Discovery
Corporate and
Employee Benefits

Group Risk
Life Plan

Terms and conditions

Version GRLPG01/26

Group Risk **Life Plan Guide**

Terms And Conditions



DEFINITIONS IN THIS DOCUMENT

Unless defined differently in a particular section:

- *You/your* refers to the *policyholder* or *member* as indicated at the top of each section
- *Discovery Group Risk* or *we/us/our* refers to Discovery Group Risk, a division of Discovery Life Limited, a public company with limited liability, as well as a licensed life insurer and authorised financial and credit services provider, registered under the company laws of the Republic of South Africa, registration number 1966/003901/06
- *Life Plan Guide* and *Life Plan Guide version GRLPG01/26* refer to this guide, which, together with the other documents mentioned in the clause Documents that make up the *Plan*, set out the terms and conditions of the *Plan* providing group risk insurance
- *Plan* refers to the insurance policy set up to provide insurance to *lives assured* for specific group risk benefits under this *Life Plan Guide.*



NAVIGATING THIS DOCUMENT

- Interactive links on the contents page can be used to navigate to specific sections. Click the icon in the top right corner of the page to return to the contents page.
- Hyperlinked phrases or words, underlined and coloured blue, refer to sections or clauses in this document. Click on the hyperlinks to go to the section or clause they refer to.
- Underlined terms refer to other documents which should be read together with this *Life Plan Guide*.
- Terms in *italics* are explained in the About the people involved in the *Plan* and Explaining key terms sections of this document.
- Examples are in text



SECTIONS OF THIS DOCUMENT

- Sections 1 to 10 refer to terms and conditions which apply to all benefits.
- Sections 11 to 21 refer to terms and conditions which apply to specific benefits.

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General terms and conditions

Sections 1 to 10 detail terms and conditions which apply to all benefits

DEFINITION OF *YOU/YOUR* FOR THIS SECTION

In this section, *you/your* refers to the *policyholder*.

This section gives an overview of what the Plan is, what documents make up the Plan, and who you can contact if you have questions or complaints.

1.1 | COVER FOR *MEMBERS* AND THEIR FAMILIES

The *Plan* is an insurance policy. The *Plan* covers *members* of the *Plan* and their families for *life-changing events* that are covered under the *Plan*, for example death, disability or severe illness.

We pay all valid claims covered under the *Plan* if:

- *You* pay the correct premiums based on the risk insured, on time each month
- *You* and the *lives assured* comply with the terms and conditions of the *Plan*.

1.2 | DOCUMENTS THAT MAKE UP THE *PLAN*

Your Plan is made up of the following six documents:

- This *Life Plan Guide* (including its appendices, and any endorsements or special arrangements in writing signed by *you* and *us*).
- The quote that *you* sign in acceptance of the *Plan.*
- The *Policyholder's* Application Form that *you* complete.
- The Client Benefit Schedule that specifies the benefit levels and structure of *your Plan.*
- The Member Benefit Schedule that specifies the benefits for each *member* of *your Plan.*
- The General Benefit Limits Document that specifies the maximums and limits that apply to *your Plan* and will be updated from time to time.

Together, these documents form the whole agreement between *you* and *us*. This means that *you* must read them together. Even if other benefits are described in this *Life Plan Guide* or the quote, *your members* are only covered for benefits shown in the Member Benefit Schedule and Client Benefit Schedule.

1.3 | THE MOST RECENT VERSION OF THE *PLAN* APPLIES

The most recent version of each document that makes up the *Plan* that *we have* emailed to *you* or to *your* appointed financial adviser applies at the date of a *life-changing event* that leads to a claim. As an existing *policyholder,* the terms and conditions of the latest *Life Plan Guide* apply to *you* 31 days after *you* or *your* financial adviser receive it.

If an endorsement to the *Plan* is agreed between *you* and *us*, it will only form part of the *Plan* once submitted in writing and signed by *you* and *us*. If the *Plan* and any signed endorsements disagree with any other documents or communication between *you* or *your* financial adviser and *us*, the *Plan* and any signed endorsements will override all other documents or communications.

1.4 | CHANGES TO THE *PLAN*

We or *you* may change the *Plan* after giving 31 days' written notice to each other, unless:

- The law requires *us* to make the change immediately
- *We* and *you* agree in writing to a shorter time.

Any changes that *you* make will apply to all *members*.

The Client Benefit Schedule provides details of *members'* benefits, including premiums and any exclusions. *You* will receive a Client Benefit Schedule from *us* at the start date and at the annual renewal of the *Plan*. If any of the *Plan* details change, *we* will send *you* a new Client Benefit Schedule detailing the changes.

1.5 | OUR PROMISE TO *YOU* AND THE *MEMBERS*

We promise to always deal with *you* and the *members* fairly and objectively. The *Policyholder* Protection Rules under section 62 of the Long-Term Insurance Act 52 of 1998 apply to *your Plan*. See Appendix 1: Shared responsibilities undertaking which shows how *we* comply with the *Policyholder* Protection Rules.

1.6 | CONTACT INFORMATION RELATING TO THE *PLAN*

We aim to respond to *your* queries, claims and *complaints* as quickly as possible. *We* recommend that *you* contact *us* or *your* financial adviser first, as *we* may be able to resolve *your* issue quickly. *Your* financial adviser's details are given on the Client Benefit Schedule.

You can also contact *us* for any issues related to this *Plan* as follows:

General enquiries

Telephone: 0860 04 76 87
Email: groupinfo@discovery.co.za

Claims

Telephone: 0860 54 33 22
Email: groupriskclaims@discovery.co.za

Underwriting

Telephone: 0860 04 76 87
Email: groupriskuwquery@discovery.co.za

1.7 | *COMPLAINTS* PROCESS

At Discovery Corporate and Employee Benefits *we* take all *complaints* seriously and *we* are committed to resolving these *complaints* as speedily as possible.

Click here to view our *complaints* process.

1.8 | PRIVACY STATEMENT

The purpose of the privacy statement is to set out how *we* collect, use, share, process, and secure or store personal information, in line with the Protection of Personal Information Act ("POPIA").

Click here to read an important notice and to access the Discovery Group Privacy Statement.

DEFINITION OF *YOU/YOUR* FOR THIS SECTION

In this section, *you/your* refers to the *member*.

This section sets out the enhancements available to members of the Plan who are also members of Vitality.

2.1 | HOW VITALITY CAN IMPROVE *YOUR* BENEFITS ON THE *PLAN*

BENEFIT	HOW VITALITY IMPROVES YOUR BENEFIT	TO GET THE VITALITY BENEFITS, THE *PLAN* MUST HAVE:
Group Risk PayBack (20) Replaces the Corporate Integrator for all *Plans* quoted from 15 May 2018	PayBack of between 0% and 15% of the *Plan* premiums paid for *your* benefits, after subtracting admin and commission fees, in cash to *you*, or into *your* Discovery Life Umbrella Pension or Provident Fund, in which case it is doubled by adding an equal amount to your Boost account. The percentage PayBack depends on *your* Vitality Health Status or Vitality Health Check outcomes if *you* do not have a Vitality Health Status and the health claims *you* have made (see the General Benefit Limits Document).	▪ 20 or more *members* ▪ Life Cover Benefit with average *sum assured* of two times yearly risk salary or more ▪ Any Income Continuation Benefit except the Limited Term Income Continuation Benefit. And *you* must be a *member* of a medical aid that Discovery Health administers
Corporate Integrator (21) Discontinued for new business quoted from 15 May 2018, but still available to existing *policyholders* who had the benefit before this date	PayBack of between 0% and 40% of the *Plan* premiums paid for *your* benefits, including admin and commission fees, over three years, in cash to *you*. The percentage PayBack depends on *your* Vitality Health status.	▪ 20 to 500 *members* ▪ The Life Cover Benefit with average *sum assured* of two times the yearly risk salary ▪ The Income Continuation Benefit on the *Discovery Group Risk* recommended scale except the Limited Term Income Continuation Benefit.
Global Education Protector Private School Upgrade (12.9.2.2)	Eligible *children* are able to upgrade to a private school if *you* had Bronze Vitality Health status or higher on *your* date of death.	Too qualify for private school upgrade the policy must have the Global Education Protector Benefit.
Mortgage Protector (18)	Pays *your* mortgage payments for between 3 and 24 months depending on *your* Vitality Health status when the *life-changing event* leading to *your* claim happens.	▪ Life Cover Benefit with average *sum assured* of two times yearly risk salary or more ▪ Any Income Continuation Benefits except the Limited Term Income Continuation Benefit.
Contribution Protector (13.20)	Pays *your* premiums on various Discovery policies including Vitality, and contributions to any medical aid, for • 12 months on Core benefit • 24 months on Comprehensive benefit.	▪ Income Continuation Benefit, excluding Limited Term Income Continuation Benefit. ▪ If claimants qualify for the Upgrade on the Income Continuation Benefit Comprehensive, the Upgrade replaces the Contribution Protector.

BENEFIT	HOW VITALITY IMPROVES YOUR BENEFIT	TO GET THE VITALITY BENEFITS, THE *PLAN* MUST HAVE:
Performance Bonus Protector (13.21)	Pays between 0% and 100% of *your* average bonus over the 3 years before date of disability for 24 months. Percentage depends on *member's* Vitality Health status.	Any Income Continuation Benefit, excluding Limited Term Income Continuation Benefit.
HealthyLiving Protector (13.22)	Increases ICB Comprehensive benefit with average amount that *you* earned in cash backs from HealthyFood, HealthyGear and HealthyCare over the 6 months before *your* date of disability.	Income Continuation Benefit Comprehensive.
Free Cover Limit Multiplier (5.8)	Qualify for a *free cover limit* increase between 0% and to 40%. Percentage depends on *member's* Vitality Health status.	Any benefits to which a *free cover limit* applies, but subject to certain rand limits.

2.2 | ABOUT VITALITY

2.2.1 What the programme is

Vitality is a wellness programme administered by Discovery Vitality (Pty) Ltd. The programme empowers Vitality members to improve their health and wellness by giving them the knowledge, tools and motivation to set and meet health goals. Vitality then rewards *members* for positive behaviours that improve their health and, in turn, their productivity.

These Vitality membership enhancements have maximums, including rand maximums, and terms and conditions which, if *you* have selected them to form part of *your Plan*, are set out in this *Life Plan Guide* under the benefits to which they are linked. See the Vitality portfolio for complete details of the programme.

For clarity Vitality Membership can be membership to Vitality Active or Vitality Premium as both give the *member* a Vitality Health status.

2.3 | HOW *YOU* CAN JOIN VITALITY: THREE ROUTES TO VITALITY MEMBERSHIP

To qualify for Vitality membership, *you* must fall into one of these three categories:

Category 1 - Be a *member* of the Discovery Health Medical Scheme or a scheme administered by Discovery Health

Category 2 - Have an Individual Discovery Life *Plan*

Category 3 - Be an employee of an employer group with a *Plan*, where at least 10% of the employees are *members* of the Discovery Health Medical Scheme and where *your* employer does not restrict *members* from being a principal or adult dependant *member* on the Discovery Health Medical Scheme.

If *you* are in category 1, *your* dependants are also eligible for Vitality. If *you* fall into category 2, all lives insured on the *Plan* qualify. Similarly, if *you* fall into category 3, *your spouse* qualifies if *you* have *spouse* cover and/or family funeral cover on *your Plan*, and *your child* dependant(s) qualify if *your Plan* includes the Severe Illness or Cancer Benefit and/or the Family Funeral Cover Benefit.

If *you* join through the *Plan, you* can select the dependants *you* would like added to *your* Vitality membership. The meaning of dependants for this purpose includes family *members* who are dependent on *you* and defined as follows and excludes adult dependants:

- *Spouse* as defined in this *Life Plan Guide* in section 3.6
- *Child* as defined in this *Life Plan Guide* in section 3.7.

2.4 | VITALITY HEALTH POINTS FOR *MEMBERS* NOT ON THE DISCOVERY HEALTH MEDICAL SCHEME

Members and *spouses* who are not members of Discovery Health Medical Scheme, but are on Vitality through the *Plan* or an Individual Discovery Life *Plan*, can still receive Vitality Health points for preventive measures by submitting the results online at the Vitality Health portal for claiming points or by phoning 0860 998 877.

2.5 | PREMIUMS FOR VITALITY

There is a monthly premium for Vitality.

2.5.1 Who pays the premiums?

If *you* qualify for and select Vitality membership through *membership* of the *Plan*, then *your* Vitality contributions will be paid as follows:

APPROVED PLANS	*UNAPPROVED* PLANS
By *you*, in which case *you* will be billed separately.	By *you*, in which case the contribution may be billed with the *Plan* premiums or may be billed separately.

If *you* qualify for and select Vitality membership through membership of the *Plan*, *you* will be subject to premium requirements set out by *us* as stipulated in section 8.7 of this document.

2.5.2 Premium discounts

Vitality offers the following discount if all *members* on the *Plan* are on Vitality and if the *Plan* has 20 or more *members:*

DISCOUNT	NUMBER OF *MEMBERS*
15%	20 to 200
20%	201 to 500
25%	501 or more

2.6 | WHEN VITALITY MEMBERSHIP ENDS

Where membership in Vitality is through the *Plan*, membership in Vitality ends at the earliest of the following:

- The termination of the *Plan*.
- *You* are no longer an eligible *member,* and *you* do not have membership in Vitality through Discovery Health Medical Scheme or an Individual Discovery Life *Plan*.
- *Children* who are covered through their parent's Vitality membership turn 18 years of *age*.

Vitality defines a *child* over the age of 18 as a *child* dependent if:

- The *child* is unmarried
- Is a biological *child*, a stepchild, a legally adopted or fostered *child* of the principal *member*
- The *child* is between the ages of 18 and 21 years old
- The *child* is a full-time student or not self-supporting.

If the *Plan* no longer meets the criteria for *members* to join Vitality (that is, *your* employer restricts *members* from being principal members or adult dependants on the Discovery Health Medical Scheme, or less than 10% of *members* of the *Plan* are members of Discovery Health Medical Scheme), then:

- No more *members* of the *Plan* may join Vitality using the *Plan*, until the *Plan* returns to having the criteria met
- *Members* of the *Plan* who joined Vitality when the *Plan* did qualify retain their membership of Vitality through the *Plan*, unless one of the above termination events occurs.

2.7 | WELLNESS DAYS

Discovery Health Medical Scheme pays for Wellness days and voluntary counselling and testing for *members* who are on Discovery Health Medical Scheme.

Where 50% or more of *Plan members* are covered by the Discovery Health Medical Scheme, *we* will pay for Wellness Days and voluntary counselling and testing for up to 250 *members* of the *Plan* who are not on the Discovery Health Medical Scheme.

The *Plan* must have both the Life Cover and Income Continuation Benefits for *members* to benefit from payment of the Wellness Days and voluntary counselling and testing.

DEFINITION OF *YOU/YOUR* FOR THIS SECTION

In this section, *you/your* refers to the *policyholder*.

This section sets out the types of people involved in the Plan (their names are in italics throughout this Life Plan Guide), as well as any qualifying criteria or extra terms and conditions they may need to meet.

3.1 | THE *POLICYHOLDER*

In this *Life Plan Guide*, *policyholder* refers to the owner of the *Plan*, regardless of whether they are an *employer,* a retirement fund or an association.

We provide the group risk insurance agreed in the *Plan* between *us* and the *policyholder*.

In most cases, *Plans* have *employers* or retirement funds as *policyholders*. The employees of the *employer* or *members* of the retirement fund (both referred to as *members* of the *Plan*) are insured under a *Plan* owned by the *employer* or the retirement fund. Therefore, the *member's membership* of the *Plan* is because of their direct employment with the *employer*.

In rare cases, at *our* sole discretion, the *policyholder* may be an association which groups together individual people by association membership rules which may or may not be related to their direct employment. *We* only provide insurance to associations whose *members* are employed, even if the association is not their employer.

The name of the *policyholder* is set out on the Client Benefit Schedule which also shows whether a benefit is *approved or unapproved (4.1).*

3.1.1 If the *policyholder* is an employer

In this *Life Plan Guide*, *employer* refers to the organisation that employs the *members* of *Plans,* whose principal place of business is South Africa. The *employer's* employees who meet the criteria in the clause Criteria for qualifying as a *member* - the *policyholder* is an employer (3.2.1) below will be insured as *members* under the *Plan* owned by the *employer*.

The *employer*-owned *Plan* insures its *members* for *unapproved* benefits.

3.1.2 If the *policyholder* is a retirement fund

If a retirement fund is registered under the Pension Funds Act 24 of 1956 and is *approved (4.1)* by the South African Revenue Service to receive tax exemptions under the Income Tax Act 58 of 1962, it is called an *approved (4.1)* fund. The *Plan* will provide *approved* benefits *(4.1)* to the retirement fund in terms of the retirement fund's registered and approved rules.

Members of the retirement fund who meet the criteria in the clause Criteria for qualifying as a *member* - the *policyholder* is a retirement fund (3.2.2) below will be insured under the *Plan* owned by the retirement fund. The retirement fund-owned *Plan* insures its *members* for *approved* benefits.

3.1.3 If the *policyholder* is not a retirement fund or *employer*

We may offer insurance on a case-by-case basis, at *our* sole discretion, to an association whose membership is determined by association membership rules that may not relate to the existence of an employment relationship between the association and its *members*. *We* only provide this insurance if the *members* of the association are employed, even if the association is not their employer.

Members of the association who meet the criteria in the clause Criteria for qualifying as a *member* - the *policyholder* is an association (3.2.3) below will be covered under the *Plan* owned by the association.

The association-owned *Plan* insures its *members* for *unapproved* benefits.

3.2 | THE *MEMBER*

3.2.1 Criteria for qualifying as a *member* – the *policyholder* is an *employer*

Where the *policyholder* is an *employer*, the *member* is an employee of the *employer* and qualifies to be covered by the *Plan*. To be an "*eligible member*" and qualify for cover as a *member* of the *Plan*, an employee must be:

- A South African citizen or have a valid residence and/or work permit to work in South Africa, unless *we* agree in *our* quote to include *foreign nationals (3.9)*
- Younger than the *benefit expiry age (4.2.3)* shown on the Client Benefit Schedule
- Employed by the *employer* as a permanent, full-time employee and whose membership in the fund is compulsory as a condition of employment (no fewer than 25 hours a week, unless *we* agree to fewer hours in the quote); and
  - not a contractor, temporary employee, or part-time employee (unless *we* agree to include them in the quote in terms of the clause Waiving the membership exclusion (3.3.1) for contractors, temporary employees and part-time employees).
- An active employee who was *actively at work (7.3)* on
  - the start date of the *Plan*; or
  - the start date of their employment (for employees who join after the start date of the *Plan*).

3.2.2 Criteria for qualifying as a *member* – the *policyholder* is a retirement fund

Where the *policyholder* is a retirement fund, the *member* is an employee of the *employer* that sponsors or participates in the retirement fund and is also a *member* of the retirement fund, and qualifies to be covered by the *Plan* in line with registered and approved rules of the retirement fund or the approved special rules relating to the employer.

To be an "*eligible member*" and qualify for cover, a retirement fund *member* must be:

- A South African citizen or have a valid residence and/or work permit to work in South Africa, unless *we* agree in *our* quote to include *foreign nationals (3.9)*
- Younger than the *benefit expiry age (4.2.3)* shown on the Client Benefit Schedule
- Employed by the *employer* that sponsors or participates in the retirement fund as a permanent, full-time employee and whose membership in the Fund is compulsory as a condition of employment (no fewer than 25 hours a week, unless *we* agree to fewer hours in the quote); and
  - not a contractor, temporary employee, or part-time employee (unless *we* agree to include them in the quote in terms of the clause Waiving the membership exclusion (3.3.1) for contractors, temporary employees, and part-time employees.
- An active employee of the employer that sponsors or participates in the retirement fund and who was *actively at work (7.3)* on
  - the start date of the *Plan*; or
  - the start date of their employment (for employees who join after the start date of the *Plan*)
- A *member* of the retirement fund on the start date of the *Plan* or on the start date of their employment with the *employer* that sponsors or participates in the retirement fund (for employees who join after the start date of the *Plan*). If the employment rules of the *employer* or the rules of the retirement fund restrict membership of the retirement fund to a future date after employment has started, then such *members* only qualify for cover if they join the retirement fund at that future date.

3.2.3 Criteria for qualifying as a *member* – the *policyholder* is an association

Where the *policyholder* is an association, whose membership is organised by criteria which may or may not be employment-related, the *member* must belong to the association according to the association's rules and qualify to be covered by the *Plan*.

Associations may be organised in terms of employment-related or non-employment-related criteria. However, *we* only insure *members* of associations who are employed, whether or not employment is a criterion for association membership.

If the *members* of an association are not employed, or if it is not obvious whether they are employed at quote stage, *we* will not insure them.

The kind of associations *we* may provide insurance to are described as independent, democratically controlled groupings of people united voluntarily to meet their common economic and social needs and aspirations. This specifically includes recognised unions organised around specific types of *employers* or industries but may include other associations on a case-by-case basis.
Insurance which *we* will not provide to associations includes but is not limited to the following:

- Insurance plans offered by cell phone companies to their clients. Employees of cell phone companies may be covered under a *Plan* set up by their *employer* or retirement fund.
- Open retail funeral insurance plans offered to the public.
- Funeral insurance plans for the congregants of religious organisations. Employees of religious organisations may be covered under a *Plan* set up by their *employer* or retirement fund.
- Insurance for players of sports associations, whether amateur or professional, at any level of play, and whether or not nominally employed by the association. Employees of these organisations who are not players may be covered under a *Plan* set up by their *employer* or retirement fund.

To be an "*eligible member*" and qualify for cover, an association *member* must be:

- A South African citizen, unless *we* agree in *our* quote to include *foreign nationals (3.9)*
- Younger than the *benefit expiry age (4.2.3)* shown on the Client Benefit Schedule
- Employed by an *employer* as a permanent, full-time employee (no fewer than 25 hours a week, unless *we* agree to fewer hours in the quote); and
  - not a contractor, temporary employee, or part-time employee (unless *we* agree to include them in the quote in terms of the clause Waiving the membership exclusion (3.3.1) for contractors, temporary employees, and part-time employees).
- An employee who was *actively at work (7.3)* on
  - the start date of the *Plan*; or
  - the start date of their *membership* of the *Plan* (for association *members* who join after the start date of the *Plan*)
- An association *member* whose subscription fees are up to date
- Compliant with any other criteria *we* may require in terms of the characteristics of the association.

3.2.4 Compulsory for employees who qualify

Membership of the *Plan* is compulsory for every employee, retirement fund *member* or *member* of an association who qualifies as a *member.* A *member* may not end their *membership* of the *Plan* while they still remain employed and qualify as a *member*.

3.2.5 Previously uninsured *members* who do not wish to join a new *Plan* when it starts

If employees, retirement fund or association *members* do not wish to join the *Plan,* and *we* agree to exclude them as *members*, they may apply for membership later. However, the *free cover limit* will not apply to them, and they will need to undergo *medical underwriting* (that is, complete a medical questionnaire and go for medical tests) that *we* require. Admission to the scheme is at our sole discretion.

3.2.6 *Members* who are eligible to be *members* of more than one *Plan*

Circumstances may arise where a *member* qualifies to belong to more than one *Plan*. This is allowed, if *we* are informed of these *members* at quote stage or at any other time after that when the situation arises, and the following conditions apply:

- For benefits paid as lump sums (whether they are Core, Plus or Flex Benefits or riders attached to these benefits), the maximum *sums assured* for each benefit in the General Benefit Limits Document apply to the combined *sum assured* from all *Plans* the *member* belongs to. If a *member's* combined *sum assured* for a particular benefit exceeds the benefit's maximum, then the *sums assured* for that benefit in each *Plan* will be reduced proportionately to lower the combined *sum assured* to the maximum.
- The Global Education Protector will be paid as if it were only insured under one *Plan*, but for pricing purposes, the costs of this benefit will be shared between all the *members' Plans* which have the Life Cover Benefit, in proportion to the *sums assured* for the various *Plans'* Life Cover Benefits.
- The aggregation of benefits (see clause Aggregation of income benefit - When the amount *we* pay is reduced (13.7.4)) applies to the combined Income Continuation Benefit monthly benefits and riders from the *Plans*. If at claim stage the claim amount paid needs to be reduced to meet the aggregation limit (the combined value of the basic monthly Income Benefit, the Waiver Benefit and any Upgrade Benefit payable cannot be more than 100% of net-after tax pre-disability salary calculated as cost to company salary less tax on cost to company), then the claims from each *Plan* will be reduced proportionately to reduce the combined claim paid to the aggregation limit.

Riders will be reduced similarly to reduce them to their maximum level in the General Benefit Limits Document.

- The *free cover limit* applicable for each benefit is the highest *free cover limit* for that benefit in the various *Plans*, applied to the combined *sums assured* for all the same benefits from the *Plans*. The *sum assured* subject to *medical underwriting* will be the combined *sum assured* for each benefit from the *Plans*, less the highest *free cover limit* in the various *Plans*. Where this excess insurance above the *free cover limit* is declined, then the *member's* benefit in all *Plans* will be proportionately lowered to reduce the combined *sum assured* for that benefit to the level of the highest *free cover limit* for that benefit in the *Plans*.

EXAMPLE

If a *member* belongs to three *Plans* with the following sums assured and *free cover limits*:

	Plan A	*Plan B*	*Plan C*
Sum assured	R5 m	R7 m	R8 m
Free cover limit	R2 m	R3 m	R5 m

Then:

- The *member's* combined *sum assured* = R5 m + R7 m + R8 m = R20 m
- The *member's free cover limit* = R5 m (the highest of the *Plans' free cover limits*)
- The *member* will be *medically underwritten* for R15 m (R20m less R5 m)

- If the *member* is declined for medical reasons, then the sums assured in each *Plan* would be reduced to 25% (free cover limit / combined sum assured = R5 m/ R20 m) of their potential value as follows:

	Plan A	*Plan B*	*Plan C*
Reduced sums assured	R1.25 m (R5 m x 25%)	R1.75 m = (R7 m x 25%)	R2 m = (R8 m x 25%)

This would give a combined *sum assured* equal to the R5 m *free cover limit*.

3.3 | CONTRACTORS, TEMPORARY WORKERS, AND PART-TIME EMPLOYEES

Contractors, temporary workers, and part-time employees do not qualify as *members*

Contractors:	People employed for a limited period under a contract that ends either on a set contract end date or on the happening of a specified event or completion of a specified task or project.
Temporary workers:	People employed for temporary periods with a specific start and end date, which may be continuous or broken periods. For example, seasonal workers.
Part-time employees:	People employed for fewer than 25 hours a week.

If employees start as contractors, temporary workers or part-time employees and then later meet the criteria for qualifying as a *member*, *we* will prepare a new quote for the *Plan*. When the *policyholder* accepts the new quote, a new *Plan* that includes the newly qualifying *members* will start and may have different premiums, terms and conditions to the current *Plan*.

3.3.1 Waiving the *membership* exclusion for contractors, temporary employees, and part-time employees

The exclusion of contractors, temporary workers, and part-time employees may be waived if:

- The *policyholder* is a retirement fund, and these *members* are obligated to belong to the fund in terms of its registered rules and their employment contract; or
- The *policyholder* requests that these employees be allowed to join the *Plan* for another reason; and
  - *We* are informed of this requirement at quote stage; and
  - *We* agree to insure these employees, at *our* sole discretion; and
  - *We* include these employees for insurance in writing either in the quote or in an endorsement to the *Plan*.

We may increase the premium if *we* decide to allow these employees to join the *Plan*.

The waiver of *membership* exclusion only applies if acknowledged in writing by *us*, either in a quote or an endorsement. If *we* do not give a written waiver, then contractors, temporary employees and part-time employees are excluded, whether or not *we* were notified of the existence of these contractors, temporary employees and part-time employees.

3.4 | POLITICAL OFFICEHOLDER COVERED UNDER THE *PLAN*

A *political officeholder* is a person who is elected to their position and may be re-elected to that position, or a political appointee. *Political officeholders* include *members* of Parliament, *members* of a provincial legislature, diplomatic representatives of South Africa, *members* of a municipal council, *members* of a house or council of traditional leaders, and any elected officials of a political party or alliance or movement.

Full-time staff of the structures mentioned above who are employed (not elected) to administer and manage the day-to-day requirements of these structures are not *political officeholders*.

Political officeholders are eligible for insurance at our sole discretion and must be notified to *us* at quote stage or when *political* officeholders are first added to an existing *Plan*, whether the *policyholder* for this insurance would be the political party they stand for or the regulatory body in which they serve. The full-time staff of political parties or regulatory bodies (who are not p*olitical officeholders*) are eligible for insurance if they qualify as *members* of a *Plan*.

3.5 | THE LIFE *ASSURED*

A *life assured* is a person whose life is covered under the *Plan*. There may be more than one *life assured* on the *Plan*, for example, the *member*, their *spouse* and their *child*. In most cases, the *life assured* is the *member* of the *Plan*. For certain benefits (*Spouse* Benefits, Funeral Cover Benefits, *Child* Severe Illness and *Child* Cancer Benefits and the Family Protector), where a benefit is paid when a *life-changing event* occurs to a person related to the *member* (*spouse*, *child* or extended family member), that related person is the *life assured*.

We pay out when the *life assured* experiences a *life-changing event* that they are covered for, for example, death, disability or severe illness.

It is legally required that, on setup of the *Plan,* the *policyholder* give *us* all documentation and proof of the particulars of the *life assured*, including contact details and identity numbers (South African citizens or permanent residents) or passport numbers (*foreign nationals (3.9)* with work permits). This is so that *we* can calculate the benefits and premiums and meet other requirements in terms of the *Policyholder* Protection Rules. If *we* find out later that any of this information is incorrect, *we* may adjust the benefits and premiums or exercise any of *our* rights in terms of the Misrepresentation (4.13) or Fraud (4.14) clauses.

3.6 | A *SPOUSE*

3.6.1 *We* recognise several legal marriage systems

A *spouse* is the person or persons that a *member* is legally married to. For the purposes of the *Plan*, a *spouse* is any of the following:

- A *spouse* of the *member* in terms of the Marriage Act 68 of 1961
- A *spouse* of the *member* in terms of the Recognition of Customary Marriages Act 68 of 1997
- A civil union partner of the *member* in terms of the Civil Union Act 17 of 2006
- A *spouse* or partner of the *member* in accordance with the tenets of a religion that is recognised under South African law
- A permanent life partner of the *member* in a relationship of mutual dependence with the *member*, in the manner of a *spouse*, living together and running a common household

3.6.2 If a *member* has more than one *spouse*

If a *member* has more than one *spouse and has not informed us which spouse must be covered under this Plan, we will* treat the *spouse* that the *member* has been married to for the longest as the *spouse* for the *Plan*, and that *spouse* will be the only *spouse* that qualifies for benefits under the *Plan*.

An exception to this term is the Family Funeral Cover Benefit and the Family Protector Benefit, where up to three *spouses* can be insured. In this case, the three *spouses* that the *member* has been married to for the longest will be treated as the only *spouses* that qualify for this benefit.

3.6.3 *We* must receive proof of marriage

The *member* must give *us* proof of their marriage or marriages at claims stage.

3.7 | A *CHILD*

3.7.1 General definition of a *child*

The general definition of a *child* includes points 1 to 4 set out below. There are different definitions of a *child* for the Family Funeral Cover Benefit, the *Child* Severe Illness Benefit, the *Child* Cancer Benefit and the Global Education Protector Benefit, which are set out after this general definition.

A *child* is a person who:

01 | Is unmarried

02 | Is financially dependent on the *member*

03 | Has not reached the following *ages*:

For the *Child* Severe Illness and *Child* Cancer Benefit	18
For the Global Education Protector Benefit	24
For the Family Protector Benefit	19
For the Family Funeral Cover Benefit (*child* is not studying)	21
For Vitality membership	18

04 | And is one of the following:

- A **natural** *child* of the *member*
- A **stepchild** of the *member*, where the stepchild's parent at the time of the *life-changing event* is the *member's spouse* and *we* are informed of the existence of the stepchild. The *member* must have been legally married to the stepchild's parent before the date of the life-changing event. If the *member* and the parent of the stepchild divorce before the *life-changing event*, the benefit falls away for that stepchild
- A court-ordered **foster *child*** of the *member* or the subject of an application for court-ordered foster care by the *member*, where the application was lodged before the *life-changing event*
- A legally **adopted *child*** of the *member* or the subject of an application for adoption by the *member*, where the application was lodged before the *life-changing event*
- A **grandchild** of the *member* where both parents of the *child* are deceased, and the *child* is dependent on the *member*. The grandparent must be a parent to one of the *child's* parents.

3.7.2 Extended definition of a *child* for the Family Funeral Cover Benefit

For the **Family Funeral Cover Benefit**, the definition of a *child* is extended to include:

- A *child* of the *member* who **studies full time** at a *recognised educational institution* and who has not yet turned 24
- A **stillborn *child*** of the *member* where the fetus dies after the 26th week of pregnancy
- A *child* of the *member* who **has a mental or physical disability that means they cannot maintain themselves**. No *age* limit applies. The *child* must be completely dependent on the *member* for support and maintenance. Once a *child* becomes independent of the *member* for support and maintenance, they will not be considered as a *child* under the Family Funeral Cover Benefit if they become dependent on the *member* at a future date.

3.7.3 A *child* excluded from the Global Education Protector Benefit

The **Global Education Protector Benefit** does not cover *members'* foster *children* and grandchildren. Foster *children* and grandchildren are therefore excluded from the definition of *child* for this benefit.

3.7.4 A *Child* excluded from the *Child* Severe Illness and Cancer Benefit

The *Child* Severe Illness and *Child* Cancer Benefit do not cover *members'* stepchildren, foster *children* or grandchildren, so they are excluded from the definition of *child* for this benefit.

3.7.5 Treatment of a disabled *child*

A disabled *child* is only defined as a *child* for the purpose of the Family Funeral Cover Benefit.
For other benefits, a disabled *child* may benefit on the same terms and conditions (including *age* limits) as other *children*. Financially dependent disabled *children* may join Vitality as *child* dependants up to 21 years of *age*, and as adult dependants after 21 years of *age*.

3.7.6 Proof of *child* beneficiary status

The *member* or in the case of a deceased *member* the appointed executor or *policyholder* must tell *us* about the *children* who qualify under the *Plan* within six months after they qualify for a benefit.

We need proof that a *child* was a beneficiary before the date of claim, except in the case of an unborn *child*, in which case proof should be provided after birth. Depending on the nature of the relationship, proof could include any of the following:

- An unabridged birth certificate
- Proof of financial dependency on the *member*
- Proof of study at an educational institution
- Proof of marriage (in the case of a *stepchild*)
- Proof of adoption or of an application for adoption before the *life-changing event*
- Proof of court-ordered formal foster care or of an application for foster care before the *life-changing event.*

We will let the *policyholder* know if *we* need any extra information to make any payments.

3.8 | BENEFICIARIES AND DEPENDANTS

3.8.1 *Definition* of beneficiaries

For *approved* policies, the Life cover benefit is always paid to the Fund (*policyholder*) in terms of the rules and applicable legislation. The Trustees of the Fund will distribute the Life Cover benefits as part of the death benefit payable in terms of the rules of the Fund after applying the principles of Section 37C of the Pension Funds Act.

For *unapproved* policies, the beneficiaries are people or organisations (other than the employer) the *members* wish to receive their Life Cover and Funeral Cover Benefits. These beneficiaries must be nominated by the *member*, in writing or electronically, on the beneficiary nomination form.

The *employer* or a trust the *employer* controls, cannot be named as the beneficiary of the benefits, as this is in contrast with the intent of the Insurance Law.

3.8.2 *Definition* of dependants

For *approved* benefits, dependants are people who qualify as dependants of the *member* in terms of the Pension Funds Act 24 of 1956. This includes people who:

- Are factually financially dependent on the *member* at the time of the *member's* death (even though the *member* has no legal duty to support them)
- The *member* is legally responsible for supporting financially
- In the future would have had the legal right to receive maintenance from the *member*.

Dependants include the *member's spouse* and all biological and adopted *children* and may well include other people whom the Trustees consider to be dependent on the *member*.

3.9 | FOREIGN NATIONALS

3.9.1 *Employees* with valid work and residence permits

We may insure employees who are *foreign nationals* only if they have a permanent residence permit to live and work in South Africa, or a work permit to work in South Africa. It is illegal for *us* to insure *foreign nationals* without the relevant permits.

It is *your* responsibility to make sure that any *foreign nationals you* want to include in *your Plan* have valid permits to work in South Africa. *You* must tell *us* about these *members* at quote stage. *Foreign nationals* with a valid work permit who are not identified to *us* at quote stage will not be insured.

3.9.2 *Foreign nationals* who are legally working for the *employer* in another country

Foreign nationals who are legally working for the *employer* in a country other than South Africa are not covered under the *Plan*. In some circumstances, and at *our* sole discretion, *we* may agree to include these employees after consulting with *our* reinsurers. These foreign nationals will only be insured if acknowledged in writing by *us*, either in a quote or an endorsement. If *we* do not agree in writing to insure them, then *foreign nationals* who are legally working for the employer in another country are excluded, whether or not *we* were notified of their existence.

3.9.3 Conditions for *foreign nationals*

If *we* do agree to insure *foreign nationals* under the *Plan*, the terms and conditions below apply**.**

3.9.3.1 About receiving and making payments

We calculate premiums and sums assured and make and expect to receive all payments in South African rand.

In all cases, *we* pay claims in rand into the South African bank accounts of the persons or organisations being paid. The only exception is, at *our* sole discretion, for *unapproved* Life Cover Benefit claims (see the last point in this section).

Accepted claims are paid as follows:

- **For *approved* Life Cover Benefits:** *We* pay the retirement fund, and the Trustees decide which amounts to distribute to the dependants (and beneficiaries where appropriate) in terms of Section 37C of the Pension Funds Act 24 of 1956.
- **For *approved* Capital Disability Benefits:** *We* pay the retirement fund, and it distributes the amount to the *member*.
- **For *unapproved* Capital Disability Benefits, Severe Illness and Cancer Benefits:** *We* pay the *member*.
- **For Funeral Cover Benefits:** *We* pay the *member*, or their beneficiaries if the *member* is the *life assured* who dies, or the *member's* deceased estate if they have not elected beneficiaries.
- **Income Continuation Benefit:** *We* pay the *employer* unless instructed to pay the *member* directly for some or all benefit components. Where *we* are instructed to pay the *member* directly, *we* pay any waiver attached to the Income Continuation Benefit to the *member's* retirement vehicle (for the portion intended to insure part or all of their retirement contributions) or to their insurer (for the portion intended to insure part or all of their insurance premiums).
- **Waiver Benefit:** *We* pay the *policyholder* unless instructed to pay the Occupational Fund, of which the *member* is deemed to be a *member* for retirement funding purposes, or the *member* directly in the event of a separation or termination of employment. We will pay any portion of the waiver benefit intended to the retirement fund vehicle of the *member's* choice and the portion to cover risk benefits to the appropriate insurer.

It is not legal to pay *unapproved* Life Cover Benefits to the *employer*. These benefits may only be paid directly to the *member's* beneficiaries, or the *member's* deceased estate if there are no beneficiaries.

- **For *unapproved* Life Cover Benefits:**
  - If beneficiaries exist, and they have a South African bank account, *we* will pay their portion of the Life Cover Benefit into this account in rand.
    It is a condition of the *Plan* that benefit payments should be made into South African bank accounts. However, if a South African bank account is not available for the beneficiaries, and if there are no laws preventing *us*, we will make the necessary foreign exchange arrangements to pay into the beneficiary's foreign-based bank account. Foreign exchange rules may delay the payment, and other documents and requirements may apply. The exchange rate at the time of payment will apply and the beneficiaries will be responsible for the relevant exchange control and other approvals and any associated costs, fees or taxes.
  - If no beneficiaries exist, the *unapproved* Life Cover Benefit will be paid into the *member's* deceased estate.

3.9.3.2 Medical evidence in support of insurance above the *free cover limit*

Medical evidence for insurance above the *free cover limit* must be produced by a doctor who is recognised by one of the following embassies in the country of residence to conduct the relevant medical tests:

- South African Embassy
- United States Embassy
- British Embassy

If such a doctor is not available, the medical evidence must be produced by a South African doctor registered with the HPCSA and practising in South Africa.

3.9.3.3 Medical evidence in support of a claim

All medical evidence in support of a claim must be supplied by a South African doctor registered with the HPCSA and practising in South Africa.

3.9.3.4 Contribution Protector and Mortgage Protector

If the *member* qualifies for payment of the Contribution Protector, *we* will pay only if the *foreign national* is a *member* of a South African medical aid.

If the *member* qualifies for payment of the Mortgage Protector, *we* will pay only if the home or other place of residence is in South Africa.

3.9.3.5 Benefits that are not available to *foreign nationals* working outside South Africa

The following benefits are not available to *foreign nationals* working outside South Africa:

- Global Education Protector
- Performance Bonus Protector
- LifeTime Capital Disability Lump-sum Benefit

3.10 | LABOUR BROKERS

Labour brokers supply workers to *employers* through a contract between the labour broker and the *employer*. Workers contracted to a labour broker to be supplied to other *employers* in this way are not considered employees of the *employer*. *We* do not insure workers contracted to a labour broker in this way under any circumstances, whether or not:

- They are South Africans or *foreign nationals (3.9)*
- They are working for the *employer* in South Africa or in a foreign country
- The labour broker is based in South Africa or a foreign country
- Insurance is requested via the *employer* or the labour broker.

If an *employer* employs workers formerly provided to them by a labour broker as direct permanent employees of the *employer*, then for the purposes of the *Plan* they are treated as if they were permanent employees.

The direct staff of a South African-based labour broker, employed by the labour broker to manage the brokerage and not provided to other employers, may be insured through a *Plan* set up by their labour broker *employer* or retirement fund.

DEFINITION OF *YOU/YOUR* FOR THIS SECTION

In this section, *you/your* refers to the *policyholder*.

This section gives explanations of key terms and sets out the general legal provisions used in the Plan and other documents that relate to the Plan. Explained terms are in italics throughout this Life Plan Guide.

4.1 | ABOUT *APPROVED* AND *UNAPPROVED* BENEFITS

The *Plan* can be structured as supplying *approved* risk benefits or *unapproved* risk benefits or both. The words *approved* and *unapproved* here do not have the usual English meaning of something that is desirable or undesirable.

For insurance purposes, benefits provided by a retirement fund are normally *approved* by the Receiver of Revenue and they provide the *member* with tax benefits. Only Life Cover and Capital Disability can be *approved* in this way, and approval can only be given to these benefits when they are offered by a retirement fund.

Unapproved benefits are offered by a *policyholder* other than a retirement fund, normally by the *employer*, and do not get the same tax treatment as *approved* benefits offered by retirement funds.

The table on the right gives a high-level overview of the differences between the two structures. The Client Benefit Schedule reflects which benefits under the *Plan* are *approved* and *unapproved*.

TYPE OF *PLAN* ***FOR LIFE COVER***	WHO IS THE *POLICYHOLDER?*	DO PREMIUMS QUALIFY FOR A TAX DEDUCTION?	ARE BENEFITS TAXED AT DEATH?	WHO ARE BENEFITS PAID TO ON THE ***MEMBER'S*** DEATH?
Approved	The retirement fund	Yes	Yes, amounts above R550,000 are taxed. Any amounts received tax free from withdrawals or severance benefit payouts count towards the R550,000 tax exempt amount that a *member* receives over his lifetime.	The retirement fund. The Trustees of the retirement fund then decide who the benefits are paid to. They distribute them to people they decide were legally and/or financially dependent on the *member*, after an investigation required by Section 37C of the Pension Funds Act. These dependants might not be the same as the beneficiaries chosen by the *member* in their beneficiary nomination form.
Unapproved	The *employer* or association	No. The *member's* premiums are paid by the *employer* from the *member's* salary, and the *member* pays fringe-benefit tax on the premiums that the *employer* makes.	The benefits are not taxed in the hands of the recipient, but Estate Duty may apply.	The *member's* beneficiaries as named in their beneficiary nomination form, or the *member's* deceased estate if there are no recorded beneficiaries.

4.2 | ABOUT *AGE*

For all *ages* referred to in the *Plan*, except the *maximum entry age (4.2.1)*, the *life assured* will be regarded as having reached the *age* at the end of the month in which the relevant *age* is reached. *Members* must be older than 15 to get the benefits of the *Plan*.

4.2.1 *Maximum entry age* (oldest joining age for benefits)

The *maximum entry age* is the oldest age a *life assured* can be on the date they join the *Plan* to qualify to be insured for a specific benefit. A *life assured* that is older than the relevant *maximum entry age* for a particular benefit on the date they join the *Plan* will not qualify for insurance.

The *life assured* will be regarded as having reached the *age* at the end of the month before the month in which the relevant *age* is reached. For example, if the *maximum entry age* is 60 and the *life assured* turns 60 in February, the latest the *life assured* can join in order to be insured under the *Plan* is in January.

BENEFIT	OLDEST JOINING *AGE*
All benefits where the *member* was covered for those same benefits under another compulsory group insurance policy, up to the *benefit expiry age*, immediately before joining the *Plan*	*Benefit expiry age*
All Core and Plus Benefits where the *member* was not covered under another compulsory group insurance policy for those same benefits immediately before joining the *Plan*	65
Flex Benefits where the *member* was not covered for them immediately before joining the *Plan*	55

4.2.2 Proof of *age*

Before *we* make a claim payment, *we* will ask for proof of a *life assured's age*.

4.2.3 *Benefit expiry age* (age when the benefits end)

You choose the *benefit expiry age* for the benefits. This is normally the *age* when the *member* would reach normal retirement *age*. The *ages* that *you* may choose are 60, 63 or 65 for most benefits.

We can provide life and funeral insurance to a maximum benefit *age* of 70 years. The *members* must still qualify as *members,* and *you* must specifically ask for this *age*.

Your chosen *benefit expiry age* is shown on the Client Benefit Schedule.

You and the *members* must meet the *age* requirements of the Basic Conditions of Employment Act 75 of 1997.

4.3 | THE FREE COVER LIMITS

The *free cover limit* for each benefit is the maximum *sum assured* that *we* provide to *members* for that benefit without requiring them to go for medical tests and/or complete medical and other insurance questionnaires (referred to as *medical underwriting*). *We* set the *free cover limit* for the benefits and for the *Plan*. *We* may review the *free cover limit* at any time.

