

This is subject to the following:

- If you have not already satisfied the qualifying period under your existing policy, you will still need to wait the unexpired qualifying period of that policy or satisfy the qualifying period under your new Trauma Cover (whichever is shorter).
- Where the benefit amount of your new Trauma Cover exceeds that of the policy being replaced, the full qualifying period under your new cover will apply to the increased amount.

2.4.1 Child Cover benefit (pages 21 and 22 of the RD)

In 'Limitations, exclusions and other information' of this section on page 21 of the RD, the sixth bullet point is deleted and replaced by:

No Child Cover benefit is payable when:

- the child life insured's Child Trauma Cover condition is caused directly or indirectly by any intentional self-inflicted injury or any attempt at suicide; or
- the child life insured's death or Child Trauma Cover condition is caused by a malicious act of the child life insured's parent or guardian, or by a malicious act of someone who lives with or supervises the child life insured and who is acting in collusion with the child life insured's parent or guardian.

The section titled 'Replacing an existing trauma policy' on page 22 of the RD is deleted and replaced by:

If you already have a trauma insurance policy for your child, either with us or another company and we agree to issue you with the Child Cover Option, you will not have to go through another qualifying period for the same medical conditions.

This is subject to the following:

- If you have not already satisfied the qualifying period under your existing policy, you will need to wait the unexpired qualifying period of that policy or satisfy the qualifying period under the new Child Cover Option (whichever is shorter).
- Where the benefit amount of the new Child Cover Option exceeds that of the policy being replaced, the full qualifying period under your new Child Cover Option will apply to the increased amount.

Section 4 Medical condition definitions

4.3.1 Cancer (pages 29 and 30 of the RD)

This section on pages 29 and 30 of the RD is deleted and replaced by:

Cancer means any one of the following seven conditions, provided the condition is not AIDS-related:

1. Any malignant (severe and progressively worsening) neoplastic disease characterised by the uncontrolled growth in number and spread of malignant cells that has progressed to a stage that either:

- requires major interventionist treatment such as surgery, radiotherapy, chemotherapy or biological response modifiers, or

- cannot be treated with curative intent;

but excluding:

- conditions classified by their clinical features, cytopathology and/or histopathology as tumours showing the malignant changes of 'carcinoma in situ' or which are histopathologically described as premalignant. Uterine cervical intraepithelial lesions, cervical dysplasias and cervical intraepithelial neoplasias, including those classified as CIN1, CIN2 and CIN3 are examples of tumours categorised as either being carcinoma in situ and/or premalignant and are excluded.

- all non-melanoma skin tumours and cancers originating in skin, unless there has been evidence of metastatic spread
 - prostatic cancers which remain histopathologically classified as TNM (Tumour, Nodes, Metastases) Stage T1a or T1b or are of another equivalent or lower classification
 - prostatic cancers which remain histopathologically classified as TNM Stage T1c unless curative intent therapy has been administered in connection with such cancer
 - tumours treated by endoscopic procedures alone
 - melanomas which have a depth of invasion of less than Clark Level 3 or less than 1.5mm in Breslow thickness
 - Chronic Lymphocytic Leukaemia diagnosed as RAI Stage 0 or 1, which is defined to be in the blood and bone marrow and/or lymph nodes only
2. Leukaemia that is not Chronic Lymphocytic Leukaemia diagnosed as RAI Stage 0 or 1, which is defined to be in the blood and bone marrow and/or lymph nodes only
 3. Malignant bone marrow disorder that is not Chronic Lymphocytic Leukaemia diagnosed as RAI Stage 0 or 1, which is defined to be in the blood and bone marrow and/or lymph nodes only
 4. Hodgkin's Disease
 5. Malignant lymphoma except where treated by endoscopic procedures alone
 6. Melanomas which have a depth of invasion of Clark Level 3 or 1.5mm or more in Breslow thickness
 7. Carcinoma in situ of the breast requiring removal of all breast tissue from the breast.

