and have reasonable prospect of success.

We adopt a professional, compassionate and positive approach to claims management and actively seek to keep members at the heart of everything we do. We acknowledge that each claim is unique and must be dealt with on its own merits and we're committed to being easy to deal with and providing outcomes to our members in a timely manner.

Managing your claim

Your claim is unique. That's why we'll take care to assess your personal situation on its own merits. When your claim is lodged with the insurer, you'll be appointed a **dedicated claims assessor** to guide you through the entire claims process. If you need help with the claims process, understanding what's required of you, completing claim forms or providing requested claim information, we'll work with you and the insurer to find a solution.

If you like, you can appoint a representative on your claim form 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 members. We'll do this by providing insurance arrangements that aim to help support you and your beneficiaries at a time when it is needed most.

Once you've supplied your complete claims pack, we'll do everything reasonable to pursue your claim with the insurer so that it's processed efficiently and fairly.

Role of the insurer

The role of the insurer is to provide us with insurance policies that support the insurance arrangements, and to manage and pay claims covered by those policies.

We'll work with the insurer to make sure that all genuine claims are paid quickly, with a minimum of fuss.

The insurance policy

You'll find specific details about the terms and conditions of the insurance arrangement in the **Insurance Policy** document.

If you'd like a copy of the **Insurance Policy**, please call us on **132 652**.

Do you have cover under other insurance policies?

It's important to check what other insurance policies you hold, particularly if you have more than one super account. If you have multiple insurance policies, you might be paying premiums for policies you don't need.

What's next?

In the following pages of this guide, you'll find claims process information for specific insurance types to help you understand what's required to make a claim and what's involved at each step of the claims management process.

Our claims process

Our insurance claims process typically has six key steps, and there are roles for us, the insurer and you.

1. Make a claim
2. We check your eligibility
3. We submit your claim to the insurer
4. The insurer assesses your claim
5. We review the insurer's decision
6. You'll be provided with an outcome

Step 1: Make a claim

To make a claim, simply call us on **132 652**, we'll explain our claims process.

Step 2: We check your eligibility

We'll ask you some initial questions to assess your eligibility to claim and to make sure we send you the right claims pack.

If you need help with the claims process, understanding what's required of you, completing claim forms or providing requested claim information, we'll work with you and the insurer to find a solution.

Remember, it's important to provide complete and correct details in your claims pack. If you've already submitted a claims pack that may contain incorrect details, please contact us straight away.

Step 3: We submit your claim to the insurer

When we receive your completed claims pack, we'll:

- acknowledge receipt of your claim
- check if it contains all the required information, and
- conduct another assessment of your eligibility to claim.

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 confident you're eligible to claim, we'll direct your claims pack to the insurer.

Step 4: The insurer assesses your claim

The insurer will start assessing your claim when they receive your claims pack and a **dedicated claims assessor** will be appointed to manage your claim. The insurer may need more information to finalise the claim. We or the insurer will let you know if that's the case.

We'll keep you updated throughout the claims process. Of course, you can contact your claims assessor at any time if you have questions.

Step 5: We review the insurer's decision

Once the insurer has made a decision about your claim, our dedicated claims team will review the outcome. If we believe you should have received a different outcome, we'll ask the insurer to reassess your claim.

Step 6: You'll be provided with an outcome

Once we're satisfied with the insurer's decision, we'll confirm the outcome of your claim in writing.

Resolving complaints

If you have a complaint, we can usually resolve it quickly over the phone on **132 652**. If you'd prefer to put your complaint in writing, you can email us at **contactmlc@mlc.com.au** or send us a letter. We'll conduct a review and provide you with a response in writing. For more information, visit **mlc.com.au/complaint**

If you're not satisfied with our resolution, or we haven't responded to you in 90 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 by writing to **GPO Box 3, Melbourne, VIC 3001,** via their website **(afca.org.au)**, by email at **info@afca.org.au**, or by phone on **1800 931 678** (free call).