For insurance above the *free cover limit*, *we* require *medical underwriting*. This excludes the Funeral Cover Benefit and Spouse's Life Cover where no medical underwriting is required.

4.4 | MEDICAL UNDERWRITING

Obtaining medical tests and/or completing other insurance questionnaires required to determine if the *member* qualifies for insurance above the *free cover limit*.

Should the *member* not complete the questionnaires and tests required by *us* within the timeframes communicated by *us* with the request for underwriting, we will stop issuing requests for underwriting and set the member's benefit equal to the *free cover limit* or insurance cover previously accepted. Should the *member* be willing to undergo underwriting after this, it is the member's responsibility to request the underwriting forms to start the underwriting process.

4.5 | A LIFE-CHANGING EVENT

A *life-changing event* is death, illness, injury or disability that is severe enough to affect a *life assured*'s lifestyle, possibly including their ability to earn an income.

4.6 | SUM ASSURED

The *sum assured* for benefits and maximum benefit limits are set out in the Client Benefit Schedule. Maximum benefit limits not set out in the Client Benefit Schedule are set out in the General Benefit Limits Document. For all applicable benefits, the *sum assured* is the amount that *we* will pay for a benefit when a *life-changing event* happens, and the terms and conditions of the *Plan* have been met. In other words, it is the amount that *we* insure the *life assured* for, for the particular benefit. Some benefits, such as the Global Education Protector Benefit, are based on the *indemnity principle*. They do not have a *sum assured* but have limits applicable as per the General Benefit Limits Document and so are not added to the sum assured for the free cover limit calculation.

4.7 | WHAT IS AN *ACCIDENT*?

For some benefits, *we* insure death, disability or illness that is caused by an *accident*. *We* only pay a benefit for this if an *accident* has directly and solely caused the death, disability or illness.

We define an *accident* as an event that happens:

- Directly, solely, suddenly and unexpectedly
- At a known time and place
- From a visible, violent and external cause.

Murder, or unprovoked assault by a third party, is included in the definition of *accident*.

4.7.1 Causes of death, disability or illness that *we* exclude from the definition of *accident*

We do not consider the events listed below as *accident*s. *Accident* insurance will exclude claims as a result of the following:

- Suicide or attempted suicide
- Any self-inflicted injury or self-inflicted illness, whether intended or not (harm, injury or illness that the *life assured* causes to themselves)
- The *life assured's* intentional and negligent consumption of poisons, alcohol, drugs or narcotics, unless a registered medical practitioner prescribes the drugs or narcotics and they are taken in accordance with that prescription. Neither the *life assured* nor their family members or relatives may perform the role of a registered medical practitioner in these circumstances.
- Events that result from the *life assured* deliberately performing any illegal act in terms of any law, common law or any code that has the force of law in South Africa, regardless of whether the *life assured* was criminally charged by the applicable law enforcement agencies or found guilty of an offence by a court of law
- Events that result from the life assured driving without possession of the relevant driver's licence
- Events that result from the *life assured* committing an act of war or taking part in riots or acts of public hostility
- Events that result from the *life assured* taking part in dangerous activities, for example mountaineering or base jumping
- Events that result from the *life assured* taking part in any type of air travel, aviation or airborne activity, except as a passenger or a pilot with a current commercial pilot's licence flying on a recognised route between licensed airfields in:
  - A registered passenger aircraft that is owned and operated by a licensed airline or air-transport company
  - A military passenger aircraft.

4.8 | WHAT IS A RECOGNISED EDUCATIONAL INSTITUTION?

We provide some benefits only if a *child* is attending a *recognised education institution.*

A *recognised educational institution* is an educational institution that is registered with the appropriate registration body which awards certified qualifications. The registering body will depend on the type of study (for example, schools and universities must be registered with the South African Department of Education, a flying school needs to be registered with the South African Civil Aviation Authority, etc). The requirement for recognition applies to all education levels.

When the word *recognised* is used with a specific educational institution (for example, *recognised* primary school) the meaning is the same for that specific institution.

4.9 | *CESSIONS* (TRANSFERRING OF *PLAN* BENEFITS)

A *cessionary* is usually a lending institution that a transfer of part of the Life Cover Benefit (*cession*) is made in favour of, for example a bank, to provide security for a debt.

4.9.1 *Approved* Life Cover Benefits should not be ceded (transferred) as security for a debt

As the *policyholder* is the retirement fund, the pay out of *approved* Life Cover Benefits is regulated by Section 37C of the Pension Funds Act 24 of 1956. The Trustees of the retirement fund distribute the Life Cover Benefit among dependants and beneficiaries. This means that *members* cannot cede the *approved* Life Cover Benefit as security for a debt.

4.9.2 *Unapproved* Group Life Cover Benefits may be ceded (transferred) as security for a debt

If the *policyholder* agrees, *a member* may transfer (cede) *their unapproved* Life Cover Benefit to a *cessionary* as security for a debt to a bank. The *cessionary* must be regulated by the National Credit Act 34 of 2005. This transfer is referred to as a *cession*. It is *the member's* responsibility to understand the consequences of any *cession* they agree to.

The *member* will need to complete and sign the *cession* form and provide the relevant supporting documents, including an agreement of *cession* signed by the *member*, for *us* to note the *cession*. Both the *cessionary* and the *member* will need to accept the *cession* in writing. No *cession* will be valid or binding on *us* unless the *cession* is recorded and confirmed by *us* in writing.

It is the *member's* responsibility as the *cedent* to provide the *cessionary* with the policy contract.

We will not be liable if *unapproved* Life Cover Benefit payouts are not made to a valid *cessionary* because the *cession* was not recorded and confirmed by *us* in writing.

It is the *member's* responsibility to tell *us* if the *cession* is cancelled. If a *member* does not tell *us* about a cancelled *cession*, *we* will not be liable if *unapproved* Life Cover

Benefit payouts are made to a valid *cessionary* after a *cession* has been cancelled.

CESSION	**CONSEQUENCES OF THE** *CESSION*	**LIMITS TO WHAT** *YOU* **CAN TRANSFER BY** *CESSION*
Transfer of all or part of an unapproved Life Cover Benefit as security for a debt (also referred to as a collateral *cession*)	*Member* borrows from a *cessionary* (lending institution). *Member* transfers rights to receive Life Cover Benefit payouts to the *cessionary* while the debt remains unpaid or outstanding. If *we* pay out on a Life Cover Benefit claim under the *Plan*, *we* first pay the *cessionary* the amount of the outstanding debt the *member* has secured with the *cession*, and then *we* pay the balance (if any) to the member's nominated beneficiaries or the member's deceased estate (if there are no nominated beneficiaries).	*You* cannot transfer as security for a debt the right to payouts from an *approved* Life Cover Benefit

4.9.3 When is the *cessionary's claim* no longer payable

If the *cessionary's claim* is no longer payable, it is the *member's* responsibility to tell the *cessionary* of this fact.

A cessionary's claim is no longer payable when:

- A claim is made against the policy which depletes the Life Fund
- The *cedent* is no longer a qualifying *member*
- The premiums for the *Plan* or the *member* are in arrears
- The *Plan* ends for any reason.

4.10 | WHAT IS THE INDEMNITY PRINCIPLE?

The *indemnity principle* is a rule of insurance law which states that an insurance policy should not confer a benefit greater in value than the loss actually suffered by the insured. Where applicable, the *indemnity principle* applies to the *Plan*.

4.11 | WHAT IS THE DIFFERENCE IN THE DEFINITION OF DISABILITY BETWEEN *OWN JOB* AND *OWN OCCUPATION?*

Own job

- *Own job* refers to the day-to-day functions of the job which the *life assured* has been employed to do, with or without reasonable accommodations, or any other suitable job that their *employer* can offer, when the *life-changing event* takes place. This could include climbing stairs, lifting files, sitting for long periods of time, typing, etc.
- Where a definition of disability in this *Plan* refers to *own job*, the *life assured* will be assessed on their ability or inability to continue performing the functions of their *own job*, with or without reasonable accommodations, or any other suitable job that their *employer* can offer, after the *life-changing* event takes place. So, for example, if the *life assured* could not climb stairs and their day-to-day functions required them to climb stairs, and their *employer* could not reasonably accommodate this limitation while recovering or on a long-term basis, they may be considered disabled for the initial period.

Own occupation

- *Own occupation* refers to a generic description of the *life assured's* job functions in the marketplace. For example, an administrator's generic job functions could include 60% typing, 20% filing, 20% general queries.
- Where a definition of disability in this *Plan* refers to *own occupation*, the *life assured* will be assessed on their ability or inability to continue performing the functions of their *own occupation* after the occurrence of the *life-changing* event.
- So, for example, if the *life assured* is not able to climb stairs, the assessment will look at whether this is crucial to doing the work of an administrator in terms of the generic description, and not to the specific working environment. In this case, climbing is not crucial to doing the work of an administrator and the *life assured* may not qualify for a claim.

4.12 | *YOUR* DUTIES

You have a continuing duty to provide *us* with accurate information. This means *you* must continually:

- Give *us* accurate, complete and up-to-date information when required, including at claim stage
- Give *us* a list of *members* whom *you* are aware will not qualify for a benefit under the *Plan*
- Tell *us* if the *membership* of the *Plan* changes by more than 15% (increase or decrease) at any time, in which case *we* have the right to revise the rates, *free cover limits* and terms and conditions of the *Plan* at *our* sole discretion

- Tell *us* if the nature of *your* industry changes
- Give *us* information relating to any *life assureds* who have ongoing claims at any previous or other insurers
- Tell *us* in writing about an increase of more than 20% in any *member's* yearly risk salary. If *you* do not tell *us* about this, *we* reserve the right during claim assessment to request a motivation of salary increase from *you* if the increase occurred within six months of a claim event and, at our sole discretion, to limit the claim payout to the sum assured that applied immediately before the increase.

4.13 | MISREPRESENTATION

The *Plan* is issued based on information given to *us* in the quote or *policyholder* application form, or in any other documents that were provided in support of the application or at renewal or benefit change stages.

You and the *life assured* must disclose all information required when applying for the *Plan* and during the life of the *Plan* or *membership*. *You* and the *life assured* must not misrepresent any information related to the *Plan*, including withholding any information or giving false information or distorting information. If information is misrepresented and this affects the assessment of risk related to the *Plan*, *we* have the right to cancel the insurance provided under the *Plan* from the start date of the *Plan*.

We will also have the right to:

- Refuse to pay out any current or future claims related to the misrepresentation or non-disclosure
- Adjust the premium from the date of the misrepresentation or non-disclosure
- Recover monies already paid to the *life assured* for claims that relate to the misrepresentation or non-disclosure
- Cancel or reduce certain benefits or the entire *Plan* with immediate effect, and keep any premiums paid to *us* as penalty.

4.13.1 Adjusting for incorrect ages

If *you* or a *member* gives *us* an incorrect *age* for a *life assured*, *we* will adjust the benefits to those that *we* would have provided if the *age* had been correct. If the premiums would have been higher, *you* must pay in the difference before insurance will apply for that *life assured*. *We* also reserve the right to make any other equitable adjustments to the policy benefits in accordance with the applicable law.

4.14 | FRAUD

We have the right to cancel the insurance provided under the *Plan*, from claim report date or the incident date (whichever is the earliest), and all premiums paid will be forfeited, should *you* or the *life assured*

- Submit a fraudulent claim
- Use any fraudulent means or devices to make claims
- Provide false information to obtain a benefit
- Knowingly allow anyone acting on their behalf to provide false information to obtain a benefit
- Deliberately and wilfully conspire to cause the illness or disability that leads to a claim.

The recourse available to *us* under the Misrepresentation (4.13) clause will also apply in case of fraud.

4.15 | PRECEDENT

No decision by *us* regarding the *Plan* may be interpreted as a precedent.

4.16 | NO POLICY LOANS

Members may not borrow against the *Plan*.

4.17 | CURRENCY OF THE *PLAN*

Premiums and benefit payments must be paid in South African Rand (ZAR).

The laws of South Africa apply to the *Plan*. Only South African courts with the relevant jurisdiction have the authority to adjudicate on matters arising from the *Plan*.

4.18 | ANTI-MONEY LAUNDERING POLICY

_We_ need the latest _employer_ and _member_ information

We are obligated to conduct the business relationship between *us* and *our* clients in compliance with the Financial Intelligence Centre Act 38 of 2001 (FICA) and other applicable financial crime law, as well as in accordance with *our* Risk Management and Compliance Programme. The law requires *us* to know some things about *you* and *your members* (this is called Know *Your* Client (KYC) information). This includes making sure that *we* always have up-to-date *employer* and *member* details.

What is money laundering?

Money laundering is a process where criminals hide or disguise the nature, source, location, disposition or movement of money obtained through unlawful activities. The purpose of FICA is to stop money-laundering activities and the financing of terrorist and related activities. In terms of Anti-Money Laundering regulations, FICA requires accountable institutions like *us* to know their individual and corporate clients.

At application stage

- *We* need additional Know *Your* Client information at application stage, including the following:
  - Company owner or director details
  - Company contact details

- Registration number and date of registration
- Company address
- Country where company was registered
- Nature of the business and country of operation.

At policy renewal date

- *We* need additional due diligence confirmations every year when the policy is renewed, telling *us* whether there have been changes in the source of funds, beneficial owners or directors, etc.
- This will include verifying that the details given at application stage are still correct.

At claim stage

- *We* need additional Know *Your* Client information at claim stage and will also need to screen and verify beneficiaries.
- For individual beneficiaries, this will include the following:
  - Proof of identity
  - Proof of address
  - Verification of banking details in the form of a stamped bank statement (not older than three months) that shows the beneficiary's banking details
- For academic institutions being paid under the Global Education Protector, this will include the following:
  - Proof of registration of the beneficiary (if applicable)
  - Registration number and date of registration of the institution (if applicable)
  - Verification of banking details in the form of a stamped bank statement (not older than three months) that shows the institution's banking details.

Enhanced due diligence

One of *our* responsibilities is to verify the information *you* have given *us*. *We* require specific documents for Directors that specifies the Director's name, surname and a copy of their ID or passport (if they are not South African Citizens).

For Beneficial Ownership, for each owner with a shareholding above 5%, *we* require their name, surname, trust deeds or shareholding certificates and a copy of the ID or passport (if they are not South African citizens). *We* might request further documentation.

Ongoing due diligence

For *us* to continue servicing *your* policy, *we* must be able to confirm and verify who *we* are doing business with on an ongoing basis. *You* have to tell *us* about any changes in *your* registered details. *We* consider the details *we* have on record to be correct and unchanged until *you* or *your* financial adviser tells *us* otherwise by completing the Know *Your* Client form. This form must be completed at the *Plan* renewal date or when there have been any changes in beneficial owners or source of funds.

One of *our* responsibilities is to verify that the information *you* have given *us* at application for *your* group risk policy is still correct. If *we* do not hear from *you* after 31 days of *our* request, *we* will assume that the information *you* have provided *us* with is correct until *you* tell *us* otherwise or if *we* become aware of any changes.

If *we* become aware of any changes in *your* registered details, source of funds, beneficial owners, directorship, etc, *we* will request additional due diligence documentation from *you*. *We* must notify the Financial Intelligence Centre if the mandatory due diligence information and documentation is not submitted to *us* within 31 days of *our* request. *We* will not be responsible for any further investigations that may take place if the non-compliance is reported to the Financial Intelligence Centre.

If *you* do not send *us* the requested FICA verification information or documentation within a reasonable time, then *we* will have the right to suspend or end *our* contract with *you* and *our* business relationship with *you*, without liability as a result of such termination.

DEFINITION OF *YOU/YOUR* FOR THIS SECTION

In this section, *you/your* refers to the *policyholder*.

This section gives an overview of the benefits we offer, as well as the medical and other information we need about you.

5.1 | THE BENEFIT OPTIONS *WE* OFFER

The *Plan* provides insurance for *life-changing events* for the whole family. These *life-changing events* include death, severe illness and disability. To choose the best combination of benefits, *you* can choose from the following options:

- Core Benefits only
- Core Benefits and Plus Benefits
- Core Benefits, Plus Benefits and/or Flex Benefits

5.2 | CORE BENEFITS ONLY (COMPULSORY FOR ALL *MEMBERS*)

Core Benefits are compulsory and apply to all *members* in a *Plan* or category. They ensure that all *members* receive an essential level of protection. The core benefits are:

5.2.1 Life Cover Benefit

This includes:

- Global Education Protector (12)
- Accidental Life Cover Benefit (11.4)
- Mortgage Protector (18)

5.2.2 Income Continuation Benefit

This includes:

- Waiver Benefit (13.8)
- Upgrade Benefit (13.15)
- Return-to-Health programme (13.12)
- LifeTime Capital Disability Lump-sum Benefit (13.17)
- Contribution Protector (13.20)
- Transport Protector (13.19)
- Family Protector (13.18)
- Performance Bonus Protector (13.21)
- HealthyLiving Protector (13.22)
- Mortgage Protector (18)

You do not have to have both the Life Cover and Income Continuation Benefits on *your Plan,* but some associated benefits are only available if *you* included: Group Risk PayBack (20) (or Corporate Integrator (21) – before 15 May 2018).

The accepted Life Cover Benefit amount must exceed the Severe Illness, Cancer and Capital Disability Benefit amounts.

5.3 | PLUS BENEFITS (COMPULSORY FOR ALL *MEMBERS*)

Any Plus Benefits that *you* choose become compulsory for all *members* in a *Plan* or category. These benefits insure extra risk needs and make sure that all *members* receive an extra level of protection.

The Plus Benefits are:

5.3.1 Severe Illness and Cancer Benefit

This includes:

- *Child* Severe Illness and Cancer Benefit
- Early Cancer Benefit
- Global Treatment Benefit

5.3.2 Capital Disability Benefit

5.3.3 Funeral Cover Benefit

This includes:

- *Member*-Only Funeral Cover Benefit
- Family Funeral Cover Benefit

5.3.4 *Spouse* Benefits

- Life Cover, Capital Disability, Severe Illness and Cancer Benefits for a *member's spouse*

5.4 | FLEX BENEFITS (OPTIONAL FOR *MEMBERS*)

5.4.1 Increase in insurance

You may choose to allow *members* to increase their insurance with Flex Benefits. Flex Benefits are not compulsory and apply only to individual *members* who choose them. Flex Benefits may be expressed as a multiple of salary or a fixed Rand amount. Flex Benefits may be added to the:

- Life Cover Benefit
- Severe Illness Benefit
- Capital Disability Benefit.

Extended Family Funeral Cover Benefit may also be made available for *members* to choose.

5.4.2 General conditions for the Flex Benefits

We define the structure and benefit maximums for the Flex Benefits. Flex Benefits are calculated as a multiple of the *member's* yearly risk salary.

Flex Benefits are not available on *Spouse* Benefits. There is no *free cover limit* for Flex Benefits, so *members* will have to complete a medical questionnaire and go for medical tests (*medical underwriting*).

After the initial *medical underwriting*, if the *members'* cover above the f*ree cover limits* and Flex Benefits are accepted, *members* may be granted forward underwriting for Flex Benefits at the sole discretion of *our* underwriters (see the clause Benefits above the *free cover limit* and Flex Benefits (5.6.2)).

If forward cover is granted *members* will not need to undergo more *medical underwriting* for Flex Benefits that

increase because of salary increases, unless:

- The initial Flex multiple increases (that is, the multiple of the *member's* yearly risk salary)
- The *member's* risk salary increases by more than 20% in a year.
- The period for which the advance decision applies lapses.

If a *member* reduces their Flex multiple and then increases it again, they will be underwritten for the full increase, even if they were underwritten to the increased level before.

5.4.3 When *members* may add Flex Benefits

Members may add Flex Benefits within three months of:

- The start date of the *Plan*
- A *member* joining the *Plan* as a new *member* after the start date
- The review date of the *Plan*
- A major *life-changing event* such as marriage, divorce, death, birth or adoption of a *child*.

5.4.4 When *members* may decrease or remove Flex Benefits

A *member* may remove or decrease their Flex Benefits within three months of the annual *Plan* renewal or within three months after a major *life-changing event* such as marriage, divorce, death, birth or adoption of a *child*.

After Flex Benefits have been removed, a *member* may add them again within three months of:

- The review or renewal date of the *Plan*
- A major *life-changing event* such as marriage, divorce, death, birth or adoption of a *child*.

5.5 | STANDALONE BENEFITS

5.5.1 Benefits that can be standalone benefits

The *policyholder* may choose the following benefits as standalone benefit without purchasing additional benefits:

- Life Cover Benefit
- Funeral Cover Benefit.

In special circumstances we may allow the following benefits as standalone benefits:

- Capital Disability Benefit
- Income Continuation Benefit
- Severe Illness Benefit
- Cancer Benefit
- Spouse Benefits

5.5.2 Benefits that cannot be standalone benefits

- The Global Education Benefit, which is an automatic enhancement to the Life Cover Benefit when certain conditions are met
- All other benefits attached to the main Core and Plus Benefits (these are only available as enhancements to the Core and Plus plans of which they are part).

5.5.3 Check the schedules for the benefits *you* have

Members are covered only for the benefits set out on the Client Benefit Schedule and *Member* Benefit Schedule, even if extra benefits are referred to in these terms and conditions.

5.6 | WHAT MEDICAL INFORMATION *WE* REQUIRE

5.6.1 Benefits under the *free cover limit*

We provide all Core and Plus Benefits free of *medical underwriting* up to the *free cover limit*. *We* set the *free cover limit* and it varies from *Plan to Plan*.

5.6.2 Benefits above the *free cover limit* and Flex Benefits

Any benefits that *members* want above the *free cover limit* and all Flex Benefits require *medical underwriting*. *Our* underwriters may accept or decline the extra cover.

Insurance above the *free cover limit* and Flex Benefits start only if *we* accept the risk.

Our underwriters may grant an advance underwriting decision at their sole discretion, which means that under certain conditions no underwriting will be required for further increases to the sum *insured* above the *level underwritten and accepted*. The underwriters will set conditions when they make this decision. These could include the following:

- The amount of insurance to which the advance decision applies, which may be any percentage of the sum insured underwritten and accepted
- The period for which the advance decision applies, which may be from two to five years
- The maximum annual salary increase allowed in any year during the period, which may be any percentage up to 20% (increasing the *sum assured* by less than 20% by adding a Flex Benefit, does not fall under this rule, all increased cover under Flex Benefits will be underwritten).

Where these conditions are not met, *medical underwriting* will be needed again for any potential cover above the previously accepted cover.

5.6.3 90 days to get the medical evidence

Members have 90 days from the date they apply for insurance above the *free cover limit* to undergo the *medical underwriting we* require. These 90 days are called the *medical evidence period.*

For some *Plans*, *we* may make the *medical evidence period* shorter than 90 days.

5.6.4 *We* pay for medical tests up to a maximum

We will pay the costs of the *medical underwriting* required, up to *our* maximums. If the *member* disagrees with the *medical underwriting* decision, they will have to pay for any extra evidence they wish to bring to *us*.

Where the costs for screening tests included in the Vitality Health Check or equivalent regular screening is covered by the member's medical aid scheme insured benefits (not savings), the cost of these tests will be recovered from the medical aid, if possible.

5.7 | ACCIDENT INSURANCE IS AVAILABLE DURING *MEDICAL UNDERWRITING*

5.7.1 Accident insurance above the free cover limit

Where a benefit is charged as a percentage of salary, *accident* insurance is always available for the *sum assured* above the *free cover limit*.

Where a benefit is charged as a unit rate, during the *medical evidence period we* will supply insurance up to the *free cover limit* for a *member* at the standard rates, terms and conditions of the *Plan*.

Accident insurance is also available during this period for the *sum assured* above the *free cover limit* for the Life Cover, Capital Disability and Income Continuation Benefits only. Claims are limited to those which are solely and directly caused by an *accident* which arises during the *medical evidence period*.

5.7.2 When *accident* insurance above the *free cover limit* ends for unit rated benefits

For unit rated benefits *accident* insurance for the part above the *free cover limit* ends at the earlier of:

- The end of the medical evidence period
- *Us* advising the *member* of our medical underwriting decision.

Accident insurance can be introduced, removed or reintroduced at installation, renewal or benefit change stages.

Accident insurance will only be valid for the first three months (or shorter period, if *the medical evidence period* is shorter) from the day that a *member* first becomes eligible for benefits above the *free cover limit* or until *we* issue an underwriting decision, whichever happens first.

5.7.3 When *accident* insurance will not apply

Accident insurance will not be granted for unit rated benefits if a *member* has been restricted previously by medical underwriting decision or because they did not give all the requested medical evidence within the *medical evidence period*.

5.8 | ABOUT THE FREE COVER LIMIT MULTIPLIER

Members on Vitality may qualify for a higher *free cover limit*. The higher amount is shown as a percentage of the *free cover limit* (known as the Free Cover Limit Multiplier) and depends on the *member's* Vitality Health status as set out in the table below:

VITALITY HEALTH STATUS ON THE DATE *MEDICAL UNDERWRITING* REQUESTED:				
Blue	Bronze	Silver	Gold	Diamond
0%	10%	20%	30%	40%

5.8.1 The following conditions apply to the Free Cover Limit Multiplier

- The higher *free cover limit* applies only to Vitality members, and only while they are Vitality members.
- The Free Cover Limit Multiplier is based on the *member's* Vitality Health status on the date that *we* ask the *member* to undergo medical tests.
- Maximum *free cover limits* after allowing for the Free Cover Limit Multiplier apply (see the General Benefit Limits Document).

5.9 | DIFFERENT CATEGORIES OF *MEMBERS* CAN HAVE DIFFERENT BENEFITS

The *policyholder* may group *members* into various categories with different benefits.

5.9.1 Standard *categories* which are not flexible are allowed without *medical underwriting*

Standard *categories* are based on *member* characteristics that are controlled by the *employer* and not the *member*, for example, level in company, company subdivision, salary and *age*. No extra *medical underwriting* requirements apply to these standard categories.

5.9.2 *Categories* which allow *member* choice are not allowed without Flex Benefit medical underwriting

Some category structures allow *members* to choose which category they fall into (normally categories based on different multiples of yearly risk salary) without Flex Benefit underwriting. *We* either convert these structures to Flex Benefits or require extra *medical underwriting*.

EXAMPLE

Some category structures are based on various multiples of yearly risk salary (say from 1x to 10x, or 3x/5x/10x, or 3x and 5x, where the *member* can choose their category with no medical underwriting being done. *We* will convert these structures to Flex Benefits with a level of core insurance (chosen by the *policyholder*) and allow the *member* to flex up or down to other multiples of yearly risk salary, with normal Flex medical underwriting being needed for the Flex Benefits.

5.9.3 Empty categories and normal retirement *age* categories are not allowed

Categories based on normal retirement *ages* and empty categories (that is, categories with no *membership* when they are created) may not be set up. If existing *Plans* have these categories, they will be closed at the next renewal, unless *we* agree in writing to keep them.

DEFINITION OF *YOU/YOUR* FOR THIS SECTION

In this section, *you/your* refers to the *policyholder*.

This section sets out your and our responsibilities in relation to the sharing of information.

6.1 | *WE* MAY COLLECT AND SHARE INFORMATION ACCORDING TO *OUR* PRIVACY POLICY

You and *your members* agree to information, including medical information, being shared between *us*, any medical practitioner consulted, any other life office, Discovery Health (Pty) Ltd, Discovery Health Medical Scheme and Discovery Vitality Health (Pty) Ltd. *You* and *your members* give *us* permission to access this information on the Policyholder's Application Form. *We* will only use the information as set out in our Privacy Statement.

6.2 | *YOU* MUST GIVE *US* COMPLETE AND TRUE INFORMATION

You must give *us* complete and true information about the *members* and the other lives insured under the *Plan*. (This is referred to as the legal duty to disclose information.) *We* use the information to:

- Decide if *we* will provide insurance to *members* and the other *lives assured*
- Calculate the benefit amounts for each benefit that *your members* are insured for
- Impose any exclusions or endorsements on the insurance that *we* provide
- Calculate the premiums that *you* must pay.

6.3 | TELL *US* ABOUT ANY CHANGES IN THE INFORMATION

The legal duty to disclose information is ongoing. This means *you* and the *member* must tell *us* at once if there is a change in the information *we* have on record for *you*, the *members* and the other *lives assured* under the *Plan* (for example, if a *member* or any of the other *lives assured* takes up a dangerous sport or changes occupation). There are certain high-risk occupations that *we* charge a higher premium for. If a *member* changes their occupation to a high-risk occupation, *we* have the right to increase their premiums or lower their *sum assured* or *payouts*.

6.4 | HOW INFORMATION IS GIVEN TO *US*

The information might have been given to *us* on the Policyholder's Application Form, on the phone, by email, by letter or online, at any time before or during insurance. If *you* give anyone else permission to act on *your* behalf, *you* are responsible for making sure that the information *we* receive is complete and true.

If a *member* acts on behalf of another *life assured* or third party older than 18 years of *age* (for example, a *spouse* or parent), the *member* confirms that they have received permission to give *us* information about that other *life assured* or third party.

We require membership information to be consistently provided in *our* Standard Billing Template and to always include Risk Salaries as well as details of *member's* disability status.

DEFINITION OF *YOU/YOUR* FOR THIS SECTION

In this section, *you/your* refers to the *member*.

This section sets out when your cover starts and ends, including when it may be extended, removed and reinstated under certain circumstances.

7.1 | WHEN *MEMBERSHIP* STARTS

If the actively at work (7.3) rule is met, any employee who qualifies as a *member* at the start date of the *Plan* will become a *member* on the start date.

If the actively at work (7.3) rule is met, any employee who qualifies as a *member* after the start date of the *Plan* will become a *member* on the date they qualify, which may be during a month.

7.2 | WHEN A *MEMBER'S* BENEFITS END

The *policyholder* may end some or all of the benefits of a particular *member* and their dependants (who are *lives assured*) as soon as any of the following events happen:

- The *member* dies
- The *member* no longer qualifies as a *member*
- The *member* reaches the *benefit expiry age*
- The *policyholder* stops paying some or all premiums for the *member*

7.3 | ABOUT THE ACTIVELY AT WORK RULE

7.3.1 At the start of the *Plan*

To be covered from the first day *you become eligible* for insurance, *you* must be *actively at work*, meaning that *you* must meet one of the following criteria:

- *You* must have been *actively at work* (at *your employer's* physical offices or elsewhere as agreed with *your employer*) and attending to *your* normal daily duties on the first working day on which *your* insurance started
- Where you do not meet the first criteria, but *you* or the *policyholder* are able to provide proof that on the first working day on which *your* insurance started *you* were medically capable of fulfilling *your* normal daily duties and were not receiving medical treatment for a condition that led to *your* claim (in this case, *you* will be considered to have been *actively at work*).

If *you* were not *actively at work* at the time *your* insurance started (under either of the above conditions), *we* will treat the start date for insurance as the first day after *you* were *actively at work* for eight consecutive weeks of uninterrupted service. This means that if *you* die or experience another *life-changing event* before the eight consecutive weeks are complete, *we* will not pay out the relevant benefit.

If *you* are on *sabbatical leave* on the first working day on which *your* cover starts, *you* will not qualify for cover and will not qualify as being *actively at work*.

Sabbatical leave refers to a *member's* leave of absence from work:

- For a lengthy and uninterrupted period which does not fall within the usual categories of workplace leave such as sick leave, annual leave, maternity leave, paternity leave and short-duration study leave
- Granted to a *member* by their *employer* in terms of the contract of employment or the *employer*'s workplace policy relating to sabbatical leave, where the *member* is not *actively at work* during the sabbatical leave
- Where the *member* may or may not continue to be employed and receive a salary during the sabbatical leave.

7.3.2 From the start of any new, increased or improved benefits

Members must meet the above definition of *actively at work* on the following dates:

- The date that the *policyholder* increases benefits, for the portion of the increase
- The date the *policyholder* amends the benefits or definitions of benefits selected
- The start date of any benefit improvements or additions initiated by the *policyholder*, for the additional sums assured introduced by those benefits only
- The start date of a *Plan* for all *members* who did not have group risk cover previously with the same *policyholder*
- The start date of cover for a new *member* who joins an existing *Plan*
- At all times for the Global Education Protector, Contribution Protector and Mortgage Protector, unless specifically waived for those benefits in terms of a clause of this *Life Plan Guide.*

7.3.3 *Members* on maternity leave

If *you* are on maternity leave at the start date of the *Plan*, *you* will be considered *actively at work* if *you* did not receive medical treatment for a condition unrelated to *your* pregnancy that led to a claim event within eight weeks of *your* intended date of return to work.

It is *your* and the *policyholder's* responsibility to prove that *you* met the *actively at work* requirement at the start date of *your* insurance.

7.3.4 When *we* waive the *actively at work* rule

We will always waive this rule for a *member* who:

- Immediately before joining *our Plan* had **equivalent benefits with their previous insurer** and met the *actively at work* requirement at the start date of insurance with that insurer. This waiver will only apply if

there was no break in cover from the time the *member* was insured under the previous insurer's policy to the start date of the *Plan*

- **Was on annual, maternity, paternity or family responsibility leave** on the start date, but only if they did not receive medical treatment for a condition unrelated to pregnancy that led to a claim event within eight weeks of their intended date of return to work.

If the *policyholder* applies for a waiver, *we* may agree in the case of a new *Plan*. However, this is at *our* sole discretion. *We* will tell *you* which terms, conditions and increased premiums will apply if *we* do agree.

Members who are **on sabbatical leave** at the date they would otherwise have joined the *Plan* will not be covered until they return to work and satisfy the *actively at work* rule.

7.4 | CONTINUED INSURANCE FOR DEATH BENEFITS FOR *MEMBERS* RECEIVING DISABILITY INCOME BENEFITS

Definition of *you*/*your* for this section.

In this section only, *you*/*your* refers to the disability claimant who is receiving disability income benefits.

7.4.1 Conditions for *death benefits* to continue during receipt of a disability income benefit

Death benefits refer to the Life Cover Benefit, the Global Education Protector or the Funeral Cover Benefit, and collectively to all these mentioned benefits where all are applicable.

If *you* were covered for the Life Cover Benefit, the Global Education Protector or the Funeral Cover Benefit (or the same benefits at a previous insurer) before becoming disabled, *we* will continue to insure *you* for this insurance if the following conditions are met:

- *You* are receiving disability income benefits (that is, *you* are a disability claimant) under any disability income policy taken out by the *employer* with *us* or a previous insurer.
- *You* were an eligible employee of the *employer* at the time *you* started receiving disability benefits, immediately before starting to receive disability income benefits (this employment may have ended after payment of the disability income began).
- For *approved* benefits, *you* continue to be a *member* of the retirement fund that owns this *Plan* with *us,* and which provides death benefits.
- For *unapproved* benefits, *your employer* continues to pay premiums for *your* continued death benefits.
- Alternatively, for *approved* or *unapproved* benefits, *you* receive a Waiver Benefit payable to *your* retirement fund (*approved*) or *us* as insurer (*unapproved*) linked to *your* income disability benefit which includes a portion which can pay these premiums.

We will not insure *you* for continued death benefits if any of the following apply:

- For *approved* benefits, *you* are no longer a *member* of the retirement fund. Insurance will stop from the date *your* membership of the retirement fund ends.
- *You* are being covered for continued death benefits by another insurer who is paying *your* income disability benefits. This can occur when *you* are no longer considered to be employed by the *policyholder*, but the previous insurer still covers *you* for continued death benefits based on continued payment of premiums from a Waiver Benefit, or retirement fund.

For *approved* and *unapproved* benefits, *you* **do not** need to continue to be an employee of the *employer* to continue being covered for life benefits during receipt of a disability income if all the other conditions in this subclause are met.

The continued death benefit insurance will only be payable for the disability claimant until the earlier of:

- The date the disability income benefit stops payment
- The date the premiums are no longer paid
- The date the claimant reaches the *age* of 65
- The date the claimant reaches normal retirement *age*
- The death of the claimant
- The termination of the policy.

7.4.2 *We* must have known about disability claimants before the *Plan* starts

If *you* became a disability claimant with a date of disability before life insurance began with *us*, to receive continued death benefits insurance under t*he Plan*, the following conditions must be met:

- *We* must have been informed that *you* are a disability claimant or have applied for a disability claim at quote stage.
- *Your* data must be provided under a separate disability claimant life insurance category at quote stage.
- *We* must have accepted the take-over of disability claimants in writing in the accepted quote.

7.4.3 The amount of the disability claimant's Life Cover Benefit

If *your* disability occurred while *we* insured *you*, the Life Cover Benefit will be based on the yearly risk salary that applied on the day before *your* date of disability. This amount will increase yearly if *you* remain covered for the Life Cover Benefit. The yearly risk salary will increase at *our* Income Continuation Benefit escalation rate (limited to an escalation rate of 10%). After the increase in yearly risk salary, *we* will calculate the premium for the life insurance based on the increased yearly risk salary.

If *your* disability occurred before *we* insured *you*, the Life Cover Benefit will be based on the yearly risk salary that the previous insurer used for death benefit cover immediately before *your* insurance moved to *us*, including

any increases granted to that date. After that, this amount will increase yearly if *you* remain covered for the Life Cover Benefit with *us*. The yearly risk salary will increase at the disability income benefit escalation rate declared by the previous insurer on *your* income disability benefit paid by that insurer (limited to an escalation rate of 10%). After the increase in yearly risk salary, *we* will calculate the premium for the life insurance based on the increased yearly risk salary.

7.4.4 How the *free cover limit* affects the Life Cover Benefit for disability claimants

If the Life Cover Benefit exceeds the *free cover limit*, *you* will need to undergo *medical underwriting* for the amount above the *free cover limit*. This applies regardless of when the *life-changing event* took place that led to the disability income benefit claim.

7.4.5 Disability claimants not entitled to other disability benefits

You do not have the right to receive any other Disability Benefits or any Severe Illness or Cancer Benefits, unless:

- *You* were covered for Severe Illness or Cancer Benefits by the *Plan* or another insurer's policy, both before and after *you* became a disability claimant with no break in insurance
- The Severe Illness or Cancer Benefit for disability claimants is included in the quote.

We will not automatically waive the *actively at work (7.3)* condition for a disability claimant.

We will notify the *policyholder* of the premium rates, terms, conditions and exclusions on which *we* will provide the Life Cover Benefit, the Global Education Protector and the Funeral Cover Benefit for disability claimants, including any *medical underwriting* requirements.

7.5 | INSURANCE DURING A *MEMBER'S* TEMPORARY ABSENCE FROM WORK

If *you* are temporarily absent from the service of the *employer* other than for maternity leave, sabbatical leave, disability or illness, but are still residing in South Africa, the following conditions apply:

- If the *policyholder* continues to pay premiums for *you*, insurance will continue for six months without the *policyholder* having to tell *us*.
- For insurance for more than six months and up to a maximum period of 24 months (including the initial six months), the *policyholder* may apply for an extension of insurance. If *we* grant an extension in writing, at *our* sole discretion, the *policyholder* must continue to pay premiums for *you*. *We* must also receive the following information for *you*:
  - Name
  - Occupation and description of work
  - Reason for absence from work
  - Date when absence started
  - Expected date of return to work.

Insurance will end if:

- It becomes apparent the absence is permanent and not temporary (that is, *you* do not intend to return to work within 24 months). In this case *you* will be allowed to remain on the *Plan* until the earlier of:
  - The date *you* obtain alternate insurance
  - Six months after the date that the permanent nature of the absence became known
  - The expiry of the previously granted cover period
- The *policyholder* stops paying premiums for *you* at any time
- *You* have been absent for 24 months or more, unless *we* agree to a further extension in writing, at *our* sole discretion
- *You* replace *your* group risk insurance with alternate insurance from another insurer.

If the *member* resumes active employment after insurance has ended and needs to be covered by the *Plan* again, *we* will treat them as a new *member* and the *actively at work (7.3)* rule will need to be met again.

Absences from work that are not separated by at least three consecutive months will be added together to determine whether the six months or the 24 months have elapsed.

Maternity leave where the *member* returns to work within the contracted period of maternity leave is not considered temporary absence from work.

The war, riot and terrorism exclusion continue to apply while a *member* is temporarily absent from work .This only applies until *we* are no longer able to reinsure this insurance, at which point *we* may withdraw the partial waiver with 24 hours' notice.

7.5.1 *Members* placed on gardening leave

For the sake of clarity, the above clause applies if *you* are placed on gardening leave.

7.6 | INSURANCE DURING A *MEMBER'S* TEMPORARY OR PERMANENT ABSENCE FROM SOUTH AFRICA (TERRITORIAL LIMITATION)

Members and *lives assured* must belong to a *policyholder* who's principle place of business is based in South Africa.

- *Members* residing or traveling outside of South Africa will be covered in all countries not listed on the countries of concern list or the declined countries list without notifying *us*, subject to *members* satisfy all other eligibility criteria. For *members* permanently absent from South Africa it is the *policyholder's* responsibility to ensure all tax obligations regarding the premium or claims are met.

- *Members* residing or traveling outside South Africa in the countries of concern need to notify us of their country of temporary residence or travel if this is more than 42 days per 12-month period. Once the country of temporary residence or travel moves into the decline list, the decline list rules will be applied immediately. *We* must receive the following information for each of these *members* or life assureds living in countries of concern:
  - Name
  - ID or passport number
  - Occupation, description of work (including any hazards and mitigation of risk related to this occupation in foreign countries) and place of work (location)
  - Foreign countries the *member* is expected to be in (for any period)
  - Reason for absence from South Africa
  - Date when absence from South Africa starts
  - Expected date of return to South Africa (if applicable).

Cover outside of South Africa in the countries on the decline list is limited to 42 days per 12-month period and certain maximum benefit amount limits. Cover during these 42 days and any period granted thereafter will be limited to:

- For lump sum benefits: The lesser of the Free Cover Limit on the scheme, R10 million Sum Assured and the individual member's applied Sum Assured.
- For the Income Continuation Benefits and the Limited Term Income Continuation Benefit: The lesser of the Free Cover Limit of the scheme, R100,000 per month (including the waiver benefit) and the individual member's applied monthly benefit (including waiver benefit).

The war, riot and terrorism exclusion continues to apply while *the member is* temporarily out of South Africa.

Contractors, temporary workers and part-time employees permanently living outside of South Africa will be eligible for life cover at the Insurer's discretion.
The list of countries of concern or countries of declined cover can be found by following this link.

7.6.1 Claim payments during temporary or permanent absence from South Africa

Cover for *members* permanently residing in countries outside of South Africa will be covered in rands and any benefits will be paid into a South African bank account. All salary information, underwriting information and claims information must be provided in English and from a doctor or organisation registered with the HPCSA.

Reimbursement for reviewed medical reports will be based on our pre-approved medical tariff rates and calculated according to the prevailing exchange rate. *We* retain the right to insist that claims assessment is done in South Africa if need be. It remains the claimants' responsibility to provide the insurer with all claims information require to validate a claim.

Income Continuation Benefit claimants that became disabled in South Africa but want to reside in a country outside of South Africa and continue receiving their benefit, need to notify the Head of Assessment in writing of their intent to move. While residing outside of South Africa it will remain the claimant's responsibility to timeously provide the claims assessor with the valid claims information required to validate the continuous payment of the claim. Should the claimant fail to do so, *we* have the right to terminate the benefit payment for the period for which the information is outstanding.

For Income Continuation Benefits where the claimant could have received the benefit of rehabilitation intervention in South Africa which would have increased their probability of returning to work, and because of living outside of South Africa remains disabled, *we* do reserve the right to decline the request to receive the benefit while in another country, or to terminate the claim where the claimant resides in another country.

7.7 | WHEN *WE* TAKE OVER EXISTING PLANS

7.7.1 *People* who have been medically underwritten

We will take over the medically underwritten insurance of *members* who are *actively at work (7.3)* in the existing *plan* on the same terms and conditions as those of the previous underwriter, in the form of a valid underwriting decision letter, subject to any maximum limits determined by *us*. However, *we* must receive written proof from the previous insurer that the *members* were *medically underwritten*.

We will not automatically take over *free cover limits* or insurance levels that were not *medically underwritten* under the existing *plan*.

Our maximum limits apply (see the General Benefit Limits Document).

7.7.2 People with potential cover above the *free cover limits* who have not been medically underwritten

If the *policyholder* wishes *us* to take over cover above the *free cover limits* from an existing insurer for *members* who had not been medically underwritten at the insurer, it must tell *us* in writing. *We* will advise the *policyholder* if this will be allowed and, if so, what rates, terms and conditions, and any *medical underwriting* requirements apply.

7.7.3 *We* do not automatically take over *free cover limits*

We do not automatically take over *free cover limits* unless a *member* has been *medically underwritten* on the current *Plan*. *We* will indicate in the quote document that *we* may do one of the following:

- Set *our* own *free cover limit* which may be higher or lower than the previous insurer's *free cover limit*
- Take over the previous insurer's *free cover limit* for current *members* only, with *our* (lower) *free cover limit* applying to future *members*
- Take over the previous insurer's *free cover limit* for all current and future *members*
- Take over the previous insurer's current insurance level only, but apply *our* (lower) *free cover limit* to all current and future *members* (which may result in current *members* being underwritten after their next salary increase)

Members changing employment or transferring from a *Plan* with a higher *free cover limit* to a *Plan* with a lower *free cover limit*, will be subject to meet the underwriting requirements of the lower *free cover limit* under the existing *Plan* they are transferring into.

7.7.4 People receiving disability income benefits

There may be people receiving disability income benefits from the previous insurer (disability income claimants). *We* will consider these claimants for the Life Cover Benefit, the Global Education Protector and the Funeral Cover Benefit if they meet all the criteria set out in the clause Insurance for *members* receiving disablity income benefits (7.4).

7.7.5 People receiving Severe Illness or Cancer Benefits

We will not take over Severe Illness or Cancer Benefit insurance for *members* who have already claimed for the same or a similar benefit under a previous insurer.

7.8 | CANCELLING THE *PLAN*

7.8.1 When the *policyholder* may cancel the *Plan*

7.8.1.1 In the first 31 days (cooling-off period)

If the *policyholder* is not satisfied with the terms of the *Plan*, the *policyholder* may cancel it by sending *us* a written cancellation notice within 31 days after it starts. *We* will refund any premiums that have been paid, less claims *we* have already paid out and admin costs.