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3. Direct Debit Request Customer Service Agreement

Personal Insurance Portfolio

The Colonial Mutual Life Assurance Society Limited ABN 12 004 021 809 AFSL 235035 (CMLA). CommInsure is a registered business name of CMLA.

We, The Colonial Mutual Life Assurance Society Limited, note our commitment to you, as follows:

- We will advise you by notice, statement or invoice of the drawings.
- Where the drawing date falls on a non-business day, we will draw the amount on the next business day.
- We will provide written notice of any proposed changes to your drawing arrangement (other than those detailed in your policy conditions), providing no less than 14 days notice.
- We reserve the right to cancel the drawing arrangement if drawings are continually returned unpaid by your nominated financial institution. Where drawings are returned unpaid we will arrange an alternative payment method. A fee may apply for drawings that are returned unpaid.
- We will keep all information provided by you and details of your nominated account at the financial institution, private and confidential. However, we may disclose information that we have about you to the extent specifically permitted by the law or for the purpose of this agreement (including disclosing information in connection with any query, dispute or claim).
- We will investigate and deal promptly with any queries, claims or complaints regarding debits, providing a response within 20 business days.

You, the customer, note your commitment to us as the following:

- It is your responsibility to check with your financial institution before completing the Direct Debit Request, that direct debiting is available on that account.
- It is your responsibility to ensure that the authorisation on the Direct Debit Request is identical to the account signing instruction held by the financial institution of the nominated account.

- It is your responsibility to ensure that, at all times, sufficient funds are available in the nominated account to meet a drawing on the due date for payment.
- It is your responsibility to advise us if the account nominated by you to receive the drawings is altered, transferred or closed.
- It is your responsibility to arrange with us a suitable alternative payment method, if the drawing arrangements are stopped, either by you or the nominated Financial Institution.
- It is your responsibility to meet any charges resulting from the use of the Direct Debit System. This may include fees charged to us as a result of returned drawings.

You may request to defer or alter the agreed drawing schedule, by giving written notice to us. Such notice should be received by us at least 14 business days prior to the drawing date.

You may stop your individual debit by giving written notice to us. Such notice should be received by us at least 14 business days prior to the drawing date.

You may cancel the Direct Debit arrangement at any time by giving written notice to us. Such notice should be received by us at least 14 business days prior to the drawing date. Your nominated financial institution is unable to cancel your Direct Debit arrangement.

All transaction disputes, queries and claims should be raised directly with us. We will provide a verbal or written response within 20 business days from the date of the notice. If the claim/dispute is successful, we will reimburse you by way of cheque or electronic credit to your nominated account.

Important: This section must be provided to, and retained by the Payer.

Personal Insurance Portfolio

- Supplementary Product Disclosure Statement (SPDS),
- Reference Document Supplement and
- Direct Debit Request Customer Service Agreement.

1. Supplementary Product Disclosure Statement (SPDS)

Preparation date: 25 May 2009

This Supplementary Product Disclosure Statement (SPDS) supplements the information contained in the Personal Insurance Portfolio Product Disclosure Statement (PDS), with a preparation date 3 March 2008. This SPDS should be read together with the PDS.

Your Personal Insurance Portfolio – overview

Applying for cover (page 2 of the PDS)

The section titled 'Applying for cover' on page 2 of the PDS is deleted and replaced by:

Applying for cover

You can apply for cover by:

- completing and forwarding to us the current Personal Insurance Portfolio Application form which accompanies this PDS, or
- completing and submitting an application electronically via our online application facility (available through your financial adviser).

Important: If you apply electronically via our online application facility, you must return the signed Confirmation of Electronic Application and Personal Statement to us within 30 days of your policy commencing. Failure to do this will result in your policy ending. The Confirmation must be returned in the form required by us.

Section 1 Income Care Range

Factors you need to choose that affect your premium

Policy type (page 6 of the PDS)

The section titled 'Income Care or Income Care Plus Agreed value policy' on page 6 of the PDS is deleted and replaced by:

Income Care or Income Care Plus

Agreed value policy

If you select an agreed value policy, we agree to pay the monthly benefit that you have been insured for. This payment includes any indexation increases. We will pay you this amount regardless of any reduction in your income since you took out the policy.