If you have a complaint about financial advice you receive, you should follow the complaint resolution process explained in the **Financial Services Guide** (FSG) provided by your financial adviser.

Why does it take so long?

It's important your claim is processed correctly. In order for us to do that, we'll work with the insurer to review all the relevant information. This includes information from you, your doctor, medical specialists and your employer. This can take a while – sometimes even months – but we'll make sure we keep you updated.

Total and Permanent Disablement (TPD) insurance

The intention of TPD insurance cover is to pay you a lump sum if you become totally and permanently disabled and you're unable to ever work again due to illness or injury.

When would I make a claim?

Generally, you must have stopped work for a set period of time before you can lodge a TPD claim.

How do I make a claim?

To make a TPD claim, call us on **132 652**. We'll ask you a few questions to form an initial assessment of your eligibility to make a claim, and make sure we send you the correct claims pack to complete.

How will my claim be assessed?

You may be eligible for a TPD benefit if the insurer is satisfied that, due to an illness or injury, you:

- have ceased work, and
- satisfy a TPD definition.

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

The insurer will assess your capacity to work under the definitions that apply to you, based on your ability to perform any reasonably suitable occupation relating to your education, training or experience – not just the occupation you hold when you become injured or ill.

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

Frequently asked questions

What forms need be completed?

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

- Claim form (Completed by you)
- Tax File Number (TFN) Declaration (Completed by you)
- Two Treating Doctors' Reports (Completed by your treating doctors), and
- Employer Statement (Completed by your employer).

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

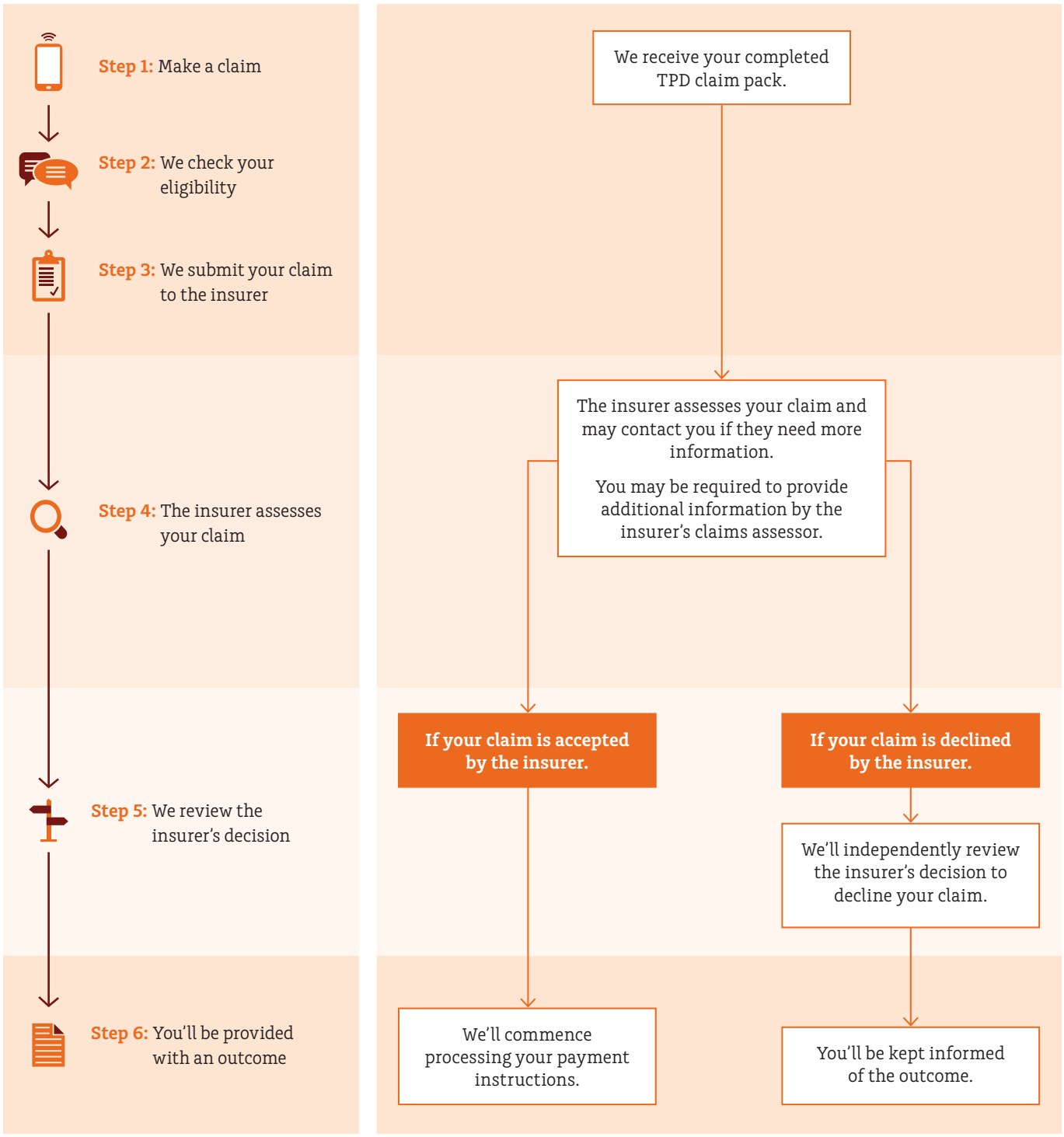
No. Any premiums paid from the date of your disablement will be refunded to your super account.