7.8.1.2 After the first month

The policyholder must give *us* 31 days' written notice if it wishes to cancel the *Plan*. In terms of the *Policyholder* Protection Rules, this notice must confirm the *policyholder's* intention to end the *Plan* and tell *us* whether they:

- Have arranged this insurance with another insurer
- Have decided not to have insurance for the benefit.

If the *policyholder* wishes to reinstate the *Plan* after the end of the notice period, the *policyholder* will need our written agreement to do so, which *we* may give at our sole discretion.

Where the *Plan* is cancelled, the *Policyholder* MUST notify all *members* who were covered under the *Plan* of the cancellation.

Following cancellation of the *Plan*, any new claims must be submitted within 90 days from the effective date of cancellation. For claims that were initiated prior to cancellation, all outstanding supporting documentation must be submitted within 90 days of the cancellation date. Claims or documentation submitted after these timeframes may not be considered for admission under the scheme.

7.8.2 If *member* participation in the *Plan* is voluntary

In terms of the *Policyholder* Protection Rules, if *membership* to the *policyholder's Plan* is voluntary for the *policyholder's* employees or retirement fund *members*, the *policyholder* agrees to give every *member* of the *Plan* a right to end participation in the *Plan* equal to the right afforded to a *policyholder* to cancel the *Plan* in terms of the clause When the *policyholder* may cancel the *Plan (7.8.1)*.

As a fundamental group risk management rule, it is standard that all benefits in *Plans* are compulsory for all *members*. It is rare for *us* to allow a benefit to be voluntary. If *we* do allow it, this concession:

- Will be included in the quote
- Will cost more than the compulsory benefit equivalent
- Could be withdrawn at any policy anniversary.

If *we* grant this concession, then the *Policyholder* Protection Rules requirement applies. *We* offer only two types of benefits which are voluntary and do not need a special concession from *us*:

- Flex Benefits, which are voluntary for all *members*
- The Extended Family Funeral Cover Benefit, which is voluntary although the Family Funeral Cover Benefit on which the extended cover is based is not voluntary

If these two benefits apply to the *Plan*, the *policyholder* also has the obligation to communicate under the *Policyholder* Protection Rules requirement.

7.8.3 When *we* may cancel the *Plan*

We may end the *Plan* and stop the benefits provided to *members* and dependants if:

- The *policyholder* does not comply with material provisions of the *Plan*
- The *policyholder* is liquidated or is placed under judicial management or enters into a compromise with its creditors.
- If we at our sole discretion decide to terminate the *Plan*, the *Plan* will be terminated on the anniversary date of the *Plan*. We will inform the *Policyholder* in writing at least 31 days before the policy anniversary if we intend to terminate the *Plan*.

7.8.4 When the *Plan* ends automatically

The *Plan* will automatically end when:

- The last remaining *member's* participation in the *Plan* ends
- All benefits are stopped for whatever reason.

DEFINITION OF *YOU/YOUR* FOR THIS SECTION

In this section, *you/your* refers to the *policyholder*.

This section sets out when premiums must be paid and your duties relating to salary increases.

8.1 | *YOU* MUST PAY PREMIUMS BY THE PREMIUM DUE DATE

You must make sure that *we* receive the premiums every month by the premium due date shown in the Employer Guide.

Unless otherwise agreed and recorded in the Employer Guide, premiums for *members* who are *members* of the *Plan* at the beginning of a month are calculated and become due at the beginning of that month but need only be paid at the end of that month (payable in arrears).

8.2 | PREMIUMS FOR *MEMBERS* WHO ENTER THE *PLAN* DURING A MONTH

Members who enter the P*lan* on a date other than the first day of a month are covered for their group risk benefits at their full *sum assured* from their entry date.

Unless otherwise agreed by *you* and *us* and recorded in writing at the beginning of the *Plan*, whether or not premiums must be paid for the first partial month of their *membership* is determined by the *15-day rule* which requires the following:

- If a *member* joins the *Plan* from the 2nd day to the 15th day of the month, then a full month's premium is due for their month of entry and must be paid at the end of their month of entry.
- If a *member* joins the *Plan* after the 15th day of the month, then no premium is due for their month of entry, but they are covered for the part-month of their *membership*.

8.3 | PREMIUMS FOR *MEMBERS* WHO EXIT THE *PLAN* DURING A MONTH

For *Members* who exit the *Plan* before the end of a month, their premium becomes due at the beginning of the month and must be paid at the end of the month of exit.

Unless otherwise agreed by *you* and *us* and recorded in writing at the beginning of the *Plan*, premiums for these *members* must be paid in full for the month regardless of when the *member* leaves in that month and is no longer insured by the *Plan*. The 15-day rule does not apply to these premiums.

8.4 | *YOU* MUST GIVE *US* ACCURATE AND COMPLETE INFORMATION

- *You* must give *us* accurate and complete information about the *lives assured* so that *we* can accurately assess *our* risk and calculate the premiums and premium ratings.
- *You* must tell *us* if the nature of *your* industry changes at any time, as this may affect *our* assessment of risk and calculation of premiums and premium ratings.

8.5 | *YOU* MUST TELL *US* WHEN THERE ARE SALARY INCREASES

You must tell *us* in writing when a *member's* salary increases by more than 20%. If *you* do not tell us about this, *we* reserve the right during claim assessment to request a motivation of salary increase from *you* if the increase occurred within six months of a claim event and, at our sole discretion, to limit the claim payout to the sum assured that applied immediately before the increase.

8.6 | *OUR* RIGHTS IF *YOU* DO NOT CARRY OUT *YOUR* DUTIES

If *you* do not meet *your* duties set out above, *we* have the right to cancel or to revise the *Plan*, including the premiums and premium ratings.

8.7 | IF *YOU* DO NOT PAY THE CORRECT PREMIUMS IN TIME

8.7.1 First missed or under payment – 31-day grace period

We allow *you* 31 days from the premium due date to pay the outstanding premium. This is known as the *grace period*. If an insured event happens during the *grace period*, *we* must receive the outstanding premium before *we* consider the claim (depending on the terms of the policy).

8.7.2 Second missed or under payment – the *Plan* is suspended

If *we* do not receive the arrears premium or *your* next full premium by the next premium due date (that is, *you* have not paid or under paid two premiums), *we* will suspend *your Plan*. If an insured event happens when two premium payments have not been paid or have been under paid, *we* will not consider the claim and no benefit will be paid to *you*, even if *you* then pay both outstanding premiums. *We* have the right to waive this stipulation, at *our* sole discretion.

8.7.3 Third missed or under payment – the *Plan* ends

If *you* miss a third premium payment by its due date or have a third under payment, *your Plan* will automatically end. When the *Plan* ends, it cannot be reinstated even if *you* pay all late payments. In exceptional circumstances and after receiving all arrear payments, *we* may consider a written motivation from *you* about why the *Plan* should be reinstated. If the *Plan* is reinstated, the clauses about pre-existing medical conditions (9.8), *actively at work (7.3)* and underwriting will apply to all *members*, even those who were previously covered.

8.8 | HOW *WE* CALCULATE THE PREMIUMS, PREMIUM RATINGS AND BENEFITS

8.8.1 *We* use information about the *lives assured* to assess *our* risk

We use the following information about the *lives assured* to assess *our* risk of insuring them and to calculate the premiums:

- *Age* and gender
- Yearly risk salary
- Occupation
- The nature of industry they work in
- The region they work in
- Their previous claims experience
- Their previous medical claims information if they are Discovery Health Medical Scheme *members*
- Changes in the risk of events occurring which would lead to higher claims than expected from the benefits *we* insure
- Any other factors that *we* consider will affect the risk associated with the *lives assured*

8.8.2 Yearly risk salary

The yearly salary used to calculate *your* benefit values is called the yearly risk benefit salary.

The yearly salary used to calculate *your* monthly premium values is called the yearly risk premium salary.

If the yearly risk benefit salary and the yearly risk premium salary are the same (as in most cases), they are simply referred to as the yearly risk salary.

8.8.3 The yearly risk salary determines sums assured and premiums

A *member's* actual salary and yearly risk salary determine the sums assured for the benefits they have and the premiums they pay. *We* use the yearly risk salary defined in the *membership* data that *you* gave *us* at quote stage, which could be one of the following:

- Pensionable salary (as determined in the retirement fund rules)
- A percentage of cost-to-company salary (up to 100%)
- Gross salary (including items of the *member's* package that might not be pensionable)
- Basic salary plus a portion of salary which changes from month to month
- Running average salary, where the running average is calculated over several months determined at the start of insurance (normally 12 months if not otherwise decided)
- Net salary

The yearly risk salary of a *member* cannot be more than their actual salary. The actual salary may include a fixed 13th cheque (not linked to performance), but then it must be included in both the yearly risk benefit salary and the yearly risk premium salary.

The *member* cannot choose to increase their yearly risk salary. Only the employer may increase the yearly risk salary by increasing the *member's* actual salary.

If a member's risk salary increases by more than 20% in the six months before a claim event, *we* reserve the right to investigate the validity of the risk salary increase and limit the risk salary for claim payment to the risk salary prior to the increase (or an amount higher than this) at our sole discretion.

8.8.4 Yearly risk salary for *members* who earn commission

We calculate the yearly risk benefit salary for commission earners using a running average. The risk premium salary will fluctuate from month to month as commission levels fluctuate. The benefit paid will be based on the running average risk salary.

We add the base salary and commission that the *member* received in the six to twenty four months before the *life-changing event* that gave rise to the claim. The total is then divided by the number of months *we* use for the calculation. The *policyholder* must make sure that the commission or wage earners' yearly risk salary definition is agreed to at the start date of the *six to twenty four months*. If this is not agreed, *we* will use 12 months. If the *member* has been on the *Plan* for a shorter period than the averaging period, then the full time on the *Plan* will be used, until *membership* time reaches the averaging period.

In the absence of a specified total cost to company for a *member* earning commission, *we* calculate the total cost to company used for the calculation of the net after tax salary of the *member* by looking at total salary and commission income received.

EXAMPLE

Assume a commission earner generated the following monthly income, and select six months as the period for the calculation of the running average salary:

January:	R15,000
February:	R25,000
March:	R12,000
April:	R22,000
May:	R21,000
June:	R23,000
July:	R18,000

The risk salary used for benefits would be calculated as follows:

June risk benefit salary = (23,000 + 21,000 + 22,000 + 12,000 + 25,000 +15,000) ÷ 6 = R19,667

July risk benefit salary = (18,000+ 23,000 + 21,000 + 22,000 + 12,000 + 25,000) ÷ 6 = R20,167

8.8.5 Yearly risk salary for financial intermediaries who earn commission

The salary of financial intermediaries for premium and benefit purposes will be calculated the same way as in the above clause (Yearly risk salary for *members* who earn commission (8.8.4)).

8.8.6 The *net after-tax salary* sets benefit limits

We use a *member's net after-tax salary* to set the maximum amount payable for the combined Income Continuation Benefit, Upgrade Benefit and Waiver Benefit (if included in the insurance).

Net after-tax salary is defined as the cost to company salary less Pay As *You* Earn on cost to company.

If the Income Continuation Benefit is based on the recommended scale benefit, then the *net after-tax salary* maximum limit does not apply to the Income Continuation Benefit, Upgrade Benefit or the Waiver Benefit.

8.9 | WHEN PREMIUMS ARE SET AND WHEN PREMIUMS CHANGE

8.9.1 Premiums are set at the start of the *Plan*

We set the premiums at the start date of the *Plan*. These premiums are fixed until 12 months from the commencement of the *Plan*, unless one of the events mentioned in this section happen.

8.9.2 When premiums can change

We may recalculate and change the premiums:

01 | At the anniversary of the start date of the *Plan* each year

02 | Before the *Plan* anniversary in any of the following circumstances:

- *You* change the *Plan* in any way, including by requesting the addition or removal of Core, Plus or Flex Benefits, or the addition or removal of *members*. These changes will result in the increase or decrease of premiums and may be subject to *medical underwriting*.
- *Your* business activities change, and *we* consider that the new activities fall into a different risk category.
- *You* have given *us* incorrect information, including incorrect information about *members*.
- *Your business* is taken over by another entity, or *you* take over another entity, or *you* merge with another entity.
- There is a change of more than 15% in the *membership* of the *Plan*.
- Legislation or regulations require a change to the policy or any of its benefits.
- There are unforeseen circumstances that have an impact on the current risk rating of the policy, including but not limited to unforeseen deaths, disabilities or incapacities happening within the territorial limits or globally, caused by or related to a communicable disease, whether or not an official pandemic or epidemic has been declared by the World Health Organization or similar supranational, international or national organisations, or by government.
- A *Plan* premium reduces below the specified minimum annual premium income in the General Benefit Limits Document.
- In the time after *you* have accepted the quote and before *we* have installed the *Plan* or before the start date of the *Plan*, if any of the circumstances set out in (02) above are present.

8.10 | WHEN PREMIUMS AND BENEFITS INCREASE

8.10.1 If benefits are based on the yearly risk salary

The initial Life Fund and benefits are normally set as a multiple of a *member's* yearly risk salary. These benefits increase when the *member* receives a salary increase, as long as *you* tell *us* about an increase of more than 20% in writing.

If the increased benefit amount is above the *free cover limit*, then *we* may ask the *member* to complete a medical questionnaire and have medical tests (that is, conduct *medical underwriting*).

8.10.2 If benefits are based on a fixed rand amount of insurance

If the *member's* benefits are set as a flat rand amount of insurance, the benefits will remain level and will not increase, unless *you* ask *us* to change them.

8.11 | THE CLIENT BENEFIT SCHEDULE SHOWS THE DETAILS OF THE *MEMBERS'* COVER

The Client Benefit Schedule shows details of the *members'* benefits, including premiums and any applicable exclusions. *You* will receive a Client Benefit Schedule from *us* at the start date and at the annual renewal of the *Plan*. If any of the *Plan* details change at any time, *we* will send *you* a new Client Benefit Schedule detailing the changes.

DEFINITION OF *YOU/YOUR* FOR THIS SECTION

In this section, *you/your* refers to the *member*.

This section sets out how and when to claim, who we pay and what is excluded from claims under the Plan.

9.1 | HOW TO CLAIM A BENEFIT

The *policyholder* and their intermediary are responsible for making sure that their *members* are aware of the benefits they have a right to, and that they make claims according to *our* claims procedure.

If a *member* or *life assured* experiences a *life-changing event* for which a claim may be payable, they must contact their human resources manager, their *financial adviser* or *our* contact centre on 0860 543 322. *We* will then provide the necessary forms and explain what must be done for *us* to consider the claim.

9.2 | CLAIMS MUST BE MADE WITHIN A SET TIME

Claims must be made within a set time after the date of the event that led to the claim. All documents and medical evidence that *we* need to consider the claim must also be sent within a set time. The time periods are set out in the table below:

TYPE OF CLAIM	PERIOD FOR MAKING THE CLAIM	PERIOD FOR SUBMITTING ALL DOCUMENTS
Death	6 months from date of death	9 months from date of death
Disability and severe illness	3 months from *date of the life-changing event*	6 months from *date of the life-changing event*

When making a disability or severe illness claim, the *policyholder* and *member* must not wait to report the claim until *the policyholder* or *employer* or doctor says that the *member* can no longer work and should claim. *We* must be informed of any event that may lead to a disability claim as soon as possible and not more than three months after the event. There is a much higher likelihood of a good outcome if *our* health management staff become involved in helping *the claimant* and *their* medical advisors as soon as possible.

We have the right to reject a claim if *you* submit *your* claim outside of the above timelines.

9.3 | GETTING THE MEDICAL INFORMATION

The claimant, or their medical aid, must pay for the costs of getting the medical information *we* need. *We* may delay assessing the claim until *we* have all the medical evidence we require. For ongoing claims, *we* may ask the claimant to give *us* extra medical information from time to time. The claimant is responsible for sending in any extra information *we* ask for. If *we* do not receive the information *we* ask for, *we* may end benefit payouts.

All medical professionals involved in producing medical evidence must be registered with the HPCSA council, unless otherwise agreed by *us* in writing.

9.4 | WHO *WE* PAY

9.4.1 Payment of the *unapproved* Life Cover Benefits

For *unapproved* Life Cover Benefits (benefits provided under a *Plan* owned by *your employer* or an association) *we* will pay the benefit as set out in the Client Benefit Schedule and Member Benefit Schedule to:

- The *member's* nominated beneficiaries
- To the *member's* deceased estate if there are no nominated beneficiaries.

The member must complete the beneficiary nomination form and keep it up to date. If the *member* completes a physical beneficiary nomination form the *policyholder* must keep the form in safe custody. If the *member* dies, the *policyholder* must send *us* the *member's* most recently signed beneficiary nomination form so that *we* know who to pay. *We* will pay based on the most recently signed beneficiary nomination form or the most recently completed one for those completed online with *us*.

In terms of the law, *unapproved* Life Cover Benefits may not be paid to the *employer* or on the instruction of the *employer*.

9.4.2 Payment of the *approved* Life Cover Benefits

For *approved* Life Cover Benefits (benefits provided under a *Plan* owned by *your* retirement fund) *we* will pay the benefit as set out in the Client Benefit Schedule and Member Benefit Schedule to *your* retirement fund.

The *member* must complete a beneficiary nomination form to guide the Trustees of *the member's* retirement fund on how *the member* would like *their* Life Cover Benefits to be distributed. In terms of the law, the Trustees of the retirement fund are not bound by the *member's* nomination of beneficiaries. The Trustees must investigate who *the member's* dependants are and make sure they are taken care of before considering the *member's* nominated non-dependent beneficiaries.

9.4.3 Payment of Funeral Cover Benefits

For Funeral Cover Benefits, on *your* death or on the death of another *life assured*, *we* will pay the benefit set out in the Client Benefit Schedule and Member Benefit Schedule to:

- The *member* if the *member* is not the deceased *life assured*
- The *member's* nominated beneficiaries if the *member* is the deceased *life assured*

The *member* must complete the beneficiary nomination form and keep it up to date. The *policyholder* must keep the beneficiary nomination form in safe custody. If the *member* dies, the *policyholder* must send *us* the *member's* beneficiary's nomination form so that *we* know who to pay.

9.4.4 Beneficiaries under 18

Where a nominated beneficiary is under 18 years of age (a minor), *we* will pay their portion of the Life Cover Benefits to the surviving parent or, if there is no appointed surviving parent to an appointed legal guardian. If there is none, *we* will pay the portion to a beneficiary trust or a beneficiary fund.

If, through, the claims investigation process, *we* become aware that the surviving parent or the appointed legal guardian (including the surviving parent) is not financially astute or may mismanage the benefit due to the minor beneficiaries, *we* may, at our sole discretion, pay the benefit due to a beneficiary trust or a beneficiary fund.

9.4.5 Payment of Capital Disability, Severe Illness, Cancer and Income Continuation Benefits

On the disability or severe illness of a *member* or *life assured*, *we* will pay the benefit set out in the Client Benefit Schedule and Member Benefit Schedule for Core, Plus and Flex Benefits to the *member*.

This benefit may have benefit maximums (see the General Benefit Limits Document).

9.5 | CLAIMS THAT ARE EXCLUDED

We do not pay out claims for Income Continuation, Capital Disability or Severe Illness Benefits in the following circumstances:
A *life-changing event* occurs at a time when *we* have not received premiums for the *life assured*.

- The *life assured*, *member* or *policyholder* at any time misrepresented or did not disclose information, which would have had an impact on the premium calculated or risk assessed, about the physical disabilities or medical conditions that the *life assured* had when insurance above the *free cover limit* started.
- The disability or severe illness results from any self-inflicted injury or self-inflicted illness, whether intended or not (that is, from harm the *life assured* caused to themselves).
- The disability or severe illness results from voluntary exposure to danger or obvious risk of injury or illness.
- The disability or severe illness results from the *life assured* taking part in a hazardous occupation that was not disclosed to *us* and is not normally associated with the industry in which the *life assured* is employed.
- *We* did not get enough medical evidence from the *life assured* or treating medical practitioner to fulfil the criteria to make a benefit payment.
- The *life assured* does not provide medical evidence within 90 days for a claim to be considered.
- The *life assured* does not give *us* enough medical evidence and other proof that they manage their lifestyle and chronic medical conditions reasonably, and the disability claim results directly from the poor management of these conditions. This includes not complying with the reasonable recommendations and treatment protocols made by the *life assured's* treating medical specialists.
- The disability or severe illness results from the *life assured* deliberately breaking any law (including driving without a valid licence) or performing any illegal act in terms of any law, the common law or any code that has the force of law in South Africa.
- The disability or severe illness results from the *life assured* committing an act of war or taking part in riots or acts of public hostility in terms of any law, the common law or any code that has the force of law in South Africa, whether or not the *life assured* was criminally charged by the applicable law enforcement agencies or found guilty of an offence by a court of law. See the clause *We* exclude claims that result from war, riot and terrorism (9.10).
- The disability or severe illness is caused or worsened by the *life assured*'s intentional and negligent consumption of poisons, alcohol, drugs or narcotics, unless a registered medical practitioner prescribes the drugs or narcotics and it was taken in accordance with a medical prescription. Neither the *life assured,* nor their family members or relatives may perform the role of a registered medical practitioner in these circumstances.
- The disability or severe illness results from the *life assured's* excessive consumption of alcohol or self-elected surgery, including but not limited to cosmetic procedures.
- Pregnancy and maternity leave are excluded for the definition of disability. Only complications of pregnancy confirmed by the treating gynaecologist and/or obstetrician will be assessed for eligibility of a disability claim.
- The *policyholder*, *member* or *life assured* commits any act of dishonesty or fraud relating to any provisions contained in the *Plan*.
- The claimant refuses or neglects to undergo reasonable medical treatment when there is a reasonable likelihood that the medical treatment would improve the disability or severe illness.
- The benefits applied for under the *Plan* have been increased, or the waiting period for the Income Continuation Benefit has been reduced, from those enjoyed under the previous plan with a previous group insurance underwriter where:
  - The *member* is medically impaired during the 12-month period immediately following the alteration
  - The *member's* medical impairment, in the opinion of *our* medical panel, is directly or indirectly

attributable to an injury or illness for which they sought medical advice, or which they knew about or could reasonably be expected to have known about, before the effective date of the alteration.

9.6 | WHEN *WE* WILL ADJUST THE CLAIM AMOUNT THAT WE PAY

We will pay less than the member's sum assured in the following circumstances:

- The *policyholder* did not tell *us* about an increase of more than 20% in the *member's* yearly risk salary (only the amount above the sum assured associated with the previous salary level will be disputed).
- The *member's* risk salary is more than their actual salary (their actual salary will be used for to calculate the sum assured to be paid).
- If *we* use a tracing agency to locate nominated beneficiaries of a Life Cover or Global Education Protector Benefit, the associated costs will be proportionally allocated among the beneficiaries for whom the service was required. These costs will be deducted from the respective sum assured. *We* reserve the right to waive this cost for the Global Education Protector Benefit ONLY.

9.7 | *WE* DO NOT PAY OUT FOR CLAIMS BASED ON FRAUD

We do not pay out where the claimant does any of the following:

- Submits a fraudulent claim
- Uses any fraudulent means or devices to make claims
- Gives false information to obtain a benefit
- Knowingly allows anyone acting on their behalf to give false information to obtain a benefit
- Deliberately and wilfully conspires to cause the illness or disability that leads to a claim.

9.8 | CLAIMS THAT RESULT FROM MEDICAL CONDITIONS THAT EXISTED BEFORE COVER (PRE-EXISTING CONDITIONS)

We exclude claims that begin or occur within the first 12 months of cover for a *life assured* if the claim is for a medical condition that existed before the date that cover started (a pre-existing condition). A *pre-existing condition* is one that is, in the opinion of *our* medical panel, directly or indirectly caused by or attributable to a physical defect, illness or injury that the *life assured* or *member*:

- Was aware of before the date of joining the *Plan*
- Should reasonably have been aware of before the date of joining the *Plan*
- Sought medical advice or treatment for before the date of joining the *Plan*.

We will still, however, consider claims for the Life Cover Benefit and the Funeral Cover Benefit.

9.8.1 When *we* do not apply this rule

We do not apply this rule to the core Life Cover Benefit and the Funeral Benefits. At the start of the *Plan*, *we* automatically waive the pre-existing conditions rule for *members* who, immediately before moving to *our Plan* and without a break in insurance cover:

- Had the same benefits at a previous group insurance underwriter
- Met this condition at their previous group insurance underwriter.

We will only waive the pre-existing conditions rule to the extent that the previous benefits were at the same level as those that *we* provide.

Where *we* waive the pre-existing conditions rule for previous benefits that are at a lower level of cover than the benefits on the *Plan,* the benefits provided for the first 12 months of joining the *Plan* will be the same level of cover that was in place under the previous group insurance provider. An example of this is where the waiting period of an Income Continuation Benefit is reduced from 6 months under the previous benefits to 3 months under the *Plan*, we will provide benefits with a 6 month waiting period within the first 12 months of joining the *Plan*. The pre-existing conditions rule will apply to the improved benefits in the case where improved benefits are selected.

We will not waive the pre-existing conditions rule for individual life insurance policies that a *member* has in addition to group insurance.

The *policyholder* may ask *us* to waive the pre-existing conditions rule for *Plans* or *members* where it would not be automatically waived in terms of this clause. However, *we* are not obliged to agree to the request, and *we* normally will not because of the additional risk to which this will expose the *Plan*. *We* will tell the *policyholder* about any extra terms, conditions and premiums that apply if *we*, at *our* sole discretion, do agree to waive this rule.

If *we* do waive the pre-existing conditions rule either automatically or by agreement, *we* will only waive it for *members* who were *members* of a group life insurance plan where they received the same benefits as the *Plan* immediately before the start of the *Plan*.

The pre-existing conditions rule will not be waived for new *members* who were not employed by the *policyholder* immediately before the start of the *Plan*, unless they can provide proof that they met the conditions for waiver in this section, immediately before joining the *policyholder* through insurance with a previous group insurance underwriter.

9.9 | SET-OFF

We have the right to deduct (set-off) from any benefit due to *members*, any amount that *members* may owe to *us.*

9.10 | *WE* EXCLUDE CLAIMS THAT RESULT FROM WAR, RIOT AND TERRORISM

We do not pay out Life Cover, Income Continuation, Capital Disability, Severe Illness, Cancer or Funeral Cover Benefits if the claim results from a wilful and deliberate breaking of any law or wilful involvement in any riot, insurrection, usurpation of power, martial law, war, act of terrorism or similar events.

9.11 | *WE* EXCLUDE CLAIMS THAT RESULT FROM ATOMIC, BIOLOGICAL AND CHEMICAL WAR AND TERRORISM

We do not pay out Life Cover, Income Continuation, Capital Disability, Severe Illness, Cancer or Funeral Cover Benefits if the claim results directly or indirectly from any of the following:

- Use of nuclear, biological or chemical weapons, or any radioactive contamination
- Attacks on or sabotage of facilities (including nuclear power plants, reprocessing plants, final repository sites and research reactors) and storage depots, which lead to the release of radioactivity of nuclear, biological or chemical warfare agents, whether or not any of these have been done with the specific use of information technology
- Attacks on or sabotage of the facilities mentioned above which are done with the specific use of information technology.

We will not waive these exclusions.

9.12 | *WE* EXCLUDE CLAIMS THAT RESULT FROM ORGAN DONATION

We exclude claims that occur due to complications as a result of Organ donation at the time of donation or after the donation took place.

9.13 | REVIEWING THE CLAIM DECISION

If the *policyholder or life assured* wants *us* to review a claim decision, they must tell *us* within 90 days of the initial claim decision. If the *policyholder* or *life assured* is still dissatisfied after the review, they may approach the Ombudsman for Long-term Insurance for assistance or seek legal assistance within six months.

The *policyholder* or claimant must pay for the costs of the review. *We* have the final discretion in deciding to accept or reject a claim. *We* will communicate *our* final decision to the *policyholder* in writing.

9.14 | PRECEDENT

No decision by *us* concerning the *Plan* may be interpreted as a precedent.

DEFINITION OF *YOU/YOUR* FOR THIS SECTION

In this section, *you/your* refers to the *policyholder*.

This section sets out how Life and Impairment Funds act as the payment mechanisms for benefits.

10.1 | ABOUT THE LIFE FUND AND IMPAIRMENT FUNDS

10.1.1 Each *member* covered for Life Cover Benefits has a Life Fund

The Life Fund acts as a central account of the *sum assured* in the *member's* name. It is a single source of the *sum assured* that pays out for the Life Cover Benefit, and for the Capital Disability Benefit, Severe Illness Benefit and Cancer Benefit that are structured as advances of the Life Cover Benefit (if these are not structured as standalone benefits). Benefit payouts from the Life Fund reduce the Life Fund by the amount paid. The Client Benefit Schedule will show whether the *Plan* covers the Severe Illness and Cancer Benefit and Capital Disability Benefit. It will also show whether these benefits are attached to the Life Cover Benefit or operate as standalone benefits.

10.1.2 *Members* might have one or more Impairment Fund

Where Severe Illness and Cancer Benefits and Capital Disability Benefits are not attached to the Life Cover Benefit, they are standalone benefits. There is an Impairment Fund for each of these standalone benefits. The Impairment Funds work in the same way as the Life Fund, but only for the Severe Illness and Cancer Benefit or Capital Disability Benefit to which they are attached. This means that benefit payouts for these standalone benefits reduce the relevant Impairment Fund but do not reduce the Life Fund.

10.1.3 Other standalone benefits

The Income Continuation Benefit (and its riders), the Global Education Protector and the Funeral Cover Benefit are all standalone benefits that pay out directly from the benefit. Payouts for these benefits do not reduce the Life Fund or Impairment Fund.

10.2 | HOW BENEFIT PAYOUTS WORK

10.2.1 The Life or Impairment Funds are reduced by payouts

A benefit pay out from the Life Fund or Impairment Fund reduces these funds by the amount of the payout. Later benefit payouts will be made from the new reduced value in the Life Fund or Impairment Fund. Once the Life Fund or Impairment Fund has no more *sum assured* available in it to pay for benefits, the Life Fund or Impairment Fund ends. After this, no further claims can be paid for the Life Cover Benefit, Capital Disability Benefit and Severe Illness and Cancer Benefit. (See the clause Minimum Protected Fund (10.5) for how this benefit may reinstate the Life Fund or Impairment Fund partially or fully.)

10.3 | MORE THAN ONE CLAIM FROM ONE EVENT

If a *member* qualifies for benefit payouts from more than one benefit because of the same *life-changing event*:

- *We* pay the highest benefit pay out first. The *member's* Life Fund reduces by the amount of the payout.
- *We* pay the lower benefit payouts in order of their value. Each payout reduces the Life Fund by the amount of the payout. *We* use the reduced values for each payout.

The same effective date applies for assessing benefit payouts for these multiple claims. (The effective date is the date when the *life-changing event* occurs.)

EXAMPLE

Sarah has the following:
A Life Cover Benefit with a linked Life Fund that is four times her yearly risk salary.

A Capital Disability Benefit attached to the Life Cover Benefit that is twice her yearly risk salary (which is 50% of the Life Fund).

Sarah claims for a disability that meets the criteria of Category A disabilities as defined in Appendix 2: Disability benefits assesment. Category A disabilities receive a 100% payout for Capital Disability. This means Sarah has received 50% of the value of the Life Fund and 50% will remain. Later claims will be calculated from the reduced value. If Sarah dies, she will receive the remaining Life Fund as a payout, not the amount of her Life Cover Benefit.

10.4 | THE LIFE AND IMPAIRMENT FUNDS WILL CONTINUE TO GROW

The Life Fund and Impairment Fund will be reduced by the amount of a benefit payment. However, the remaining Life Fund will continue to grow by the yearly salary increase percentage of the *member,* subject to underwriting and to the terms and conditions of the *Plan* relating to salary increases being met.

10.5 | THE LIFE FUND CAN BE PROTECTED USING THE MINIMUM PROTECTED FUND

The Minimum Protected Fund is a benefit that restores the level of insurance in the Life Fund to a specific level if a benefit payout results in the Life Fund dropping below that level. The Client Benefit Schedule will show if *you* have a Minimum Protected Fund, the premium *you* pay for it, and the minimum level *you* chose for it.

The additional premium payable for the Minimum Protected Fund will depend on the Minimum Protected Fund level and the cover selected for the benefits.

Subject to the 14-day survival period (including the 14th day), the value in the *member's* Life Fund will never drop below the specified minimum level, regardless of how many benefit payments have been made or what the monetary value of these payments was.

It is a condition of this benefit that the *life assured* survive for at least 14 days (including the 14th day) from the date of the *life-changing event* which reduced the Life Fund by the value of the Capital Disability Benefit or Severe Illness or Cancer Benefit claim paid. If the *life assured* does not survive for the 14 days (including the 14th day), then the Life Fund will not be restored to the chosen level, and the Life Cover Benefit will only pay out the *sum assured* remaining in the Life Fund after earlier payment of the Capital Disability Benefit or Severe Illness or Cancer Benefit claim.

The Minimum Protected Fund only restores the Life Fund after payouts of Capital Disability, Severe Illness and Cancer Benefits. It does not restore the Life Fund after the payment for Life Cover Benefits. On the death of the *member*, the Life Fund is fully depleted, and the Minimum Protected Fund will no longer affect the Life Fund.

The Minimum Protected Fund Benefit applies to accelerated Life Funds and existing standalone Impairment Funds.

See the Capital Disability Benefit (14) and Life Cover Benefit (11) sections for how *we* calculate the payouts.

EXAMPLE

LEBO HAS THE FOLLOWING LIFE FUND, LIFE COVER BENEFIT, CAPITAL DISABILITY BENEFIT AND MINIMUM PROTECTED FUND VALUES WHEN SHE STARTS BEING COVERED BY *US*, BEFORE SHE SUBMITS ANY CLAIMS:

Lebo has R2 million in her Life Fund before claims.	Life Fund = R2 million
She has a starting Life Cover Benefit of 100% of her Life Fund.	Life Cover Benefit before any claims = 100% of Life Fund = 100% of R2 million = R2 million
She has a starting Capital Disability Benefit of 50% of her Life Fund.	Initial Capital Disability Benefit before any claims = 50% of Life Fund = 50% of R2 million = R1 million
She has the Minimum Protected Fund benefit of 75% of her starting Life Fund.	Minimum Protected Fund, after 14 days from the date of the life-changing event = 75% of Life Fund = 75% of R2 million = R1.5 million
Lebo has a car accident which leads to a capital disability claim that meets the criteria for Category A disabilities. She would receive a payout of 100% of her Capital Disability Benefit, which is 50% of her Life Fund.	First Capital Disability Benefit = 100% of starting capital disability cover insurance = 100% of 50% of the Life Fund = 100% x 50% x R2 million = R1 million
Immediately after the claim, Lebo's Life Fund reduces by the amount of the payout. It is not restored to 75% of its initial value for 14 days, because the Minimum Protected Fund benefit only restores the Life Fund after 14 days have passed from the date of the life-changing event.	Life Fund for 14 days after first claim = R2 million – R1 million = R1 million
If Lebo has another disabling event or dies within 14 days of her first claim, then the next claim will be based on the reduced value of the Life Fund.	Reduced Life Cover Benefit for 14 days after first claim = 100% of reduced Life Fund = 100% of R1 million = R1 million Reduced Capital Disability Benefit for 14 days after first claim = 50% of reduced Life Fund = 50% of R1 million = R500,000
If Lebo has another disabling event or dies after more than 14 days have passed since the date of her first life-changing event, then the next claim would be based on the Life Fund after it was restored to its minimum value of 75% of its original value by the Minimum Protected Fund benefit.	Restored Life Cover Benefit after more than 14 days = 100% of restored Life Fund = 100% of 75% of initial Life Fund = 100% of 75% of R2 million = R1.5 million Restored Capital Disability Benefit after more than 14 days = 50% of restored Life Fund = 50% of 75% of R2 million = R750,000

Benefit terms and conditions

- Sections 11 to 21 refer to terms and conditions which apply to specific benefits.
- Only the sections that apply to the benefits selected for the *policyholder's Plan* as indicated in the Client Benefit Schedule and Member Benefit Schedule are applicable for the *Plan*.

DEFINITION OF *YOU/YOUR* FOR THIS SECTION
In this section, you/your refers to the member.

11.1 | WHAT THE LIFE COVER BENEFIT IS

The Life Cover Benefit pays out if *you* die before the *benefit expiry age* while *you* are a *member* under the *Plan*.

If the *Plan* includes insurance for the *Spouse* Life Cover Benefit, *we* also pay out if *your spouse* dies while *you* are a *member* under the *Plan*. The standard terms and conditions that apply to *your* Life Cover Benefit will apply to the *Spouse* Life Cover Benefit, except for the necessary changes and any additional terms and conditions set out in any policy document (including this *Life Plan Guide*, the quote, the *Policyholder's* Application, the Client Benefit Schedule, the Member Benefit Schedule, the General Benefit Limits Document) that apply specifically to *Spouse* Benefits (see the *Spouse* Benefits (17) section).

If selected for the *Plan*, the Life Cover Benefit and *Spouse* Life Cover Benefit will appear on the Client Benefit Schedule. If the Life Cover Benefit and *Spouse* Life Cover Benefit do not appear on the Client Benefit Schedule, then the benefits do not apply for *your Plan*.

11.2 | HOW MUCH *WE* PAY OUT

We pay out the value of *your* Life Fund at the date of *your* death.

Your initial Life Fund is the sum of *your* core and flex life cover benefits. *Your* Life Fund will increase with salary increases. *Your* Life Fund is reduced by any claims made from the Life Fund and is increased or decreased by changes in *your* Flex Life Cover Benefit.

11.3 | WHEN THE LIFE COVER BENEFIT ENDS

The Life Cover Benefit ends at the earliest of the following:

- The date *you* no longer qualify as a *member*
- The end of the month in which *you* reach the *benefit expiry age*
- The date the Life Fund is depleted due to payment of claims.
- The date the *Plan* terminates or ends

11.3.1 No insurance or premiums after the *benefit expiry age*

The *policyholder* chooses the *benefit expiry age*, which is usually *your* normal retirement *age*. This means that if *you* die in service before the end of the month in which *you* reach the *benefit expiry age* (and *you* were a *member* at the time), the claim will be considered. If *you* die after the end of the month in which *you* reached the *benefit expiry age*, *we* will not accept or consider the claim.

After *you* reach the benefit expiry age:

- *You* do not have insurance under the Life Cover Benefit
- *We* do not charge premiums for the Life Cover Benefit

11.4 | THE ACCIDENTAL LIFE COVER BENEFIT

An Accidental Life Cover Benefit may be chosen by the *policyholder* for either the *member* or their *spouse*, or both, at the start of the *Plan*.

This benefit offers a lump sum at death if it is caused by an *accident*. For the definition of *accident* see the clause *What is an accident? (4.7)*.

This benefit could be taken in addition to the standard Life Cover Benefit, or as a standalone benefit. The combined Accidental and standard Life Cover, or the standalone Accidental Life Cover, cannot exceed the maximum for the Life Cover Benefit in the General Benefit Limits Document.

EXAMPLE (only for illustrative purposes)

01 | Accidental Life Cover Benefit In addition to the standard Life Cover Benefit

A *policyholder* provides five times yearly risk salary to its *members* through a *Plan.*

The *policyholder* wants to provide *members* with an additional two times yearly risk salary which only pays a benefit if the *members* die from accidental causes.

The Life Fund is unchanged at five times yearly risk salary, and an additional two times yearly risk salary will be payable on accidental death.

This means that if a *member* dies from **natural causes**, their beneficiaries will be paid five times yearly risk salary. The two times Accidental Life Cover Benefit will not be paid because the death did not happen accidentally.

However, if a *member* dies from **accidental causes**, their beneficiaries will be paid seven times yearly risk salary (five times from the standard Life Cover Benefit, and two times from the Accidental Life Cover Benefit).

02 | Standalone Accidental Life Cover Benefit (no standard Life Cover Benefit)

A *policyholder* does not provide any standard Life Benefits to its *members*.

The *policyholder* wants to provide *members* with two times yearly risk salary which only pays a benefit if the *members* die from accidental causes.

After a new quote for the Accidental Life Cover is accepted by the *policyholder,* the Life Fund for accidental death will be set to two times yearly risk salary.

This means that if a *member* dies from **natural causes,** their beneficiaries will not be paid a benefit because the death did not happen accidentally, and there is no standard Life Cover Benefit insured.

If a *member* dies from **accidental causes,** their beneficiaries will be paid two times yearly risk salary only.

The maximum benefit payable in both cases will be the maximum Life Cover Benefit in the General Benefit Limits Document.

A benefit may be claimed when the definition of an *accident* and all the following conditions are met:

- *Your* death results directly and solely from a bodily injury caused by an *accident*
- *Your* death takes place within 12 months after the *accident*
- *You* are still a *member* of the *Plan* at *your* date of death

Cover ceases at the earlier of reaching normal retirement *age* or reaching *age* 65.

The premium for Accidental Life Cover Benefit is charged as a percentage of yearly risk salary.

11.5 | LUMP-SUM LIFE COVER BENEFIT TO INSURE PENSIONS OF *SPOUSES* AND *CHILDREN* (*APPROVED* RETIREMENT FUNDS ONLY)

Some *approved* retirement funds pay the pensions of *spouses* and *children* on the death of the *member*. These pensions are shown as percentages of the pension that the *member* would have received at date of death if they had retired on that day as set out in the rules of the retirement fund.

We do not insure or pay pensions. However, the *policyholder* (that is, an *approved* retirement fund) may elect the Lump-sum Life Cover Benefit to insure *spouse's* or *child's* pensions in the quote. If selected, this will appear on the Client Benefit Schedule. The Lump-sum Life Cover Benefit to insure *spouse's* or *child's* pensions allows the *policyholder* to increase the *sum assured* for the Life Cover Benefit by the approximate value of the *spouse's* or *child's* pensions at *your* death (so the Life Fund may be increased by a value approximately equivalent to the present value of the *spouse's* or *child's* pensions at *your* date of death). This allows the retirement fund to use the Lump-sum Life Cover Benefit to buy *spouse's* or *child's* pensions when *you* die.

There may be a shortfall in the amount needed to buy the *spouse's* or *child's* pensions for the following reasons:

- *We* make assumptions about the value of pensions at *your* death, while the pricing assumptions of pension providers may be different. This means the actual pension provider's values (the amount required to buy the pensions) might be higher or lower.
- The basic Life Cover *sum assured* combined with the *spouse's* and *children's* pensions *sum assured* may not total more than *our* maximum Life Cover Benefit in rand terms or in multiples of salary terms (see the General Benefit Limits Document). *We* will reduce the total *sum assured* for the Life Cover Benefit to the maximums stated in General Benefit Limits Document, if necessary.

We only pay the estimated insured amount, even if there is a shortfall between this and the amount the retirement fund needs to purchase the pensions.

EXAMPLE (only for illustrative purposes)

Your approved retirement fund provides all the following benefits to *your spouse* and *children* if *you* die:

- Two times *your* yearly risk salary at *your* date of death
- A pension for *your spouse* of 50% of *your* yearly risk salary at *your* date of death
- A pension for up to five *children* of 10% of *your* yearly risk salary at *your* date of death

Examples of some payments which may be made:

MEMBER TYPE	YEARLY RISK SALARY	CORE MULTIPLE	PENSIONS MULTIPLE*	TOTAL MULTIPLE	VALUE BEFORE MAXIMUMS	VALUE AFTER MAXIMUMS**	SHORTFALL
Not married, no *children*	R500,000	2x	0x	2.0x	R1,000,000	R1,000,000	R0
Married, no *children*	R500,000	2x	7.5x	9.5x	R4,750,000	R4,750,000	R0
Married, 5 *children*	R500,000	2x	15x	17.0x	R8,500,000	R5,000,000	(R3,500,000)

*The present value of future pension payments from date of death based on assumptions

** 10x yearly risk salary or R33,500,000

11.6 | INCREASING OR SPLITTING THE LIFE COVER BENEFIT FOR TAX REASONS (*APPROVED* RETIREMENT FUNDS ONLY)

If the *policyholder* is a retirement fund, it may choose one of the following options for dealing with the tax that would be payable when the *approved* Life Cover Benefit payout is distributed by the retirement fund to *your* dependants and beneficiaries:

- Increasing the *approved* Life Cover Benefit – tax replacement benefit
- Splitting the Life Cover Benefit between *approved* and *unapproved* benefits – tax optimiser benefit

The retirement fund can only select one of the above benefit options on its quote. The two options are priced differently. If either benefit is selected, the selected benefit will appear on the Client Benefit Schedule.

11.6.1 Increasing the *approved* Life Cover Benefit – tax replacement benefit

A *policyholder*, which is an *approved* retirement fund, may elect to increase the *approved* Life Cover Benefit to insure the estimated tax payable on *approved* lump-sum benefits when they are paid by the retirement fund to *your* dependants and beneficiaries. This will ensure that *your* dependants and beneficiaries receive the rand benefit the retirement fund promises after tax is deducted, with some variations if assumptions made in the benefit calculation are not accurate.

If selected, the increased *approved* Life Cover Benefit *sum assured* will appear on the Client Benefit Schedule.

The amount *we* pay out for tax may not fully cover the tax liability because the real circumstances may be different from the assumptions made to calculate the estimate. The main assumption made is that the tax-free allowance that applies to the *member's* retirement fund lump-sum benefits is available at the time of the claim. The current tax-free allowance per *member's* lifetime is R550,000 and may change from time to time in terms of applicable law. Above the R550,000 (as may change from time to time), *approved* Life Cover Benefit payouts distributed by the retirement fund to the *member's* dependants and beneficiaries are taxed. However, if *you* used up some or all of the allowance for earlier tax-free payouts, the Life Cover Benefit *we* pay out may be different.

We will not increase *your* Life Cover Benefit to more than *our* maximum Life Cover Benefit in rand terms or multiples of salary terms (see the General Benefit Limits Document). *We* will reduce the total *sum assured* for the Life Cover Benefit to the maximums stated in General Benefit Limits Document, if necessary.

The *policyholder* will need to request a quote for updated cover levels when the tax tables change.

EXAMPLE (only for illustrative purposes)

For the 2024 tax year (1 March 2024 to 28 February 2025) lump-sum death benefits paid to *members* from an *approved* retirement fund are subject to the following tax:

TAXABLE INCOME (R)	RATE OF TAX (R)
1 – 550,000	0% of taxable income
550,001 – 770,000	18% of taxable income above 550,000
770,001 – 1,155,000	36,000 + 27% of taxable income above 770,000
1,155,001 and above	143,550 + 36% of taxable income above 1,155,000

If *your* retirement fund intends for *your* dependants and beneficiaries to receive five times *your* yearly risk salary after tax if *you* die, then the retirement fund must insure a higher amount than five times to make sure there is enough *sum assured* to pay for tax.