For example, if the monthly benefit for which you are insured is \$3,000 and you become entitled to a Total Disability Benefit, we will pay you a Total Disability Benefit of \$3,000 per month, even if the monthly income that you were earning at the time you took out your cover decreased and would no longer justify a monthly benefit of \$3,000.

The agreed value amount which we cover you for is based on your average monthly income in the 12 months before applying for cover. We will, at claim time, require you to satisfy us that your average monthly income in the relevant 12 month period justified the amount of cover that we provided you. If you cannot satisfy this requirement, the monthly benefit will be the lesser of the amount of your cover (including any indexation increases) and 75% of your pre-disability income.

Guaranteed agreed value policy

If you have a guaranteed agreed value policy, we will not ask you to justify the amount of your cover if you make a claim. This is because at the time you applied for cover, you provided us with the evidence of your income

Section 2 Total Care Plan

Factors you need to choose that affect your premium

The version of the 'Absent From Active Employment' TPD Cover definition which applies to you (page 14 of the PDS)

The section titled 'Any occupation' on page 14 of the PDS is deleted and replaced by:

Any occupation

In addition to the other requirements of the 'Absent From Active Employment' TPD Cover definition, you will need to satisfy us that you're unable to engage in any occupation:

- for which you are reasonably suited by education, training or experience; and
- which would pay remuneration at a rate greater than 25% of your earnings during your last consecutive 12 months of work.

Nomination of beneficiaries (page 16 of the PDS)

An additional bullet point has been added to the section 'Nomination of beneficiaries' on page 16 of the PDS as follows:

- you cannot include the life insured or child life insured as one of the nominated beneficiaries as it will make the nomination invalid.

Also, the second last paragraph in this section is deleted and replaced by:

To nominate beneficiaries under your policy, please refer to the relevant section of your application form.

Risks (page 22 of the PDS)

The following is inserted as the third bullet point under the section titled 'Risks' on page 22 of the PDS:

- if you apply for a policy electronically via our online application facility and we do not receive, in the form required by us, a signed Confirmation of Electronic Application and Personal Statement within 30 days of your policy commencing, your policy automatically ends and you will not be covered for an event which occurs after the end of the policy.

Who can be covered (page 22 of the PDS)

The words 'see page 5 of the Application form' are deleted from the first bullet point under the section titled 'Who can be covered' on page 22 of the PDS.

Your duty of disclosure (page 22 of the PDS)

The section titled 'Your duty of disclosure' on page 22 of the PDS is deleted and replaced by:

Your duty of disclosure

Before you enter into a contract of life insurance with an insurer you have a duty, under the Insurance Contracts Act 1984, to disclose to the insurer every matter that you know, or could reasonably be expected to know, is relevant to the insurer's decision whether to accept the risk of the insurance and, if so, on what terms.

You have the same duty to disclose those matters to the insurer before you extend, vary or reinstate your insurance.

Your duty, however, does not require disclosure of a matter:

- that diminishes the risk to be undertaken by the insurer
- that is of common knowledge
- that your insurer knows or, in the ordinary course of its business, ought to know, or
- as to which compliance with your duty is waived by the insurer.

Non-disclosure

If you fail to comply with your duty of disclosure and the insurer would not have entered into the contract on any terms if the failure had not occurred, the insurer may avoid the contract within three years of entering into it. If your non-disclosure is fraudulent, the insurer may avoid the contract at any time.

An insurer who is entitled to avoid a contract of life insurance may, within three years of entering into it, elect not to avoid it but to reduce the sum that you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to the insurer.

Guaranteed renewable (page 22 of the PDS)

The section titled 'Guaranteed renewable' on page 22 of the PDS is deleted and replaced by:

Guaranteed renewable

Provided you pay your premiums and comply with the policy conditions (including, for an electronic application via our online application facility, the requirement to provide us with a signed Confirmation of Electronic Application and Personal Statement within 30 days of policy commencement), the policy is guaranteed renewable up until the policy expiry date. This means that we will not cancel it or increase the premium because of the number of claims you make or any change to your state of health, occupation or pastimes.