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

Approved TPD claims can be paid:

- as a lump sum
- as a pension, and
- to another complying super account, via a rollover.

Total and Permanent Disablement (TPD) claims process



Income Protection (IP) insurance

The intention of Income Protection insurance is to provide you with an ongoing income and financial support, should you become temporarily unable to work due to an illness or injury. It can help to give peace of mind knowing you have an income to help pay your expenses while you focus on your health and recovery.

When would I make a claim?

You may start an IP claim if you're temporarily unable to work due to an illness or injury.

How do I make a claim?

To start an IP claim, call us on **132 652**. We'll ask you a few questions to form an initial assessment of your eligibility and make sure we send you the correct claims pack to complete.

How will my claim be assessed?

You may be eligible to claim for an IP benefit if the insurer is satisfied that, due to illness or injury, you're:

- unable to perform at least one of the important duties in your job, and
- in the care of a medical professional related to your illness or injury, and following regular and continuous advice from them, and
- not engaged in any occupation, whether paid or unpaid.

To find out which IP definition applies to you, refer to the **Insurance Guide**.

Frequently asked questions

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

You don't need to wait to lodge a claim.

What forms need to be completed?

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

- Claim form (Completed by you)
- Tax File Number (TFN) Declaration (Completed by you)
- Two Treating Doctors' Reports (Completed by your treating doctors), and
- Employer Statement (Completed by your employer).

When will I receive my first payment?

You need to be absent from work for your nominated waiting period (30, 60, 90 or 180 days) before you can receive a payment. You can check your waiting period online or on your annual statement. Payment is monthly in arrears.

How long is my benefit paid for?

Depending on your chosen benefit period, your IP benefit will be paid for a maximum of two or five years, or up to age 65 (for the time you're still disabled). You can check your benefit period on your annual statement. This benefit will start from the first day after your waiting period has expired.