If the fund only insures five times *members'* yearly risk salary, the amounts received after tax by dependants and beneficiaries will be:

YEARLY RISK SALARY	BENEFIT INSURED AND PAID		BENEFIT RECEIVED (AMOUNT PAID LESS TAX)			
			TAX-FREE R550,000 AVAILABLE		NO TAX-FREE AMOUNT	
	5x salary	Multiple[1] insured	Benefit paid after tax	Multiple[2] paid after tax	Benefit paid after tax	Multiple[3] paid after tax
R50,000	R250,000	5.0	R250,000	5.0	R205,000	4.1
R120,000	R600,000	5.0	R492,000	4.1	R492,000	4.1
R175,000	R875,000	5.0	R791,750	4.5	R701,750	4.0
R400,000	R2,000,000	5.0	R1,527,500	3.8	R1,437,500	3.6

The table above shows that the fund insures the intended five times yearly risk salary, but there are two possible outcomes:

01 | If *your* full tax-free amount is available when *you* die, then after tax *your* dependants and beneficiaries receive less than five times after tax, except if *you* earn R110,000 or less because *your* benefit will be within the tax-free amount. How much less the multiple is will depend on how large the benefit is and which tax bracket it falls into.

01 | Some or all of *your* full tax-free amount has been used up, then *your* dependants and beneficiaries will receive an even lower multiple of *your* yearly salary because of the tax on the expected tax-free amount.

If the fund insures five times the *member's* salary plus the expected tax payable on the five times, then the amounts received after tax by dependants after the *member* dies will be:

YEARLY RISK SALARY	BENEFIT INSURED AND PAID		BENEFIT RECEIVED (AMOUNT PAID LESS TAX)			
			TAX-FREE R550,000 AVAILABLE		NO TAX-FREE AMOUNT	
	5x salary + tax payable	Multiple insured	Benefit paid after tax	Multiple[2] paid after tax	Benefit paid after tax	Multiple[3] paid after tax
R50,000	R250,000	5.0	R250,000	5.0	R205,000	4.1
R120,000	R621,951	5.2	R600,000	5.0	R510,000	4.3
R175,000	R989,041	5.7	R875,000	5.0	R785,000	4.5
R400,000	R2,738,281	6.8	R2,000,000	5.0	R1,910,000	4.8

So, dependants and beneficiaries will receive five time the *member's* yearly annual risk salary after tax as intended by the retirement fund as long as you have not previously used the tax-free amount.

11.6.2 Splitting the Life Cover Benefit – tax optimiser benefit

A *policyholder* (that is a retirement fund) may elect to split the Life Cover Benefit between *approved* and *unapproved* benefits, using separate but related *approved* and *unapproved Plans*

In terms of applicable law, the first R550,000 (this amount may change from time to time) of an *approved* life insurance benefit paid by the retirement fund to the dependants and beneficiaries will be tax-free. Above the R550,000 (as may change from time to time), the *approved* life insurance benefit paid by the retirement fund to *your* dependants and beneficiaries will be taxed.

To optimise the tax payable on *approved* life insurance payouts, the *sum assured* for the *approved* life insurance benefit can be limited to the tax-free allowance that applies to the *member's* retirement fund lump-sum benefits (currently R550,000, but this may change from time to time in terms of applicable law). The remainder of the *sum assured* above R550,000 can be provided as an *unapproved* life insurance benefit.

If the *member* used up some or all of the tax-free allowance for earlier tax-free payouts, tax would be payable on the *approved* Life Cover Benefit payout distributed by the retirement fund to the *member's* dependants and beneficiaries.

The tax-free allowance may be increased from time to time by law. If this happens, the *policyholder* may request a new quote to increase the *sum assured* of the *approved* life insurance benefit to the new tax-free allowance amount, and to rebalance the sums assured in the *unapproved* life insurance, with appropriate changes in premiums.

DEFINITION OF *YOU/YOUR* FOR THIS SECTION
In this section, you/your refer to the member

12.1 | ABOUT THE GLOBAL EDUCATION PROTECTOR

12.1.1 How the benefit works

The Global Education Protector is a benefit that pays the standard education fees of *your children* if *you* die while the *Plan* is in force.

This benefit follows the *indemnity principle*. This means that it is designed to compensate for the actual financial loss of the ability to pay for standard education fees (depending on the limits and terms and conditions set out in the *Plan*) of a *member's children* because of the *member's* death.

Based on the *indemnity principle*, the standard education fees which the *member* was paying, or would have paid in the future, will be continued by the Global Education Protector Benefit. The limits and terms and conditions set out in the *Plan* will apply.

The level of indemnity or cover provided is determined by the actual standard education fees charged by the educational institution attended by the *children* at the time of the *member's* death, up to the maximum benefit limits applicable in the year of education. The minimum annual amount set by *us* from time to time will also apply. The standard education fees charged by the educational institution attended by the *children* at the time of the *member's* death will determine future payments, considering annual education inflationary increases, based on Stats SA's education CPI indices amended for the specific inflation factors affecting the benefits. If the *children* move to a more expensive educational institution, payments will be limited to the level of standard education fees that were payable at the educational institution they were attending at the time of the *member's* death, allowing for inflation. The limits and terms and conditions set out in the *Plan* will also apply.

This means *we* will not pay out more than the standard education fees (subject to the limits and terms and conditions set out in the *Plan*) for the *member's children* that the *member* was actually paying at the time of their death or would have paid if they had not died.

There are minimum yearly amounts and maximum amounts that *we* pay for this benefit. See the General Benefit Limits Document.

12.1.2 Who has this benefit?

If the average Life Cover Benefit considering all *members* of *the Plan* is two times or more of the average yearly risk salary for the *Plan*, all *members* of the *Plan* will automatically qualify for this benefit, including those *members* whose Life Cover Benefit is less than two times their yearly salary. If selected for the *Plan*, the Global Education Protector Benefit will appear on the Client Benefit Schedule. If the Global Education Protector Benefit does not appear on the Client Benefit Schedule, then the benefit does not apply for *your Plan*.

The Global Education Protector is not available as a standalone product or benefit.

Benefit payments from the Global Education Protector have no impact on the *member's* Life Fund.

12.1.3 When the benefit ends

The Global Education Protector Benefit ends at the earliest of the following:

- The *date you* no longer qualify as a *member*
- The end of the month in which *you* reach the *benefit expiry age*
- When the average *sum assured* for the Life Cover Benefit for all *members* of the *Plan* reduces to below two times the average yearly risk salary or average yearly risk benefit salary for the *Plan*
- The date the *Plan* terminates or ends

We will not consider claims for this benefit where the claim event is after any of the above dates.

12.1.4 Benefit payments for the Global Education Protector will end in the following instances

Benefit payments will stop if any event listed below occurs:

- The *child* completes their schooling and does not attend a tertiary institution immediately afterwards. A one-year break or gap year may apply, as set out in the clause If the *child* takes a gap year (12.3.2).
- The *child* leaves their school or tertiary institution and does not return within a year.
- The *child* completes their tertiary education. The benefit maximums set out in the clause The years of education that the benefit pays for (12.3) will apply.
- The *child* turns 24 years of *age* (the benefit payments will stop at the end of the education year).
- The *child* does not return to school or a tertiary institution after the gap year.
- The *child* dies.
- The *child* starts employment.

Benefit payments for the Global Education Protector will be suspended in the following instances:

- The *child* fails two successive years of primary or secondary education, until they progress to the next grade as set out in the clause If the *child* fails a year of education - Pre-school, primary school and high school (12.3.1.1).

- The *child* fails a year of tertiary education, until they pass that year as set out in the clause If the *child* fails a year of education - Tertiary education (12.3.1.2).

We will only continue payments once the specified criteria are met as stipulated in section 12.3.1.

12.2 | BENEFICIARIES OF THE BENEFIT (THE *MEMBER'S CHILDREN*)

12.2.1 Definition of *child*

Children of the *member* who meet the definition of *child (3.7)*, including the requirement that they have not reached the *age* of 24.

12.2.2 The *member* must tell *us* about the *children* who qualify under the *Plan*

At claims stage *we* require proof of each *child's* status as a beneficiary as set out in the definition of *child (3.7)*.
We will let *you* know at claims stage if *we* need any extra information to assess a claim.

12.3 | THE YEARS OF EDUCATION THAT THE BENEFIT COVERS

We insure a *child's* years of education for pre-school, primary school, high school and tertiary education. The description of pre-school, primary school, high school and tertiary education and the maximum number of years *we* pay the benefit are set out in the table on the right.

EDUCATION LEVEL	DESCRIPTION	MAXIMUM NUMBER OF YEARS *WE* PAY THE BENEFIT
Before Grade 0	There is no benefit before Grade 0 (also known as Grade R). However, *we* consider the standard education fees paid for the *child* for Grade 00 or equivalent grade when determining the fees for Grade 0/Grade R.	No payment
Pre-school	Grade 0/Grade R	One year. There is a maximum amount per month (see the General Benefit Limits Document).
Primary school	Grades 1 to 7 at a *recognised* primary school	Seven years. There is a maximum amount per month (see the General Benefit Limits Document).
High school	Grades 8 to 12 at a *recognised* high school	Five years. There is a maximum amount per month (see the General Benefit Limits Document).
Tertiary education	▪ *Recognised* undergraduate degree ▪ *Recognised* trade diploma or certificate ▪ Bachelor of Dentistry (BDS) ▪ Medical degree (MBSc or MBChB) Note: All *recognised* South African universities, recognised universities of technology (technikons), recognised institutions providing for a trade (for example, plumbing and electrical) and specific international universities are included in this benefit. For the definition of *recognised educational institutions*, see the clause What is a recognised educational institution? (4.8) For the international universities *we* cover, see Appendix 8: Specific international universities recognised for the Global Education Protector. A child who has been accepted by a university on this list and wishes to attend must apply, in good faith and as best they can, for any financial aid offered by that university in order to qualify for cover of tuition and other costs. We will cover the shortfall after the financial aid has been applied, subject to the Benefit Limits Maximum.	Four years Four years Five years Six years There is a maximum amount per year for all tertiary education (see the General Benefit Limits Document). *We* do not pay for the extra years if the *child* changes to a degree with a longer duration than the one they initially applied for after completing Grade 12. **EXAMPLE** If the student begins a three-year undergraduate degree and then decides to change to a six-year medical degree, *we* pay for three years of study only. **To note:** The four-year degree is not to extend the payment of a three-year degree if a student failed a subject but to make allowance for degrees that have a four year study term as part of the degree requirements. Examples of these degrees are LLB, BEd, Bachelors in Architectural Studies, certain Engineering and IT degrees. We will not cover further postgraduate degrees. This change becomes effective January 2026 and is only applicable for claim trigger events (the death of a member) on or after 1 January 2026.

12.3.1 If the *child* fails a year of education

12.3.1.1 Pre-school, primary school and high school

If the *child* fails a year from pre-school until the end of high school, *we* will only cover a maximum of one repeat year. *We* will pay 33% of the standard education fees or minimum yearly payment, whichever is applicable, for the *child* to repeat the year.

If the *child* fails a second time (whether in the same grade or a different grade), *we* will not pay for the repeat year. *We* will stop payments and only resume payments when the *child* progresses to the next school grade.

If a *child* has passed grade 12 and wishes to pass further subjects to get entry to a tertiary institution, *we* will pay up to one-third of the actual fees that *we* paid for Grade 12 or up to the minimum yearly amount if no or lower fees were paid.

12.3.1.2 Tertiary education

If a *child* fails a full year of a degree, diploma, trade qualification or similar tertiary qualification, *we* will not pay for the *child* to repeat the year. *We* will resume payments when the *child* progresses to the next year of education. *We* consider failing two-thirds or more of the subjects in a year as failing a full year.

If the *child* passes more than one-third of the subjects and progresses to the next year of education, *we* will continue to make benefit payments in full including repeat modules provided these modules are taken within the stipulated number of years for the chosen degree. This means if a *child* fails a subject or subjects for a three-year degree, we will only make benefit payments for three years.

12.3.2 If the *child* takes a gap year

Years of education must run consecutively. However, the *child* may take one year off (a gap year) between completing high school and starting tertiary education. *We* will not make any payments during the gap year. The rules about When the benefit ends (12.1.3) apply. This means that benefit payments may end before the *child* completes their education.

12.4 | WHAT FEES AND EXPENSES ARE COVERED BY THE BENEFIT?

12.4.1 For school years

12.4.1.1 What *we* pay for

We pay the standard education fees for the *children* that the *member* was actually paying at the time of their death or would have paid if they had not died. The standard education fees covered by this benefit at primary and secondary school level only refer to the basic tuition fees (basic fees for teaching). They exclude other related fees set out in the clause What *we* do not pay for (12.6).

We pay 100% of the standard education fees (that is, basic tuition fees) that apply to all learners in the *child's* respective year of study or grade. The maximum amounts that *we* pay for this benefit will apply (see the General Benefit Limits Document).

There is a minimum yearly amount that *we* pay out even if the *child* attends a no-fees school or is exempt from paying fees. The minimum yearly amount is set out in the General Benefit Limits Document.

In the year that the *member* dies, *we* pay the proportion of the minimum yearly amount or a proportion of the standard education fees (as the case may be) for the months from the *member's* death to the end of that year.

We will decide whether to pay the minimum yearly benefit amount or the relevant standard education fees only after *we* receive confirmation of the circumstances of the *child's* education, such as:

- The amount of the standard education fees (for example, an invoice from the school or the school's fee schedule)
- Whether the school is a no-fees school
- Whether the *child* is exempt from paying fees to the school.

12.4.2 Standard education fees for tertiary education

12.4.2.1 What *we* pay for

We pay the standard education fees for the *child* that the *member* was actually paying at the time of their death or would have paid if they had not died. The standard education fees covered by this benefit at tertiary level only refer to the basic tuition fees (basic fees for teaching) and exclude other related fees set out in the clause What *we* do not pay for (12.6).

We pay 100% of the standard education fees (basic tuition fees) at a *recognised* tertiary education institution or international university on *our* list of approved international universities. The maximum amounts that *we* pay for this benefit will apply (see the General Benefit Limits Document).

We may change *our* list of approved international universities from time to time. There is a maximum limit for tertiary education (see the General Benefit Limits Document).

We pay for the actual cost of books (including eBooks) required for the *child's* chosen field of study or course, up to a maximum of 10% of the lower of actual tertiary standard education fees or the maximum for those fees as set out in the General Benefit Limits Document.

We cover accommodation according to one of the following options:

- *We* pay for the actual cost of residence fees at a recognised tertiary education institution up to a maximum of 30% of the lower of the actual tertiary standard education fees or the maximum for those fees as set out in the General Benefit Limits Document.
- *We* pay for the actual cost of off-campus rental costs, as long as there is a valid lease agreement in place, the lessor is not a parent or other extended family *member*, the accommodation is accredited by the

relevant tertiary institution as acceptable student accommodation, and the rental is limited to a maximum of the cost of residence fees of the on-campus residence to which the *child* would have otherwise been allocated. The following documents must be provided:

- A signed lease agreement that must include the lessor, lessee and student's details, residential address, rental period, costs and rules for residence
- The lessor's and lessee's identity documents
- Banking details of the lessor or rental company, including a cancelled cheque, or a bank statement stating the branch code and banking details on a signed and dated bank letterhead (not older than three months)

In both cases, a maximum of 30% of the lower of the actual tertiary standard education fees or the maximum for those fees as set out in the General Benefit Limits Document applies.

12.4.2.2 What *we* do not pay for

We do not pay any fees at all if the *child* attends a tertiary education institution that *we* do not recognise as such.

12.5 | TREATMENT OF HOME SCHOOLS AND ONLINE SCHOOLING

The Global Education Protector does provide cover for home-schooling or online schooling costs if the following requirements are met:

- Tuition is conducted by an educator, or educators, registered with the South African Council for Educators or a registered tutor centre (where applicable)
- The *child* is registered with the Provincial Department of Education for Home Schooling, applicable from Grade 1 to 9 or age 15

Note that home schooling does not apply during the FET Phase (Grade 10 to 12) in South Africa. *Children* must be registered with an examination board through an independent service provider since examination boards do not register independent candidates.

Costs covered will include:

- Tuition fees incurred in relation to the minimum outcomes set out in the national curriculum by the Department of Education in the year of cover
- Cost of study material needed to cover the minimum outcomes of the national curriculum.
- Formal examination fees including registration, venue and courier costs

Expenses not covered are described in the section ,what we do not pay for, below.

12.6 | WHAT *WE* DO NOT PAY FOR

This benefit is payable on the death of the *member*. *We* do not pay if the *member's spouse* dies.

We do not pay the following fees and expenses:

- Residence or boarding fees for pre-school, primary school and high school
- Book fees or expenses for pre-school, primary school and high school
- School uniforms and stationary
- Registration fees or administration fees charged by any school or tertiary institution for all education levels
- Remedial education fees and extra tuition fees for studies that do not form part of the school or tertiary institution's normal curriculum (for example, extra maths or extra English) for all education levels
- Any fees extra to the standard education fees for all education levels
- Fees for extramural activities for all education levels
- Fees for excursions for all education levels
- Fees for aftercare and au pairs for all education levels
- Equipment and utensils required for studies for all education levels

12.7 | WHO *WE* PAY

12.7.1 Directly to the educational institution

We pay the educational institution that the *child* is attending directly where possible, including all standard education fees, on-campus residence fees and on-campus bookstores.

Off-campus accommodation fees are paid to the provider of that accommodation where possible.

If any law or circumstance prevents *us* from paying the educational institution or off-campus accommodation provider directly, *we* may, at *our* sole discretion, pay the benefits to the *child's* guardian or caregiver.

12.7.2 To the *child's* guardian or caregiver

If the *child* attends an educational institution where the yearly standard education fees are lower than a minimum yearly amount, *we* will pay the difference between the fees and the yearly minimum amount to the *child's* guardian or caregiver. The minimum yearly amount is set out in the General Benefit Limits Document.

If the *child* attends a no-fees educational institution or is exempt from paying fees, *we* will pay the minimum yearly amount to the *child's* guardian or caregiver.

12.8 | HOW *WE* CATER FOR *CHILDREN* WHO QUALIFY FOR BENEFITS FROM THE GLOBAL EDUCATION PROTECTOR BEFORE SCHOOL-GOING AGE

If a *member* dies before a *child* reaches Grade 0/Grade R), the *child* will only be covered from Grade 0/Grade R subject to a maximum amount (see the General Benefit Limits Document). The educational institution the *child* attends in Grade 0/Grade R will become the indemnity base of the benefit and will determine the level of indemnity cover for all future Global Education Protector claims. *We* will not be responsible for fees before Grade 0/Grade R.

When determining the fees applicable from Grade 0/Grade R, the fees paid in Grade 00 will be considered. As the *child* progresses through their education, *we* will also consider the levels of cover provided to the *child's* siblings under the Global Education Protector when determining the cover the *child* will receive.

A defined default fee of the pre-school (Grade 0/Grade R) maximum in the General Benefit Limits Document will be paid in most cases. However, *we* will consider the payment of private school fees under the Global Education Protector if one of the following applied before the *member's* death:

- The *child* (who had not yet reached Grade 0/Grade R at the time of the *member's* death) was registered at or placed on a waiting list for a private school or higher fee non-private school.
- The *child* (who had not yet reached Grade 0/Grade R at the time of the *member's* death) had elder siblings already attending a private school or higher fee non-private school.

12.9 | CHANGES IN EDUCATION LEVELS OR INSTITUTIONS

12.9.1 Moving from one education level to another

We will pay the increase in fees when the *child* moves from one education level to the next (for example, from primary school to high school, or from high school to tertiary education).

If no fees were charged in primary school, no fees would be payable in high school. However, if the natural feeder high school of the primary school is a high school that charges fees, the fees will be considered up to the applicable maximums from a school with no fees to one with fees.

If the primary school does not have a natural feeder (all learners from the primary school automatically feed to one specific high school) *we* will cover the cost of the closest feeder school of the indemnity primary school up to the applicable benefit maximums from a school with no fees to one with fees.

In the scenario where a *child* attended a school that does not offer all the grades to finalise schooling to move on to secondary school or tertiary education, and therefore the guardian is forced to change schools, we will pay for schooling to the changed school but only at the same fees paid in the previous school.

In the scenario where the *child* moves to a lower fee-paying school, we will pay the lower fee facility.

There are limits to the increases *we* make:

FROM EDUCATION LEVEL	TO EDUCATION LEVEL	MAXIMUM INCREASE *WE* PAY
Before Grade 0/Grade R	Grade 0/Grade R	100% of Grade 00 fees
Grade 0/Grade R	Primary school	100% of Grade 0/Grade R fees
Primary school	High school	20% of Grade 7 fees

12.9.2 Moving to a higher-fee school

12.9.2.1 No increase in benefit payments

If, after the *member's* death, the *child* moves to a more expensive school (for example, from a low-cost or no-fee school to a Model C school), *we* will not pay the higher fees. *We* will continue to pay the same fees as *we* paid previously, adjusted for inflationary increases based on the Stats SA CPI education indices. The *child's* guardian will be responsible for the difference in the fees.
This rule applies even if the *child's* siblings are at a more expensive school at the time of the *member's* death. The *child* attending the lower-fee school will not be allowed to upgrade to a higher-fee school or private school.

EXAMPLE

Thabo is in Grade 3 at Mount Primary School. It is a low-cost school where the fees are R100 a month. Thabo's brother, Sifiso, is at Mount Model C Primary School where the fees are R2,000 a month. If Thabo moves to Mount Model C Primary School, *we* will continue to pay R100 a month. Thabo's guardian will be responsible for the difference in fees.

12.9.2.2 Private school upgrade

The *child* may apply to change from their current school to a private school if the *member's* Vitality Health status was Bronze or higher at the time of the *member's* death for *children* that are of school going age at the time of the member's death and within 12 months from commencement of schooling, from Grade 0/Grade R for unborn/*children* that are not of school going age at the time of the member's death. The application must include proof that the private school has accepted the *child*. *We* must receive the application for the upgrade within 12 months of the *member's* death for *children* that are of school going age at the time of the *member's* death and within 12 months from commencement of schooling, from Grade 0/Grade R for unborn/*children* that are not of school going age at the time of the *member's* death.

Payment of the benefit for a private school is limited to a maximum term of 12 years. Fees for private school education are limited to a maximum amount set by *us* from time to time (see the General Benefit Limits Document).

12.9.2.3 *Children* or siblings already in private schools

We will pay for private schooling or a higher fee non-private school if one of the following applied before the *member's* death:

- The *child* was registered at a private school or a higher fee non-private school.
- The *child* was on a waiting list for a private school or a higher fee non-private school and was not at school-going age when the *member* died.
- The *child*'s elder siblings were already attending a private school or a higher fee non-private school and the *child* was not of school-going age when the *member* died.

If, at the *member's* death, some of their *children* are attending private schools and others are attending public schools, the benefit for each *child* will be based on the school they are attending at the time of the *member's* death. This applies unless the *children* attending public schools are on waiting lists for private schools.

Payment of the benefit for a private school is limited to 12 years. Fees for private school education are limited to a maximum amount set by *us* from time to time (see the General Benefit Limits Document).

12.9.3 Moving to a higher-fee South African tertiary education institution

If, after the *member's* death, the *child* moves from a South African tertiary educational institution that they were attending to another, higher-fee South African tertiary educational institution, there will be no increase in payments, and *we* will not pay for additional years of study.

12.9.4 Moving to an international university

If, after the *member's* death, a *child* moves from a South African tertiary educational institution that they were attending to a university on *our* list of approved international universities, there will be no increase in payments, and *we* will not pay for additional years of study.

12.9.5 Moving out of South Africa

If, after the *member's* death, the *child* emigrates from South Africa, *we* will pay the benefits based on the standard education fees for South African educational institutions, and not the on rate of fees for education in the *child's* new country of residence.

12.10 | ABOUT THE PREMIUMS

The premium for this benefit is included in the premium for the standard Life Cover Benefit. The premium is not shown separately in the *Plan* schedules but will have a deemed value. This means that there is no additional premium above the premium for the Life Cover Benefit required for this benefit. For tax purposes, however, *we* may need to show it as a separate premium, in which case *we* will reduce the Core Life Cover Benefit premium by the same amount.

12.11 | THE *MEMBER* IS RESPONSIBLE FOR FRINGE-BENEFIT TAX

The Global Education Protector is offered on an *unapproved* basis only. This means that the premiums do not qualify for a tax deduction. The *member* pays fringe-benefit tax on the premium that is deemed to be paid for the benefit.

Members should seek appropriate guidance from a tax professional or from their registered financial adviser for the correct tax treatment of the Global Education Protector payments and premiums.

12.12 | *MEMBER* MUST HAVE BEEN *ACTIVELY AT WORK*

12.12.1 The *member* must have been *actively at work* at the start date of insurance.

12.12.2 *We* do not pay for medical conditions that existed before

The clause about pre-existing medical conditions (9.8) automatically applies even if *we* have waived the clauses for other benefits. *We* will waive this rule if the requirements for waiving the rule (9.8.1) are met and *we* have confirmed our waiver in writing.

12.13 | THE GLOBAL EDUCATION PROTECTOR CANNOT BE TRANSFERRED (CEDED)

Neither *you* nor the *policyholder* may transfer (cede) this benefit to any other person.

12.14 | LEGAL PROVISIONS ON MULTIPLE POLICIES PROVIDING EDUCATION BENEFITS

In terms of the *indemnity principle*, the *member* may only be compensated from all education policies up to the cost of the *child's* standard education fees, and the limits and terms and conditions set out in the *Plan* will apply.

Both parents of *children* covered under the Global Education Protector Benefit may be *members* of the same or different *Plans* insured by *us*. One or both parents may have individual life policies or group risk with Discovery Life Limited or another insurer that also provides education benefits. If two or more valid claims for education benefits arise from the *Plans* and one or more individual life policies or group risk, then in total only the actual costs of the *child's* standard education fees covered by the *Plan* will be paid.

If a *member* and *spouse* has other individual or group life policies that also provide education benefits, Discovery will reduce its benefit payments in the ratio of the potential Discovery payment to the total payment received from all policies. This is applied to each type of fee or expense that *we* cover in turn.

The Global Education Protector Aggregation formula for a fee type is:

$$\frac{\text{Discovery's Global Education Protector Benefit}}{\text{Total education benefit payable}} \times \text{Total cost of the fee type, restricted to Discovery's Global Education Protector Benefit.}$$

The amounts payable by *us* for a *child* are subject to a minimum of the minimum annual amount from all *Plans* covered by *us* for that *child*.

The Global Education Protector will not be paid on the death of a *member's spouse.*

Some insurers do not apply aggregation, in this instance the aggregation method will be a direct minus of the other insurer's payments from the actual education cost and if there is a difference, *we* would then cover the difference up to the General Benefit Limits Document Maximum.

EXAMPLE 1

The actual cost of tuition is R20,000 per year, less than the total benefit maximums of the two insurers combined.

The benefit maximums of the insurers are:

- Discovery Group Risk *Plan*: R10,000 per year
- Other insurer: R11,000 per year

The amounts payable from each insurer will be:

$$\frac{\text{*Plan* indemnity payment subject to General Benefit Limit maximum}}{\text{Total indemnity payment}} \times \text{Total cost of tuition, restricted to the *Plan* indemnity payment subject to General Benefit Limit maximum}$$

= R10,000 (*Plan* payment limited to maximum) ÷ (R10,000 + R11,000) x R20,000, restricted to R10,000

= R9,523.81 from Discovery Group Risk *Plan* Aggregated benefit and R10,476.19 from other Insurer Aggregated benefit. These are both below the maximums for each insurer so do not need to be restricted.

EXAMPLE 2

The actual cost of tuition is R25,000 per year.

The benefit maximums of the insurers are:

- Discovery Group Risk *Plan*: R10,000 per year
- Other insurer: R11,000 per year

If the General Benefit Limits Document Maximum Group Risk indemnity payment for a year is R10,000, then the amounts payable from each insurer will be:

$$\frac{\text{*Plan* indemnity payment subject to General Benefit Limit maximum}}{\text{Total indemnity payment}} \times \text{Total cost of tuition, restricted to the *Plan* indemnity payment subject to General Benefit Limit maximum}$$

= R10,000 (*Plan* payment limited to maximum) ÷ (R10,000 + R11,000) x R25,000, restricted to R10,000

= R10,000 from Discovery Group Risk *Plan* Aggregated benefit (R11,904.76 restricted to R10,000) and R11,000 from Other Insurer's Aggregated benefit (R13,095.24 restricted to R11,000).

12.15 | WHAT INFORMATION IS REQUIRED FOR THE PAYMENT OF THE GLOBAL EDUCATION PROTECTOR?

You (or whomever *you* have told to do this on *your* behalf) are responsible for proving that *you* qualify for the Global Education Protector. *We* will decide what information *we* need for this proof. If the claim is accepted, *we* will only make the benefit payment once *we* have all the information *we* need. At least an unabridged birth certificate for the *child* showing the deceased *member* as a parent will be required.

In addition, *we* will only pay the minimum annual benefit amount once *we* have confirmation of the *children's* educational fees or that the *children* attend a no-fees school or are exempt from paying fees.

If *we* do not receive this confirmation and other information *we* ask for, *we* will not pay the benefit in that calendar year. *We* will carry the amount forward to the next calendar year and pay it in that year if *we* receive the confirmation. *We* can carry benefits forward for a maximum of three years. After three years, *your* beneficiaries will forfeit the benefit for that year.
For subsequent years of education, *we* will need proof of enrolment, proof of fees or proof of attendance of a no-fees school or exemption from paying fees, and the previous year's education results.

DEFINITION OF *YOU/YOUR* FOR THIS SECTION
In this section, you/your refer to the member

13.1 | ABOUT THE INCOME CONTINUATION BENEFIT

13.1.1 What the benefit is

The Income Continuation Benefit provides disability insurance. This means that the Income Continuation Benefit pays *you* an income if *our* medical panel determines, at its sole discretion, that *you* are disabled by illness, injury or disease to the extent that *you* are no longer able to perform *your* work functions, and *you* have experienced loss of income because of this disability, illness or injury.

If selected for the *Plan*, the Income Continuation Benefit will appear on the Client Benefit Schedule. If the Income Continuation Benefit does not appear on the Client Benefit Schedule, then the benefit does not apply for *your Plan*.

13.2 | THE AMOUNT *YOU* ARE INSURED FOR

13.2.1 The benefit scale structures

We use the benefit scale structure set out in the Client Benefit Schedule to calculate the *sum assured*. *You* will have chosen either *our* benefit scale (recommended) or another benefit scale to calculate benefits.

13.2.1.1 *Our* benefit scale (recommended)

Our benefit scale (see the General Benefit Limits Document for details of the scale) is calculated using a sliding scale, as determined by *us* (see the General Benefit Limits Document), which is applied to the monthly risk salary. The *net after-tax salary* limit does not apply, even if the Upgrade Benefit is included.

13.2.1.2 Any other benefit scales

All other benefit scales (including flat-percentage benefit scales) have a maximum limit of 100% of *your net after-tax salary* at the date of *disability* for the combined Income Continuation Benefit, Waiver Benefit and Upgrade Benefit.

The *net after-tax salary* is the cost to company salary less Pay As *You* Earn on the cost to company. The *net after-tax salary* limit is applied to combined Income Continuation Benefits, Waiver Benefits and Upgrade Benefits.

13.2.2 Maximum benefit limits apply

An overall maximum benefit limit may apply to the amounts *we* pay under the Income Continuation Benefit, including for the additional benefits (see the General Benefit Limits Document).

13.2.3 Duty to tell *us* about changes that could affect *your* risk

The *policyholder* must tell *us* if their industry changes. The *policyholder* and *member* must tell *us* if the *member* changes occupation or takes up new hobbies, sporting or leisure activities that *we* consider may fall into a higher-risk category. If *we* are notified of these changes, *we* have the right to terminate the insurance or adjust the premium rating.

If *you* do not notify *us* of these changes, *we* may terminate/end insurance for a specific *member* or adjust their premium to account for the higher risk. *We* may also rely on *our* other rights set out in this *Life Plan Guide*, including our rights in the clause *Our* rights if *you* do not carry out *your* duties (8.6).

13.3 | CHECK WHETHER *YOU* HAVE THE COMPREHENSIVE, CORE OR LIMITED TERM DISABILITY OPTION

The *policyholder* chooses between Core, Comprehensive or Limited Term options for the Income Continuation Benefit. The chosen option is shown on the Client Benefit Schedule, as well as the Member Benefit Schedule. The benefit options are outlined in the tables below and described in more detail in the rest of this section. Only the option selected for the *Plan* will apply to the *Plan*.

13.3.1 The Core option

The table below outlines the benefit structures and options that apply to the Core option.

BENEFIT STRUCTURE AND OTHER COMPONENTS OF THE INCOME CONTINUATION BENEFIT (ICB)	INCLUDED IN CORE OPTION
Our recommended benefit scale ▪ Limited to maximum benefit per month, see General Benefit Limits Document)	**Yes,** if selected by the *policyholder* ▪ Calculated using a sliding scale, as determined by Discovery (see General Benefit Limits Document), which is applied to the monthly risk salary ▪ The net after-tax salary limit does not apply to this benefit structure
Any other benefit structure including flat percentage structures ▪ Limited to maximum benefit per month, see General Benefit Limits Document)	**Yes,** if selected by the *policyholder* ▪ The benefit combined with the Waiver (if applicable) is limited to net after tax salary
Return-to-Health Benefit (13.12)	**Yes,** if the *member* qualifies for the benefit after doing the Return-to-Health assessment
Rehabilitation Benefit ▪ Limited to maximum benefit per month, see General Benefit Limits Document	**Yes,** if the *member* does not qualify for the Return-to-Health benefit and is considered a candidate for rehabilitation, at *our* sole discretion
Waiver Benefitx(13.8) ▪ Limited to maximum benefit per month, see General Benefit Limits Document	**Yes,** if selected by the *policyholder* ▪ Limited to net after-tax salary limit when combined with the basic monthly benefit, unless the recommended basic monthly ICB scale structure is used, in which case the net after-tax salary limit does not apply
Group Risk PayBack (20) ▪ Up to 15% of net contributions - that is contributions after admin and commission expenses have been subtracted ▪ Limited to maximum benefit per year, see General Benefit Limits Document	**Yes,** if the *Plan* (or a category of the *Plan*, in which case only that category qualifies) has: ▪ At least 20 *members* covered for at least two times Life Cover Benefit ▪ The *member* must belong to a medical aid administered by Discovery Health.
LifeTime Capital Disability Lump-sum Benefit (13.17) ▪ Up to 18 times basic monthly ICB sum assured ▪ Limited to maximum benefit amount as per General Benefit Limits Document	**Yes,** if selected
Performance Bonus Protector (13.2.1) ▪ Up to 50% of the *member's* yearly risk salary ▪ Limited to maximum benefit amount as per General Benefit Limits Document	**Yes,** if the *member* meets the Category A criteria of the Appendix 2: Disablilty benefits assessment, and the *member* belongs to Vitality
Contribution Protector (13.20) ▪ Up to 33% of the basic monthly ICB sum assured for up to 12 months	**Yes**
Mortgage Protector (18) ▪ Up to 30% of monthly risk salary	**Yes**, if the *member* belongs to Vitality, with at least two times Life Cover Benefit ▪ The *member* must have a registered bond in their own name, or jointly with their *spouse*, over the *member's* primary residence with an outstanding balance, with a recognised financial institution
Upgrade Benefit (13.15)	**No**
Family Protector (13.19)	**No**
HealthyLiving Protector (13.22)	**No**
Transport Protector (13.19)	**No**

13.3.2 The Comprehensive option

The table below outlines the benefit structures and options that apply to the Comprehensive option.

BENEFIT STRUCTURE AND OTHER COMPONENTS OF THE INCOME CONTINUATION BENEFIT (ICB)	INCLUDED IN COMPREHENSIVE OPTION
Our recommended benefit scale ▪ Limited to maximum benefit per month, see General Benefit Limits Document)	**Yes,** if selected by the *policyholder* ▪ Calculated using a sliding scale, as determined by Discovery (see General Benefit Limits Document), which is applied to the monthly risk salary ▪ The net after-tax salary limit does not apply to this benefit structure
Any other benefit structure including flat percentage structures ▪ Limited to maximum benefit per month, see General Benefit Limits Document)	**Yes,** if selected by the *policyholder* ▪ The monthly basic benefit combined with the Waiver (if applicable) and Upgrade Benefit is limited to net after tax salary
Return-to-Health Benefit (13.12)	**Yes,** if the *member* qualifies for the benefit after doing the Return-to-Health assessment
Rehabilitation Benefit ▪ Limited to maximum benefit amount, see General Benefit Limits Document	**Yes,** if the *member* does not qualify for the Return-to-Health benefit and is considered a candidate for rehabilitation, at *our* sole discretion
Waiver Benefit (13.8) ▪ Limited to maximum benefit per month, see General Benefit Limits Document	**Yes,** if selected by the *policyholder* ▪ Limited to net after-tax salary limit when combined with the basic monthly benefit and the Upgrade Benefit, unless the recommended basic monthly scale structure is used, in which case the net after-tax salary limit does not apply
Group Risk PayBack (20) ▪ Up to 15% of net contributions - that is contributions after admin and commission expenses have been subtracted ▪ Limited to maximum benefit per year, see General Benefit Limits Document	**Yes,** if the *Plan* (or a category of the *Plan*, in which case only that category qualifies) has: ▪ At least 20 *members* covered for at least two times Life Cover Benefit ▪ The *member* must belong to a medical aid administered by Discovery Health.
LifeTime Capital Disability Lump-sum Benefit (13.17) ▪ Up to 36 times basic monthly ICB sum assured ▪ Limited to maximum benefit amount as per General Benefit Limits Document	**Yes,** automatically included
Performance Bonus Protector (13.21) ▪ Up to 75% of the *member's* yearly risk salary ▪ Limited to maximum benefit amount as per General Benefit Limits Document	**Yes,** if the *member* meets the Category A criteria of the Appendix 2: Disablilty benefits assessment, and the *member* belongs to Vitality
Contribution Protector (13.20) ▪ Up to 33% of the basic monthly ICB sum assured for up to 24 months	**Yes,** if the *member* does not satisfy Category A criteria of Appendix 2: Disablilty benefits assessment ▪ The Contribution Protector will be replaced by the Upgrade Benefit if the *member* meets the Category A criteria of Appendix 2: Disablilty benefits assessment

BENEFIT STRUCTURE AND OTHER COMPONENTS OF THE INCOME CONTINUATION BENEFIT (ICB)	INCLUDED IN COMPREHENSIVE OPTION
Mortgage Protector (18) ▪ Up to 30% of monthly risk salary	**Yes**, if the *member* belongs to Vitality, with two times Life Cover Benefit ▪ The *member* must have a registered bond in their own name, or jointly with their *spouse*, over the *member's* primary residence with an outstanding balance, with a recognised financial institution
Upgrade Benefit (13.15) ▪ Up to one-third of basic monthly ICB sum assured	**Yes,** if the *member* meets the Category A criteria of Appendix 2: Disablilty benefits assessment ▪ If the Upgrade benefit is payable, it replaces the Contribution Protector ▪ Limited to net after-tax salary limit when combined with the basic monthly benefit and the Waiver Benefit, unless the recommended basic monthly scale structure is used, in which case the net after-tax salary limit does not apply
Family Protector (13.19) ▪ Up to 50% of basic monthly ICB sum assured for three months ▪ Limited to maximum benefit amount as per General Benefit Limits Document	**Yes**
HealthyLiving Protector (13.22) ▪ Up to 20% of basic monthly ICB sum assured ▪ Limited to maximum benefit amount as per General Benefit Limits Document	**Yes,** if the *member* meets the Category A criteria of Appendix 2: Disablilty benefits assessment and belongs to Vitality
Transport Protector (13.19) ▪ Up to two unrelated claims per year with a combined benefit of up to 20% of basic monthly ICB sum assured ▪ Limited to maximum benefit amount as per General Benefit Limits Document	**Yes,** if the *member* meets the Category A criteria of Appendix 2: Disablilty benefits assessment

13.3.3 The Limited Term option

The table below outlines the benefit structures and options that apply to the Limited Term option.

BENEFIT STRUCTURE AND OTHER COMPONENTS OF THE INCOME CONTINUATION BENEFIT (ICB)	INCLUDED IN LIMITED TERM OPTION
Our recommended benefit scale ▪ Limited to maximum benefit per month, see General Benefit Limits Document)	**Yes,** if selected by the *policyholder* ▪ Calculated using a sliding scale, as determined by Discovery (see General Benefit Limits Document), which is applied to the monthly risk salary ▪ The net after-tax salary limit does not apply to this benefit structure
Any other benefit structure including flat percentage structures ▪ Limited to maximum benefit per month, see General Benefit Limits Document)	**Yes,** if selected by the *policyholder* The benefit combined with the Waiver (if applicable) and Upgrade Benefit is limited to net after tax salary
Waiver Benefit (13.8) ▪ Limited to maximum benefit per month, see General Benefit Limits Document	**Yes,** if selected by the *policyholder* ▪ Limited to net after-tax salary limit when combined with the basic monthly benefit, unless the recommended basic monthly ICB scale structure is used, in which case the net after-tax salary limit does not apply
Performance Bonus Protector (13.21) ▪ Up to 50% of the *member's* yearly risk salary limited to maximum benefit amount as per General Benefit Limits Document	**No**
Contribution Protector (13.20) ▪ Up to 33% of the basic monthly ICB sum assured for up to 12 months	**No**
Return-to-Health Benefit (13.12)	**No**
Rehabilitation Benefit	**No**
Group Risk PayBack (20)	**No**
LifeTime Capital Disability Lump-sum Benefit (13.17)	**No**
Mortgage Protector (18)	**No**
Upgrade Benefit (13.15)	**No**
Family Protector (13.18)	**No**
HealthyLiving Protector (13.22)	**No**
Transport Protector (13.19)	**No**

13.4 | NOTIFICATION OF A CLAIM

13.4.1 When should an *employer/policyholder* consider submitting a notification for a disability claim?

The *policyholder* should inform *us* of a potential claim as follows:

- When an employee has been booked off from work for ten or more days due to a medical condition or ill-health
- When there is a significant decline in an employee's work performance, possibly due to a medical condition or ill-health
- When an employee needs excessive or unreasonable work adjustments or accommodation due to health reasons
- When an employee is scheduled to have major surgery.

13.4.2 Time frame for disability claim submission

You are required to notify *us* of a potential disability claim within three months from the last day the employee was at work or performing their material and substantial duties.

If a claim is submitted after three months from the employee's last active date of service, *we* will treat it as a late notification, in this instance, reasons for late notification need to be supplied.

13.4.3 Mandatory documents required when notifying us of a disability claim

You are required to provide the following documents when notifying *us* of a claim:

- Completed claim notification form
- Employer statement
- Sick note or medical report from the treating doctor.

13.5 | HOW *WE* ASSESS DISABILITY

13.5.1 Defining disability

Disability refers to *your* inability to perform *your* work functions properly, with or without reasonable accommodations, or any other suitable job that *your* employer can offer, because of injury, illness or disease as determined by *our* medical panel at its sole discretion. *We* assess disability on objective medical criteria and evidence.

Disability does not include *you* losing gainful employment for reasons unrelated to *your* injury, illness or disease, for example, retrenchment or redundancy.

13.5.2 *We* use objective medical criteria to determine *your* date of disability

The *date of disability* is the date that *our* medical panel determines as the date that *you* were last able to perform with reasonable continuity the material and substantial duties of *your* own job with *your employer* with or without reasonable accommodations, or any other suitable job that *your employer* can offer. *Our* assessment is based on the objective, recognised and valid medical evidence that *we* receive.

13.5.3 *We* use objective medical criteria to assess *your* disability

We assess disability differently in the first 12 months after the *date of disability*, and after the end of the first 12 months. Disability is also assessed differently for *members* who are licensed pilots.

13.5.3.1 In the first 12 months

A different definition applies for the first 12 months of disability, and after the first 12 months. The first 12 months starts on the *date of disability*, and continues for 12 months after that, including the waiting period.

For the first 12 months of disability from the *date of disability*, *we* assess the effect that the disability has on *your* ability to function and *perform* the regular defined work functions of *your own job* as at the date of the *life-changing event* (see the clause What is the difference in the definition of disability between *own* job and *own* occupation (4.11)?). During the first 12 months, *you* will be regarded as disabled if, in the opinion of *our* medical panel, *you* have been so disabled by injury, illness or disease that *you* cannot, with reasonable continuity, perform the material and substantial duties of:

- *Your own job* with *your employer* (that is, the *employer* as at the date of the *life-changing event*)
- Any other suitable job that *your employer* (that is, the *employer* as at the date of the *life-changing event*) can offer *you* under the principles set out in the Labour Relations Act 66 of 1995.

13.5.3.2 After the end of the first 12 months

After the end of the first 12 months, *you* will be regarded as disabled if, in the opinion of *our* medical panel, *you* have been so disabled by injury, illness or disease that *you* cannot, with reasonable continuity, perform the material and substantial duties of:

- *Your own occupation* or any other occupation with *your employer* (that is, the *employer* at the date of the *life-changing event*)
- *Your own occupation* or any other occupation with any other *employer* (including self-employment)

The remuneration associated with the *own job* or *own occupation,* or any other occupation is not relevant for *our* assessment. *We* consider the duties and functions of the *own occupation* or any other occupation that *you* could reasonably be expected to be qualified for or suited to, considering:

- The degree of *your* disability
- *Your age*
- *Your* knowledge, training, education, ability and experience.

13.5.4 If *you* are a licensed pilot

If *your* employment (*own job*) requires *you* to hold a valid pilot's licence from the South African Civil Aviation Authority, *we* assess *your* disability based on whether a 'loss of licence' clause applies in *your* employment contract and, if so, whether *we* endorsed this 'loss of licence' clause. For a 'loss of licence' clause to be applicable, *we* must have endorsed this clause in our quote and priced for it accordingly.

