American Income Life Insurance Company

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Policy Summary – Hospital Indemnity Policy

In this Policy Summary, the words "we", "our" and "us" mean the *American Income Life Insurance Company*, the insurer under the Policy.

The words "you" and "your" mean the person who is named as the "Insured" in the Policy Schedule.

The Policy provides benefits due to Sickness or Injury

The Policy insures against a Covered Person's Sickness or accidental Injury.

We will pay the applicable benefit only if the Injury occurs, or treatment for Sickness starts, while the Policy is in force. "In force" means that the insurance cover has not stopped.

We refer to you and each of your insured family members as a "Covered Person".

You have the right to cancel the Policy within 10 working days

If you choose to cancel the Policy within 10 working days of receiving it from us, then we and you will be in the same position as if no policy had been issued. In that case, we will refund any premiums you have paid.

You can cancel the Policy by notifying:

- us, at our contact details above; or
- the *AIL of NZ* adviser who sold it to you.

If you cancel the Policy after 10 working days of receiving it, we will not refund the premiums you have paid.

The purpose of this Policy Summary is to help explain some of the main features of the Policy.

This Policy Summary is only a brief overview and does not form part of the contract between you and us.

PLEASE READ THE POLICY CAREFULLY ONCE YOU RECEIVE IT.

The actual Policy has full information and sets out any limits.

Your family can be insured under the Policy

The members of your family who can be insured are:

- your spouse, civil union partner or de facto partner;
- any of your children under 19 who are not married, in a civil union or in a de facto relationship, and who are dependent on you for support.

But in each case, to be insured they must be named in the application or added to the Policy after it is issued. Cover for other dependents is subject to our approval.

The Policy contains detailed provisions about when insurance for family members comes to an end under the Policy. These provisions include for example, what happens when your children reach 19 years old.

We may refuse to pay benefits if you tell us something wrong in your application

If you tell us something wrong in your application for the Policy (or leave something out), then in the first two years we may (where the law allows):

- cancel or void the Policy; and
- refuse to pay any claims you make.

After those two years have passed, then we will not void the Policy or refuse to pay any claims if you told us something wrong in your application (or left something out). This is unless you have been fraudulent in doing so.

We pay different types of benefits

The following benefits may be paid if a Covered Person suffers an Injury or Sickness.

In-Hospital Indemnity Benefit

We will pay the In-Hospital Indemnity Benefit if a Covered Person has to stay in hospital due to Injury or Sickness. For us to pay:

- the Policy must be in force for each day of the stay in hospital; and
- the stay in hospital must be required by a doctor.

This benefit is paid for each day the Covered Person stays overnight in hospital for required care and treatment. The amount we pay for each day is set out in the Policy Schedule. The maximum number of days is 365.

Out-Patient Surgical Indemnity Benefit

We will pay the Out-Patient Surgical Indemnity Benefit if a Covered Person has surgery as an out-patient in a hospital or out-patient surgical facility.

This benefit is paid for a number of days (as set out in the Policy) depending on the type of surgery.

At-Home Indemnity Benefit

We will pay the At-Home Indemnity Benefit if a doctor considers it necessary for a Covered Person to be visited at home for:

- skilled nursing services; and
- physical, speech, hearing and occupational therapy.

The home visits must start within 7 days of the Covered Person's hospital stay.

We will pay not more than one week of the At-Home Weekly Benefit for each day the Covered Person stays in hospital. We pay this benefit for a maximum of 12 weeks.

Emergency Accident Benefit

We will pay expenses if a Covered Person receives treatment in a hospital or out-patient facility for Injury caused by an accident. We will pay only those expenses that are incurred within 72 hours of the accident.

The maximum amount we will pay for any one accident is set out in the Policy Schedule. We will not pay the Emergency Accident Benefit if the Covered Person:

- requires a hospital stay as a result of the accident;
- or is eligible for any other benefit under the Policy.

We will not pay the Emergency Accident Benefit for more than 3 accidents per calendar year for each Covered Person.

Accidental Death and Dismemberment Benefit

We will pay the Accidental Death and Dismemberment Benefit if an Injury to a Covered Person results in any of the losses set out in the Policy (including loss of life) for this benefit.

We pay the Accidental Death and Dismemberment Benefit in place of any other benefits that may be payable under the Policy resulting from the same accident.

Additional benefit may be added to the Policy

An additional benefit may be added to the Policy for an additional premium.

The additional benefit is paid if a Covered Person is hospitalised and receives the In-Hospital Indemnity Benefit under the Policy. The benefit is paid while the Covered Person:

- is unable to perform their regular and customary duties; and
- is under the care of a doctor.

The additional benefit is a weekly payment starting from the date of discharge of the Covered Person from hospital. The number of weeks the benefit is paid depends on how long the Covered Person was in hospital. The maximum benefit period is 12 weeks.

The additional benefit will be set out in a document called a "Recuperation Indemnity Benefit Policy Add-on".

The Recuperation Indemnity Benefit Policy Add-on becomes part of the Policy and should be read together with that Policy. Unless the Policy Add-on says otherwise, it doesn't change the Policy itself.

We do not pay a benefit in certain circumstances

We will not pay benefits where the loss is caused or contributed to by:

- war or any act of war, or any injury sustained while serving in the military forces engaged in war, whether declared or undeclared;
- suicide or any attempted suicide, while sane or insane; or from intentionally self-inflicted injury;
- mental, nervous or emotional disorder;
- normal pregnancy, normal childbirth or abortion;
- committing or attempting to commit a crime punishable by imprisonment;
- air travel, except as a fare-paying passenger on regularly scheduled commercial airlines; or
- ingesting or being under the influence of alcohol or other intoxicant, or taking or being under the influence of any drug or narcotic (other than lawful drugs prescribed by a doctor).

We will not pay benefits for an event during the first two years of a Covered Person's cover if:

- that event is due to a condition for which a doctor recommended or gave medical advice or treatment; and
- the doctor did so in the two years before that person's cover became effective.

However, health conditions listed on the application will be covered immediately, unless they are excluded from cover by a document attached to the Policy.

Regular premium payments must be made

Regular premium payments must be paid to us to keep the Policy in force. The amount of the premium payments is set out in the Policy Schedule.

If the premium is not paid before the due date, we allow 31 days for the premium to be paid.

The Policy renews automatically

The Policy is guaranteed to be renewable for as long as you live. This is provided premiums are paid and your obligations under the Policy are met. As long as the Policy is in force and your obligations under the Policy are met, we cannot cancel the Policy or place any additional restriction on it.

We have the right to change the renewal premium rates for the Policy. Such a change shall apply to all policies in New Zealand in the same form as the Policy. We will give you 31 days' notice of a change.

How you can make a claim

You must notify us (or an *AIL of NZ* adviser), in writing, of a claim. You must do so within 60 days of the start of any loss covered by the Policy, or as soon as reasonably possible after that period.

We will send you claim forms to complete once you have notified us of a claim.

You must complete the claim forms and return them to us (or an *AIL of NZ* adviser), along with any supporting medical information. You must do so within 90 days of the date of the loss. If it is not reasonably possible to complete and return the forms within this time limit, you may have extra time to do so (as detailed in the Policy).

Benefits payable under the Policy will be paid by us once we receive written proof of loss.