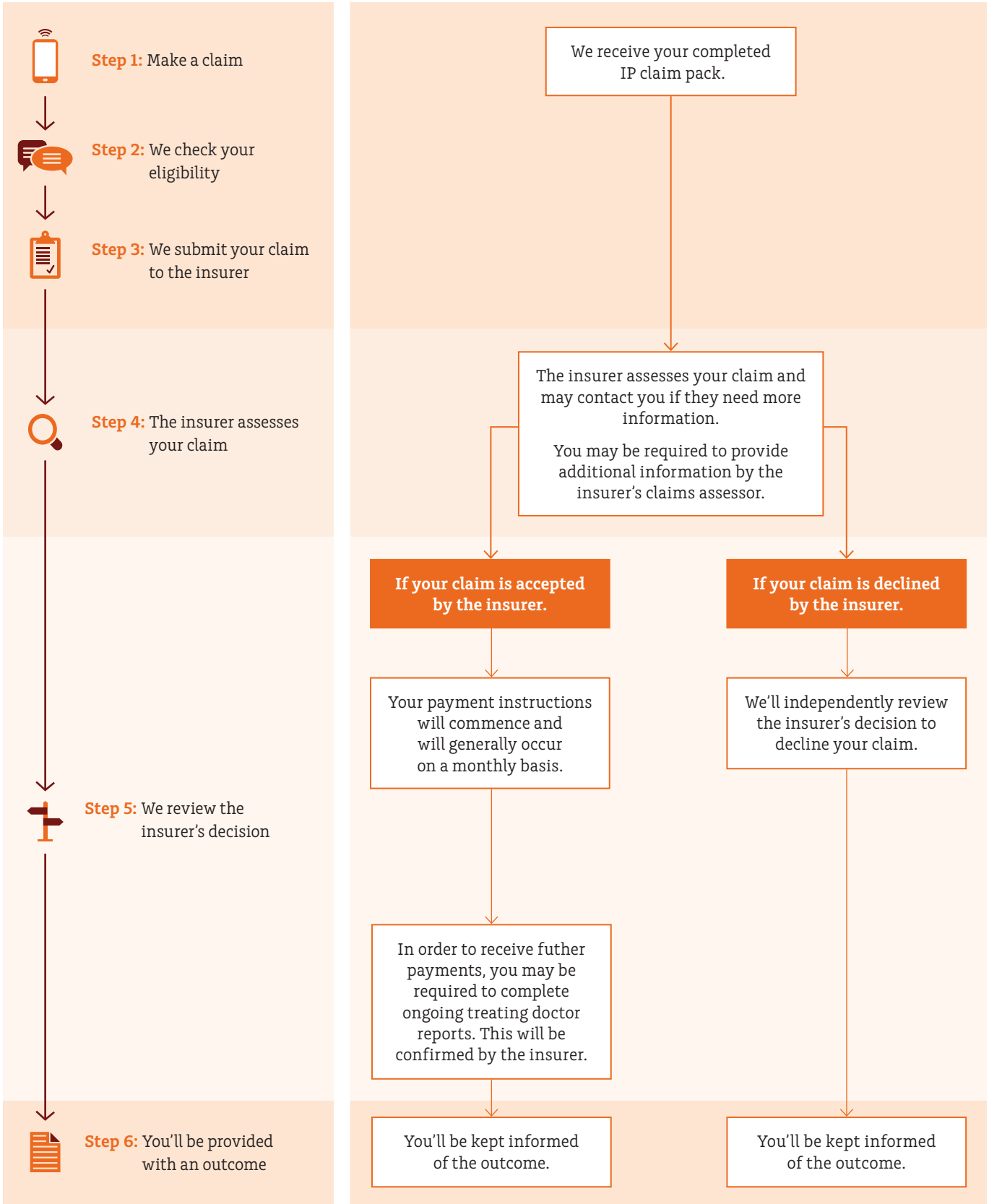
Will my premiums stop when I am on a claim?

Yes. Your IP premiums will be waived by the insurer and we won't charge your super account.

Can I claim on multiple policies?

Generally, you can only claim on one IP policy. It's important to check what other insurance policies you hold. For IP cover, you can generally only claim on one policy. If you have multiple policies, you might be paying premiums for policies you don't require-or you're not eligible to claim on.

Income Protection (IP) claims process



Death insurance

The intention of Death insurance is to help the dependants of someone who has passed away.

When should a claim be made?

A claim for a Death benefit should be made as soon as possible.

How is a claim made?

To make a Death claim, call us on **132 652**. We'll ask a few questions in order to provide a correct claims pack to complete.