13.5.4.1 'Loss of licence' clause not applicable

If *your* employment (*own job*) requires *you* to hold a valid pilot's licence and no 'loss of licence' clause is applicable, *you* will be regarded as disabled if, in the opinion of *our* medical panel, *you* have been so disabled by injury, illness or disease that *you* cannot, with reasonable continuity, work in any occupation for remuneration or profit, including self-employment.
This means that *you* must be unable to function in:

- *Your* own job with *your* employer (that is, the employer as at the date of the life-changing event)
- *Your* own occupation or any occupation with *your* employer (that is, the employer as at the date of the life-changing event)
- *Your* own occupation or any occupation with any employer (including self-employment).

This definition always applies from the *date of disability* and any period after that.

13.5.4.2 A 'loss of licence' clause applies

If *your* employment (*own job*) depends on *you* having a valid pilot's licence and the 'loss of licence' clause is applicable (which means *we* have endorsed it and priced for it), then **in the first 24 months from the *date of disability*** *we* will regard *you* as disabled if, in the opinion of *our* medical panel, injury, illness or disease has resulted in both of the following:

- *Your* pilot's licence (Commercial Pilot Licence/Airline Transport Pilot) is revoked (taken away) by the South African Civil Aviation Authority (SACAA), following an assessment of objective medical evidence by a competent Medical Board of the SACAA and corroborated by *our* Chief Medical Officer. *We* require a certified copy of the certificate issued by the SACAA setting out the medical basis and terms and conditions for the loss of licence.
- *You* are unable to perform the duties of *your own occupation* or any other suitable job that *your employer* at the date of disability can offer.

After the end of the first 24 months, which includes the waiting period, *we* will regard *you* as disabled if, in the opinion of *our* medical panel, injury, illness or disease has resulted in *you* being unable to perform the duties of *your*:

- *Own occupation* or any occupation with *your employer* (that is, the *employer* as at the date of the *life-changing event*)
- *Own occupation* or any occupation with any other *employer* (including self-employment).
  The remuneration associated with the *own job* or *own occupation*, or any other occupation is not relevant for our assessment. *We* consider the duties and functions of the *own occupation* or any other occupation that *you* could reasonably be expected to be qualified for or suited to, considering:
  - The degree of *your* disability
  - *Your* age
  - *Your* knowledge, training, education, ability and experience.

13.6 | A WAITING PERIOD APPLIES

13.6.1 Defining the waiting period

The *waiting period* is the time from the *date of disability* to the end of a set period that the *policyholder* has chosen for the *Plan*. The *waiting period* could be one month, three months, six months or twelve months. The *waiting period* that applies to *your Plan* is shown on the Client Benefit Schedule under the Income Continuation Benefit.

13.6.2 No insurance during a waiting period

During a *waiting period, you* do not qualify for any Income Continuation Benefit payments. If *you* remain disabled after the end of the waiting period, *you* will have the right to receive benefit payments only for periods after the waiting period. Payments are not backdated to the date of disability. There is no insurance at all during a *waiting period*. The *waiting period* starts from the determined date of disability.

EXAMPLE

The *policyholder* chose a waiting period of 1 month. Sally is injured in a car accident and cannot work for 90 consecutive days (3 months). Sally will receive the benefit payment for 2 months (3 months of disability minus the 1-month waiting period).
If the *policyholder* had chosen a waiting period of 3 months, Sally would not receive any payments.

13.6.3 If *you* claim for the same disability within three months

If *you* recover or are rehabilitated and then claim again for the same *life-changing event* with a date of disability that is within three months of the end of *your* claim period, the waiting period will not be applied for the later claim. *Your* benefit payments will start again from the later *date of disability* and for the same benefit amount as for the initial claim.

If *you* claim for the same *life-changing event* with a date of disability after three months of the end of *your* claim period, the waiting period will be applied, and *we* will consider your claim as a new claim.

13.7 | ABOUT BENEFIT PAYMENTS

13.7.1 Who *we* pay

***We* pay:**

- The *policyholder* (employer) if the *member* remains employed, or else
- The *member* directly
- If the *member* dies after the ICB claim is admitted (when *we* agree to pay the claim) but before the claim is paid, *we* will pay the member's deceased estate. This payment will be in respect of the valid ICB claim period, after that *we* will apply the Life Cover Benefit rules.

13.7.2 What *we* pay

If *you* have a valid claim, *we* pay the Income Continuation Benefit amount that is shown on the Member Benefit Schedule subject to the net after-tax salary definition in section 8.8.6. This is the amount that the *policyholder* requested when the benefit started or was renewed.

If a *member* is claiming under two or more policies for the same claim event, *we* will aggregate the benefits according to clause 13.7.4. We will pay the riders that are set as a percentage of the benefit in accordance with the aggregation but riders that are linked to Vitality Health status will only be paid once. *We* will also pay for the riders on the most comprehensive *Plan* choice if the riders are not consistent between the policies.

If a *member* becomes disabled before the 15th of any calendar month, we will use the salary information as at the end of the previous calendar month, otherwise we will use the salary information in the month of becoming disabled.

13.7.3 When Income Continuation Benefit payments increase

Once *we* start paying the Income Continuation Benefit, the benefit payments will not increase unless the *policyholder* chose for them to increase each year by selecting the in-claim escalation benefit. This will be shown on the Client Benefit Schedule.

If the in-claim escalation benefit was chosen, the Income Continuation Benefit payments will increase by the lower of either of the following:

- Core CPI as published by Statistics South Africa three months before the date of the in-claim escalation anniversary
- The escalation percentage that the *policyholder* chose as shown in the Client Benefit Schedule, which could be 0%, 3%, 5%, 7.5% or 10%.

Increases will be effective for each 12-month period from the date on which benefit payments started.

EXAMPLE

The Income Continuation Benefit has a 3-month waiting period, and the admitted claim has a date of disability of 13/03/2022. This means that:

- Monthly benefit payments will begin on 14/06/2022 (3 months after the date of disability)
- The first annual escalation will be applied on 1/06/2023 (at the beginning of the 13th month from the date of the first benefit payment)

13.7.4 Aggregation of income benefit – When the amount *we* pay is reduced

13.7.4.1 If the *member* has other income or income replacement benefits

Before allowing for a benefit increase from the Performance Bonus Protector and the Contribution Protector benefits, *our* overall maximum benefit limits (see the General Benefit Limits Document) will apply to the monthly income amount paid on disability.

If *you* receive income or income replacement benefits from other policies or employment, *we* will reduce the payment *we* make to *you* if the amounts *you* receive, added to *your* Income Continuation Benefit payment, are more than the net after-tax salary limit. For aggregation (reducing the benefit payments) of the Income Continuation Benefit, *we* consider both the basic Income Continuation Benefit and the Upgrade Benefit on meeting the Category A criteria of Appendix 2: Disablilty benefits assessment, if applicable.

The reduction in payment from the Income Continuation Benefit is due to the *indemnity principle*, which prohibits a *life assured* from receiving more income than they would have received if they had not claimed.

Rider benefits are not included in the total benefit *we* pay when the aggregation is calculated, except for the Waiver benefit.

If a partial benefit is paid to a *member* the income received from the salary that causes the partial benefit, is not used to reduce the partial benefit payment again. Any income from a new source of income can however reduce the partial benefit according to the aggregation rules.

It is the *member's* and *policyholder's* duty to tell *us* if the *member* receives any income or income replacement benefits from other policies. If the *member* or *policyholder* do not tell *us*, we may recover any amount paid in excess of what *we* would have paid had *we* known.

13.7.4.2 If a *member* is a financial intermediary

For a financial intermediary regulated by the Financial Advisory and Intermediary Services Act 37 of 2002 (FAIS Act), the inability to perform their own job (part of the definition of disability) is equivalent to them not being able to earn commission. An intermediary under the FAIS Act may only earn commission by servicing their policies at least once

during the year before the commission is received. This means that if they become disabled and cannot do their own job, they should not be able to earn commission except in the first year after becoming disabled.

For these intermediaries, it is assumed that they serviced their policies during the year before disability, and so they may continue earning commission on their policies in their first year of disability. Any commission earned in the first year of disability will be considered income and will be deducted from the yearly risk salary calculated as set out in the previous clause above (see the clause Partial Income Continuation Benefit). This commission will also be added to the income calculated for aggregation purposes as set out in the clause Aggregation of income benefit – When the amount *we* pay is reduced.

Any commission earned after the first year of disability would similarly be deducted from the yearly risk salary calculation and added to income for aggregation. However, from the second year of disability onwards, the intermediary should not be able to earn commission because to be defined as disabled they should not have been able to service their policies in that year. If they do earn commission after the first year of disability, this is proof of their ability to continue performing their own job and this will be considered when reviewing the continued validity of the Income Continuation Benefit claim.

In summary, any income received as commission during disability will be considered as active income, however income received in the first 12 months will not be considered as a proof of ability for the *member* to do their occupation, but any income after 12 months will be considered as proof.

13.7.4.3 Which income and income replacement benefits *we* evaluate for reducing payments

13.7.4.4 How *we* calculate the reduction

INCLUDED INCOME AND BENEFITS (GENERALLY LONGER-TERM INCOME REPLACEMENT)	**EXCLUDED INCOME AND BENEFITS** (GENERALLY SHORT-TERM INCOME REPLACEMENT)
▪ Dividends issued from an employer, partnership, close corporation or part-ownership of a company ▪ Income replacement benefits from other policies that are similar in form and purpose to the Income Continuation Benefit ▪ Benefits that replace a main part of income that the *member* earned before the claim (normally 75% to 100%) ▪ Benefits that have names such as income replacement, disability income, permanent health insurance and salary continuance benefits, and that have the main purpose of compensating the claimant (*member*) for the income they lose because of their inability to work, for a long-term period until they receive pension income from a retirement product ▪ Any other rider benefits connected to income replacement benefits that have the main purpose of replacing lost income over the same period as the basic income replacement benefit ▪ Benefits that are paid from the disability date to the date the *member* would have received an income if they were not disabled (normally the *policyholder's* normal retirement date) or to the date the *member* recovers, if earlier ▪ Any benefits that have the main purpose of compensating the *member* for the income they lose because of their inability to work until they receive pension income from a retirement product ▪ Benefits that are provided by both group risk and individual life underwriters, but not by short-term insurance providers (which are excluded) ▪ Commission earned by a *member* that is an intermediary/financial adviser in terms of the Financial Intermediary and Advisory Services Act 37 of 2002 (FAIS) ▪ Additional income from any other source	▪ Passive income, for example interest, rent and dividends from JSE-type shares ▪ Lump-sum capital disability benefits that the *member* received or is due to receive from any insurer ▪ Temporary disability benefits used to replace income for a short-term waiting period before a Capital Disability Benefit is admitted or paid (normally less than 36 months) ▪ Sickness benefits that replace a part of income for shorter periods of sickness that are not expected to last for a long term (normally less than 24 months) ▪ Any rider benefits connected to income replacement benefits that do not have the main purpose of replacing lost income over the same period as the basic income replacement benefit

The general method *we* use is known as aggregation:

- Add up (aggregate) all the *member's* income and income replacement benefits from **all sources** to get total benefits.
- If total benefits are more than 100% of either the lower of the *member's* net *after-tax income* or the benefit maximum (see the General Benefit Limits Document), before the claim, then *we* reduce all amounts payable from each source proportionately to their share of the total benefits.

The formula we use to calculate the reduced payment we must make is:

- Our Income Continuation Benefit payment plus any upgrades on meeting the Category A criteria of Appendix 2: Disablilty benefits assessment.
- Divided by total benefits (from all sources).
- Multiplied by the lower of the net after-tax salary, or the benefit maximum.

This formula shows the maximum *we* will pay if all other income sources included in the aggregation agree to aggregate. If one of the income providers chooses not to reduce payments using the above formula, *we* will pay the difference, if any, between the lower of *net after-tax salary* or the benefit maximum as per the General Benefit Limits Document and the total income received by the *member* from other sources. This includes any income the *member* receives in claim and any benefit payments the *member* receives from other insurers.

EXAMPLE

Discovery Income Continuation Benefit = R50 000

Insurer A benefit = R30 000

Salary earned in disability = R20 000

100% net after tax salary = R60 000

Scenario 1: Claimant receives benefit payments from Insurer A, Insurer A aggregates against other insurers payments:

Discovery payment:

$$= \frac{50\,000}{50\,000+30\,000} \times 60\,000$$

$$= R37\,500$$

Scenario 2: Claimant receives benefit payments from Insurer A, Insurer A does not aggregate against other insurers payments:

Discovery payment:

= 60 000-30 000

= R30 000

Scenario 3: Claimant receives benefit payments from Insurer A and an additional salary, Insurer A does not aggregate against other insurers payments:

Discovery payment:

= 60 000-30 000-20 000

= R10 000

Scenario 4: Claimant receives benefit payments from Insurer A and an additional salary, Insurer A aggregates against other insurers payments:

Discovery payment:

$$= \frac{50\,000}{50\,000+30\,000} \times (60\,000-20\,000)$$

$$= R25\,000$$

13.7.5 When *we* pay

We pay benefit payments by the last business day of each calendar month. If *you* are disabled for a portion of a month only, *we* will reduce the benefit payment proportionately.

13.7.6 No premiums during disability payments

We continue to collect premiums for a *member* who has submitted a claim until the claim is admitted. This includes during the waiting period while the claim is being assessed. If the claim is admitted, *we* will refund premiums collected from the beginning of the waiting period, if applicable.

We will not collect premiums for *your* Income Continuation Benefit while *we* are paying *you* benefit payments. If *you* are still insured for other benefits, these may be deducted from *your* Waiver Benefit, if applicable.

13.7.7 No effect on the Life Fund

Benefit payments for the Income Continuation Benefit and its additional benefits have no effect on the Life Fund.

13.7.8 What happens if the *member* recovers?

If *the member* recovers, the monthly benefit payments will end. The Income Continuation Benefit *sum assured* will go back to the original Income Continuation Benefit *sum assured* that the *policyholder* chose before the *member's* claim, plus the value of any in-claim escalation that applies. This means that if there has been any escalation in the benefit amount while *the member* was receiving benefit payments, *we* will increase the *sum assured* accordingly. The *policyholder* will be required to pay premiums for this reinstated benefit.

If the claimant relapses within three months after returning to work and the benefit payments ended, the original claim will be opened again if it is related to the same claims cause. Returning to work means the *member* can perform the material and substantial duties of the role they have returned to. This means a new waiting period will not be applied to the claim.

If the *member* relapses after three months of returning to work, or has been performing sub-optimally for a continuous period exceeding three months, a new date of disability and waiting period will apply. This condition will be enforced regardless of the *member's* diagnosis or the occupational duties performed at the time. In this scenario, all additional benefits related to Income Disability, will reset, except the LifeTime Capital Disability Benefit.

13.8 | THE WAIVER BENEFIT

13.8.1 About the benefit

The *policyholder* may choose the Waiver Benefit. If chosen, the benefit will show on the Client Benefit Schedule. The Waiver Benefit applies to *members* who are in-claim and are receiving an Income Continuation Benefit. After the waiting period ends, *we* pay a percentage of the *member's* monthly risk salary in either or both of the following ways only:

- To fund the *member's* or *their employer*'s contributions towards retirement by paying the Waiver Benefit, or part of it, to the employer *policyholder* or directly into a retirement funding vehicle, including a retirement annuity fund.
- To obtain *unapproved* group risk benefits from *us* using part or all of the Waiver Benefit to fund the premiums for the insurance.

After the waiting period ends:

- Retirement funding contributions will only begin if or when a retirement funding vehicle is in place
- Premiums for extended *unapproved* group risk benefits will only begin if or when a policy providing these benefits is in place
- If a retirement fund or risk policy is not available for *us* to pay the Waiver Benefit, it will not be paid and the Waiver Benefit will ONLY be paid from the date on which such vehicles are established and supporting documentation is received confirming that these policies exist. In the event that, the amount payable to the retirement vehicle is less than R1,000 we will pay the amount directly to the *member* as there are limited individual retirement vehicles that accept contributions less than R1,000 per month.

13.8.2 What we pay

We pay the lower amount of:

- The Waiver Benefit shown on the Client Benefit Schedule and Member Benefit Schedule, and priced for in the *Plan* quote, even if the Waiver Benefit amount does not equate to any actual retirement fund or risk contributions
- The maximum Waiver Benefit amount *we* set from time to time (see the General Benefit Limits Document).

13.8.3 How long *we* pay

We pay the Waiver Benefit for as long as *the member* receives an Income Continuation Benefit payment. This benefit is available on all forms of Income Continuation Benefit (Core, Comprehensive and Limited Term Benefit).

The Waiver Benefit is not available if the *member* left the employ of the *policyholder* (where the *policyholder* is the *member's employer*) or if the *member* ceased to be a *member* before *we* admitted a claim for the Income Continuation Benefit.

13.9 | PARTIAL INCOME CONTINUATION BENEFIT

13.9.1 About the benefit

The Partial Income Continuation Benefit pays a partial benefit to a *member* if the *member* meets the definition of disability but the *member* is capable or partly capable of performing the functions of their *own job*, with workplace modifications or assistance or other enabling circumstances.

13.9.2 To qualify for the benefit

To qualify for the benefit, the *member* must meet all the following criteria:

- The *member* must meet the definition of disability for the Income Continuation Benefit and the *member* is capable or partly capable of performing the functions of their own job, with workplace modifications or assistance or other enabling circumstances.
- The *member* must earn an income (as defined in the clause Aggregation of income benefit – When the amount *we* pay is reduced (13.7.4)), but the income must be less than the benefit level that the *policyholder* chose for the Income Continuation Benefit.
- The *member* must immediately tell *us* if the *member* starts earning an income while *we* are paying the *member* Income Continuation Benefit payments. If the *member* does not tell *us* and *we* become aware, *we* will recover any amount paid in excess of what *we* would have paid had *we* known, and end the Income Continuation Benefit payment to this *member.*

13.9.3 How *we* calculate the benefit

13.9.3.1 The formula *we* use

The Partial Income Continuation Benefit is calculated as follows:

Partial Disability Benefit = Income Continuation Benefit – Net after-tax current earnings.

Where net after-tax current earnings refers to any amounts earned from activities that the *member* is capable or partly capable of performing, based on the definition of disability, including:

- The average monthly earnings after income tax from an alternative occupation
- Any monthly income received (as defined in the clause Which income and income replacement benefits we evaluate for reducing payments(13.7.4.3)),
- An amount that could be earned, based on the definition of disability.

A *member* must notify *us* if they start earning an income while a claim is in payment. If *we* determine that *we* were not notified of this while a claim was in payment, *we* may recover any amount that was paid in excess of the amount that would have been paid if the *member* had notified *us* that they were earning an income.

13.9.4 When Partial Income Continuation Benefit payments increase

If an increase was chosen, the Partial Income Continuation Benefit will increase as set out in the clause When Income Continuation Benefit payments increase (13.7.3) above.

13.10 | PROGRAMMES TO REDUCE BENEFIT-RELATED RISK

From time to time, *we* may offer benefit-related programmes which will help reduce risk for both the *members* and *us* during the life of the *Plan*.

The *member* can choose to participate in these programmes.

We will make sure that terms and conditions are clearly communicated to participating *members* before the programmes start.

13.11 | HEALTH-IS-WEALTH PROGRAMME (ON CORE AND COMPREHENSIVE OPTIONS)

The Health-is-Wealth programme is a wellness coaching and rewards programme that identifies *members* at risk of long-term ill-health and helps them manage and reduce their health risks. The aim is to change *our members'* life trajectories, creating a healthier workforce and supporting more sustainable group life premiums.

The programme involves the following steps:

01 | Identification and enrolment: *We* identify *members* showing signs of intervenable ill-health such as back pain, cardiovascular difficulties and psychological struggle. *We* contact the *members we* feel will benefit from the programme.

02 | Health coach: We connect *members* enrolled in the Health-is-Wealth programme with a dedicated Health Coach who will guide them throughout their Health-is-Wealth journey.

03 | Assessment: Depending on the *member's* ill-health symptoms, *we* may ask them to do an initial assessment to establish their health baseline.

04 | Health Starter Reward: Qualifying *members* may receive a Health Starter Reward that they can use to kickstart their wellness journey.

05 | Setting goals and programmes: The Health Coach will help *members* map out their health goals and will compile a programme for reaching those goals.

06 | Regular checkpoints: *Members* will chat to their Health Coach once a month on email or a phone call to see if they are on track with their health goals.

07 | Final evaluations: Once the *members* have completed the programmes, *we* may ask them to do a final health assessment to determine their improvement in health.

08 | Cash completion bonus: *Members* who show a significant improvement in health may receive up to 100% of their insured salary as a Completion Bonus.

Depending on the nature of each case, it will be determined by *us* whether or not the *member* will be offered rewards and bonuses as part of the program, and whether or not *we* will provide other funded benefits to support the *member's* health improvement journey.

13.12 | RETURN-TO-HEALTH PROGRAMME (ON CORE AND COMPREHENSIVE OPTIONS)

13.12.1 About the programme

The Return-to-Health programme is a tailored vocational rehabilitation programme. It is designed to help Income Continuation Benefit claimants under the *Plan* to reach a level of performance allowing them to perform gainful employment or occupation. It consists of two steps: the Return-to-Health Assessment and the Return-to-Health Rehabilitation.

13.12.2 Step 1: Return-to-Health Assessment

13.12.2.1 *We* assess whether *the claimant* qualifies for the programme

We appoint a board of medical professionals to assess the feasibility of Return-to-Health Rehabilitation if *the claimant is* disabled. The feasibility assessment includes an interview with a disability case manager, who is *an* occupational therapist appointed by *us*.

If *we* decide that *the claimant* does not qualify for the programme, their Income Continuation Benefit will

become payable after their waiting period if they meet the definition of disability, and the claim is assessed to be medically valid.

We determine if a claimant qualifies for Return-to-Health Rehabilitation and the applicable bonuses based on factors like age, occupation, cause of disability and medical prognosis. These factors are decided at *our* sole discretion and may be reviewed from time to time.

13.12.2.2 Written undertaking of intent to follow the programme in good faith

If, at *our* sole discretion, *we* consider that *the claimant* qualifies to participate in the Return-to-Health Rehabilitation, the claimant will need to confirm *their* genuine intention to follow the programme. They do this by signing a written undertaking (called a letter of acceptance).

If the claimant does not agree to participate in Return-to-Health Rehabilitation, *we* may refuse to pay the Income Continuation Benefit.

13.12.2.3 Bonuses that the *claimant* can earn

We will also assess whether the *claimant* qualifies for two Return-to-Health bonuses:

- **The Sign-on Bonus** after signing the letter of acceptance. The bonus is calculated as: 10% x basic monthly Income Continuation Benefit
- **The Employment Bonus** (described below)

13.12.3 Step 2: Return-to-Health Rehabilitation

13.12.3.1 Aim to get the *claimant* fit to return to work

Return-to-Health Rehabilitation starts immediately after the letter of acceptance is signed. The *claimant's* disability case manager will help *the claimant* manage their medical condition so that the *claimant* can become fit to return to work. This may include finding services that the *claimant* may need, creating treatment plans, engaging with the claimant's current treating medical practitioners, working with other health service providers and monitoring the *claimant's* recovery progress. *We* may ask for frequent rehabilitation reports and assessments.

13.12.3.2 Does not replace medical aid or primary rehabilitation

Return-to-Health Rehabilitation does not replace medical aid schemes or primary rehabilitation offered in clinics, hospitals and homes. *We* pay the cost of Return-to-Health Rehabilitation directly to the service provider. The amount *we* pay for rehabilitation is limited to a maximum that *we* set from time to time (see the General Benefit Limits Document).

13.12.3.3 Pays only for functional upskilling

The Return-to-Health programme does not pay for any form of formal higher education or training (for example, undergraduate or postgraduate degrees or diplomas, or NQF level training). It may, at *our* sole discretion, pay for short courses (for example, short admin or computer courses) designed to help the *claimant* to achieve a minimum level of functionality so they can gain suitable employment.

13.12.3.4 *We* pay *your* Income Continuation Benefit after *your* waiting period

The Income Continuation Benefit becomes payable after the *claimant's* waiting period even if the *claimant is* undergoing Return-to-Health Rehabilitation, as long as the claimant meets the definition of disability, and the claim is assessed to be medically valid.

13.12.3.5 When the programme ends

The duration of Return-to-Health Rehabilitation will be determined at *our* discretion, based on the assessment outcomes. However, this benefit will end or terminate when:

- *We* assess *the claimant* as rehabilitated through the Return-to-Health programme
- The claimant does not comply with the requirements detailed in Return-to-Health Rehabilitation
- *We* decide, at *our* sole discretion, that the Return-to-Health Rehabilitation is not effective.

13.12.3.6 The Employment Bonus

We will pay *the claimant* an employment bonus if they meet the following criteria:

- *We* assess *the claimant* as rehabilitated.
- *The claimant* qualifies for the Return-to-Health bonuses.
- The claimant starts working again or is considered able to work in terms of the *own job* definition (if within the first twelve months of disability) or the *own occupation* definition (after the first twelve months), and therefore no longer qualifies for Income Continuation Benefit payments.

We calculate the bonus depending on the value of *your* benefit that *we* are able to cease paying:
If the *claimant* returns to employment and the full Income Continuation Benefit is no longer paid, the *claimant's* employment bonus will be 300% of the full Income Continuation Benefit that is no longer being paid.
If the claimant returns to employment and qualifies for a Partial Disability Benefit (as defined in the clause Partial Income Continuation Benefit (13.9)), the claimant's employment bonus will be 300% of the portion of the Income Continuation Benefit no longer being paid.

If the claimant relapses within three months after being assessed as rehabilitated, the *claimant* will receive a reduced percentage of their monthly Income Continuation Benefit payments for 12 months after the relapse. After 12 months, if the claimant is still disabled, they will again

receive 100% of their monthly benefit. The reduced percentage that applies is explained in the table below:

MONTHS BETWEEN REGAINING EMPLOYMENT AND RELAPSE	PERCENTAGE OF MONTHLY BENEFIT RECEIVED FOR 12 MONTHS AFTER RELAPSE
Less than one	75%
Between one and two	83%
Between two and three	92%

If *the claimant* relapses after three months or more after being assessed as rehabilitated, the benefit will not be reduced.

If *the claimant* is assessed as rehabilitated in the 12-month period after having relapsed, they will receive another employment bonus calculated according to the formula above, but it will be reduced by the amount intended to be recovered by *us* through the reduced monthly benefit.

If the claimant suffers from an unrelated disability after being assessed as rehabilitated, *we* will assess *their* disability as a new claim.

The sign-on and employment bonuses form part of the proceeds of the *Plan* and are therefore tax-free. The calculation of the bonuses may be reviewed by *us* from time to time.

13.13 | GENERAL REHABILITATION

Where the Return-to-Health rehabilitation programme in the clause Return-to-Health rehabilitation programme (13.12) does not apply, *we* at *our* sole discretion may decide that the claimant is able to be rehabilitated, and *we* may then ask the claimant to undergo rehabilitation. The purpose of rehabilitation is to help the claimant reach a level of performance that allows them to perform any gainful employment or occupation. This rehabilitation does not replace medical aid schemes and primary rehabilitation offered in clinics, hospitals and homes. *We* may ask for frequent rehabilitation reports and assessments.

Our appointed board of medical professionals will determine the feasibility of the rehabilitation programme. On accepting the programme, the claimant will have to sign a written undertaking showing their genuine intent to follow the rehabilitation programme. *We* will pay the cost of the rehabilitation programme directly to the service provider. It will be limited to a maximum determined by *us* from time to time (see the General Benefit Limits Document). This benefit will end when:

- *We* assess the claimant as being rehabilitated
- The claimant does not meet the requirements of the rehabilitation programme
- *We* decide, at *our* sole discretion, that the rehabilitation programme is not effective.

To remove any doubt, this rehabilitation benefit will not pay for any form of formal higher education or training (for example, undergraduate or postgraduate degrees or diplomas, or NQF level training). It may, at *our* sole discretion, pay for short courses (for example, short admin or computer courses) designed to help the claimant to achieve a minimum level of functionality so they can gain suitable employment.

13.14 | WHEN INCOME CONTINUATION BENEFIT PAYMENTS END

The payment or partial payment of the Income Continuation Benefit will end or terminate when the *member*:

- No longer meets the relevant definition of disability in the clause How *we* assess disability (13.5)
- Earns an income that is the same or more than their earnings before disability, despite their disability, injury, illness or disease
- Does not or refuses to give *us* satisfactory proof of *their* disability or medical evidence within 31 days of *us* asking for medical evidence, including any request made as part of the claim review process
- Unreasonably refuses to have recommended medical treatment or rehabilitation to reduce or improve their disability, injury, illness or disease
- Does not manage *their* lifestyle or medical chronic condition with appropriate and reasonable recommendations and treatment protocols from *their* treating medical specialist
- Does not have a physical examination and tests at *our* request and expense, including any request made as part of the claim review process
- Does not tell *us* about any income earned while they are classified as a disability claimant and are still receiving Income Continuation Benefit payments
- Reaches the *benefit expiry age* shown in the Client Benefit Schedule
- Dies
- If *we* agree to provide income continuation benefits to contractors or temporary employees the benefit will end on the end date of the member's contract with the employer.
- If we, at our sole discretion offer to commute the benefit to a lump sum benefit to replace future income benefit payments and/or eligibility to the *Plan*.

13.15 | UPGRADING THE INCOME CONTINUATION BENEFIT (ON COMPREHENSIVE OPTION ONLY)

13.15.1 When *you* qualify for an upgrade

We may upgrade *your* monthly Income Continuation Benefit at the *disability date* in the following circumstances:

- *You* are covered for the benefits under the Comprehensive Option.

- *You* meet the Category A criteria of Appendix 2: Disablilty benefits assessment at the *date of disability* or at any other later assessment done after the *date of disability*, while *we* are still paying the Income Continuation Benefit and *you* are a *member* on the *Plan*.

If *you* meet the criteria for upgrading at the date of disability, the waiting period is waived for the Income Continuation Benefit as well as any additional benefits *you* are eligible for.

If *you* meet the criteria for upgrading before the first payment date after the expiry of the waiting period, then the upgrade will be effective on the first payment date. If *you* only meet the criteria for upgrading at a later assessment after the first payment date, then the upgrade will only be effective in the month after the month in which *you* meet the criteria.

13.15.2 How *we* calculate the upgrade

We calculate the increase to be added to the Basic Income Continuation Benefit as follows:

The difference between:

- The minimum of
  - the net after-tax salary and
  - the Basic Income Continuation Benefit plus the Waiver Benefit

AND

- The minimum of
  - the net after-tax salary and
  - the Basic Income Continuation Benefit multiplied by 4 and divided by 3 plus the Waiver Benefit.

EXAMPLE

Nono's monthly risk salary is R50,000. Her Income Continuation Benefit sum assured is calculated using a benefit scale of 75% of monthly risk salary. For this example, *we* will assume that her monthly net after-tax salary is R40,000.

So, her basic Income Continuation Benefit payment will be R37,500 (R50,000 x 75%) each month.

Nono meets the Category A criteria of Appendix 2: Disablilty benefits assessment and is on the Comprehensive Option, so she qualifies for the upgrade. *We* will calculate her revised benefit as follows:

Basic Income Continuation Benefit at disability date multiplied by 4

R37,500 x 4 =R150,000

Total divided by 3 (capped* at the member's net after-tax salary at disability date)

R150,000 ÷ 3 = R50,000

However, as Nono's net after-tax salary at the disability date is R40,000, *we* only pay R40,000.

If her benefit were calculated using our recommended benefit scale structure she would receive

80% of the first R11,300, 60% of the next R33,000, and 50% of any remainder, increased to allow for the upgrade with no net after-tax salary cap:

= (80% x R11,300) + (60% x R33,000) + 50% x (R50,000 – R44,000)

= R31,840 x 4 = R127,360

= R127,360 ÷ 3 = R42,453.

* If insurance is on the recommended benefit scale structure, the cap does not apply.

13.15.3 Upgraded benefit also increases yearly

Once *we* are paying the Income Continuation Benefit, the upgraded benefit will increase yearly in line with the escalation rate that the *policyholder* chose.

13.15.4 The waiting period no longer applies

The *waiting period* will not apply if *the member* qualifies for the upgrade at the date of disability and this will be applicable to all qualifying benefits.

13.15.5 Maximum benefit limits apply

If the *member's* insurance is capped at the *free cover limit* (including the Free Cover Limit Multiplier, if applicable) or due to an underwriting decision, the total benefit payable, including the upgrade, will be capped at the free cover limit.

13.16 | THE LIMITED TERM INCOME CONTINUATION BENEFIT

13.16.1 What the benefit is

The Limited Term Income Continuation Benefit is only available on the Core option. It pays a regular income for a limited payment period if the *member* experiences a loss of income after an injury, illness or disease leaves them unable to do the normal duties of their *own job* in the first twelve months of disability, or their *own occupation* after that. The benefit term is chosen by the *policyholder* and may be 3 months, 6 months, 12 months, 24 months or 36 months, including a waiting period also chosen by the *employer* from those shown in the table on the right.

The maximum number of monthly income payments that will be made under this benefit will be calculated as the benefit term less the waiting period.

The *policyholder* may choose this benefit instead of the Income Continuation Benefit. A *policyholder* cannot choose both the Income Continuation Benefit and the Limited Term Income Continuation Benefit for the same group of *members*.

The Limited Term Income Continuation Benefit may be a standalone benefit or may be attached to a Capital Disability Benefit. *We* will pay the full or partial number of payments after the waiting period for a maximum of three times for unrelated claims causes.

If the claimant relapses within three months after regaining employment due to the same or a related claim cause, *we* will consider these claims as one claim event. *We* will only pay on the claim event once until the accumulated payments equal the full number of payments after the waiting period.

If the claimant suffers from an unrelated disability after regaining employment, *we* will assess their disability as a new claim.

Waiting periods which may be chosen by the policyholder for each payment period they may choose:

BENEFIT TERM	POSSIBLE WAITING PERIODS	NUMBER OF PAYMENTS AFTER WAITING PERIOD
3 months	1 month waiting period	2 monthly payments
6 months	1 month waiting period, or 3 months waiting period	5 monthly payments, or 3 monthly payments
12 months	1 month waiting period, or 3 months waiting period, or 6 months waiting period	11 monthly payments, or 9 monthly payments, or 6 monthly payments
24 months	1 month waiting period, or 3 months waiting period, or 6 months waiting period, or 12 months waiting period	23 monthly payments, or 21 monthly payments, or 18 monthly payments, or 12 monthly payments
36 months	1 month waiting period, or 3 months waiting period, or 6 months waiting period, or 12 months waiting period, or 24 months waiting period	35 monthly payments, or 33 monthly payments, or 30 monthly payments, or 24 monthly payments, or 12 monthly payments

13.16.2 Waiting periods apply if the benefit is attached to a Capital Disability Benefit

When this benefit is attached to a Capital Disability Benefit, a separate waiting period applies to the Capital Disability Benefit. This waiting period will be the same as the benefit term for the Limited Term Income Continuation Benefit. This means that the Capital Disability Benefit will be paid at the end of the Limited Term Income Continuation Benefit payment period.

13.16.3 *We* assess the Capital Disability Benefit only at the end of this benefit

We assess the Capital Disability Benefit claim at the end of the benefit term for the Limited Term Income Continuation Benefit if the *member* is still receiving this benefit at the end of the term. *We* may ask for medical information at any time after *we* have accepted the Limited Term Income Continuation Benefit claim.

13.16.4 Terms and conditions that apply

Except as noted below, all the terms and conditions in this section which apply to Core and Comprehensive Income Continuation Benefit options also apply to the Limited Term Income Continuation Benefit option *mutatis mutandis* (except for the necessary changes).
They are also adjusted to allow for the benefit term for the Limited Term Income Continuation Benefit as follows:

- The clause A waiting period applies (13.6) is modified by the above payment period versus waiting period table.
- The clause When Income Continuation Benefit payments end (13.14) is modified to add that the Limited Term Income Continuation Benefit payments will end at the end of the benefit term.
- The clause Contribution Protector (13.20) is modified to indicate that the Contribution Protector is payable for the maximum payment period of 12 months or the benefit term for the Limited Term Income Continuation Benefit less the waiting period (whichever period is shorter).
- The clause Performance Bonus Protector (13.21) is modified to indicate that the Performance Bonus Protector percentage of the *member's* annual risk salary is capped at 50% and is payable for the maximum period of 24 months or the benefit term for the Limited Term Income Continuation Benefit less the waiting period (whichever period is shorter).

13.16.5 Terms and conditions that do not apply

The following **do not** apply to the Limited Term Income Continuation Benefit option:

- Return-to-Health Benefit
- Group Risk PayBack
- LifeTime Capital Disability Lump-sum Benefit
- Upgrade for Category A disability
- Family Protector
- Transport Protector
- HealthyLiving Protector
- Free Cover Limit Multiplier
- Mortgage Protector

13.16.6 To qualify for more than one payment

To qualify for a subsequent Limited Term Income Continuation Benefit claim, the *member's* Limited Term Income Continuation Benefit payments must have ended due to the *member* returning to work. Also, the conditions below will apply, depending on whether the subsequent claim arises from the same cause as the initial claim or from a different cause.

Claim from the same cause within three months

If *the member* claims again for the same medical condition within three months of returning to work:

- *We* treat the claim as a continuation of the previous claim
- The waiting period does not apply
- *We* will pay the benefit for the remaining payment period (the maximum benefit term less the waiting period and less the number of months paid under previous claims

Claim from the same cause after three months

If *the member* claims again and the claim results from the same cause or *life-changing event,* after having to work and been fully active at work for at least three months from returning to work:

- The waiting period will apply
- Benefit payments made in respect of the same cause of disability cannot exceed the maximum benefit term as stated in the Client Benefit Schedule

Claim from a different cause:

If *the member* claims again and the claim results from a different cause or life-changing event, after any number of months of returning to work:

- *We* treat the claim as a new claim
- All conditions for a new claim apply and the waiting period will apply
- The *member* will qualify for the full benefit term (the benefit term less than the waiting period)

EXAMPLE

(a subsequent claim for the same cause within less than three months of returning to work)
Alindile has a 24-month benefit and a 3-month waiting period. She claims for a life-changing event that has caused a disability. If she does not return to work during the 24-month benefit term, she has the right to 21 monthly payments (24-month benefit term less the 3-month waiting period).
After *we* have paid benefit payouts for 10 months (which started after the 3-month waiting period), Alindile returns to work at which time benefit payments stop. Two months later she claims for the same cause of disability and does not return to work after that. *We* pay benefit payouts for an extra 11 months.

01 | Payment Period 24 months
Less Waiting Period 3 months
Monthly payments available 21 months
Less Payments made 10 months
Remaining payments 11 months
The number of months during which Alindile returned to work (2 months) does not reduce the number of payments remaining for later claims from the same cause of disability within 3 months of returning to work.

02 | If instead of claiming 2 months after returning to work Alindile claimed for the same cause of disability 4 months after returning to work, she would have the right to 8 more payments. This is the 11 payments in the above example less the 3 payments in the re-applied waiting period.

03 | If instead of claiming for the same cause of disability after returning to work Alindile claimed for a different cause of disability, then the claim is treated as a new claim for which she may receive 21 months of payment (24-month payment period less 3-month waiting period).

13.17 | LIFETIME CAPITAL DISABILITY LUMP-SUM BENEFIT (OPTIONAL ON CORE; COMPULSORY ON COMPREHENSIVE)

13.17.1 What the benefit is

The LifeTime Capital Disability Lump-sum Benefit pays a lump sum of between 0 to 36 times *your* basic monthly Income Continuation Benefit *sum assured* if *you* meet the Category A criteria of Appendix 2: Disablilty benefits assessment at:

- Disability date
- Any later assessment after the disability date, while *we* are paying the Income Continuation Benefit and *you* are a member on the *Plan*.

The maximum LifeTime Capital Disability Lump-sum Benefit will be capped at the Capital Disability Benefit maximum benefit (see the General Benefit Limits Document). The LifeTime Capital Disability Lump-sum Benefit will not affect the Life Fund or Impairment Fund.

13.17.2 The benefit amounts

- Core Option (optional): Up to 18 times the basic monthly Income Continuation Benefit *sum assured.*
- Comprehensive Option (compulsory): Up to 36 times the basic monthly Income Continuation Benefit *sum assured.*

The lump sum paid depends on the *member's* LifeTime Impact Category. The calculation of the LifeTime Impact Category is set out in Appendix 2: Disablilty benefits assessment.

The benefit amount is calculated according to the table that follows:

	MULTIPLE OF BASIC MONTHLY INCOME CONTINUATION BENEFIT (ICB) SUM ASSURED	
LifeTime Impact Category	Core ICB (optional)	Comprehensive ICB (compulsory)
1	0	0
2	1.5	3
3	3	6
4	4.5	9
5	6	12
6	9	18
7	12	24
8	18	36

13.17.3 About the LifeTime Impact categories and scores

The amount *we* pay depends on the claimant's LifeTime Impact Category.

13.17.3.1 How *we* calculate the LifeTime Impact Category

The LifeTime Impact Category is determined by calculating the LifeTime Impact Scores by adding the score for the various LifeTime Impact factors set out in Appendix 2: Disablilty benefits assessment, for Category A disability only, to an additional *age*-based score for conditions where the LifeTime Impact Score is marked by a degree sign (°) in Appendix 2: Disablilty benefits assessment. All changes shown in Appendix 2: Disablilty benefits assessment must be permanent, regardless of treatment according to recognised medical protocols. These new *life-changing events* must have taken place after the date the *Plan* commences.

The LifeTime Impact Category is then determined by applying the LifeTime Impact Score to the table that follows:

LIFETIME IMPACT SCORE	LIFETIME IMPACT CATEGORY
0 to 4	1
5 to 9	2
10 to 14	3
15 to 19	4
20 to 24	5
25 to 29	6
30 to 34	7
35 to 39	8

13.17.4 *Age* gives an extra score to the LifeTime Impact Score

The *age*-based scores added to LifeTime Impact factors are:

AGE AT CLAIM	ADDITIONAL SCORE
<30	30
31 to 40	22
41 to 50	14
51 to 55	8
56 to 60	4
61+	0

13.17.5 If *you* claim a second time

If *you* claim under the Income Continuation Benefit the first time, *you* may qualify for the LifeTime Capital Disability Lump-Sum Benefit based on the LifeTime Impact Category of the disability suffered. If *you* return to work later and then claim again under the Income Continuation Benefit for the same *life-changing event* as the first claim, the LifeTime Capital Disability Lump-Sum Benefit will not pay out again.

However, if the second claim is due to a new *life-changing event*, *you* will be reassessed, and the LifeTime Capital Disability Lump-Sum Benefit may be paid based on *your* new LifeTime Impact Category. To qualify for more than one LifeTime Capital Disability Lump-Sum Benefit payment (due to a new *life-changing event*), *you* need to return to work between the two *life-changing events*, premiums must be paid for the period *you* did not receive Income Continuation Benefit payments, and *you* must be continuously at work for at least three months after the Income Continuation Benefit payments for the first claim ended.

If a *member* has multiple conditions under one *life changing event*, in other words under one Income Continuation Benefit claim, we will calculate the amount due to the *member* under the LifeTime Capital Disability Lump-Sum Benefit using the condition that gives the highest amount payable.

Only one condition will qualify for the LifeTime Capital Disability Lump-Sum Benefit.

This LifeTime Capital Disability Lump-Sum Benefit will automatically terminate after the second claim has been admitted and paid.

13.18 | FAMILY PROTECTOR (ON COMPREHENSIVE OPTION ONLY)

13.18.1 What the benefit is

We pay 50% of the *member's* basic monthly Income Continuation Benefit *sum assured* for up to 3 months from the date of diagnosis if the *member's spouse* or *child* suffers a severe illness (Severity A or B, as defined in Appendix 3: Severe illness benefit assessment).

The amount will be paid from the date of diagnosis once the claim is admitted. However, payment will only begin on admission, with back payments if necessary.

The Family Protector is only available on the Income Continuation Benefit Comprehensive Option. It is available even if the *Plan* does not provide cover for standard Severe Illness benefits for the *member*, *spouse* or *children*.
We insure a maximum of three *spouses* and five *children*.
(See the About the people involved in the *Plan* (3) section for definitions of *child* and *spouse*.)

13.18.2 No *medical underwriting* or waiting periods

The insurance for the *member's spouse* and each *child* in the family is provided without *medical underwriting* but excludes pre-existing medical conditions (9.8).

The Income Continuation Benefit waiting period does not apply to this Family Protector benefit. Claim payments will start as soon as the claim has been accepted, irrespective of the chosen Income Continuation Benefit waiting period.

13.18.3 Claims must be made within three months

All claims must be submitted within three months of the date of the event. The maximum payout for each claim is the maximum for the *Spouse* or *Child* Severe Illness Benefit (see the General Benefit Limits Document). To determine whether this maximum applies, all three payments are added together and compared to the *Spouse* or *Child* Severe Illness Benefit maximum.

The payments for the Family Protector will not increase by the *member's* benefit escalation rate (in-claim escalation rate) while the benefit is being paid.

A maximum of three payouts (subject to benefit and claim payment expiry below) for any related severe illness conditions or conditions in the same body system will apply. *You* can, however, claim for subsequent claims if the condition is unrelated to the previous claim and is in a different body system and will have the right to a further maximum of three payouts. Payments for severe illness will only be made if *your* severely ill *spouse* or *child* is alive at the time of payment.

In the event that the *member* is a disability claimant at the time of the *Spouse* or *Child's* diagnosis the amount payable will be based on the *member's* Income Continuation Benefit amount at the date of diagnosis. This amount will follow the escalation pattern applicable to the *member's* Income Continuation Benefit payable.

13.18.4 No effect on the Life Fund

The Family Protector will not affect the *member's* or *spouse's* Life Fund.

13.18.5 Eligibility of the benefit

The *member's spouse* or *child* will be eligible to claim at the date of diagnosis of the severe illness if the following conditions hold :

- The *member* has not reached the *benefit expiry age* of the Income Continuation Benefit
- The *spouse* is below the *benefit expiry age*
- The *spouse* is below 65 years of *age*
- The *member* still qualifies to be a *member*
- The period of claim is for when the *child* or *spouse* is still alive
- The *child* is under 18 years of *age*
- The *spouse* still meets the definition of *spouse*.
- The disability claimant is still a member of the scheme.