Section 4 Important information

Complaint handling procedures (page 23 of the PDS)

The last paragraph in point 2 on page 23 of the PDS is deleted.

Also, point 3 of this section on page 23 of the PDS is deleted and replaced by:

3. Upon receipt of your complaint, the Complaints Manager will investigate the cause of your concern and respond to you as quickly as possible. If the matter cannot be resolved quickly you will be kept informed of its progress. If you are not satisfied with the handling of your complaint or a decision of CMLA you may have the right to lodge a complaint with the Financial Ombudsman Service Limited (FOS).

Before FOS has jurisdiction to deal with the matter, it must be satisfied that the same complaint was previously made to an appropriate person under our internal enquiries and complaints procedures and the complaint was not resolved to the satisfaction of the complainant within 45 days. The FOS can only deal with complaints which concern a particular policyholder. It cannot deal with complaints about

management as a whole. If FOS accepts your complaint it will attempt to resolve the matter through conciliation, which involves assisting both parties to come to a mutual agreement. If conciliation is unsuccessful, the complaint is referred to FOS for a determination which is binding.

You can contact FOS by phoning **1300 780 808** between 9am and 5pm (Melbourne time), Monday to Friday from anywhere in Australia. Alternatively, visit their web site at **www.fos.org.au**.

The section 'Financial Industry Complaints Service Limited (FICS)' on page 23 of the PDS is deleted.

How to apply (page 24 of the PDS)

The section titled 'How to apply' on page 24 of the PDS is deleted and replaced by:

How to apply

To apply for any cover under the Personal Insurance Portfolio, you need to complete either:

- the forms accompanying this PDS or
- an electronic application via our online application facility

Try to always provide more information where you can. We want to get a good picture of your situation, so any extra detail you can give us is useful. Brief answers will generally result in more information being requested and a delay in processing your application.

If you are competing the forms accompanying the PDS, please use the checklist on the front of the application to make sure that you fill in all the information we need to process your application as soon as possible.

If you are completing an electronic application via our online application facility, your adviser will explain what information is required to process your application.

What happens next? (page 24 of the PDS)

The section titled 'What happens next?' on page 24 of the PDS is deleted and replaced by:

What happens next?

When we receive your application it will be underwritten. Underwriting is the process by which we work out how likely you are to make a claim, based on health, occupation, lifestyle and sporting activities. In some cases, we will require more information to help make an accurate assessment; whilst in other cases we may have to exclude some dangerous pastimes or health problems in order to offer you cover for all other situations.

If your application is accepted, we will send you:

- a Policy Document which sets out the terms and conditions of the policy
- a Policy Schedule, which is an individual summary of how much cover you have, and what selections you have made.

If you applied for your policy electronically via our online application facility, you will also be provided with a Confirmation of Electronic Application and Personal Statement. Unless you sign and return the Confirmation to us within 30 days of your policy commencing, the policy automatically ends. The Confirmation must be returned in the form required by us.

From the date we issue you the policy, you begin the 28-day cooling-off period (see 'Cooling off Period' in the PDS).

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2. Reference Document Supplement

Dated: 25 May 2009

This Reference Document Supplement supplements the information contained in the Personal Insurance Portfolio Reference Document (RD), dated 3 March 2008. This Reference Document Supplement should be read together with the RD.

Section 1 Income Care Range

1.2.13 Guaranteed insurability (page 6 of the RD)

The second paragraph of this section on page 6 of the RD is deleted and replaced by:

To increase your cover, you must apply in writing. If you have an Agreed Value or Guaranteed Agreed Value policy, or the monthly benefit exceeds the limits as per our financial guidelines, proof to our satisfaction must be provided of your income over the previous two years.