Death benefit payments

The law sets out who is eligible to receive a Death benefit from a super fund. We can pay a Death benefit to the deceased's:

- legal personal representative, or
- dependant(s).

In addition to the deceased's super account balance, beneficiaries may be eligible to claim for a Death benefit if they had Death insurance cover as part of their super.

Types of nominations

Binding Nomination: Where we've accepted a binding beneficiary nomination from a member and that nomination remains valid at the date of the member's death, it must be followed.

Non-Binding Nomination or no nomination: Where a member's nomination is not binding, or where the member hasn't made a nomination, we must decide to whom the member's superannuation Death benefit is to be paid.

Where there's a non-binding nomination, we consider a range of factors, such as:

- the deceased's will
- any nominations made by the deceased
- submissions made by potential beneficiaries, and
- submissions made by any other person, if a dependant or legal personal representative can't be found.

We'll identify all potential beneficiaries and send a letter to them with details of the proposed benefit payments. This letter also outlines how objections to the decision can be submitted.

If an objection is received by us, the information will be reassessed and further information may be requested.

Variation or confirmation of the decision will then be communicated to all potential beneficiaries. Any complaints in relation to our decision can be directed to AFCA. No payment will be made until the AFCA process is finalised. (See 'Resolving complaints' on **page 4** for more information).

Frequently asked questions

What happens to the deceased's account when the fund is notified of their death?

The deceased's super balance will be switched to the MLC Cash Fund investment option from the day we're notified of their death to protect their assets while the Death benefit claim is being assessed.

What forms need to be completed?

Beneficiaries need to complete the following forms:

- Potential Beneficiary Statutory Declaration (Completed by beneficiaries)
- Proof of Identity form (Completed by beneficiaries), and
- Medical Authority (Completed by beneficiaries).

Does anything else need to be provided with the forms?

Yes. A certified copy of the deceased's death certificate must be provided with the forms. A copy of their will, probate or letters of administration may also be required.

Who is a dependant?

A dependant is generally defined as:

- a spouse, including de facto and same-sex spouse
- a child
- any person with whom the deceased had an interdependent relationship, or
- any person who is wholly or partially financially dependent on the deceased.