13.19 | TRANSPORT PROTECTOR (COMPREHENSIVE OPTION ONLY)

13.19.1 What the benefit is

If a *member* is booked off work for longer than the waiting period, they can use *our* preferred transport provider up to

a set rand amount for 60 days after *we* accept the Income Continuation Benefit claim. After 60 days, the benefit falls away, whether or not the *member* used the full benefit amount. The Transport Protector is only available on the Income Continuation Benefit Comprehensive option.

13.19.2 How *we* calculate the benefit payout

Payments under the Transport Protector are capped at 20% of the monthly basic Income Continuation Benefit *sum assured*. The maximums *we* set from time to time will also apply (see the General Benefit Limits Document). The *member* must pay for the difference between the maximum benefit amount and the actual cost of using the transport provider.

You may only claim for the Transport Protector for up to two unrelated claims (ie the two claims a year must result from different *life-changing events*).

No payments will be made from the Transport Protector for a claim submitted during the time the *member* is booked off work before the end of the waiting period.

See the General Benefit Limits Document for more details on the preferred transport provider and claim maximum amounts.

13.19.3 Where *you* can use the benefit

You may only use the Transport Protector in areas where *our* preferred transport provider operates. The preferred transport provider may also require *you* to have access to certain technology before *you* can use their services.
We may change the:

- Preferred transport provider
- Methods used to provide the benefit, including cash payments if necessary
- Term at which the benefit payment will end
- Total maximum payment.

13.19.4 When the benefit ends

The Transport Protector will end at the earlier of:

- The date *you* reach the *benefit expiry age* of the Income Continuation Benefit
- 60 days after *your* Income Continuation Benefit claim is admitted
- *Your* death.

13.20 | THE CONTRIBUTION PROTECTOR (ON CORE AND COMPREHENSIVE OPTIONS)

13.20.1 What the benefit is

We temporarily pay the premiums for the benefits listed below for a *member* who is disabled and is receiving Income Continuation Benefits, as long as they were in force at the disability date and the *member* who is disabled was responsible for paying the premium at date of disability:

- The Individual Discovery Life Plan
- The Discovery Retirement Optimiser
- Any Discovery Retirement Plan
- Discovery Insure
- Vitality
- The Discovery Health Plan
- Contributions to other health plans or medical schemes. (*Our* benefit maximums will apply. See the General Benefit Limits Document.)

The Contribution Protector will not insure any upgrades to a higher Discovery Health Plan or other health plan. We will cover newborns that were born at any point while the benefit is payable from one month prior to the Date of Disability.

13.20.2 How much *we* pay

We pay a maximum of 33% of the basic monthly Income Continuation Benefit *sum assured* that the *member* is receiving.

13.20.3 When and for how long *we* pay

We pay the Contribution Protector from after the waiting period if the *member* has a successful claim for the Income Continuation Benefit Core Option or Comprehensive Option but has not qualified for the upgrade on the Income Continuation Benefit because they do not satisfy the Category A criteria of Appendix 2: Disability benefits assessment.

You will receive the Contribution Protector for up to:

- 12 months under the Core option
- 24 months under the Comprehensive option.

If the *member* qualifies for the upgrade on the Income Continuation Benefit at the date of disability and before the first benefit payment is made, the Contribution Protector will no longer be valid. However, if the *member* qualifies for the upgrade for the Income Continuation Benefit because they satisfy the Category A criteria of Appendix 2: Disability benefits assessment and the upgrade amount is higher than the Contribution Protector amount payable, then the Contribution Protector falls away.

The *member* must have been *actively at work*

The *actively at work (7.3)* rule automatically applies, even if *we* have waived this rule for other benefits. *We* will waive this rule if the requirements for waiving the rule are met. (See the *actively at work (7.3)* clause for the rule and when *we* will waive it.)

13.20.4 *We* do not pay for medical conditions that existed before

The pre-existing medical conditions (9.8) clause automatically applies even if *we* have waived the clauses for other benefits. *We* will waive this rule if the requirements for waiving the rule (9.8.1) are met.

13.20.5 *We* reduce the payout if *you* have other policies

If *you* have other individual or group life policies that also provide this kind of benefit, *we* will reduce its benefit payments in the ratio of *our* payment to the total payment received from all other policies or contracts.

13.20.6 13.20.6 We reduce the payout if you have other

If you have other individual or group life policies that also provide this kind of benefit, we will reduce its benefit payments in the ratio of our payment to the total payment received from all other policies or contracts.

13.21 | THE PERFORMANCE BONUS PROTECTOR (ON CORE AND COMPREHENSIVE OPTIONS) (VITALITY MEMBERS ONLY)

13.21.1 What the benefit is

The Performance Bonus Protector pays a portion of the *member's* past bonuses in addition to the monthly disability income.

13.21.2 Definition of bonus

Bonus is defined as participation in any incentive or bonus scheme that is paid in money at the discretion of the *life assured's employer*. *We* measure it according to published and defined criteria on the condition that the incentive is not an entitlement and is not automatic. If any part of *your* bonus is already included in the Income Continuation Benefit amount, it cannot also be added as a discretionary incentive or bonus scheme. The bonus amount used to calculate the bonus percentage to be paid, will be the net after tax bonus the *member* received.

Participation in a scheme where a bonus is paid by way of share options or phantom share options is specifically excluded. For schemes where bonuses are paid part share options and part money, only the money part clearly shown on the payslip will be considered when calculating the Performance Bonus Protector amount.

13.21.3 When *we* pay the benefit

We will pay the Performance Bonus Protector if the *life assured* meets the Category A criteria of Appendix 2: Disability benefits assessment and is a *member* of Vitality at the date of disability.

We pay the Performance Bonus Protector for a maximum of 24 months. *We* pay only while the *member* receives an Income Continuation Benefit payment.

13.21.4 When the benefit ends

The benefit ends at the earlier of:

- The end of 24 months
- The end of the Income Continuation Benefit.

13.21.5 How much *we* pay

We base the payment on the following:

- **The average bonuses** the *life assured* received over the three years before meeting the Category A criteria of Appendix 2: Disability benefits assessment.
- *We* cap the payment at 50% of the *member's* yearly risk salary on the Core option and at 75% of the *member's* yearly risk salary on the Comprehensive option.
- **The *member's* Vitality Health status** at the time of the claim as set out in following table:

Vitality Health status at date of claim event				
BLUE	BRONZE	SILVER	GOLD	DIAMOND
10%	20%	50%	75%	100%

We calculate the payment using the following formula:
Monthly risk salary x applicable percentage
Where applicable percentage is the lower of:

- Average bonus percentage x Vitality Health status percentage; or
- 50% for the Core option or 75% for the Comprehensive option

EXAMPLE Calculating the bonus percentage

Consider a *member* earning the following yearly risk income over the past 3 years:

YEAR	RISK SALARY	BONUS	BONUS %
Year One	R250 000	R37 500	15%
Year Two	R275 000	R13 750	5%
Year Three	R300 000	R75 000	25%

The average bonus would be calculated as (15% + 5% + 25%) ÷ 3 = 15% of yearly risk salary.
This must then have the Vitality Health percentage applied to it and be limited to 50% of yearly risk salary on the Core option, and 75% of yearly risk salary on the Comprehensive option.

The benefit will be paid monthly, regardless of the frequency of the performance bonus. The onus will be on the *member* to prove past bonuses.
Members who have not earned past performance bonuses will not qualify for this benefit. This rule applies even if a *member* has recently joined a performance incentive scheme but has not yet received a performance bonus. Similarly, *members* in their first year of work will not qualify for this benefit. A maximum of three years' service under current employment will be used to calculate the average bonus, if only two full years or one full year of service has been completed the average will be calculated over the full years of service completed.

The average bonus will be calculated over a three-year period even if the *member* did not receive bonuses in some of these years. This rule will apply even if a *member* has taken a sabbatical year.

EXAMPLE Calculating the Performance Bonus Protector Benefit

Scenario 1 – Bonus percentage lower than the 50% or 75% of risk salary cap

At disability date, the *member* is on Bronze Vitality Health status and has:

- A monthly risk salary of R27,500
- An Income Continuation Benefit of R18,500
- A **15%** of risk salary average bonus percentage over the last 3 years

The monthly Performance Bonus Protector for both options would be:

The lower of:

Annual risk salary x average bonus percentage x Bronze Vitality Health status percentage

or

Cap of 50% of monthly risk salary (Core option) or 75% of monthly risk salary (Comprehensive option)

= the lower of [R27,500 x 12 × 15% × 20%]/12 or [50% x R27,500 x 12]/12 or 75% x R27,500 x 12]/12

= the lower of R825 or [R13 750 or R20 625]

= R825 monthly

The calculation for both the Core and Comprehensive options are the same because the average bonus of 15% of salary does not exceed either the 50% or 75% of risk salary maximum cap.

Scenario 2 – Bonus percentage more than the 50% or 75% of risk salary cap

At disability date, the *member* is on Gold Vitality Health status and has:

- A monthly risk salary of R27,500
- An Income Continuation Benefit of R18,500
- A **120%** of risk salary average bonus percentage over the last 3 years.

The monthly Performance Bonus Protector for the Core option would be:

The lower of

Annual risk salary x average bonus percentage x Gold Vitality Health status percentage/12

or

Cap of 50% of annual risk salary (Core option)

= the lower of [R27,500 x 12 × 120% × 75%]/12 or [50% x R27,500 x 12]/12

= the lower of R24 750 or R13 750

= R13 750 monthly

The monthly Performance Bonus Protector for the Comprehensive option would be:

The lower of

Annual risk salary x average bonus percentage x Gold Vitality Health status percentage

or

Cap of 75% of monthly risk salary (Comprehensive option)

= the lower of [R27,500 x 12 × 120% × 75%]/12 or [75% x R27,500 x 12]/12

= the lower of R24 750 or R20 625

= R20,625 monthly

13.22 | THE HEALTHYLIVING PROTECTOR (ON COMPREHENSIVE OPTION ONLY) (VITALITY *MEMBERS* ONLY)

13.22.1 What the benefit is

Payment of the average cash back a *member* receives over six months from the HealthyFood, HealthyGear and HealthyCare benefits.

13.22.2 How much *we* pay

The HealthyLiving Protector will pay the claimant's average HealthyFood, HealthyGear and HealthyCare cash back or Discovery Miles that they received in the six months before the disability event, for every month while the claimant receives the Income Continuation Benefit. This will be paid in addition to the monthly disability income.

The average cash back will be calculated by looking at the six-month period before the disability event. A six-month period will always be used, regardless of when any of the HealthyLiving benefits were activated. If a *member's* Vitality HealthyLiving benefit was not activated for some of the six months before the disability event, R0,00 will be used for these months when determining the average cash back.

The monthly HealthyLiving Protector amount is capped at 20% of the claimant's Income Continuation Benefit basic *sum assured*. There may also be a maximum payout for the HealthyLiving Protector.

13.22.3 To qualify for this benefit

At the time of the claim, the *member* must:

- Be on the Income Continuation Benefit Comprehensive option
- Have Vitality with the HealthyLiving benefits activated

- Meet the Category A criteria of Appendix 2: Disablilty benefits assessment at *disability date* or at any other later assessment done after the *disability date*, while the *member* is still receiving Income Continuation Benefits.

13.22.4 When the benefit ends

The HealthyLiving Protector and its payments end on the earliest of:

- The *member* no longer receiving the Income Continuation Benefit payments
- The *member* reaching the *benefit expiry age* of the Income Continuation Benefit
- The *member's* death.

EXAMPLE

HealthyFood, HealthyGear and HealthyCare were all activated six months before the disability event. During the six months before the disability event, the combined cash back for HealthyFood, HealthyGear and HealthyCare was: R100, R250, R500, R120, R0 and R1,000. So, the average monthly cash back over the six months before disability is:
(R100 + R250 + R500 + R120 + R0 + R1,000) ÷ 6 = R328,33

The client will receive R328,33 (increasing yearly with the Income Continuation Benefit escalation rate) until the claimant stops receiving payments for the Income Continuation Benefit.

If the Income Continuation Benefit *sum assured* was R1,200 per month, a monthly cap of 20% x R1,500 = R300 would apply, so the client will get R300 (increasing yearly with the Income Continuation Benefit escalation rate) instead of R328,33 per month.

Vitality may change the amount of the refund, as well as the partner stores, from time to time.

13.23 | TRANSITIONAL ARRANGEMENTS

If a *policyholder* with existing Income Continuation Benefits with *us* on 1 April 2015 chooses not to upgrade to the enhanced Income Continuation Benefit set out in this section, their benefits will remain as they were on 1 April 2015.

This *Life Plan Guide* version GRLPG01/26 will apply to these benefits. However, the following clauses **will not** apply:

- LifeTime Capital Disability Lump-Sum Benefit
- Family Protector
- Transport Protector
- Corporate Integrator

For the sake of clarity, all schemes with existing Income Continuation Benefits on 1 April 2015, where the *policyholder* chooses to remain on those benefits, will still be subject to the net after-tax salary limitations on the combined Income Continuation, Retirement Waiver and Upgrade Benefits as set out in this *Life Plan Guide* version GRLPG01/26

All existing schemes that choose to convert to the enhanced Income Continuation Benefit on or after 1 April 2015, and all schemes not currently assured by *us*, quoted for on or after 1 April 2015, will be subject to all the terms and conditions of this *Life Plan Guide* version GRLPG01/26.

The terms and conditions of this *Life Plan Guide* version GRLPG01/26 will apply to an existing *Plan* 31 days after receipt of this document by the *policyholder* or their recorded representative.

DEFINITION OF *YOU/YOUR* FOR THIS SECTION

IIn this section, you/your refers to the member and the member's spouse (where applicable for the Spouse Capital Disability Benefit), both of whom may be the life assured.

14.1 | ABOUT THE CAPITAL DISABILITY BENEFIT

14.1.1 The benefit is a lump-sum payout

The Capital Disability Benefit pays a lump-sum amount if the *life assured* (either the *member* or *spouse*, as applicable) suffers a permanent medical impairment as defined in the protocols set out in Appendix 2: Disability benefits assessment. The amount depends on how severe the medical impairment is by reference to the same Appendix 2: Disablilty benefits assessment.

The standard terms and conditions that apply to the *member's* Capital Disability Benefit will apply to the *Spouse* Capital Disability Benefit, except for the necessary changes and for any additional terms and conditions set out in any policy document (including *this Life Plan Guide*, the quote, *Policyholder's* Application Form, Client Benefit Schedule, Member Benefit Schedule, or General Benefit Limits Document) that apply specifically to *Spouse* Benefits. See the *Spouse* Benefits section for the terms and conditions applicable to the *Spouse* Capital Disability Benefit.

If selected for the *Plan*, the Capital Disability Benefit and *Spouse* Capital Disability Benefit will appear on the Client Benefit Schedule. If the Capital Disability Benefit and *Spouse* Capital Disability Benefit do not appear on the Client Benefit Schedule, then the benefits do not apply for *your Plan*.

14.2 | HOW *WE* ASSESS HOW SEVERE THE MEDICAL IMPAIRMENT IS

14.2.1 About the disability benefits assessment

Appendix 2: Disability benefits assessment sets out protocols that describe every anatomical (physical) and physiological system disorder in the body, using objective medical criteria. The protocol is a system of rules that allows *us* to evaluate the *life assured*'s claim objectively and fairly, based on medical criteria.

The nature of the work that the claimant does to earn an income is not considered in the assessment of the claim. Using the protocols, *our* medical panel will, at their sole discretion, decide how severe the *life assured*'s medical impairment is.

14.2.2 Loss of licence for pilots

The Capital Disability Benefit may also be priced for loss of license for pilots licensed with the South African Civil Aviation Authority (*member* or *spouse*). If *we* have quoted and priced for a loss of licence clause for a *life assured* who is a pilot, *we* will consider the claim only if all the following conditions are met:

- In *our* quote, *we* have endorsed and priced for the 'loss of licence' clause applicable to the *life assured's* employment contact
- The *life assured* is completely incapable of doing their *own occupation* because of the injury, illness, disease or disability
- The *life assured*'s pilot's licence (Commercial Pilot Licence/Airline Transport Pilot) has been permanently revoked (taken away) by the South African Civil Aviation Authority (SACAA), following an assessment of objective medical evidence by a competent Medical Board of the SACAA and corroborated by *our* Chief Medical Officer
- *We* have been given a certified copy of the certificate issued by the South African Civil Aviation Authority setting out the medical basis and terms and conditions for the loss of licence.

14.2.3 The date of disability is based on medical evidence

We use objective medical evidence to decide, at *our* sole discretion, the date on which the *life assured* became disabled or medically impaired. This date is referred to as the date of disability. *We* pay only for disability or medical impairment that occurred during the period when the Capital Disability Benefit is in force. This means that if the date of disability occurs before the start date of the Capital Disability Benefit or after it ends, *the life assured* will not receive a payout.

14.3 | HOW MUCH *WE* PAY

14.3.1 Impairment Fund

The Capital Disability Benefit may be selected as a standalone benefit. In this case, there will be an Impairment Fund that will operate as the financial mechanism of the benefit. This will work the same as the Life Fund, but it will be used only to fund the Capital Disability Benefit payouts.

All other features applicable to the Life Fund are also applicable to the Impairment Fund. This includes the Minimum Protected Fund and Vitality.

14.3.2 An objective and fair system is used to assess the severity of the disability

We evaluate the payout based on an objective and fair system that determines the severity of the medical impairment. This benefit rates how severe a medical impairment or disability is in two categories:

CATEGORY	SEVERITY OF DISABILITY	PAYOUT PERCENTAGE OF CAPITAL DISABILITY BENEFIT
A	The *life assured* suffers a disability or medical impairment that falls into one of the Category A definitions in Appendix 2: Disability benefits assessment.	100%
B	The *life assured* suffers a disability or illness that falls into one of the Category B definitions in Appendix 2: Disability benefits assessment.	50%

See Appendix 2: Disability benefits assessment for details on how the criteria used to establish severity ratings will determine which category will apply.

14.3.3 How the benefit amount (*sum assured*) is determined

The benefit amount may be calculated as a multiple of the *member's* yearly risk salary. Alternatively, the *sum assured* can be shown as a flat rand amount. In both cases, the benefit maximums set out in the General Benefit Limits Document will apply.

If the Capital Disability Benefit is structured as an advance of the Life Cover Benefit, then the benefit amount is shown as a percentage of the Life Fund, where benefit payments will reduce the **Life Fund**.

If the Capital Disability Benefit is a standalone benefit,

then the benefit amount is shown as a percentage of the Impairment Fund, where benefit payments will reduce the **Impairment Fund**. The applicable benefit amount will appear on the Client Benefit Schedule.

To understand how the Life Fund and Impairment Fund

are used to pay Capital Disability Benefits, see the clause Where *we* pay benefits from.

There are maximum benefit amounts that apply to the benefit (see the General Benefit Limits Document).

EXAMPLE

John has a Capital Disability Benefit that is two times (the multiple) his yearly risk salary. He has a Life Fund that is four times his yearly risk salary. This means his Capital Disability Benefit is half of the Life Fund, which is 50%.

If he suffers a Category A disability, *we* pay him out the full Capital Disability Benefit which will be 50% of the Life Fund.

14.3.4 More than one claim for Capital Disability

14.3.4.1 *You* can claim again if there is still money in the Life Fund or Impairment Fund

The Capital Disability Benefit might not fall away after the first benefit payment. Benefit payments reduce the Life Fund or Impairment Fund, but the *life assured* can claim multiple times if there is a benefit amount available in the Life Fund or Impairment Fund. The benefit maximums set out in the General Benefit Limits Document will apply.

The *life assured* may qualify for multiple claims within or across any body systems because of the same *life-changing event*. In this case, the claim with the highest severity would be paid first, with a second claim being paid 6 months later, as long as the second disease or impairment process is still present at the time and the Life Fund or Impairment Fund is not depleted. An example would be paraplegia and kidney failure because of a motor vehicle *accident*.

14.3.4.2 If the later claim is for a progressive illness or disability

A **progressive illness or disability** is one that becomes more severe over time. At the time of the first claim, *we* will evaluate the severity of the disability according to the categories defined in the protocols in Appendix 2: Disability benefits assessment.

If the disability becomes more severe later and relates to the same *life-changing event*, *we* will reassess its severity category. If the severity category of the disability increases, an additional payment will be made for the difference between the lower and increased severity category, as long as the Life Fund or Impairment Fund is not depleted. If the severity category for the disability remains the same for the second claim, then no further benefit payments can be made for that same *life-changing event*.

If the disability or illness progresses from Category B to Category A, while the *member* remains a *member* insured under the *Plan*, *we* will pay out the difference between the Category B and Category A payment. This means *you* will be in the same financial position *you* would have been in if the disability or illness had been assessed in the higher category. The Category A payment will be calculated using the risk salary at the time and deducting the payment already made for the Category B claim assessment at an earlier date, subject to a benefit amount available in the Life Fund or Impairment Fund and to an overall maximum of the benefit amount.

EXAMPLE

Susan is diagnosed with Grade 3 retinopathy. This is a Category B disability, so she receives 50% of her Capital Disability Benefit. Six months later, Susan's retinopathy deteriorates to a grade 4 retinopathy. This is a Category A disability, so she would receive an additional 50% payout, as long as the Life Fund or Impairment Fund is not depleted. If her retinopathy does not deteriorate, no more payments would be made after the first 50% payment.

14.3.4.3 If the later claim relates to a new *life-changing event*

If a later claim is for an illness or disability that is not a progression of earlier claims, the claim will be treated as a new claim and will be independent of any previous claims. This is provided that it relates to a *new life-changing event* and the Life Fund or Impairment Fund is not depleted. Any condition or disability that exists or arises at the same time, or is a consequence of another condition or disability, will not be regarded as a *new life-changing event.*

For a subsequent claim that results from a new *life-changing event*, the benefit payment will be based on the category of the later claim. The benefit payment will not be based on the difference in categories between the later claim and the previous claim.

EXAMPLE

Sifiso has upper and lower digestive tract disease which meets the Category B criteria. He receives a payout of 50% of the Capital Disability Benefit. Six months later, he suffers from liver and biliary disease which meets the Category A criteria. This second claim is not a progression of the first claim, so he will receive 100% of the Capital Disability Benefit, limited to the value remaining in the Life Fund or Impairment Fund, and as long as the Life Fund or Impairment Fund is not depleted.

14.4 | OTHER FACTORS THAT INFLUENCE THE CAPITAL DISABILITY BENEFIT

We assess the risk and set the *member's* and *spouse's* Capital Disability Benefit premium according to the information given on the *Policyholder's* Application Form and at the request for medical evidence (where the *member* has potential insurance above the *free cover limit*). This information includes the *employer*'s industry and the expected occupation and may include the *member's* or *spouse's* pastime pursuits.

If the *employer*'s industry or the *life assured*'s occupation or pastime pursuits change, it is important that *we* are informed of these changes to ensure that the *life assured* is covered at all times. If this information is not given within two months of a change, *we* may, at *our* sole discretion, stop the disability insurance. *We* may also rely on *our* other rights as set out in in this *Life Plan Guide*, including in the clause *Our* rights if *you* do not carry out *your* duties (8.6).

14.5 | WHEN THE BENEFIT ENDS

The Capital Disability Benefit ends or will terminate at the earliest of:

- The *member* turning 65 years of *age*
- The *member* reaching the *benefit expiry age* for the Capital Disability Benefit shown on the Client Benefit Schedule
- *Us* paying out the maximum benefit amount in the General Benefit Limits Document
- The Life Fund or Impairment Fund becoming depleted
- The *member* no longer being an eligible *member*
- The *member's* death.

We will consider claims for *life-changing events* that happened before the benefit ended. *We* will not accept claims for *life-changing events* after the benefit ends.

DEFINITION OF *YOU/YOUR* FOR THIS SECTION

In this section, *you/your* refers to the *member* or the *member's spouse* or the *member's child* (where applicable for the *Spouse* Severe Illness Benefit and *Child* Severe Illness Benefit), all of whom may be the *life assured*.

15.1 | ABOUT THE SEVERE ILLNESS AND CANCER BENEFIT (LUMP-SUM)

15.1.1 What the benefit is

The Severe Illness Benefit pays a lump-sum amount if the *life assured* is diagnosed with a severe illness or disorder listed in Appendix 3: Severe illness benefit assessment.

The Cancer Benefit pays a lump-sum amount if the life assured is diagnosed with a severe illness or disorder listed in Appendix 4: Cancer benefit assessment.

The payout is intended to give *you* financial support so that *you* can maintain *your* existing lifestyle or manage *your* lifestyle according to *your* new circumstances.

If the *Plan* includes insurance for the *Spouse* Severe Illness or Cancer Benefit or the *Child* Severe Illness or Cancer Benefit, *we* also pay out if the qualifying *member's spouse* or *child* suffers a severe illness or disorder or cancer. The standard terms and conditions that apply to the *member's* Severe Illness Benefit and Cancer Benefit will apply to the *Spouse* Severe Illness and Cancer Benefit, except for the necessary changes and any additional terms and conditions set out in any policy document (including this *Life Plan Guide*, the quote, the *Policyholder's* Application, the Client Benefit Schedule, the Member Benefit Schedule and the General Benefit Limits Document) that apply specifically to *Spouse* Benefits. See the *Spouse* Benefits (17) section for the terms and conditions applicable to the *Spouse* Severe Illness Benefit. See the *Child* Severe Illness Benefit (15.4) section for the terms and conditions applicable to the *Child* Severe Illness Benefit.

If selected for the *Plan*, the Severe Illness Benefit and *Spouse* Severe Illness Benefit will appear on the Client Benefit Schedule. If the Severe Illness or Cancer Benefit and *Spouse* Severe Illness or Cancer Benefit do not appear on the Client Benefit Schedule, then the benefits do not apply for *your Plan*.

It is not possible for any *member* to be covered for both the Cancer Benefit and the Severe Illness Benefit at the same time.

15.1.1.1 How *we* calculate the benefit amount

The benefit amount is defined as:

- A multiple of *the member's* yearly risk salary or a set rand amount, both subject to the benefit maximums set out in the General Benefit Limits Document and Client Benefit Schedule.
- A percentage of the Life Fund or Impairment Fund, where benefit payments will reduce the Life Fund or Impairment Fund.

The applicable benefit amount will appear on the Client Benefit Schedule.

If the Severe Illness or Cancer Benefit is structured as an advance of a Life Cover Benefit, then this is shown as a percentage of the Life Fund. Alternatively, it can be shown as a flat rand amount.

If the Severe Illness or Cancer Benefit is a standalone benefit, then the sum assured is equal to the Impairment Fund.

To understand how the Life Fund and Impairment Funds are used to pay Severe Illness or Cancer Benefits, see the clause Where *we* pay benefits from (10).

There are maximum benefit amounts that apply to the benefit (see the General Benefit Limits Document).

EXAMPLE

John has a Life Fund that is four times his yearly risk salary. His Severe Illness Benefit is three times his yearly risk salary. Therefore, his Severe Illness Benefit is calculated as 75% of his Life Fund.

15.1.2 Body systems and illnesses covered by the benefit

The Severe Illness Benefit covers a range of severe medical conditions, including terminal illnesses. Appendix 3: Severe illness benefit assessment sets out the criteria that an illness needs to meet to qualify for benefit payments under the Severe Illness Benefit.

The Severe Illness Benefit provides insurance for all the following:

- Heart and artery benefit
- Cancer benefit, including early cancer benefit if it applies to *your Plan*
- Nervous system benefit
- Respiratory diseases benefit
- Gastrointestinal benefit
- Urogenital tract and kidney benefit
- Connective tissue diseases benefit
- Advanced Aids and accidental HIV benefit
- Eye benefit
- Ear, nose and throat benefit
- Endocrine and metabolic diseases benefit
- Musculoskeletal benefit
- Automatic *child* severe illness benefit (limited insurance)
- Global treatment benefit

The Cancer Benefit covers a range of severe medical conditions, including terminal illnesses. Appendix 4: Cancer benefit assessment sets out the criteria that an illness needs to meet to qualify

for benefit payments under the Cancer Benefit. The Cancer Benefit provides insurance for all the following:

- Cancer Benefit, including Early Cancer Benefit
- Automatic *child* Cancer Benefit (limited insurance)
- Global Treatment Benefit

15.1.3 Check the version of the *Life Plan Guide* that applies to *your Plan*

In January 2017, *policyholders* were offered an upgrade to the Severe Illness Benefit, including the Early Cancer Benefit.

If the *policyholder* did not take up the offer, the Early Cancer Benefit is excluded from the benefits under this *Life Plan Guide*. This *Life Plan Guide version GRLPG01/26* will apply to these benefits, except that the following clause and appendix will not apply:

- Early Cancer Benefit in this section
- Appendix 3: Severe illness benefit assessment of this *Life Plan Guide version GRLPG01/26* is replaced with the Severe Illness Benefit assessment appendix of the *Life Plan Guide* version GRLPG09/15.

All existing schemes that chose to convert to the Early Cancer Benefit and the enhanced Severe Illness Benefit assessment criteria on or after 1 January 2017, and all schemes not currently assured by *us*, quoted for on or after 1 January 2017, will be subject to all the terms and conditions of this *Life Plan Guide version GRLPG01/26*.

The terms and conditions of this *Life Plan Guide version GRLPG01/26* will apply to an existing *Plan* 31 days after receipt of this document by the *policyholder* or their recorded representative.

15.1.4 How is the date of impairment determined for the Severe Illness or Cancer Benefit?

We will decide the date on which the *life assured* was diagnosed for a defined severe illness or cancer, in relation to the applicable severity level, based on objective medical evidence. This date is referred to as the date of impairment. The Severe Illness or Cancer Benefit will not become payable if the date of impairment occurs before the *life assured* qualifies for a Severe Illness or Cancer Benefit or after the *life assured* no longer qualifies for a Severe Illness or Cancer Benefit.

For medical conditions that have been diagnosed before the *member* joins the *Plan*, the *member's* condition will be assessed to determine the severity level that they would have met before joining the *Plan*. If the *member* now meets a higher severity level and the *member* was a *member* of the *Plan* for at least 12 months before the date of the higher impairment event, the *member* may qualify for a benefit for the difference between the higher and lower severity levels. An upgrade will then be applied, if applicable

For the sake of clarity, the above paragraph applies to cancer that has been diagnosed before the *member* joins the *Plan* and has since been in remission. If the same type of cancer is diagnosed while the *member* is on the *Plan*, no benefit will be payable unless the severity is higher than the severity of the earlier cancer. In that case a benefit equal to the difference in severity levels will be payable.

15.1.5 How the severity levels affect benefit payments

The Severe Illness or Cancer Benefit is designed so that benefit payments are in proportion to the severity of the illness itself. The assessment of the severity levels that apply to specific medical conditions is detailed in Appendix 3: Severe illness benefit assessment and Appendix 4: Cancer benefit assessment and is based on objective medical definitions and criteria.

There are seven severity levels used to decide benefit payments. These levels have been set to make sure that benefit payments provide enough insurance for the effect that the severe illness is expected to have on the *life assured*'s lifestyle.

Each of the illnesses and medical procedures that *we* insure are graded into severity levels, from level A to level G. The *policyholder* may choose insurance for severity levels A to D (Comprehensive) or severity levels A to G (Comprehensive Plus). Whichever option is chosen, the Early Cancer Benefit will apply unless it is excluded from *your Plan*. The applicable option selected by the *policyholder* will appear on the Client Benefit Schedule.

The severity level of an illness depends on set medical criteria listed in Appendix 3: Severe illness benefit assessment, and Appendix 4: Cancer benefit assessment, which must be supported by objective medical evidence. The nature of the work that the *life assured* does to generate an income is not considered in the assessment of the claim.

Appendix 3: Severe illness benefit assessment and Appendix 4: Cancer benefit assessment shows which severity level an illness, medical procedure or medical condition qualifies for. The severity levels are judged using objective medical information provided by the *life assured*'s treating medical specialists. *Our* medical panel, at their sole discretion, will decide the severity level of an illness based on the objective medical evidence obtained from the *life assured*'s treating medical specialists. There is no payout if the *life assured*'s illness, medical procedure or medical condition:

- Does not qualify for any severity level
- Qualifies for a severity level that the *life assured*'s *Plan* does not insure.

15.1.6 The percentage payouts based on the severity levels

The benefit payment percentages for each severity level are as follows:

15.1.6.1 Comprehensive A – D

- Severity A: Pays 100% of the benefit cover
- Severity B: Pays 75% of the benefit cover
- Severity C: Pays 50% of the benefit cover
- Severity D: Pays 25% of the benefit cover

15.1.6.2 Comprehensive Plus A – G

- Severity A: Pays 100% of the benefit cover
- Severity B: Pays 75% of the benefit cover
- Severity C: Pays 50% of the benefit cover
- Severity D: Pays 25% of the benefit cover
- Severity E: Pays 15% of the benefit cover
- Severity F: Pays 10% of the benefit cover
- Severity G: Pays 5% of the benefit cover

15.1.6.3 Cancer Benefit

The benefit payment percentages for each severity level for the Cancer Benefit are as follows:

- Severity A: Pays 100% of the benefit cover
- Severity C: Pays 50% of the benefit cover
- Severity D: Pays 25% of the benefit cover
- Severity E: Pays 15% of the benefit cover
- Severity G: Pays 5% of the benefit cover

15.1.7 Early Cancer Benefit

15.1.7.1 What the benefit is

The Early Cancer Benefit is automatically included in the Severe Illness Benefit with effect from January 2017, except if the *policyholder* did not take up the upgrade of the Severe Illness Benefit as set out in the clause. This benefit provides insurance for qualifying in situ cancers and precancerous prostatic lesions.

An overall maximum benefit amount will apply to claims under the Early Cancer Benefit. Multiple payments are possible, subject to this overall maximum. This maximum will be reviewed annually (see the General Benefit Limits Document).

The Early Cancer Benefit pays out for medical procedures required for certain in situ Severity E and Severity G cancers that are detected early. Appendix 5: Early Cancer benefit assessment sets out the definitions of the cancers and procedures that qualify for a payout.

15.1.7.2 There is a waiting period before the benefit starts

A six-month waiting period applies for the Early Cancer Benefit and no claims will be paid for any diagnosis of in situ cancer or other diagnosis that qualifies for the Early Cancer Benefit made in the first six months after the:

- Start date of the Severe Illness or Cancer Benefit insurance for a *life assured*
- Reinstatement date of the Severe Illness or Cancer Benefit insurance for a *life assured*
- Addition of the Severe Illness or Cancer Benefit insurance for a *life assured*
- Reinstatement date of the *Plan*.

The benefit starts after six months have passed since the start date of the Severe Illness Benefit or the reinstatement date of the *Plan* or the benefit.

EXAMPLE

Judy has a *Plan* with an accelerated Comprehensive Plus Severe Illness Benefit of R2 million. The Early Cancer Benefit maximum benefit amount is R100,000. Judy claims for a severity E in situ cancer procedure. The percentage that applies to severity E is 15% of the Severe Illness benefit.

15% of R2 million = R300,000

However, as the Early Cancer Benefit maximum is R100,000, *we* will pay out R100,000 for Judy's claim. The Life Fund will be reduced by the payout and will now be R1,900,000.

Claims that arise in the six-month waiting period will not be paid out, even after the waiting period has passed.

The waiting period for the Early Cancer Benefit is only applied once from inception of the Severe Illness and Cancer Benefit should the *Policyholder* change benefits between the Severe Illness and Cancer Benefit given that there was no break in cover.

15.1.7.3 How the payouts work

Claims under this benefit count towards the maximum benefit amount (see the General Benefit Limits Document). Payouts reduce the Life Fund or Impairment Fund (as relevant).

15.1.7.4 Subsequent claims

More than one claim can be made under this benefit, as long as the Life Fund or Impairment Fund is not depleted. However, the benefit amount will be reduced by payments.

For progressive claims for the same cancer, where the cancer becomes more severe and results in a later claim of a higher severity level, *we* apply the benefit percentage to the initial benefit amount and deduct the amounts *we* paid for previous claims. Claims under the Early Cancer Benefit will be treated as part of the normal progressive claims process in this section.

EXAMPLE

Continuing from the example above, Judy's cancer progresses to severity A ten months later. The percentage that applies to severity A is 100% of the Life Fund. So, *we* will pay Judy:

100% of R2 million less R100,000 = R1,874,000

The Life Fund will now be depleted.

15.2 | MORE THAN ONE CLAIM CAN BE MADE UNDER THE SEVERE ILLNESS AND CANCER BENEFIT

15.2.1 The Severe Illness or Cancer Benefit does not fall away after the first benefit payment

The Severe Illness or Cancer Benefit does not fall away after the first benefit payment. If there is a benefit amount available in the Life Fund or Impairment Fund to pay for further benefit payments, *we* allow multiple claims.

15.2.2 *We* pay the most severe claim first

The *life assured* may qualify for multiple claims within or across any body systems from the same *life-changing event*. In this case, *we* would pay the claim with the highest severity first. *We* would pay a second claim six months later if the disease or illness that leads to the later claim is still present at the time and as long as the Life Fund or Impairment Fund is not depleted. An example is paraplegia and kidney failure from a motor vehicle *accident*.

Once the *life assured* meets the criteria for a later benefit payment, *we* calculate the benefit payment depending on whether the illness is progressive or is a new *life-changing event*, and on the balance of the Life Fund or Impairment Fund.

15.2.2.1 Progressive illnesses

At the time of the first claim, *we* evaluate the severity of the illness according to the severity rating scale defined in Appendix 3: Severe illness benefit assessment and Appendix 4: Cancer benefit assessment. If the illness becomes more severe and results in a later claim, *we* will reassess its severity rating. If the severity of the illness increases, *we* will make a further payment for the difference between the lower and increased severity ratings, as long as the Life Fund or Impairment Fund is not depleted.

If the illness progresses from one severity to a higher severity while the *member* remains insured under the *Plan*, the further benefit payment will put the *life assured* in the same financial position they would have been in if *we* had assessed the original benefit payment on the higher severity level at the later date with a potentially higher benefit amount.

If the severity level for the illness remains the same for the later claim, then no further benefit payments can be made for that same *life-changing* event.

Examples of illnesses that are often progressive include cancer, many of the chronic neurological diseases (for example, multiple sclerosis), many of the connective tissue diseases, chronic lung diseases (for example, emphysema), chronic liver diseases, progressive blindness or deafness, and chronic kidney diseases.

EXAMPLE

Stage 1 cancer is classified as Severity D, while stage 2 cancer is classified as Severity C. Therefore, 25% of the benefit will be paid for stage 1 cancer and then an additional 25% of the benefit will be paid when stage 2 cancer occurs, as long as the Life Fund or Impairment Fund is not depleted.

15.2.2.2 New life-changing event

A subsequent claim may occur that is not regarded as a progression of previous claims. Any condition or illness that exists or arises at the same time as or is a consequence of another condition or illness will not be regarded as a new *life-changing event*.

In the case of a new *life-changing event*, the benefit payment for the later claim will be treated as a new claim and will be independent of any previous claims. The benefit payment will be based on the full severity level of the later claim and not the difference in severity level between the later claim and the previous claim, as long as the Life Fund or Impairment Fund is not depleted.

EXAMPLE

If a *member* has a heart attack at Severity C (50%), followed later by a heart attack at Severity B (75%), where the second claim is not a progression of the first claim, the benefit payment for the second claim will be 75% and not the difference in severity between the first and second claims (75% minus 50%), as long as the Life Fund or Impairment Fund is not depleted.

15.3 | WHEN THE BENEFIT ENDS

The Severe Illness or Cancer Benefit ends or will terminate at the earliest of:

- The *member* turning 65 years of *age*
- The *member* reaching the *benefit expiry age* for the Severe Illness benefit shown on the Client Benefit Schedule
- *Us* paying out the maximum benefit amount
- The Life Fund or Impairment Fund becoming depleted
- The *member* no longer being an eligible *member*
- The *member's* death.

We will consider claims for *life-changing events* that happened before the benefit ended. *We* will not accept claims for *life-changing events* after the benefit ends. *We* will not deduct premiums for this benefit after it ends.

15.4 | THE *CHILD* SEVERE ILLNESS BENEFIT

15.4.1 Automatic insurance for *children* under 18

If the *member* is covered for the Severe Illness or Cancer Benefit, an amount of severe illness insurance is automatically included for *children of the member* who meet the definition of *child (3.7)*, including the requirement that they have not reached the *age* of 18.

15.4.2 No *medical underwriting* for automatic insurance

The *member's children* do not have to go through *medical underwriting* for the automatic insurance, but *we* do not insure any pre-existing medical conditions (9.8).

15.4.3 Conditions included for *children*

All body systems set out in the main Appendix 3: Severe illness benefit assessment are covered, including organ transplants, abnormalities of the heart requiring major surgery, severe brain damage following trauma, and some severe infections that can permanently affect the *child*.

Appendix 6: activities of daily living measures of the Severe Illness Benefit do not apply to the assessment of claims for the *Child* Severe Illness Benefit. All conditions set out in Appendix 4: Cancer benefit assessment are covered on the *Child* Cancer Benefit.

15.4.4 Benefit payouts are capped at 10% of the *member's sum assured* (benefit amount)

A claim for any *child* is limited to 10% of the *member's sum assured* (benefit amount) for the Severe Illness or Cancer Benefit, up to the benefit limit for each *life-changing* event that led to a claim (see the General Benefit Limits Document).

15.4.5 No effect on the Life Fund or Impairment Fund

Claims for *children* have no impact on the Life Fund or Impairment Fund (as relevant).

15.4.6 When the benefit ends

The benefit ends at the earlier of:

- The *member* turning 65 years of *age*
- The *member* reaching *benefit expiry age* for Severe Illness or Cancer Benefits (shown on the Client Benefit Schedule)
- *Us* paying out the maximum benefit amount or the Life Fund or Impairment Fund becoming depleted
- The *member* no longer being an eligible *member*
- The *member's* death.

We will consider claims for *life-changing events* that happened before the benefit ended. *We* will not accept claims for *life-changing events* after the benefit ends.

15.5 | GLOBAL TREATMENT BENEFIT

15.5.1 What the benefit is

If *you* have a claim for a Severe Illness or Cancer Benefit, *you* may choose whether to have the medical treatment in South Africa or at a hospital in the United States of America (USA) that *we have* authorised and have a relationship with at the time of *your* claim. The payout for treatment at the USA hospital is called the Global Treatment Benefit.

You must tell *us* at the time *you* claim whether *you* want to claim under the Global Treatment Benefit.

15.5.2 Who qualifies for the benefit?

To receive the Global Treatment Benefit:

- The *life assured* must have either the Comprehensive or Comprehensive Plus Severe Illness or Cancer Benefit
- The *life assured* must satisfy the criteria under Severity levels A, B, C or D of the Severe Illness or Cancer Benefit.

15.5.3 What is covered under the benefit?

This benefit only covers:

- Claims for severe illnesses or cancer that fall into Severity levels A, B, C or D (see the clause The percentage payouts based on the severity levels (15.1.6))
- Treatment that is approved by the American Medical Association
- Medicine that is approved by the USA's Food and Drug Administration.

15.5.4 What is not covered under the Global Treatment Benefit

This benefit does not insure or cover:

- Any treatment that *you* receive in South Africa before or after *you* are treated in the USA
- Any therapy, for example, physiotherapy or occupational therapy
- Any costs of travel or accommodation relating to the treatment in the USA
- Any costs of treatment at the USA facility that exceed the amount payable under the Global Treatment Benefit. The *member* must pay any excess costs.

These exclusions also apply to the *Spouse* Severe Illness or Cancer Benefit and the automatic *Child* Severe Illness or Cancer Benefit.

15.5.5 How *we* calculate the payout under the benefit

This is how *we* calculate what *we* pay under the Global Treatment Benefit. The ***severe illness or cancer payout*** is the amount *you* would have received if *you* had chosen not to claim under the Global Treatment Benefit.

***We* pay**	80% of the *severe illness* or cancer *payout*
Plus	The lower of: • The actual cost of the treatment in the USA • The *severe illness* or cancer *payout* as set out in the clause The percentage payouts based on the severity levels (15.1.6).
Minus	The amount that Discovery Health would have paid for the treatment in South Africa (whether or not *you* are a Discovery Health *member*). *We* make this deduction even if *your* own medical scheme (if *you* have one) does not pay for the treatment in the USA.
Equals	**The Global Treatment Benefit payout**

The Life Fund will decrease by the *severe illness or cancer payout* and not the amount paid including the Global Treatment Benefit.

We base the payout for a *progressive medical condition* on the severity of the illness at the time *you* claim, less any earlier payouts for claims at a lower severity.

***You* are personally responsible for paying for any amounts that *we* do not pay.**

EXAMPLE

Keke has R1 million severe illness insurance. She requires a kidney transplant. She chooses to claim under the Global Treatment Benefit to go to the USA for the transplant.
A kidney transplant is a severity level A illness, so the *severe illness payout* will be 100% of the severe illness benefit amount. This means if Keke stayed in South Africa and received treatment here, she would receive a *severe illness payout* of 100% of R1 million, that is, R1 million.

The kidney transplant in the USA costs R700,000 (medical costs). Keke's medical aid is Discovery Health, which pays R200,000 for the treatment (because this is the amount it would have paid for a transplant to be done in South Africa).
Applying the calculation above:
80% of the *severe illness payout* (80% of R1 million) = R800,000
Plus, the lower of actual cost of treatment (R700,000) or *severe illness payout* (R1 million)
= R800,000 + R700,000 = R1.5 million
Minus the Discovery Health payment of R200,000
= R1.5 million - R200,000 = R1.3 million

15.5.5.1 Timings of USA treatment

Treatment in the USA must start within three months of the *claim event date,* except for organ transplants.
For organ transplants, *you* must be placed on an organ transplant waiting list within six months of the *claim event date*. If *your* treatment does not take place within these time periods, *you* will not be able to claim under the Global Treatment Benefit. If *we* have already paid *you* the first 80% of *your severe illness or cancer payout*, *we* will then pay *you* the remaining 20%. This is so that *you* receive the amount *you* would have received if *you* had not chosen to claim under this benefit. The Global Treatment Benefit will not be available afterwards for the event that led to the claim under the Severe Illness or Cancer Benefit.

15.5.5.2 Effects on *your* Life Fund (effect on later claims)

Your Life Fund or Impairment Fund (as relevant) will decrease by the *severe illness or cancer payout* and not by the amount paid under the Global Treatment Benefit.
You can be treated in the USA more than once. However, the most *we* will pay for all claims for a particular or related illness is:

The *severe illness or cancer payout you* would have received if *you* had not claimed under the Global Treatment Benefit
Less
The amount Discovery Health would pay for the treatment. (If *you* are not a *member* of Discovery Health, then *we* deduct the amount Discovery Health would have paid to a *member* for the same treatment even if *your* medical scheme does not pay the amount.)

