American Income Life Insurance Company

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Policy Summary – Cancer 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 where a Covered Person is treated for Cancer

The Policy provides benefits where a Covered Person is treated for Cancer in a hospital or as an outpatient.

We will pay the applicable benefit only if Cancer is diagnosed after the first 30 days the Policy is in force.

After those first 30 days, we will pay the applicable benefit if a Covered Person is treated for Cancer 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;
- your children under 19 on the date of the Policy 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 after your children reach 21 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 cancel or 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 benefit

Hospital Confinement Benefit

We will pay the hospital confinement benefit if a Covered Person is confined in hospital for the treatment of Cancer. We pay only for each day of hospital confinement while the Policy is in force.

The amount we will pay for each day the Covered Person stays in hospital is set out in the Policy Schedule. The maximum number of days we will pay for in a lifetime is 500 days in aggregate.

Outpatient Benefit

We will pay the outpatient benefit for each day a Covered Person receives any specified treatment (set out in the Policy) for Cancer as an outpatient in a Doctor's office, clinic, hospital, or surgical bus. We will only pay if the outpatient treatment for cancer is administered directly by the Covered Person's doctor or by medical personnel under the direct supervision of a doctor.

The amount we will pay for each day is set out in the Policy Schedule. The maximum number of days we will pay for in a lifetime is 500 days in aggregate.

We will not pay the outpatient benefit for any day the Covered Person receives the hospital confinement benefit.

Additional benefits may be added to the Policy

Additional benefits may be added to the Policy for an additional premium.

The additional benefits are:

- a lump sum payment when the Covered Person is first diagnosed with Cancer (other than skin cancer); and
- a lump sum payment when the Covered Person is first diagnosed with skin cancer.

Each Covered Person is eligible for one Cancer (other than skin cancer) benefit and one skin cancer benefit.

That additional benefit will be set out in a document called a "Cancer Detection Benefit Policy Add-on".

The Cancer Detection Benefit Policy Add-on becomes part 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

Benefits are not paid for any Cancer treatment received more than 90 days before a pathological diagnosis.

The pathological diagnosis of the Cancer must be based on a microscopic study of body tissue or fluid. Only a pathologist approved by us can make a pathological diagnosis.

We will consider a clinical diagnosis where a pathological diagnosis is not possible.

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 Premium 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 a Covered Person's treatment for Cancer, 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 the required supporting medical information, within 90 days of the end of the period of loss.

If it is not reasonably possible to complete and return the forms (and provide the supporting medical information) within this time limit, you may have extra time to do so (as set out in the Policy).

Benefits payable under the Policy will be paid by us upon receiving written proof of loss.