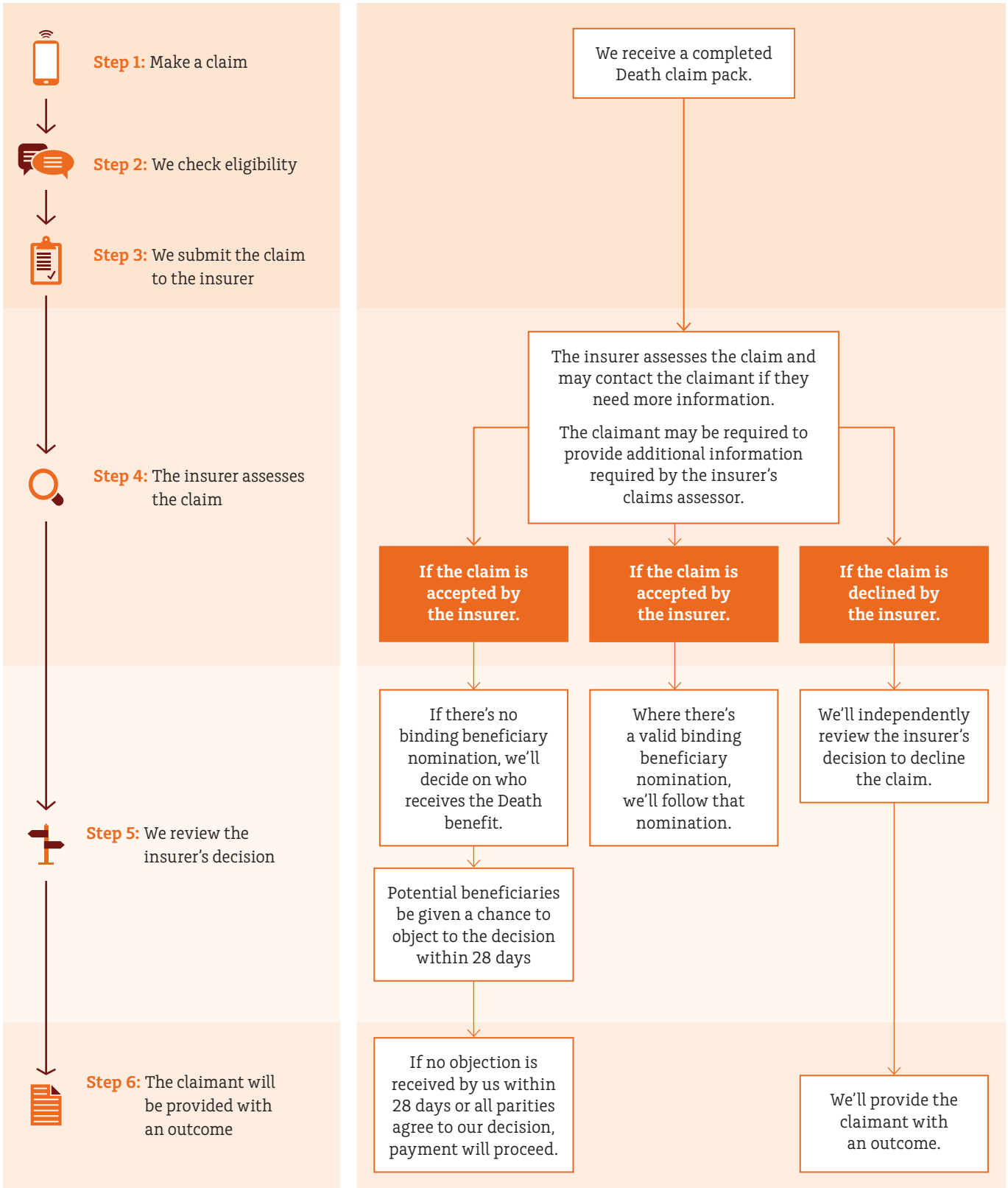
What are the payment options if the Death claim is approved?

Approved Death claims can be paid:

- as a lump sum, and
- as a pension (if applicable).

Death claims process

The process outlined below generally applies to Death claims we receive.



Terminal Illness insurance

The intention of Terminal Illness insurance is to provide you with early access to your Death insurance if your doctors certify that you're likely to pass away within the time specified in the relevant insurance policy (generally 12 or 24 months).

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.

You may also be eligible to access your super balance early.

How do I make a claim?

To make a Terminal Illness claim, call us on **132 652**.

We'll ask you a few questions to form an initial assessment of your eligibility and make sure we send you the correct claims pack to complete.

How will my claim be assessed?

You may be eligible for a Terminal Illness benefit if two doctors, one of whom is a specialist, certify that your life expectancy is reduced to less than 12 or 24 months (depending on the insurance policy which applies to you). See the relevant **Insurance Guide** for more information.

Frequently asked questions

How long do I have to wait before I can lodge a Terminal Illness claim?

There's no waiting period to lodge a Terminal Illness claim, once you've been diagnosed by two doctors.

What forms need be completed?

You and your doctors will need to complete certain forms, including:

- Claim form (Completed by you), and
- Proof of identity form (Completed by you).

You'll also need to obtain the following documents to attach to your claim submission:

- Treating Doctor's Report (Completed by your treating doctor), and
- Treating Doctor's Report (Completed by your treating specialist).

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

No. Any premiums paid from the date of your disablement will be refunded to your super account.

Do I have to repay my Terminal Illness benefit if I live longer than 12 or 24 months?