The maximum payout for all *life-changing events* is capped at 2.5 times the initial Severe Illness or Cancer Benefit *sum assured* and increased by the annual risk salary increase percentage of the *member*.

15.5.5.3 *We* are not responsible for *your* treatment

We are not responsible for the quality of medical procedures, treatment or advice that *you* receive.

15.5.5.4 The premium for the benefit

The premium for this benefit is included in *your* premium for the Severe Illness benefit or Cancer benefit. *We* review the premium each year and adjust it according to the claims *you* have made in the year.

15.5.5.5 When the benefit ends

The benefit ends at the earlier of:
- The *member* turning 65 years of *age*
- The *member* reaching the *benefit expiry age* for Severe Illness or Cancer Benefits (shown on the Client Benefit Schedule)
- *Us* paying out the maximum benefit amount, or the Life Fund or Impairment Fund becoming depleted
- The *member* no longer being an eligible *member*
- The *member's* death.

We will consider claims for *life-changing events* that happened before the benefit ended. *We* will not accept claims for *life-changing events* after the benefit ends.

15.6 | STANDARDISED CRITICAL ILLNESS DEFINITIONS PROJECT (SCIDEP)

The claims definitions for *our* Severe Illness Benefit comply with the Standardised Critical Illness Definitions Project (SCIDEP). The SCIDEP document is available at www.asisa.org.za.

For more detail, see the General Provisions clause of Appendix 3: Severe illness benefit assessment.

15.7 | OTHER FACTORS THAT INFLUENCE THE SEVERE ILLNESS BENEFIT

We assess the risk and set the *member's* and *spouse's* Severe Illness or Cancer Benefit premium according to the information given on the *Policyholder's* Application Form and at the request for medical evidence (where the *member* has potential insurance above the *free cover limit*). This information includes the *employer*'s industry and the expected occupation and may include the *member's* or *spouse's* pastime pursuits.

If the *employer*'s industry or the *life assured*'s occupation or pastime pursuits change, it is important that *we* are informed of these changes to ensure that the *life assured* is covered at all times. If this information is not given within two months of a change, *we* may, at *our* sole discretion, stop the severe illness or cancer insurance. *We* may also rely on *our* other rights as set out in this *Life Plan Guide*, including in the clause *Our* rights if *you* do not carry out *your* duties (8.6).

15.8 | APPLICATION WITH SEVERE ILLNESS BENEFIT

It is not possible for a *member* to be covered for both the Cancer Benefit and the Severe Illness Benefit at the same time.

16.1 | ABOUT THE FUNERAL COVER BENEFIT

16.1.1 What the benefit is

We pay out a lump-sum for the cost of a funeral for a life insured, including family members.

The *policyholder* can choose from three funeral benefit options, listed below.

01 | *Member*-only Funeral Cover Benefit

- Insures the *member* only
- Compulsory for all *members* if chosen by the *policyholder* as part of the *Plan*

02 | Family Funeral Cover Benefit

- Insures the *member* and their *spouses* (up to three in marriage order) and *children* (up to five in birth order) only
- Compulsory for all *members* if chosen by the *policyholder* as part of the *Plan*

03 | Extended Family Funeral Cover Benefit

- Extended family members are the *member's* and their *spouse's* (the *member's* family-in-law):
  - *Children* and *Spouses* not eligible for the Family Funeral Cover Benefit
  - Grandparents
  - Parents
  - Parents' siblings (aunts and uncles)
  - First cousins and their *children* (the *children* of aunts and uncles, and of their *children*)
  - Siblings (brothers and sisters)
  - Siblings' *children* (nieces and nephews)
  - *Children* and grandchildren excluded from the definition of *child* for the Family Funeral Cover Benefit
  - Any other family not included in this list if written approval of their membership is provided by us at our sole discretion.

16.1.2 Medical underwriting and exclusions

We do not require any medical questionnaires or tests for any *life assured*.

16.2 | THE DEFINITION OF A *SPOUSE* AND A *CHILD*

See the definition of a *spouse (3.6)* and a *child (3.7)*, including the extended definition of a *child* for the Family Funeral Cover Benefit.

A maximum of five *children* may be covered under the Family Funeral Cover Benefit.

16.2.1 Information *we* need for a claim

Within six months from the date of death, the *policyholder*, *member* or beneficiary must send *us*:

- A certified copy of the death certificate
- Any other supporting documents *we* ask for.

If *we* do not receive the documents within six months from the date of death, *we* will not pay the benefit.

16.3 | THE BENEFIT PAYOUTS

16.3.1 What and who *we* pay out

The employer discretion which was allowed under previous legislation (letting the employer decide who the beneficiary is) is no longer allowed under the Insurance Act 18 of 2017. This is especially important in the case of funeral policies which must be paid out in a short space of time, usually 2 days. If the *member* has not appointed beneficiaries, this would result in hardship for the family as the proceeds are paid to the estate. It is important that *members* are encouraged to complete or update their beneficiary nomination form at important life events, such as marriage, divorce, birth of *child* and death of beneficiary.

If the *member* dies, *we* pay the *member's* chosen beneficiary or, if the *member* did not choose a beneficiary:

- If *we* are permitted by the regulator to do so, to others according to the specific permission granted to *us*; else
- The *member's* estate

BENEFIT OPTION	PAYOUT	WHO *WE* PAY
Member-only Funeral Cover Benefit	The amount of the Funeral Cover Benefit	*We* pay the *member's* chosen beneficiary, or the *member's* estate if the *member* did not choose a beneficiary.
Family (*member*, *spouses* and *children*) Funeral Cover Benefit	The amount of the Funeral Cover Benefit	If the *member* dies, *we* pay the *member's* chosen beneficiary, or the *member's* estate if the *member* did not choose a beneficiary. If another *life assured* dies, *we* pay the *member*.
Extended (up to 10 family members) Family Funeral Cover Benefit	The amount of the Funeral Cover Benefit	if an extended family member dies we pay the *member*.

16.4 | WHEN THE FUNERAL COVER BENEFIT ENDS

The Funeral Cover Benefit ends at the earliest of the following:

- The end of the month the *member* reaches the *benefit expiry age* for Funeral Cover Benefits (The *policyholder* chooses the *benefit expiry age*, which is usually the *age* when the *member* would reach normal retirement *age*)
- The end of the month the *member* turns 70
- The *member* dies
- The *member* is no longer a qualifying employee
- For *spouses* and *children* and extended family members, when the benefit ends for the *member*
- For *spouses* and *children*, when they no longer meet the definition of *spouse* or *child*
- For the Extended Family Funeral Cover Benefit, at the end of the month the extended family member turns 100
- The date the scheme does not renew the *Plan* or does not maintain good financial standing with *us.*

We will no longer collect premiums for the Funeral Cover Benefit after the *member* reaches the *benefit expiry age* or dies.

16.5 | TERMS AND CONDITIONS OF THE EXTENDED FAMILY FUNERAL COVER BENEFIT

16.5.1 Who *we* insure

We insure extended family members who are dependent on the *member* for financial assistance for funeral and related costs. These may include *adult* dependants like parents, parents-in-law, uncles, aunts, brothers, sisters, nephews, nieces, grandparents and *children* of the *member* who are over 21 years of *age*. It may also include *children* like nephews and nieces who are below 21 years of *age* and are dependent on the *member*.

A maximum of 10 extended family members per principal *member* may be covered.

16.5.2 Definition of an Adult Dependant for Extended Family Funeral Cover Benefit

An *adult* dependant is a person over 21 years of *age* who is related to and financially dependent on the *member* but is not the *member's spouse* or *child*.

To be covered under this benefit, the *adult* dependant must be included in the *member's* list of up to ten *lives assured*. *Adult* dependants are not covered under any other benefit provided by *us* and under the *Plan*

16.5.3 Extended family member *ages*

The *maximum entry age* to the Funeral Cover Benefit is the last day of the month in which the extended family member reaches 70 years of *age* and in which the principal *member* reaches 65 years of *age*.

16.5.4 Premiums

We set the monthly premium based on the extended family members' *ages* and the amount of insurance the *member* has chosen.

16.6 | WAITING PERIOD BEFORE INSURANCE STARTS

16.6.1 For Funeral Cover Benefit

The maximum waiting period that can be applied to extended family members who join the *Plan* is three months. This means that cover starts three months after the Funeral Cover Benefit starts, and *we* have received three months of premiums for those *members*. Since premiums are normally paid in arrears with the third payment being made in the fourth month, if a *member* dies before the third payment has been received, *we* will consider the claim. If the claim is admitted, *we* will pay the claim after deducting the third payment.

Similarly, for any other form of Funeral Cover Benefit where a waiting period is applied, this waiting period cannot exceed three months. (Except for Extended Family Funeral Cover Benefits, waiting periods on funeral benefits are not common.)

If a *life assured* whose Funeral Cover Benefit is subject to a waiting period leaves the *Plan* for a month or more and later re-joins the *Plan*, the full waiting period will apply again.

16.6.2 What is the longest waiting period for Funeral Cover Benefit

For Funeral Cover Benefits, the longest waiting period which may be applied is three months.

16.6.3 For funeral benefits on a previous policy

We may impose a waiting period for the uncompleted part of the waiting period of the *policyholder's* previous funeral policy if:

- The waiting period for group risk funeral cover under the previous group risk policy funeral benefit was not complete when the *policyholder* entered this *Plan* with *us*
- The Funeral Cover Benefit *we* offer insures the same *lives assured* as those covered under the previous funeral benefit cover in terms of a group risk policy.

To apply this clause, *we* must make sure that each *life assured*:

- Was covered under a previous group risk funeral benefit policy
- Has fully or partially completed a waiting period under the previous group risk funeral policy.

Waiting periods completed for Individual Life funeral policies are not considered.

16.6.4 When *we* waive the waiting period

Where a waiting period applies, *we* will pay the claim if the death happens during a waiting period only if the death results from an *accident*.

If, within 31 calendar days before moving to *our* funeral benefit cover under the *Plan*, extended family members had the same benefits at their previous underwriter, then *we* will waive the waiting period.

16.7 | THE *POLICYHOLDER* MUST KEEP INFORMATION UP TO DATE

The *policyholder* must give *us* an updated *member* schedule by the last working day of each month for extended family members who have insurance for the following month. *We* must receive the premium that corresponds to this *member* schedule. The *member* schedule must contain the following information:

- The *member's* details
- The extended family member's relationship to the *member*
- The extended family member's name and surname
- The extended family member's date of birth and ID number
- The extended family member's gender
- The date the extended family member joined the benefit

The *policyholder* must keep records of their employees' dependants and any other family members insured under the Extended Funeral Cover Benefit.

If both *spouses* have funeral insurance under their own *Plan* insured by *us* and they both have common family members insured under the Funeral Cover Benefit, Family Funeral Cover Benefit or Extended Family Funeral Cover Benefit, the total benefit paid from both *Plans* for *lives assured* in common (including themselves) cannot exceed the maximum sums assured set by *us* from time to time (see the General Benefit Limits Document).

If these maximums are exceeded when a *life assured* dies, then the benefits to be paid under each *spouse's* insurance will be proportionately reduced. This will mean that the total benefit paid will not exceed the maximum *sum assured* for each *life assured*.

This only applies to *our* group insurance funeral *Plan* and does not consider any individual funeral policies from Discovery Life or any other insurer.

16.8 | WHEN *WE* CAN CHANGE THE TERMS AND CONDITIONS FOR FUNERAL BENEFITS

We may not change the terms of the funeral benefit in the first 12 months after the start of the *Plan*, unless *we* can show that:

- There are reasonable actuarial grounds to change the terms and conditions of the *Plan, or*
- The change will be to the benefit of the *members* concerned.

16.9 | DEATH BY SUICIDE

We will not accept funeral claims on the Funeral Cover Benefit if the death of any of the lives insured is due to suicide and occurred within 12 months of the Insured Life joining the *Plan*.

16.10 | REPATRIATION BENEFIT

If the repatriation benefit is included in the *Plan* and is recorded in the accepted quote, then the following services will be provided if the *member* or the *member's* family asks for it:

- The mortal remains of a *life assured* will be repatriated to the funeral home chosen by the *member* or their family, closest to the place of burial. The place of death must be within the Republic of South Africa, Namibia, Zimbabwe, Botswana, Swaziland, Lesotho and Mozambique (south of the 22nd parallel) and the place of burial must be in the Republic of South Africa.
- Transport will be arranged for a single relative to accompany the mortal remains of the deceased life assured to the funeral home of choice closest to the place of burial.
- Accommodation will be arranged, if required, for a maximum of one night for a single relative accompanying the mortal remains to the place of burial.
- Legal assistance will be given regarding the funeral procedures (death certificate, removal of body, etc).
- Help will be given for arranging a funeral or cremation.
- Help will be given for obtaining a death certificate.
- A referral to a pathologist will be given, if required.
- A referral to a psychologist or psychiatrist will be given, if required.
- A referral for special counselling will be given, particularly relating to the loss of a *child*, if required.

17.1 | ABOUT *SPOUSE* BENEFITS

17.1.1 What the benefit is

We offer the following benefits to *spouses*:

- *Spouse* Life Cover Benefit
- *Spouse* Capital Disability Benefit
- *Spouse* Severe Illness Benefit
- *Spouse* Cancer Benefit

The *Spouse* Benefits are shown as a fixed rand amount or as a multiple of the *member's* yearly risk salary. Maximum benefit amounts apply (see the General Benefit Limits Document).

The standard terms and conditions that apply to *members* also apply to *spouses* for the *Spouse* Benefits.

17.1.2 If chosen, *Spouse* Benefits are compulsory

The *policyholder* may choose *Spouse* Benefits. Any *Spouse* Benefits that the *policyholder* chooses are compulsory for all *members* who have a *spouse*.

17.1.2.1 Exclusions from insurance for *spouses*

We do not need information about the *spouse* when *we* quote. *We* will tell the *policyholder* and the *policyholder's* financial adviser what information *we* need about *spouses* when *we* install the *Plan*. Any exclusions for *spouses* will also be communicated to the *policyholder* and the *policyholder's* appointed financial adviser, and they will tell the *member*.

17.1.3 People who are defined as a *spouse*

See the About the people involved in the *Plan* section for the definition of a *spouse*.

17.1.3.1 If a *member* has more than one *spouse*

For the purposes of spouse benefits in this *Plan*, if a *member* has more than one *spouse*, the *spouse* is considered to be the one who the *member* has been married to for the longest.

17.1.3.2 *We* must receive proof of marriage

The *member* must give *us* proof of their marriage or marriages at claim stage.

17.2 | THE *SPOUSE* LIFE FUND AND BENEFIT PAYOUTS

17.2.1 *Spouse* Benefits do not affect the *member's* Life Fund

The *spouse* will have their own *Spouse* Life Fund. On the death of the *spouse*, *we* will pay the value in the *Spouse* Life Fund to the *member*.

Any benefit payout that *we* make under the *Spouse* Capital Disability Benefit, *Spouse* Severe Illness and *Spouse* Cancer Benefit will reduce the *Spouse* Life Fund.

The *Spouse* Life Cover Benefit does not reduce the Life Fund of the *member*. The exception is if, at the start of the *Plan*, the *policyholder* specifically asked for this as a term of the *Plan*, and *we* at *our* sole discretion agreed to this non-standard structure.

17.2.2 How *we* calculate the benefit payout

Initial *Spouse* Life Fund amount

Plus

Any amount that the *Spouse* Life Fund grew by, due to an increase in the *member's* risk salary

Less

Any benefit payouts that reduced the *Spouse* Life Fund.

17.2.3 When *Spouse* Benefits end

The *Spouse* Benefit ends automatically when the benefit ends for the *member* or at the earliest of the following dates:

- The *member* reaches the benefit expiry age
- The *member* turns 65 years of age
- The *member* dies
- The *spouse* reaches the benefit expiry age
- The *spouse* turns 65 years of age
- The *spouse* dies
- The *member* no longer qualifies as an employee on the *Plan*
- The *spouse* no longer meets the definition of *spouse*

When *we* are notified that the *member* has reached *benefit expiry age*, turned 65 years of *age* or died, *we* will stop collecting premiums for the *Spouse* Benefits.

18.1 | ABOUT MORTGAGE PROTECTOR

18.1.1 What the benefit is

The Mortgage Protector pays a fixed number of monthly instalments into a *member's* mortgage bond account if the *member* has a valid claim for either the Income Continuation Benefit or Life Cover Benefit payout. The Mortgage Protector is separate from the Income Continuation Benefit or Life Cover Benefit payout. These benefits are only used to create the event for the payment of the Mortgage Protector.

The Mortgage Protector pays out monthly for disability and as a lump-sum for death. A valid Mortgage Protector benefit payment is payable to the *member*, the bond account or the deceased estate (in the case of death).

After the Mortgage Protector has paid out for an Income Continuation Benefit or Life Cover Benefit, the Mortgage Protector falls away.

18.1.2 To qualify for the benefit

- The *member* must be a Vitality member.
- The *member* must be insured for a Life Cover Benefit and an Income Continuation Benefit.
- The *member* must have one mortgage bond registered over their primary residence with a recognised financial institution. If there is more than one bond registered over the primary residence, the benefit will apply to the earliest bond only.
- The mortgage bond must be registered in the *member's* own name or in co-ownership with their *spouse*. Properties held in companies, trusts and close corporations (CCs) are not eligible for this benefit.
- The mortgage bond must have an unpaid balance with a recognised financial institution.

The *activity at work (7.3)* clause and the pre-existing medical conditions (9.8) clause apply to the Mortgage Protector, even if *we* have waived these clauses for other benefits. The rules for waiving these clauses also apply.

18.2 | HOW *WE* CALCULATE THE BENEFIT

The monthly Mortgage Protector instalment will be the average home loan instalment calculated as:

The lesser of:

- **the sum of home loan installments paid in the last 12 months divided by 12, and**
- **the sum of home loan installments due in the last 12 months divided by 12**

The payout is capped at 30% of the *member's* monthly risk salary.

If the *member's* home loan has been in place for less than 12 months, the period will be adjusted accordingly.

The number of monthly payments will be based on the *member's* Vitality Health status at disability.

Vitality Health status at date of claim event

BLUE	BRONZE	SILVER	GOLD	DIAMOND
3 months	6 months	9 months	12 months	24 months

We calculate the Mortgage Protector Benefit on death as follows:

The monthly Mortgage Protector instalment (as calculated above)

Multiplied by

The number of monthly payments according to the *member's* Vitality Health status at the time of the claim, less any monthly instalments already paid out through the Income Continuation Benefit

EXAMPLE

Donald's average monthly home loan instalment over the past 12 months was R10,000.

Donald is on Silver Vitality status.
We pay R10,000 for 9 months if Donald is disabled, or a lump sum of R90,000 if Donald dies.

If Donald is disabled for five months and then dies, *we* will pay R10,000 per month for the five months he is disabled, and then R40,000 when he dies, adding up to a total benefit paid of R90,0000.

We do not pay any amounts that the *member* paid above the monthly instalments required in the home loan agreement with the financial institution.

18.3 | WHEN THE BENEFIT ENDS

The Mortgage Protector ends for disability in any of these circumstances:

- Once *we* have paid the total number of monthly instalments according to the Vitality Health table
- Once the Income Continuation Benefit ends (even if *we* have not paid all the monthly instalments according to the Vitality Health table)
- If the loan is paid off before *we* have paid the total number of monthly instalments according to the Vitality Health table
- Once the *member* dies (*We* will subtract any monthly instalments *we* made before the *member* died from the benefit payable at death.)

18.4 | FRINGE BENEFIT TAX MAY APPLY

Members may pay fringe benefit tax on the premium for the Mortgage Protector. The premiums for the Mortgage Protector are not guaranteed and *we* review them every year. *We* recommend that *members* get appropriate guidance from a tax professional or from their appointed financial adviser for the correct tax position on Mortgage Protector premiums and payouts.

DEFINITION OF *YOU/YOUR* FOR THIS SECTION
You/your refer to the policyholder in this section.

19.1 | WHAT IS THE CONTINUATION OPTION?

The continuation option may be selected by the *policyholder* of an *unapproved* or *approved Plan*, for both Core and Flex Benefits and premiums are paid at a *Plan* level. This lets employees who are *members* under the *Plan* but who no longer work for the *employer* apply for an Individual Discovery Life Plan without undergoing standard medical underwriting. This would be at most for the same level of insurance they had under the *Plan*. On an *unapproved Plan*, the *employer* or association is the *policyholder*. On an *approved Plan*, the retirement fund is the *policyholder*.

The benefit details and options (for example, expiry *ages*, waiting periods) available to the *member* on the Individual Discovery Life Plan will be in line with those that are offered by Discovery Individual Life at the time of conversion. Conversion to an Individual Discovery Life Plan will be governed by the rules, terms and conditions applicable to an Individual Discovery Life Plan as defined by Discovery Individual Life at the time of the conversion and may not be the same as the benefit features under the *Plan*. A quote will be provided when the *member* elects the continuation option. The quote will set out the benefit features available and the level of insurance that will be offered by Discovery Individual Life. Further *medical underwriting* will not apply.

The application for an Individual Discovery Life Plan through the continuation option will not require the standard underwriting applied by Discovery Individual Life.

Any loadings or exclusions which applied to the cover above the *free cover limit* before conversion will also apply to the converted cover. Premium loadings and exclusions may also apply to the benefits after conversion based on the *member's* occupation, claims under the territories they travel to or work in and the hazardous activities they may do. A list of hazardous activities that *we* do not cover can be found following this link. Financial underwriting will be applied at application for the Individual Disability Life product.

If benefit features are selected that are considered more comprehensive or if increased insurance cover is requested, the application for the continuation option under this *Plan* will be subject to full underwriting.

19.1.1 When may a *member* who is not a disability claimant exercise the continuation option?

- For the Life Cover Benefit, if the *member* ends employment or ends membership of the retirement fund for any reason other than death on or before 65 years of age. We allow the continuation option to be exercised for 60 days after turning 65 years of age for the Life Cover Benefit.
- For the Global Education Protector, if the *member* ends employment or ends membership of the retirement fund for any reason other than death on or before 55 year of age.
- For the Income Continuation Benefit, Capital Disability Benefit and Severe Illness Benefit, if the *member* ends employment or ends membership of the retirement fund for any reason other than death on or before 60 years of *age.*

There is no continuation option for the Funeral Cover Benefit, Accidental Death Benefit, Accidental Disability Benefit, Cancer Benefit, *Spouse* Life Cover Benefit or *Spouse* Capital Disability Benefit because *we* do not medically underwrite these benefits.

A *member* may also exercise the continuation option when *you* end the provision of risk benefits to *your members* completely, due to insolvency or liquidation. This provision does not apply if the insurance offered under this *Plan* is replaced partially or fully, whether by group risk or individual life insurance, and whether with Discovery Group Risk, Discovery Life or an alternate insurer.

19.2 | CONDITIONS FOR EXERCISING THE CONTINUATION OPTION

- The *member* has left employment or ended their membership of the retirement fund.
- *You* have opted for the continuation option, and it is quoted and paid for.
- The *member* did not previously elect the continuation option on any *Plan* because of past employment with an *employer* or past membership of a retirement fund that were *Plan policyholders.*
- The *member* must have been employed by *you* and have been active on the option of the benefit for 12 continuous months.
- If, at the date of exercising the option, a claim is being considered under the *Plan* and the payment for the claim would reduce the Life Fund, the benefits under the Individual Discovery Life Plan will be the same as those that the applicant would have under the *Plan* after the claim is paid. In other words, the applicant would be offered an Individual Discovery Life Fund as reduced by the claim under the *Plan* (subject to the Minimum Protected Fund if applicable). Any benefit that has a claim being considered before electing the continuation option under the *Plan* at the time of exercising the continuation option, will not be allowed to convert until the claim is withdrawn or an outcome on the claim has been communicated to the *member*.

- A continuation option is offered on partially claimed Capital Disability or Severe Illness Benefits for the remaining percentage of the Benefit at the date of exercising the option.
- If a *member* wants to apply for insurance more than the benefits enjoyed under the *Plan* or for any other benefits not included under the *Plan*, the normal underwriting requirements in force at the time will apply to those additional benefits.
- A *member* must apply to Discovery Individual Life for an Individual Discovery Life Plan in terms of this continuation option within **60 days** of the *member's* termination of employment or termination of membership in the retirement fund. The application for the continuation option, is subject to our General Benefit Limits (see the General Benefit Limits Document) which may change from time to time. If the *member* has not applied within this time limit, the continuation option falls away and is no longer available. The *member* may apply to Discovery Individual Life after this, but their application will be subject to the normal underwriting requirements in force at the time.
- The standard terms and conditions of the Individual Discovery Life Plan will apply. Please see the Q&A document that describes the differences in cover between the two Life Plans.
- The rates and premiums applicable under the Individual Discovery Life Plan for the benefits applied for under the continuation option will differ from those under the *Plan*.
- Any pre-existing medical conditions provisions and underwriting decisions, loadings or exclusions that applied to the *Plan* benefits or claim decisions will be transferred and continue to apply to the Individual Discovery Life Plan benefits. The waiting period will not be shorter, and the maximum insurance *age* will not be later than the *age* initially selected for the *Plan* as shown in the Client Benefit Schedule.
- An applicant will not have cover under an Individual Discovery Life Plan (subject to the terms and conditions of the Individual Life Cover Benefit) in the period between the termination of employment or termination of participation in the *Plan* and the acceptance of risk by Discovery Individual Life.
- The *member* will, however, continue to have insurance under the *Plan* for a period of 31 days after the earlier termination of employment or membership of the retirement fund or participation in the *Plan* if the employer or retirement fund selected the continuation option. The *member* must have been an eligible *member* at the last date of the participation in the Group Risk Life *Plan*. This cover ends at the earlier of:
  - The end of the 31 days whether or not the *member* has any other cover arranged using the continuation option or another insurer
  - The date a Discovery Individual Life policy obtained is issued
  - The date the *member* is covered by another group risk or individual life policy from any insurer issued after the end of their employment or membership of the retirement fund.
- Should the *member* die within this period of 31 days, the benefits due in terms of the *Plan* will be in accordance with the provisions of the clause Who we pay (12.7).
- The Individual Discovery Life Plan policy terms and conditions including maximum ages, will apply.
- *Plan* premiums for the continuation option are charged at Plan level and will end when the *member* reaches the benefit expiry age as shown in the Client Benefit Schedule.

19.3 | CONTINUATION OPTION FOR DISABILITY INCOME CLAIMANTS

A disability income claimant may not exercise the continuation option if they are still covered for continued benefits under the *Plan*. If continued benefits do not apply, then they may exercise the continuation option as detailed below:

- For the Core Life Cover and Severe Illness Benefit
- If the claimant ends employment or ends membership of the retirement fund, for any reason other than death, on or before the earlier of normal retirement date in terms of
- No partial Disability Income Benefit is available at conversion for a partial disability claimant.

DEFINITION OF *YOU/YOUR* FOR THIS SECTION
In this section, you/your refers to the member.

20.1 | WHAT IS THE *DISCOVERY GROUP RISK* PAYBACK BENEFIT?

Offered to all *Plans* quoted on or after 15 May 2018 which meet the participation criteria, in place of the discontinued Discovery Corporate Integrator Benefit.

Members who are covered by a *Plan* that qualifies for the Group Risk PayBack Benefit, and who are *members* of qualifying medical schemes administered by Discovery Health, can earn a PayBack Benefit of up to 15% per calendar year of the value of their net Group Risk premiums (net premiums are the premiums *you* paid less allowance for commission and admin fees) once they have attended a Discovery Wellness Experience or completed their Vitality Health Checks.

The Wellness Experience or Vitality Health checks should include:

- Blood Pressure Measurement
- Blood Glucose Measurement
- Cholesterol Measurement
- Weight assessment and
- Non Smoker Declaration

The PayBack Benefit applies to qualifying *members* only and is paid out as a benefit under both the *approved* and *unapproved* risk *Plan*. *Members* qualify for the PayBack Benefit primarily because of their employer or their retirement fund taking part in the *Plan*.

The percentage of PayBack Benefit earned in a calendar year depends on the *member's* health plan (for qualifying schemes administered by Discovery Health), total health claims amount and Vitality Health status or Vitality Health Check outcomes, or the number of Personal Health Pathways health actions completed. The PayBack Benefit earned each calendar year is also limited to a maximum amount decided by *us* from time to time (see the General Benefit Limits Document).

20.2 | HOW IS THE DISCOVERY GROUP RISK PAYBACK BENEFIT ACTIVATED?

The benefit is activated automatically for new qualifying *Plans* on or after 15 May 2018. The Group Risk PayBack Benefit for a calendar year is available to employees of *employers* with more than 20 employees who:

- Are covered through their *employer's Plan*, with a Life Cover Benefit of at least twice their yearly income and any income Continuation Benefit for the entire year
- Are *members* of a qualifying medical scheme administered by Discovery Health that qualifies for the PayBack Benefit for the entire year
- Have attended a Discovery Wellness Experience or completed a Vitality Health Check during the within the year, no later than 31 December.

A *member* can continue to qualify for the Group Risk PayBack Benefit as an Income Continuation Benefit claimant if they meet all the other criteria.

20.3 | HOW DOES THE *DISCOVERY GROUP RISK* PAYBACK BENEFIT WORK?

The PayBack Benefit is based on a refund of premiums paid for a calendar year specific to each *member* (with the first year being extended to the end of the following calendar year if the *member* qualifies in the year). Qualifying *members* receive a PayBack Benefit depending on their applicable health plan, their total amount of health claims for the year and their Vitality Health status or Vitality Health Check outcomes, and the number of Personal Health Pathways health actions they have completed during the year.

The PayBack Benefit earned by a qualifying member will be the higher of the PayBack percentages calculated using the Health PayBack Benefit matrix and the Personal Health Pathways PayBack Benefit matrix. The matrixes are shown in Sections 20.9 and 20.11 respectively.

The qualifying health plans can be found in the General Benefit Limits Document.

Qualifying *members* who do not attend a Discovery Wellness Experience or complete a Vitality Health Check in the year will not earn a PayBack Benefit amount. *Members* who leave the *Plan* after the end of the calculation period but before the date of payment of a PayBack Benefit will lose the benefit payments. *Members* who leave the *Plan*, Vitality or their health plan within the calculation period will lose benefit payments for that calculation period.

The PayBack Benefit is based on the net *Discovery Group Risk* premiums for all benefits (including Flex Benefits).

20.4 | RETIREMENT FUNDS BOOST TO REINVESTED GROUP RISK PAYBACK BENEFIT

Qualifying *members* who are also *members* of the Discovery Life Pension Umbrella Fund or Discovery Life Provident Umbrella Fund (the Discovery Retirement Funds) will have their earned PayBack Benefit automatically reinvested in the Discovery Retirement Funds (as a *member's* additional voluntary contribution), unless the *member* choose to receive the PayBack Benefit in cash. If their PayBack Benefits are reinvested into the Discovery Retirement Funds, Discovery will boost the reinvested PayBack amounts by 100%. See the Discovery Retirement Funds Guide for more information. If a *member* is no longer

covered by the *Plan*, *a*ny PayBack Benefit and PayBack Boost already invested in the Discovery Retirement Funds will remain invested in those Funds.

20.5 | HOW WILL THE *DISCOVERY GROUP RISK* PAYBACK BE PAID OUT?

If a *member* of the *Plan* is not also a *member* of the Discovery Retirement Funds, or if they choose to receive their PayBack Benefit in cash, then the PayBack Benefits will be paid directly into the *member's* bank account as registered with the medical scheme, by 31 March after the end of the year in which they become due. They are paid by this date to make sure that the *member's* Vitality Health status has been updated with all points earned. For *members* of the Discovery Retirement Funds, the PayBack Benefit will only be transferred on 31 May to allow the *member* to choose if they would like the benefit to be paid in cash. The choice of the benefit paid in cash should reach *us* by 15 May failing which, the benefit will be transferred into their Discovery Retirement Funds. Once the PayBack Benefit is transferred into the Discovery Retirement Funds, the transfer is irreversible, and the Rules of the Funds (from 1 June 2024) apply.

The PayBack Benefit may only be reinvested in the Discovery Retirement Funds or paid as cash directly to the *members'* bank account as registered with the medical scheme. No other methods of reinvestment or payment are allowed. If the *member* is a dependant on the medical scheme, we will request bank details from the *member* by 31 March, after the end of the year in which it becomes due.

For *members* who do not belong to the Discovery Retirement Funds, should the PayBack Benefit not be claimed by notifying *us* of the bank details within three years of the benefit becoming payable (31 March), the *member* will forfeit the PayBack Benefit.

20.6 | HOW DOES TAX AFFECT THE GROUP RISK PAYBACK BENEFIT

If a *member* chooses to have their PayBack in cash, *we* will not withhold any tax on the amount paid. If the tax laws, tax regulations, the SARS practice or other laws governing this product change, which may have an effect on the product and the PayBack Benefit payment made to the *member*, *we* reserve the right to make the appropriate changes to comply with the new laws. If the PayBack Benefits earned by the *member* are reinvested (as a *member's* additional voluntary contribution) in the Discovery Retirement Funds, the *member* can claim the amount reinvested in the Funds as a contribution deduction previously disallowed when they retire from the fund.

20.7 | WHAT HAPPENS IF THE *MEMBER* ENDS THEIR MEMBERSHIP?

If the *member* or *employer* ends their participation in the *Plan* or their membership of a qualifying scheme administered by Discovery Health they lose their PayBack Benefit. The *member* must be active on the *Plan* at the date the benefit is paid to be eligible for the benefit.

If the *member* changes *employers* and joins an *employer* where they continue being a *member* of a qualifying medical scheme administered by Discovery Health (including Vitality) and of the *Plan*, the *member* will keep their PayBack if there is no break in service.
There is no limit to how many times the *member* may change *employers* and keep their PayBack Benefit, as long as there is no break in service.

If participating schemes or *member* groups fall below 20 *members*, they no longer qualify for the PayBack Benefit for future accrual. If participation in the PayBack Benefit ends solely due to the 20-membership requirement not being met, the earned PayBack Benefit will not fall away. It is paid out as cash or reinvested in the Discovery Retirement Funds at the end of March following the year in which participation ended if all other requirements are met.

20.8 | WHAT CAN CHANGE OVER TIME?

From time to time, *we* may review and change any of the following:

- The qualifying health plan types, the mapping of the health plans, health claim amount ranges and the criteria for valid health claims
- The qualification criteria and conditions for the Group Risk PayBack Benefit
- The mapping of Personal Health Pathways to PayBack percentages
- The PayBack percentages when there are changes to the Vitality Health programme, Personal Health Pathways programme, as well as any other changes within the Discovery Group
- The maximum PayBack Benefit earned each year.

If changes are made to the PayBack Benefit during a calendar year, any PayBack earned up to the date of change will remain valid.

EXAMPLE

James is 34 years old with diabetes. He has a family of three. He works for a consulting engineering firm. His firm joins a Plan on 1 May 2023 and takes part in Vitality. James becomes a member of Discovery Health Medical scheme under the Family Saver plan type on 1 July 2023.

Since he must be a member of both Discovery Health Medical Scheme and a Discovery Group Risk Plan for at least 12 months as at 31 December of a calendar year, his PayBack will be calculated up to December 2024. He will get 18 months' worth of PayBack Benefits (6 months' worth applying for July to December 2023 and 12 months' worth applying for January to December 2024), paid in March 2025 so that Vitality Health points can be updated, and his status assigned for 31 December 2024. The PayBack Benefit paid will use 18 months' worth of premiums, but his health status, health actions and health claims for the most recent
(example continued on next page)

EXAMPLE CONTINUED

12 months (calendar year, 2024 in this case) will be used to calculate the percentage of the premiums due to him. From 1 January 2025 onwards, James' PayBack will be calculated for the full 12 months up to the end of December for that year, with payment occurring in the following March.

James, who paid a total of R18,000 for the Plan premium from July 2023 to December 2024, progressed from Bronze as at December 2024 to Silver Vitality Health status as at December 2025 and has all his Vitality Health Checks completed for the years ending December 2024 and December 2025.

James sent in health claims amounting to R1,500 in the calendar year 2024, and R6,000 in the calendar year 2025. Over the 2024 calendar year, he completed 2 Personal Health Pathways health actions, and 4 over the 2025 calendar year. He will receive the following yearly PayBack Benefit for 2024 and 2025.

December 2024 PayBack:

PayBack as calculated using the Vitality Health PayBack matrix:

=R18,000 (premium for 18 months since 1 July 2023) x Bronze Vitality Health status (with R1,500 health claims)

=R18,000 x 6%

=R1,080

PayBack as calculated using the Personal health Pathways Payback matrix:

=R18,000 (premium for 18 months since 1 July 2023) x 2 health actions completed

=R18,000 x 5%

=R900

So, James' December 2024 PayBack will be R1,080, the higher of R1,080 and R900.

December 2025 Payback:

PayBack as calculated using the Vitality Health PayBack matrix:

= R12,000 (1 year's premium from 1 January 2025) x Silver Vitality Health Status (with R6,000 health claims)

=R12,000 x 7.5%

=R900

PayBack as calculated using the Personal Health Pathways PayBack matrix:

= R12,000 (1 year's premium from 1 January 2025) x 4 health actions completed

=R12,000 x 15%

=R1,800

So James' December 2025 PayBack will be R1,800, the higher of R900 and R1,800.

20.9 | GENERIC HEALTH PAYBACK BENEFIT MATRIX

The generic PayBack matrix appears below. To decide the health claims ranges for the *member's* personal matrix, based on their qualifying health plan, see the General Benefit Limits Document.

MAIN *MEMBER*: <NAME OF MEDICAL AID[1]> OR FAMILY:<NAME OF MEDICAL AID[1]>					
HEALTH CLAIMS (R)[2]	**BLUE**	**BRONZE**	**SILVER**	**GOLD**	**DIAMOND**
Health claims range 1	5.0%	7.5%	10.0%	12.0%	15.0%
Health claims range 2	4.5%	6.0%	7.5%	10.0%	12.0%
Health claims range 3	4.0%	4.5%	6.0%	7.5%	10.0%
Health claims range 4	0.0%	0.0%	4.5%	6.0%	7.5%
Health claims range 5	0.0%	0.0%	0.0%	4.5%	6.0%

1. Replaced for each *member* by the name of the medical scheme administered by Discovery Health in which they participate
2. Replaced for each *member* by the claims ranges applicable to the medical aid in which they take part (see the General Benefit Limits Document)

Non-Vitality members can take part in the PayBack based on their completion of Vitality Health Checks. They will be mapped to a column in the PayBack tables related to their health plan type as follows:

VITALITY HEALTH CHECKS OUTCOME	APPROPRIATE COLUMN IN THE GROUP RISK PAYBACK MATRIX
Completed all Vitality Health Checks	Blue status column
Body Mass index or Waist Measurement in range	Bronze status column
All Vitality Health Check measures in range	Silver status column

20.10 | HOW ARE HEALTH CLAIMS USED TO PLACE A *MEMBER* IN THE HEALTH CLAIMS RANGE OF THEIR PERSONAL HEALTH PAYBACK MATRIX?

The submitted claims considered on the Health Plan (on a medical scheme which is administered by Discovery Health) include:

- All claims submitted by *you* or *your* medical service provider, without any qualification that they were paid or were submitted to be paid.
- Chronic medicine and in-hospital benefits (excluding childbirth claims and colonoscopy claims for lives over 50 years of *age*) attributable to the *member* and *spouse* insured under the *Plan*. In the case of the Priority Plan, the claims considered include the amount of the hospital deductibles payable by the *member*.
- Medical expenses (on all Health Plans except for the Core Plan) accumulating towards and above the Above Threshold Benefit if *your* Health Plan includes the Above Threshold Benefit, or what would have accumulated towards and above the Above Threshold Benefit if *your* Health Plan does not include the Above Threshold Benefit. These medical expenses will be considered at the rates at which they accumulate (or would have accumulated) towards and above the Above Threshold Benefit. These medical expenses will include those from both the *member* and *spouse* (if applicable) on the Health Plan. Medical expenses are included whether they are paid from the MSA, the health wallet or out of pocket. Certain medical expenses are excluded from this calculation. The excluded expenses can be found in Appendix 7: Excluded medical expenses for PayBack.

20.11 | PERSONAL HEALTH PATHWAYS PAYBACK BENEFIT MATRIX

The Personal Health Pathways Benefit matrix below will be used to calculate the PayBack earned for both Vitality and non-Vitality *members.*

NUMBER OF HEALTH ACTIONS COMPLETED IN A CALENDAR YEAR	PAYBACK PERCENTAGE EARNED FOR YEAR
0 to 1	0%
2	5%
3	10%
4 or more	15%

20.12 | TRANSITIONAL ARRANGEMENTS

If *you* were taking part in the Discovery Corporate Integrator with *us*, *you* may continue that PayBack mechanism indefinitely.

This *Life Plan Guide version GRLPG01/26* will apply to *you*, except that the benefit is governed by the Corporate Integrator (21) section below and not this section.
All existing schemes taking part in the Discovery Corporate Integrator may choose to convert to the *Discovery Group Risk* PayBack Benefit effective from 1 January 2019 or the first of January of any year after that. If this choice is made, there will be no change in the premium and the Corporate Integrator Benefit due to *members* on 31 December of the year before the conversion will be calculated and paid to qualifying *members* at the following March. The terms and conditions of the Corporate Integrator (21) section in this *Life Plan Guide version GRLPG01/26* will apply.

Members of such schemes will then begin taking part in the Group Risk PayBack from the conversion date or when they join the *Plan* after that. After conversion, the Corporate Integrator (21) section will no longer apply to the benefit which will be governed by this section.

An existing *Plan* not already taking part in the Discovery Corporate Integrator may choose to start taking part in the PayBack Benefit from any date after 1 July 2018 if they qualify. For schemes where this choice is made, a quote will be performed, and an added premium will be charged for taking part in the benefit. The *Plan* will only begin taking part in the benefit if the *policyholder* accepts the added premium in writing. In any event, this *Life Plan Guide* version GRLPG01/26 applies to such existing schemes in total. The terms and conditions of this *Life Plan Guide* version GRLPG01/26 will apply to an existing *Plan* 31 days after *you* or *your* recorded representative receive it.

21.1 | WHAT IS THE DISCOVERY CORPORATE INTEGRATOR?

It was discontinued and replaced by the Group Risk PayBack for new *Plans* quoted on or after 15 May 2018. Existing business before 15 May 2018 receiving benefits from this integrator may keep it for as long as they are covered by the *Plan* and continue to meet the qualifications for taking part. Only *members* on Vitality Premium qualifies for this benefit.

Members on a *Plan* which qualified for participation in the Discovery Corporate Integrator before 15 May 2018 can earn premium PayBack under this benefit once they have attended a Discovery Wellness Experience or Vitality Health Check.

The Wellness Experience or Vitality Health checks should include:

- Blood Pressure Measurement
- Blood Glucose Measurement
- Cholesterol Measurement
- Weight assessment and
- Non Smoker Declaration

The PayBack Benefit recognises the relative levels of their health in comparison to their colleagues' health, based on their engagement with Vitality and on their health measurements.

Qualifying *members* earn a PayBack Benefit of up to 30% based on their Vitality status each year, and a PayBack Booster of 10% based on their health measurements, accrued each year earned, but paid after three years. The combined PayBack Benefit and PayBack Booster accrued per year is limited to a maximum amount per year as decided by *us* from time to time (see the General Benefits Limits Document).

21.2 | HOW WAS THE DISCOVERY CORPORATE INTEGRATOR ACTIVATED?

The PayBack Benefit and PayBack Booster were activated for new *Plans* before 15 May 2018 for *employers* with between 20 and 500 employees and whose employees:

- Were covered through their *employer*'s *Plan*, with a Life Cover Benefit of at least twice their yearly income and the Income Continuation Benefit based on *our* recommended benefit scale
- Were *members* of the *Plan* for at least 12 months
- Had attended a Discovery Wellness Experience or completed a Vitality Health Check within the year, no later than 31 December.
- Were engaged with the Vitality programme through any channel, including their own principal membership of the medical aid or that of their *spouse*.
- Were a member of a qualifying medical scheme administered by Discovery Health.

Although this benefit is no longer offered to new *Plans*, current qualifying *members* of funds who had the benefit activated before 15 May 2018 can still participate.

21.3 | HOW DOES THE DISCOVERY CORPORATE INTEGRATOR PAYBACK BENEFIT WORK?

The PayBack Benefit works over a cycle of three calendar years, specific to each *member* (with the first year being extended if eligibility begins during a year). Qualifying *members* receive up to 30% of their *Discovery Group Risk* premiums back at the end of every year based on their Vitality status.

Vitality Health status at date of claim event

BLUE	BRONZE	SILVER	GOLD	DIAMOND
0%	5%	10%	15%	30%

Qualifying *members* who do not attend a Discovery Wellness Experience or complete a Vitality Health Check during the year will still accrue the PayBack Benefit. It becomes available if:

- The *member* attends a Wellness Experience or completes a Vitality Health Check in a later year within the three-year cycle
- At the end of the three-year cycle.

The PayBack Benefit is based on the gross *Discovery Group Risk* premiums for all benefits (including Flex Benefits).

21.4 | WHAT IS THE CORPORATE INTEGRATOR PAYBACK BOOSTER?

Qualifying *members* receive an added 10% of their *Discovery Group Risk* premium back based on their Vitality status, if their measurements for cholesterol, blood pressure, glucose and BMI (or waist circumference) obtained through the Discovery Wellness Experience or Vitality Health Check are in range, and they sign a non-smoker declaration. The PayBack Booster is earned each year if the requirements are met, but it is accrued and only paid at the end of the three-year cycle.

21.5 | HOW WILL THE CORPORATE INTEGRATOR BE PAID OUT?

The Corporate Integrator PayBack Benefit is paid directly into the *member's* latest bank account held on record by Group Risk, and if none are available, then the bank account held by the medical scheme. If there are no bank details available from Group Risk and the *member* is a dependant on the medical scheme, *we* will request bank details from the *member* by 31 March, after the end of the year in which it becomes due. No other bank details will be utilised. They are paid by this date to make sure that the *member's* Vitality status has been updated with all points earned.