Section 2 Total Care Plan

2.1.2 Terminal Illness Benefit (page 14 of the RD)

This section on page 14 of the RD is deleted and replaced by:

If this benefit is payable, your Life Care, Trauma and TPD Cover will be reduced by the total benefit payable. This benefit will not be payable after the Life Care benefit ceases.

2.1.6 Guaranteed Insurability Option (Personal Events) (page 14 of the RD)

In 'Limitations and other information' of this section on page 14 of the RD, the second bullet point is deleted and replaced by:

The increase in cover will take effect from the date we notify you of in writing, which date will be no later than 30 days from the date you satisfied our requirements.

2.1.7 Guaranteed Insurability Option (Business Events) (page 15 of the RD)

In 'Limitations and other information' of this section on page 15 of the RD, the sixth bullet point is deleted and replaced by:

The increase in cover will take effect from the date we notify you of in writing, which date will be no later than 30 days from the date we agree to the financial basis for the revised sum insured.

Also, the second last bullet point in this section is deleted and replaced by:

A Life Care benefit, Trauma Cover benefit and TPD Cover benefit can only be increased once every twelve months under this option. The business event must have occurred no more than three years before the date you apply for the increase.

2.1.8 Business Safe Cover Option (page 17 of the RD)

In 'Limitations and other information' of this section on page 17 of the RD, the fourth bullet point is deleted and replaced by:

The increase in cover will take effect from the date we notify you of in writing, which date will be no later than 30 days from the date we agree to the financial basis for the revised sum insured.

Also, the fifth bullet point is deleted and replaced by:

A Life Care benefit, Trauma Cover benefit and TPD cover benefit can only be increased once every 12 months under this option. The business event must have occurred no more than three years before the date you apply for the increase.

2.1.9 Plan Protection Option (page 17 of the RD)

The first paragraph of this section on page 17 of the RD is deleted and replaced by:

Provided you have been totally disabled for more than three months, we will waive all premiums that fall due after the first three months of total disability, up to the policy anniversary before your 65th birthday.

2.2.1 TPD definitions (page 17 and 18 of the RD)

In the section 2.2.1.1 Absent From Active Employment – 'any occupation' on page 17 of the RD, the sentence which reads '– any of the following conditions as defined in Section 4' is deleted and replaced by:

– any of the following Day 1 TPD conditions as defined in Section 4

Also, the last paragraph of the section is deleted and replaced by:

- during the period for which you must be absent from active employment, you have been unable to engage in any occupation:
 - for which you are reasonably suited by education, training or experience; and
 - which would pay remuneration at a rate greater than 25% of your earnings during your last consecutive 12 months of work,

and

- you have been under the regular treatment and following the advice of a medical practitioner

and

- you are likely to be so disabled for life.

In the section 2.2.1.2 Absent From Active Employment – 'own occupation' on page 17 of the RD, the sentence which reads '– any of the following conditions as defined in Section 4' is deleted and replaced by:

– any of the following Day 1 TPD conditions as defined in Section 4

Also, the last sentence of this section on page 18 of the RD is deleted. This sentence is:

If you are unemployed or on leave without pay for 12 months or more before the event causing the claim, the definition in Section 2.2.1.1 will automatically apply even if you chose this definition at the time of applying for cover.

In the section 2.2.1.3 Homemakers on page 18 of the RD, the sentence which reads '– any of the following conditions as defined in Section 4' is deleted and replaced by:

– any of the following Day 1 TPD conditions as defined in Section 4

2.2.3 Continuation Option (page 18 of the RD)

The following is inserted as the last bullet point under the section 'Continuation Option' on page 18 of the RD:

- for a policy issued pursuant to an electronic application via our online application facility, this option can only be exercised if we have received, in the form required by us, the signed Confirmation of Electronic Application and Personal Statement.

2.3.1 Trauma Cover benefit (page 19 of the RD)

The section titled 'Replacing an existing trauma policy' on page 19 of the RD is deleted and replaced by:

If you already have a trauma insurance policy with us or another company and we agree to issue you with a new policy, you will not have to go through another qualifying period for the same medical conditions.