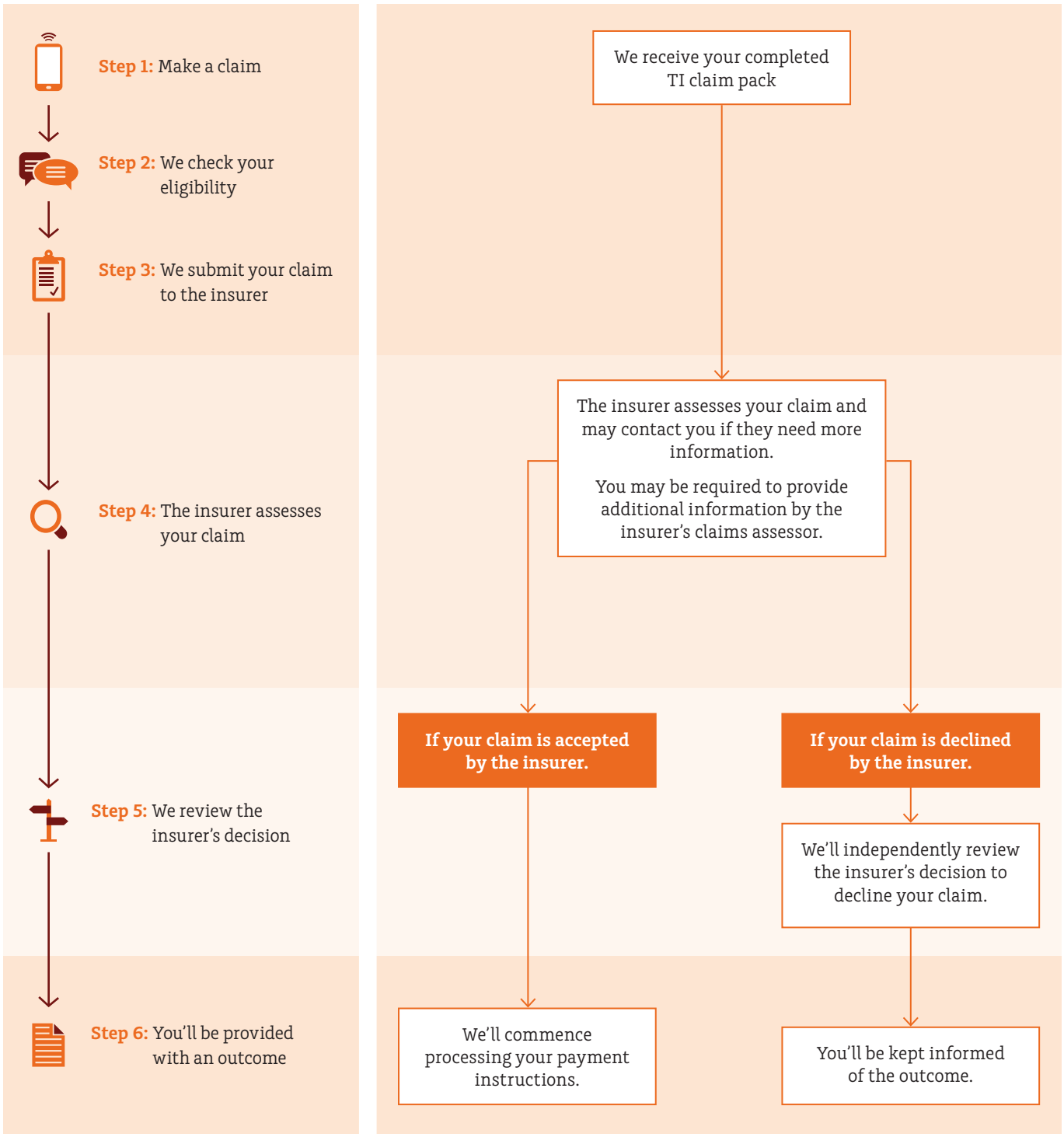
No. You won't have to repay your Terminal Illness benefit if you live longer than 12 or 24 months.

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

Approved Terminal Illness claims can be paid:

- as a lump sum
- as a pension, or
- to another complying super account, via a rollover.

Terminal Illness (TI) claims process



Your notes

Your notes

For more information visit mlc.com.au or call us from anywhere in Australia on 132 652 or contact your financial adviser.

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