No reinvestment or other methods of payment are allowed. Should the PayBack Benefit not be claimed by notifying *us* of the bank details within three years of the Benefit becoming payable (31 March) the *member* will forfeit the PayBack Benefit.

21.6 | HOW DOES TAX AFFECT THE CORPORATE INTEGRATOR?

The PayBack Benefit is only paid in cash. *We* will not withhold any tax on the amount paid. If the tax laws, tax regulations, the SARS practice or other laws governing this product change, which may have an effect on the product and the PayBack Benefit payment made to the *member*, *we* reserve the right to make appropriate changes to comply with the new laws.

21.7 | WHAT HAPPENS IF THE *MEMBER* ENDS THEIR MEMBERSHIP?

If the *member* or *employer* ends their participation in the *Plan* or their Vitality membership, they will lose their PayBack Benefit. The *member* must be active on the *Plan* at the date the benefit is paid to be eligible for the benefit.

If the *member* changes *employers* and joins an *employer* where they continue being a *member* of a qualifying medical scheme administered by Discovery Health (including Vitality) and of the *Plan*, and there is no break in service, they will keep the PayBack Benefit they earned under the previous employer. There is no limit to how many times the *member* may change *employers* and keep their PayBack Benefit, as long as there is no break in service. No benefits accrue in the interval between leaving the previous *employer* and joining the new *employer*.

If participating schemes or *member* groups reduce below 20 *members*, they will no longer qualify for the Discovery Corporate Integrator Benefit for future accrual. If participating schemes or *member* groups increase above 500 *members*, they will no longer qualify for the Discovery Corporate Integrator Benefit for future accrual, unless *Discovery Group Risk* at its sole discretion approves the *member*, *Plan*, or *member* group's continued participation in writing.

If participation in the Discovery Corporate Integrator Benefit ends solely due to the 20 to 500 member*ship* range being breached, then the accrued PayBack Benefit will not be lost and will be paid at the end of March following the year in which participation ended, if all other requirements for payment are met.

Appendix

As part of *Discovery Group Risk's* (DGR) drive for treating customers fairly and to give effect to the spirit of the Long-Term Insurance Act *Policyholder* Protection Rules (PPRs), DGR intends to enter into an agreement with the *Employer (Policyholder),* Section 13B administrator and/or financial adviser on the *Plan*

1.1 | DISCOVERY GROUP RISK OBLIGATION:

The PPRs place the following obligations on Discovery Group Risk as a division of Discovery Life Limited:

- Act with due skill, care and diligence when dealing with *policyholders* and *members*.
- Clearly explain the purpose of any engagement.
- Provide the financial adviser, section 13B administrator and/or *policyholder* with all correspondence and *member* communication, including, but not limited to:
  - Underwriting requirements
  - Benefit statements
  - Annual membership communication
  - Details on renewals and terminations
  - Claim requirements, reminders, payments and reviews
- Provide all required disclosures, before, during and after the time of entering into a policy.
- Provide support to the financial adviser, section 13B administrator and/or *policyholder* in relation to queries in respect of the above noted communication.
- Agree to transmit all required information related to *member* communication to the financial adviser and/or section 13B administrator appointed by the *policyholder*.
- Issue communication when there are updates to legislative and regulatory requirements that impact the financial adviser, section 13B administrator or *policyholder*.
- Make *member* communication available online to the *policyholder* and/or *member*s.

The online *member* communication can be accessed in the following ways:

Log on to the member zone at www.discovery.co.za.
Contact their HR department who can download a copy from the employer zone at www.discovery.co.za.
Contact Discovery Group Risk on 0860 047 687 or email *us* at groupinfo@discovery.co.za.

1.2 | *POLICYHOLDER* OBLIGATIONS:

The employer, retirement fund and/or its representative appointed will:

- Adhere to all reasonable requests from DGR in relation to the abovementioned *member* communication.
- Provide *member* contact details to DGR and the appointed financial adviser when required.
- Promptly disseminate information to the *member*s of the *Plan* as required by DGR and/or the appointed financial adviser.
- Ensure that advice provided by the financial adviser is suitable to its *members'* circumstances.
- Communicate any replacement comparisons with its *member*s before the inception of the new *Plan* (where applicable).
- Communicate any underwriting requirements with relevant *member*s.
- Submit *members'* claims timeously to DGR and/or financial adviser.
- Implement a process to ensure that all required communication is sent to *member*s when required.
- Implement any changes required as a result of changes to regulatory requirements or implement new processes to communicate to *member*s.
- Provide details of processes and procedures *you* have in place for *member* communication or proof that the communication was sent to *member*s as and when required by DGR.
- The *policyholder* authorises DGR to release all information as required by the PPRs, relating to *member*s of the *Plan*, to the financial adviser or Section 13B administrator for onward transmission to *member*s.
- Agree to DGR communicating directly to *member*s if there is any failure to disseminate the information to the *member*s of the *Plan* as required by the PPRs.

PLEASE NOTE: if a *policyholder* elects not to appoint a financial adviser, all the financial adviser's obligations will be applicable to the *policyholder*.

1.3 | FINANCIAL ADVISER AND 13B ADMINISTRATOR OBLIGATIONS:

The financial adviser and/or section 13B administrator will:

- Act with due skill, care and diligence when dealing with DGR, the *policyholder* and its *member*s
- Discharge the shared responsibilities undertaking in relation to abovementioned *member* communication on behalf of the *policyholder*
- Implement any changes required as a result of changes to regulatory requirements or implement new processes to communicate to *policyholders/members*
- Provide the *policyholder* with a replacement comparison prior to inception of the new *Plan* (where applicable)
- Share all required disclosures, before, during and after the time of entering into the policy with the *policyholder/ members*

- Ensure that all underwriting requirements are promptly distributed to the *policyholder/members*
- Review underwriting requirements after 90 days to ensure that all requirements were met by the *policyholder* and its *members*.
- Provide details of processes and procedures *you* have in place for *member* communication or proof that *policyholder* and/or *member* communication was sent as and when required by DGR
- Notify DGR, in writing if there have been any deviations from the *member* communication strategy which has resulted in the following:
  - Inability to transmit the *member* communication
  - Insufficient information being supplied to *member*s
  - The late distribution of *member* communication
- Agree to DGR communicating directly to *members* or *policyholders* if there is any failure to disseminate the information to the *members* of the scheme as required by the PPRs.

By signing the quote and the *Policyholder's* Application Form, the *policyholder*, or the individual given authority by the *policyholder*, accepts these terms and conditions, and affirms that they have read, understood and accepted the *Policyholder* Undertaking. This appendix is included in the quote and referred to in the *Policyholder's* Application Form.

2.1 | GENERAL PROVISIONS

Calculation of the LifeTime Impact Category used for deciding the level of the Lifetime Capital Disability Lump-sum Benefit

All changes shown in this appendix must be permanent despite treatment according to recognised medical protocols. These new *life-changing events* must have occurred since the start date of the *Plan*.

Permanency is defined as when maximum medical improvement (MMI) has been attained according to the treating specialist and to the satisfaction of the Discovery medical team.

Capital Disability is assessed according to the latest AMA guidelines of disability. The ability to do one's inherent job functions is not taken into consideration in the calculations and assessment of Capital Disability claims.

The LifeTime Impact Category is decided by the total LifeTime Impact score as follows:

TOTAL LIFETIME IMPACT SCORE	LIFETIME IMPACT CATEGORY
0 – 4	1
5 – 9	2
10 – 14	3
15 – 19	4
20 – 24	5
25 – 29	6
30 – 34	7
35 – 39	8

The total LifeTime Impact score is decided by adding the score for the various LifeTime Impact factors set out in the rest of this appendix, for Category A disability only, to an added *age*-based score for conditions where the score is marked by a degree sign (°).

The *age*-based scores added to LifeTime Impact factors are:

AGE BAND	ADDITIONAL LIFETIME IMPACT SCORE
<30	30
31 – 40	22
41 – 50	14
51 – 55	8
56 – 60	4
61+	0

2.2 | CARDIOVASCULAR

This benefit covers conditions of the heart and arteries as specified below.

A cardiologist, cardiothoracic surgeon, neurosurgeon, vascular surgeon or specialist physician must confirm the diagnosis. Relevant special investigations such as ECGs, echocardiograms, other imaging studies and blood tests must confirm the diagnosis.

Chronic diastolic heart failure is defined as New York Heart Association (NYHA) class IV and irreversible restriction demonstrated on Doppler echocardiography.

DISEASE	CATEGORY A	LIFETIME IMPACT SCORE	CATEGORY B
Heart failure due to myocardial infarction or valvular heart disease or cardiomyopathy or cardiac arrhythmias or congenital heart disease or hypertensive heart disease	NYHA III and EF less than 40%	7	Maximum METs achieved on effort ECG less than 5
	Maximum METs achieved on effort ECG less than two	7	EF less than 45%
	EF less than 35%	7	NYHA III and confirmed with raised proBNP levels according to age bands (below 50 years: proBNP more than 450 pg/ml; 50 years and above: proBNP more than 900 pg/ml)
	Awaiting cardiac transplantation	7	
	NYHA IV and confirmed with raised proBNP levels according to age bands (below 50 years: proBNP more than 450 pg/ml; 50 years and above: proBNP more than 900 pg/ml)	7	
Hypertension	Cardiac end-organ damage as defined by an estimated LV mass Males: more than 255 g (greater than 131 g/m2) Females: more than 193 g (greater than 113 g/m2) Inter-ventricular septum or posterior wall thickness of more than 17 mm	4	
Constrictive pericarditis	Constrictive pericarditis as confirmed on transthoracic or echocardiography with all of the following: dilatation of the inferior vena cava and hepatic veins, calcifications, abnormal septal wall motion and atrial enlargement	7	Constrictive pericarditis as confirmed on transthoracic echocardiography with two of the following: dilatation of the inferior vena cava and hepatic veins, calcifications, abnormal septal wall motion and atrial enlargement
Peripheral arterial disease	Permanent ABI less than 0.4 following vascular surgery, unless surgery is medically contra-indicated Gangrene of a limb Amputation of a limb Arterial ulceration	8	Severe claudication defined as an inability to complete a treadmill exercise stress test due to claudication with a post- exercise ankle systolic pressure of less than 50 mmHg
Peripheral venous disease			Non-healing venous ulcer for more than three months with evidence of deep venous insufficiency as confirmed by duplex ultrasonography with a reflux time that is more than 0.5 seconds in duration at the level of the ulcer

2.3 | RESPIRATORY SYSTEM

This benefit covers specified conditions of the respiratory system. The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations such as lung function tests, blood tests, histology or imaging.

The claimant must be treated by a pulmonologist, registered with the Health Professions Council of South Africa. Lung function tests should be performed by a pulmonologist. The test should include pre- and post-dilatation measurements and show less than 5% variation between three successive FVC or FEV1 readings. Two DCO tests must be done with results within three units. Corrections must be made for anaemia and carboxyhaemoglobin on the DCO test.

DISEASE	CATEGORY A	LIFETIME IMPACT SCORE	CATEGORY B
Chronic obstructive airways disease (chronic bronchitis emphysema) or asthma or restrictive or mixed lung disease	FVC less than 40% of predicted* FEV1 less than 40% of predicted* DCO less than 40% of predicted* Constant use of prescribed oxygen due to blood oxygen saturation levels below 88%	10	FVC 40% – 49% of predicted* FEV1 40% – 49% of predicted* DCO 40% – 49% predicted*
Lung cancer	See cancer table		See cancer table

* Pulmonary function tests – including post-bronchodilation testing – should be performed by a pulmonologist and show less than 5% variation between three successful readings. These tests must be technically acceptable to the treating specialist as well as to *Our* medical panel.

2.4 | MENTAL AND BEHAVIOURAL DISORDERS

After a Capital Disability Benefit claim for Category A or B has been made, future claims for mental and behavioural disorders will only be considered if the criteria for a Category A claim in respect of mental and behavioural disorders as listed below, are met:

DISEASE	CATEGORY A	LIFETIME IMPACT SCORE	CATEGORY B
Mood disorders	Permanent inability to perform at least four Activities of Daily (ADL) Living from four different ADL categories. The categories include Self-care ADLs, Communication ADLs, Physical ADLs and Advanced ADLs. ADL failure must be present despite ongoing medical treatment by a psychiatrist, with evidence of all the following: Demonstrable compliance to at least a combination of antidepressant at maximal dosages or mood stabilisers or anti-psychotic medication for more than two years Two or more in-patient admissions of longer than two weeks A complete in-patient course of ECT therapy if indicated unless medically contraindicated*	13	Permanent inability to perform at least four Activities of Daily Living (ADL) from four different ADL categories. The categories include Self-care ADLs, Communication ADLs, Physical ADLs and Advanced ADLs. ADL failure must be present despite ongoing medical treatment by a psychiatrist with evidence of all the following: Demonstrable compliance to at least a combination of antidepressant at maximal dosages and mood stabilisers or anti-psychotic medication for more than one year A complete in-patient course of ECT therapy if indicated unless medically contraindicated*
Schizophrenia and other psychotic disorders	Permanent inability to perform at least four Activities of Daily Living from four different ADL categories. The categories include Self- care ADLs, Communication ADLs, Physical ADLs and Advanced ADLs. ADL failure must be present despite demonstrable compliance with adequate trials of at least two different anti-psychotic regimes for at least one year*	13	Permanent inability to perform at least two Activities of Daily Living from two different ADL categories. The categories include Self-care ADLs, Communication ADLs, Physical ADLs and Advanced ADLs. ADL failure must be present despite demonstrable compliance with adequate trials of at least two different antipsychotic regimes for at least one year*.
	Permanent legal institutionalisation for a psychiatric disorder**		Legal institutionalisation for at least six months for a psychiatric disorder**

° Additional *age*-based score must be added to the impact score.

* Sensory Function ADLs and Hand Function ADLs are excluded.

** Excluding institutionalisation for drug or alcohol abuse or a violation of South African criminal law.

2.5 | NERVOUS SYSTEM

The claimant must be treated by a neurologist or neurosurgeon, registered with the Health Professions Council of South Africa. This benefit covers specified conditions of the brain, spinal cord nerves and arteries to the brain.

CATEGORY A	LIFETIME IMPACT SCORE	CATEGORY B
Total and permanent loss of speech	11	Loss of speech as confirmed by abnormal strobovideolaryngoscopy
Total and permanent loss of comprehension of language	11	Permanent inability to perform two out of six Activities of Daily Living
Permanent inability to perform four or more out of six Activities of Daily Living	11	Permanent inability to perform two Self-care Activities of Daily Living
Permanent inability to perform three or more Self-care Activities of Daily Living	11	
Persistent vegetative state for more than three months	11	
Permanent loss of memory recall or orientation to person, place and time, confirmed by a persistent MMSE score of less than 21	11	Three generalised epileptic attacks per week despite optimal therapy confirmed by long-term EEG monitoring. Non-epileptic seizures are excluded.
Permanent non-progressive cognitive impairment with a MMSE score of less than 21	11	
Dementia or progressive neurocognitive disorders with a permanent CDR score of 2 or more	11	
Hearing loss (deafness) of 90 DB or more in both ears measured over the frequencies (500 Hz, 2,000 Hz, 3,000 Hz) in two measurements over six months with a hearing aid		Hearing loss* of 70 dB in both ears measured over the frequencies (500 Hz, 1,000 Hz, 2,000 Hz, 3,000 Hz) in two measurements over six months with a hearing aid
Persistent quadriplegia, hemiplegia or paraplegia	11	Greater than 75% binaural hearing impairment** Permanent total hearing loss or deafness in one ear* Persistent monoplegia
Best-corrected binocular Snellen rating of 20/200* or worse*	6º	Best corrected binocular Snellen rating of than 20/125 or worse* Permanent bilateral hemianopia Complete loss of sight in one eye (no light perception)*
70% visual acuity impairment**	6º	50% visual acuity impairment**

º Additional *age*-based score must be added to the impact score

* All measurements are with appropriate aids

** AMA Guides to the Evaluation of Permanent Impairment: Latest Edition

All changes must be permanent

Neuropsychological and any other appropriate testing must be done to demonstrate permanency and pathology with regard to soft neurological signs. Functional neurological disorders are excluded.

All definitions to be confirmed by corresponding findings on specialist investigation.

2.6 | DIGESTIVE SYSTEM

This benefit covers specified conditions of the liver, pancreas, biliary system, and upper and lower gastrointestinal system. Conditions related to drug or alcohol abuse are not covered under this benefit. The claimant must be treated by a specialist physician, gastroenterologist or surgeon, registered with the Health Professions Council of South Africa. The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations, such as blood tests, histology or imaging. All definitions to be confirmed by corresponding findings on specialist investigation.

DISEASE	CATEGORY A	LIFETIME IMPACT SCORE	CATEGORY B
Upper and lower digestive tract disease	Anatomical loss and alteration in the gastrointestinal tract with medical evidence of established gastrointestinal pathology and weight loss of more than 25% below the lower limit of normal BMI or BMI of less than 14	9	Anatomic loss of alteration in gastrointestinal tract with medical evidence of established gastrointestinal pathology and weight loss of more than 15% below the lower limit of normal BMI or BMI less than 16
	Faecal incontinence defined as permanent, continuous uncontrolled passage of faecal material. Colostomies and ileostomies are not covered under this definition	9	
	Permanent disturbance of bowel function resulting in a malabsorption syndrome with evidence of any two of the following: Steatorrhoea or more than 20 g of fat in the stool Refractory anaemia (Hb less than 9 g/dl) Refractory hypoalbuminaemia of less than 28 g/l	9	
	Irreparable hernia with earlier bowel obstruction and the permanent inability to perform four or more out of six Activities of Daily Living	9	
	Permanent inability to swallow due to an anatomical or neurological abnormality as confirmed by abnormal oesophageal manometry or imaging studies	9	
Liver and biliary disease	Chronic liver disease classified as *Child* Pugh Class C	11	Chronic liver disease classified as *Child* Pugh Class B
	Primary sclerosing cholangitis	11	
	Primary biliary cirrhosis	11	
	Awaiting liver transplant on a recognised South African or international transplant list	11	

Functional disorders with no demonstrable gastrointestinal pathology are excluded under this benefit.

2.7 | RENAL SYSTEM

This benefit covers specified conditions of the urogenital tract and kidneys.
The claimant must be treated by a specialist nephrologist or urologist, registered with the Health Professions Council of South Africa. The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations, such as blood tests, histology or imaging.

CATEGORY A	LIFETIME IMPACT SCORE	CATEGORY B
Permanent kidney dysfunction with a GFR of less than 15 ml/min/1.73 m2 according to the MDRD study equation	14	Permanent kidney dysfunction with a GFR of less than 30 ml/min/1.73 m2 according to the MDRD study equation
Permanent peritoneal dialysis or haemodialysis	14	
Total or continuous permanent urinary incontinence	14	

2.8 | ENDOCRINE SYSTEM

This benefit covers specified conditions of the thyroid, pituitary or adrenal gland.

The claimant must be treated by a specialist endocrinologist or surgeon, registered with the Health Professions Council of South Africa. The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations, such as blood tests, histology or imaging.

DISEASE	CATEGORY A	LIFETIME IMPACT SCORE	CATEGORY B
Diabetes mellitus	Claims because of type 1 or type 2 diabetes mellitus with evidence of end-organ damage are assessed under the relevant body systems	13	Claims because of type 1 or type 2 diabetes mellitus with evidence of end-organ damage are assessed under the relevant body systems
Cushing's syndrome, phaeochromocytoma, syndrome of inappropriate antidiuretic hormone secretion (SIADH), chronic adrenal insufficiency, parathyroid-associated chronic hypo- or hypercalcaemia, chronic hyperaldosteronism	Claims because of any endocrine disease are assessed under the relevant body systems		Claims because of any endocrine disease are assessed under the relevant body systems

2.9 | OTHER

This benefit cannot be used for singular conditions that are defined elsewhere under Capital Disability benefits. This benefit applies only when two or more co-existing conditions do not meet CAT A or B criteria on their own, the impairment suffered may be assessed here holistically. This category provides for diseases or conditions that do not fall into any other listed category.

CATEGORY A	LIFETIME IMPACT SCORE	CATEGORY B
Permanent inability to perform four of six Activities of Daily Living or permanent inability to perform three Self- care Activities of Daily Living	6º	Permanent inability to perform two or more Activities of Daily Living or permanent inability to perform two Self-care Activities of Daily Living

° Additional *age*-based score must be added to the impact score

2.10 | HAEMATOLOGY

° Additional age-based score must be added to the impact score

CATEGORY A	LIFETIME IMPACT SCORE	CATEGORY B
A permanent treatment-resistant pancytopaenia (anaemia and eucopaenia and thrombocytopaenia) resulting in ongoing monthly transfusions of at least four units of blood or fresh blood products This excludes cancer-related pancytopaenias	6º	A permanent treatment-resistant pancytopaenia (anaemia or leucopaenia or thrombocytopaenia) resulting in ongoing monthly transfusions of at least four units of blood or fresh blood products This excludes cancer-related pancytopaenias

2.11 | ADVANCED AIDS

This benefit covers advanced AIDS and accidental human immunodeficiency virus (HIV) seroconversion as specified below. A positive HIV antibody test and confirmatory polymerase chain reaction test is needed to confirm the diagnosis.

The diagnosis of the specified AIDS-defining conditions must be supported by compatible signs and symptoms and confirmed by relevant special investigations, such as blood tests, antibody tests and histology or imaging.

CATEGORY A	LIFETIME IMPACT SCORE
Despite optimal treatment and full adherence to prescribed antiretroviral therapy, a permanent CD4 cell count less than 50 and a positive PCR OR Despite optimal treatment and full adherence to prescribed antiretroviral therapy, a CD4 cell count of less than 200 and a positive PCR, AND at least one of the following diseases must be diagnosed: ▪ Kaposi's sarcoma ▪ Pneumocystis jirovecii pneumonia (PJP) ▪ Confirmed progressive multifocal leukoencephalopathy ▪ Active extra-pulmonary tuberculosis ▪ Cryptococcosis ▪ Disseminated non-tuberculous mycobacteria infection Confirmed diagnosis of any other condition as defined as stage 4 on the World Health Organization (WHO) clinical criteria list	7

2.12 | CANCER

Cancer is a malignant tumour characterised by the uncontrolled growth of cells, invasion of normal tissue and spread to distant organs. The term malignant tumour includes leukaemia, lymphoma and sarcoma.

Pre-malignancy and carcinoma in situ tumours, except for carcinoma in situ of the breast treated by mastectomy, are not covered under this benefit. Brain tumours are covered under the Nervous System Benefit. Specified neuroendocrine tumours are covered under the Endocrine and Metabolic Diseases Benefit.

A current internationally recognised staging system will be used to assess the claim.

A report from the treating specialist, including the histology and stage of the cancer, the relevant imaging reports and other tests must confirm the diagnosis. A specialist is a person registered with the Health Professions Council of South Africa in a relevant specialty.

CATEGORY A	LIFETIME IMPACT SCORE
Stage IV cancer	8
Stage III cancer scoring 4 on the ECOG performance scale continuously for a period of over six months	8
Leukaemia or lymphoma with the following staging: Ann Arbor 3 or 4, RAI stage 3 or 4, Binet C or falling in the high-risk category on the International Prognostic index, and scoring 4 on the ECOG performance scale continuously for a period of over six months	8
Brain tumours WHO grade III or IV	8
Stage III multiple myeloma	8

2.13 | MUSCULOSKELETAL SYSTEM

This benefit covers specified conditions of the muscle, bones, joints and nerves. The claimant must be treated by a specialist, registered with the Health Professions Council of South Africa. The diagnosis must be supported by the relevant investigations and reports.

DISEASE	CATEGORY A	LIFETIME IMPACT SCORE	CATEGORY B
Hand	Total loss of use of hand at the level of the wrist Manual occupation: Failure of the hand function ADLs, as assessed by an occupational therapist, with all three of the following hand function impairments: ■ Grip strength below two standard deviations of average age and gender values (Mathiowetz) ■ Pinch strength below 2 standard deviations of average age and gender values (Mathiowetz) ■ Coordination/dexterity below norm according to coordination test ■ Or completely unable to perform 2 of the following three hand function ADLS: grasping/holding, pinching, coordination/dexterity	7º	Loss of use of more than three fingers, one of which includes either thumb or index finger
Upper limb	80% impairment of dominant upper limb** or 100% impairment of non-dominant upper limb** or bilateral upper limb impairment equivalent to 48% WPI** Manual occupation: ■ 50% impairment of either upper limb, or a bilateral upper limb impairment equivalent to a 30% WPI**	7º	60% impairment of dominant upper limb** or 90% impairment of non-dominant upper limb**or bilateral upper limb impairment equivalent to 36% WPI** Manual occupation: ■ 30% impairment of either upper limb or a bilateral upper limb impairment equivalent to a WPI of 18%**
Lower limb	80% impairment of lower limb** Manual occupation: ■ 50% impairment of lower limb or bilateral lower limb impairment equivalent to a 20% WPI**	8º	60% impairment of lower limb** Manual occupation: ■ 30% impairment of lower limb or bilateral lower limb impairment equivalent to a 12% WPI**
Upper and lower limb	Combined upper and lower limb impairment equivalent to a 50% WPI** Manual occupation: ■ Combined upper and lower limb impairment equivalent to a 35% WPI**	7º	Combined upper and lower limb impairment equivalent to a 40% WPI** Manual occupation: ■ Combined upper and lower limb impairment equivalent to a 25% WP**

DISEASE	CATEGORY A	LIFETIME IMPACT SCORE	CATEGORY B
Spine	Cauda equina syndrome or loss of bowel or bladder integrity or paraplegia or quadriplegia or cervical spine impairment resulting in 30% WPI after surgery, unless surgery is medically contra-indicated, or thoracic spine impairment resulting in 22% WPI after surgery, unless surgery is medically contra-indicated, or lumbar spine impairment resulting in 33% WPI after surgery, unless surgery is medically contraindicated, or permanent inability to perform three Self-care Activities of Daily Living	9º	Radiculopathy and significant extremity impairment as indicated by marked atrophy, total loss of reflexes and dermatomal sensory loss and muscle weakness of 3/5 or worse or cervical spine impairment resulting in 24% WPI after surgery, unless surgery is medically contra-indicated, or thoracic spine impairment resulting in 16% WPI after surgery, unless surgery is medically contra- indicated, or lumbar spine impairment resulting in 24% WPI after surgery, unless surgery is medically contra-indicated, or permanent inability to perform two Self-care Activities of Daily Living
Soft tissue	Severe facial disfigurement as per AMA Guide Class Four or 25% body surface area full thickness burns resulting in contractures with 50% WPI**	6º	Severe facial disfigurement or distortion because of trauma or accidental injury of 25% of the face with involvement of the nose, eye, ear or mouth or 15% body surface area full thickness burns resulting in contractures with 30% WPI**

To qualify for a claim under a single spinal region as specified above, multiple level disc pathology must be present with bilateral or multiple level radiculopathy at the appropriate levels. Non-verifiable radiculopathy is excluded from this benefit.

º Additional *age*-based score must be added to the impact score

* Disorders include muscle, bone, nerve or joint impairments

** Based on AMA Guides to the Evaluation of Permanent Impairment (latest edition) – examining doctor will be provided with specific valuating protocols

*** The coordinated use of both hands to perform Activities of Daily Living or work. WPI = Whole Person Impairment.

3.1 | GENERAL PROVISIONS

- The *life-changing event* must have occurred after the start of the benefit.
- Symptoms and signs must be compatible with the diagnosis. The relevant specialist investigations (including blood tests, imaging, histology and other tests) must confirm the diagnosis.
- Inability to perform Activities of Daily Living must be due to and compatible with the diagnosis of the *life-changing event*.
- Psychiatric illness, chronic fatigue syndrome (and synonyms) and fibromyalgia (and synonyms) and related terms are not covered under the Severe Illness Benefit.
- Major organ transplant claims include being on an official South African or international transplant waiting list for the relevant transplant.
- Specialist reports are required to assess all claims. A specialist is a medical practitioner registered as a specialist with the Health Professions Council of South Africa. Reports and notes from traditional and cultural healers not registered with the Health Professions Council of South Africa will not be considered valid and will not be used in the assessment of any claim.
- The claims definitions in the *Discovery Group Risk* Severe Illness Benefit are compliant with the ASISA Standard on Disclosures for Critical Illness Products. The document is available at www.asisa.org.za.

The *Discovery Group Risk* Disclosure Grid (referred to in the ASISA Standard on Disclosures for Critical Illness Products) is

SEVERITY LEVEL	A	B	C	D
Heart Attack	100%	75%	50%	25%
Coronary artery bypass graft (CABG)	100%	50%	50%	50%
Stroke	100%	100%	100%	50%
Cancer	100%	100%	50%	25%

Note that the percentages shown in the table relate to the percentages of the benefit payment, payable under each severity level as per the ASISA Standard on Disclosures for Critical Illness Products, and so give a mapping of our severity levels to those of ASISA. See clause How the severity levels affect benefit payments (15.1.6) for more details on how severity levels affect benefit payments.

- Activities of Daily Living (ADLs) are defined in Appendix 6: Activities of Daily Living.
- Note that claims relating to conditions that may have been identified because of screening tests (for example, genetic tests), but where there are no medical symptoms of the disease, will not be covered under these definitions.

3.2 | CANCER BENEFIT

Cancer is a malignant tumour characterised by the uncontrolled growth of cells, invasion of normal tissue and spread to distant organs. The term malignant tumour includes leukaemia, lymphoma and sarcoma.

Pre-malignancy and carcinoma in situ tumours, except for carcinoma in situ of the breast treated by mastectomy, are not covered under this benefit. However, a list of in situ cancers are covered, as set out in Appendix 5: Early Cancer Benefit assessment. Brain tumours are covered under the Nervous System Benefit. Specified neuroendocrine tumours are covered under the Endocrine and Metabolic Diseases Benefit.

A current internationally recognised staging system will be used to assess the claim.

A report from the treating specialist, including the histology and stage of the cancer, the relevant imaging reports and other tests, must confirm the diagnosis. A liquid biopsy and cell free DNA without histological evidence of invasive cancer cannot be considered for a claim. A specialist is a person registered with the Health Professions Council of South Africa in a relevant specialty.

Once a payment for a cancer listed under a Severity A cancer has been made, further cancer claims will only be considered for unrelated cancers. An unrelated cancer is a cancer that is not regarded as being of the same tissue and the same organ. The unrelated cancer will be considered as a new *life-changing event*.

Multiple cancer claims for related cancers will be assessed as progressive claims. A related cancer is regarded as cancer of the same tissue type and organ, for example breast cancer progressing from stage 1 to stage 2. There is no time limit on this.

Transformation of a cancer or heterogeneity of a tumour on molecular grounds will not be regarded as an unrelated cancer.

Where stem cell or bone marrow transplants are performed as treatment for cancer, only one Severity A claim will be paid. Only one bone marrow or stem cell transplant will be paid for during the lifetime of the *Plan*.

If two cancers of two different tissue types are present and have manifested independently of each other, then each cancer will be considered as a separate *life-changing event*. The Minimum Protected Fund (if applicable), the limits of the Life Fund, and the terms of the Essential and Classic Life Plan payment rules will apply. The two claims will be regarded as claims within the same body system.

Brain tumours are assessed according to the World Health Organization's grading. Pituitary microadenomas are specifically excluded under this benefit.

Where a claim is defined for both the condition and its treatment, only the claim with the higher applicable severity pay out percentage will be paid.

Severity A

- Stage IV cancer
- Stage III cancer
- Acute myelocytic leukaemia
- Chronic lymphocytic leukaemia: Stage III or IV on the Rai staging system
- Chronic myelocytic leukaemia
- Acute lymphoblastic leukaemia
- Bone marrow transplant or stem cell transplant
- Severe aplastic anaemia as defined by the International Aplastic Anaemia Study Group
- Multiple myeloma: Stage III on the Durie-Salmon scale or equivalent on an appropriate international staging system
- Hodgkin's or non-Hodgkin's lymphoma: Stage III or IV on the Ann Arbor staging system or equivalent on an appropriate staging system
- Prostate cancer T4N0M0 or with affected lymph nodes or distant metastases
- Malignant melanoma stage III or IV
- Neuroendocrine tumour stage III or IV
- Carcinoid syndrome with evidence of liver metastasis
- Borderline ovarian tumours stage III and IV
- Pseudomyxoma peritonei with disseminated peritoneal adenomucinosis
- Post-transplant lymphoproliferative disorders
- Gastrointestinal stromal tumours stage III and IV
- Dermatofibrosarcoma protuberans stage III and IV

Severity C

- Stage II cancer unless specified elsewhere
- Chronic lymphocytic leukaemia: Stage II on the Rai staging system
- Multiple myeloma: Stage 1 or 2 on the Durie-Salmon scale or equivalent on an appropriate international staging system
- Hodgkin's or non-Hodgkin's lymphoma: Stage II on the Ann Arbor staging system or equivalent on an appropriate staging system
- Prostate cancer T3N0M0
- Malignant melanoma stage II
- Basal cell carcinoma and Squamous cell carcinoma stage III
- Neuroendocrine tumour stage II
- Hairy cell leukaemia with myelofibrosis transformation
- Borderline ovarian tumours Stage II
- Gastrointestinal stromal tumours stage II
- Dermatofibrosarcoma protuberans stage II

Severity D

- Stage 1 cancer unless specified elsewhere
- Chronic lymphocytic leukaemia: Stage 0 or I on the Rai staging system
- Moderate chronic aplastic anaemia as defined by the

International Aplastic Anaemia Study Group
- Hodgkin's or non-Hodgkin's lymphoma: Stage I on the Ann Arbor staging system or equivalent on an appropriate staging system
- Prostate cancer T1N0M0 with Gleason score higher than 6
- Prostate cancer T2N0M0
- Malignant melanoma stage I
- Mastectomy for carcinoma in situ
- Prophylactic mastectomy
- Hairy cell leukaemia
- Neuroendocrine tumour stage I
- Borderline ovarian tumours stage I
- Gastrointestinal stromal tumours stage I

Severity E
- Myelodysplastic syndrome
- Myelofibrosis
- Overlap myelodysplastic/myeloproliferative neoplasms according to WHO classification

Severity G
- Basal cell carcinoma stage I or II treated with skin graft or skin flap or greater than 2 cm (only one payment)
- Squamous cell carcinoma stage I or II treated with skin graft or skin flap or greater than 2 cm (only one payment)
- Prostate cancer T1N0M0 with Gleason score of 6 or lower
- Myeloproliferative disorders: Polycythaemia vera, essential thrombocytosis

3.3 | HEART AND ARTERY BENEFIT

This benefit covers conditions of the heart and arteries as specified below. Only one payment will be made per coronary event. A single coronary event is defined as incorporating all cardiac pathologies or procedures that occur within 30 days of each other.

One payment will be made for pacemakers and one payment will be made for permanent defibrillator implants.

A cardiologist, cardiothoracic surgeon, neurosurgeon, vascular surgeon or specialist physician must confirm the diagnosis. Relevant special investigations such as ECGs, echocardiograms, other imaging studies and blood tests must confirm the diagnosis.

Permanence of the ejection fraction impairment will be established in two measurements taken three months apart unless otherwise proven to *our* satisfaction.

Severity A
- Bilateral carotid artery endarterectomy or bypass surgery
- Coronary artery bypass graft to three or more vessels
- Permanent ejection fraction of less than 40%
- Severe myocardial infarction with an ejection fraction of less than 40% at least 14 days after the acute myocardial infarction
- SCIDEP Level A heart attack
- SCIDEP Level A coronary artery bypass graft
- Heart transplant
- Heart and lung transplant
- Chronic diastolic heart failure: NYHA Class IV with raised proBNP levels according to *age* bands (below 50 years: proBNP more than 450 pg/ml; 50 years and above proBNP more than 900 pg/ml)
- Heart valve replacement
- Peripheral arterial disease with gangrene or amputation
- Surgical repair of the aortic root
- Surgical repair of thoracic or thoracoabdominal aortic aneurysm

Severity B
- Peripheral arterial disease with absent Doppler readings, persistent claudication and leg ulcers
- Permanent ejection fraction between 40% and 50%
- Myocardial infarction with an ejection fraction of less than 50% at least 14 days after the acute infarction
- SCIDEP Level B heart attack
- Surgical repair of an abdominal aortic aneurysm
- Heart valve repair

Severity C
- Coronary artery bypass graft to one or two vessels
- Unilateral carotid artery endarterectomy or bypass
- Aortoiliac occlusive disease
- Moderate myocardial infarction of specified severity, as evidenced by any one of the following three criteria:
  - Compatible clinical symptoms and new pathological Q waves
  - Raised cardiac markers and compatible clinical symptoms
  - Raised cardiac markers and characteristic ECG changes defined as either pathological Q waves or ST segment and T wave changes indicative of myocardial ischaemia or myocardial infarction
- Under criteria 2 and 3, raised cardiac markers are defined as either:
  - Troponin T of 1.0 ng/ml or more (1,000 ng/L for high sensitivity troponin T), or equivalent e.g. Abbott ARCHITECT TnI
  - CK-MB mass of more than two times the upper limit of normal in the acute presentation phase
  - CK-MB mass of more than four times the upper limit of normal after intervention
  - Total CPK elevation of more than two times the upper limit of normal with at least 6% being CK-MB
- SCIDEP Level C heart attack
- SCIDEP Coronary artery bypass graft (CABG) Level B, C, D
- Open heart surgery to correct a structural abnormality in the heart, for example, ventricular aneurysm,

hypertrophic cardiomyopathy, atrial myxoma or radical pericardiectomy
- Permanent defibrillator insertion

Severity D
- Minimally invasive pericardiectomy
- Surgical repair of an aneurysm of any of the following branches of the aorta: iliac, renal, splenic, subclavian, superior mesenteric artery
- Surgical repair of a totally occluded major peripheral artery: iliac, femoral, popliteal, tibial, peroneal, renal, splenic, subclavian, superior mesenteric or brachial artery
- Stenting of carotid artery stenosis in one or both carotid arteries
- Permanent pacemaker insertion for documented arrhythmia
- Mild myocardial infarction of specified severity, as evidenced by all three of the following three criteria:

Compatible clinical symptoms
Imaging or ECG evidence
Raised cardiac markers

- Under criterion 2, imaging or ECG evidence is defined as either:
  - Characteristic ECG changes, for example ST segment and T wave changes indicative of myocardial ischaemia or myocardial infarction
  - Angiographic evidence of stenosis of 50% or more of a coronary artery treated with a stent
  - Hypokinesis of the myocardium on echocardiogram.
  - Under criterion 3, raised cardiac markers are defined as either:
  - Troponin T of 0.5 ng/ml (500 ng/L or more for high sensitivity troponin T), or equivalent
  - CK-MB mass of more than the upper limit of normal up to two times the upper limit of normal in the acute presentation phase
  - Total CPK elevation of more than two times the upper limit of normal with at least 6% being CK-MB
- SCIDEP Level D heart attack
- Heart attack with hsTrop T between 100 and 500 ng/L or equivalent e.g. Abbott ARCHITECT TnI above 300 ng/L; with angiographic evidence of coronary artery disease

Severity E
- Acute rheumatic fever with a three-day ICU or cardiac care unit stays due to cardiac complications
- Endocarditis or pericarditis with more than a three-day ICU or cardiac care unit stay
- Acute heart failure with more than a three-day ICU or cardiac care stay

Severity F
- Acute coronary syndrome with hsTrop T of between 15 and 99 ng/L and angiographic evidence of coronary artery disease. Coronary artery spasm without evidence of coronary artery disease is excluded from this definition
- Percutaneous coronary intervention (angioplasty with or without stent)
- Minimally invasive cardiac surgery not specified elsewhere
- Pathway ablation
- Medically treated arteritis or endarteritis with more than a five-day hospital stay
- Surgical repair of symptomatic atrial or ventricular septal defect

Severity G
- Electrical cardioversion
- Chronic atrial fibrillation that persists despite electrophysiological intervention by cardiologist
- Intravenous anti-arrhythmic therapy administered as medical emergency
- Intravenous inotropic support for more than two days
- Malignant hypertension with papilloedema and a diastolic pressure of higher than 120 mmHg on optimal treatment

3.4 | NERVOUS SYSTEM BENEFIT

The claimant must be treated by a neurologist or neurosurgeon, registered with the Health Professions Council of South Africa. This benefit covers specified conditions of the brain, spinal cord nerves and arteries to the brain.

Stroke is defined as death of brain tissue due to inadequate blood supply or haemorrhage within the skull, resulting in neurological deficit lasting longer than 24 hours, confirmed by neuro-imaging investigation and appropriate clinical findings by a specialist neurologist.

Symptoms and signs, as well as imaging (computerised tomography or magnetic resonance imaging), must confirm a new stroke. Transient ischaemic attacks are specifically excluded.

A Severity D payment will be paid on receipt of objective medical and radiological evidence from the treating neurologist confirming the diagnosis of an acute stroke. A further assessment of the stroke claim will be made on receipt of a full specialist neurologist's report three months after the stroke.

Neurological deficits and ADL impairments must be compatible with the diagnosis and objective medical evidence. Permanence will be established after 90 days, unless otherwise proven to *our* satisfaction.

Functional Neurological Disorders are excluded from this benefit.

Brain tumours are assessed according to the World Health Organization's grading. Pituitary microadenomas are specifically excluded under this benefit.

Severity A
- Stroke with permanent inability to perform one category of the Activities of Daily Living Score Sheet (as defined in Appendix 6: Activities of Daily Living)

- Permanent inability to perform four or more categories of the Activities of Daily Living Score Sheet (as defined in Appendix 6: Activities of Daily Living)
- Permanent inability to perform three or more of the Self-care Activities of Daily Living (as defined in Appendix 6: Activities of Daily Living)
- Total permanent loss of speech, including expressive or receptive aphasia
- Quadriplegia
- Paraplegia
- Hemiplegia or diplegia
- Glasgow Coma Scale of less than 8/15 lasting longer than 96 hours
- Definite diagnosis of motor neuron disease
- WHO grade III and IV brain tumours
- Definite diagnosis of dementia with permanent MMSE score of 10 or less out of 30 as confirmed by formal neuropsychometric testing

Severity B

- The permanent inability to perform three categories of Activities of Daily Living
- The permanent inability to perform two Self-care Activities of Daily Living
- Extracranial monoplegia

Severity C

- Stroke with permanent, minor neurological deficit, but still able to perform six categories of the Activities of Daily Living
- The permanent inability to perform one Self-care Activity or two categories of the Activities of Daily Living
- Craniotomy
- WHO grade II brain tumours
- Ventriculostomy or insertion of a shunt for the treatment of hydrocephalus
- Definite diagnosis of dementia with permanent MMSE score of 20 or less out of 30 as confirmed by formal neuropsychometric testing

Severity D

- Definite diagnosis of an acute stroke
- Depressed skull fracture with brain laceration
- WHO grade I brain tumours
- Subarachnoid haemorrhage not requiring surgery
- Definite diagnosis of multiple sclerosis
- Definite diagnosis of generalised myaesthenia gravis confirmed with positive serology and electrophysiological testing
- Parkinson's disease confirmed by neurologist and SPECT imaging
- Parkinson-plus syndromes as confirmed by a neurologist under one of the following categories:
  - Multiple system atrophy
  - Progressive supranuclear palsy
  - Dementia with Lewy bodies
  - Corticobasal syndrome
  - Parkinsonism-dementia ALS complex
- Intracranial endovascular procedures
- Pituitary macroadenomas bigger than 10 mm or hypophysectomy
- Brain abscess

Severity E

- Depressed skull fracture
- Glasgow Coma Scale less than 8/15 for longer than 72 hours but less than 96 hours

Severity F

- Stereotactic radiosurgery
- Bacterial meningitis

Severity G

- Cerebral oedema
- Intubation and ventilation for status epilepticus

3.5 | GASTROINTESTINAL BENEFIT

This benefit covers specified conditions of the liver, pancreas, biliary system, and upper and lower gastrointestinal system. Conditions related to drug or alcohol abuse are not covered under this benefit.

The claimant must be treated by a specialist physician, gastroenterologist or surgeon registered with the Health Professions Council of South Africa. The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations such as blood tests, histology or imaging.

Severity A

- Chronic liver disease classified as *Child* Pugh Class C
- Primary sclerosing cholangitis
- Fulminant hepatic failure
- Liver transplant
- Pancreas transplant
- Portal hypertension with either varices, or refractory ascites and splenomegaly, or refractory pancytopenia
- Primary biliary cirrhosis
- Complete pancreatectomy

Severity B

- Chronic liver disease classified as *Child* Pugh Class B
- Permanent colostomy
- Permanent ileostomy
- Total colectomy

Severity C

- Chronic liver disease classified as *Child* Pugh Class A
- Chronic pancreatitis complicated by insulin-dependent diabetes mellitus or confirmed malabsorption syndrome
- Confirmed diagnosis of portal hypertension
- Repeated open surgical procedures to the small bowel or colon for Crohn's disease or ulcerative colitis. All procedures within 90 days will be considered as one event

- Chronic persistent hepatitis (Knodel score of at least 13 out of 22)

Severity D
- Partial hepatectomy of at least one-third of the organ
- Partial pancreatectomy

Severity E
- Loss of more than one-third of the tongue

Severity F
- Tracheal oesophageal fistula
- Chronic rectal fistula despite surgical repair

Severity G
- Peritonitis due to bowel perforation
- Drainage of pancreatic cyst or abscess

3.6 | CONNECTIVE TISSUE DISEASES BENEFIT

This benefit covers the following connective tissue diseases: progressive systemic sclerosis, seropositive rheumatoid arthritis, systemic lupus erythaematosus (SLE), sarcoidosis, polyarteritis nodosa, giant-cell arteritis, Wegener's granulomatosis, dermatomyositis, polymyositis, Ehlers-Danlos syndrome, Behçet's disease, and pseudoxanthoma elasticum.

Mixed connective tissue diseases or overlap syndromes will be paid as a single connective tissue disease.

The claimant must be treated by a specialist rheumatologist registered with the Health Professions Council of South Africa. The diagnosis must be made in terms of current internationally recognised criteria and supported by the relevant histology, serology and imaging.

Severity A
- Permanent inability to perform four or more categories of the Activities of Daily Living Score Sheet due to a listed connective tissue disease
- Permanent inability to perform three or more Self-care Activities of Daily Living due to a listed connective tissue disease
- Multiple organ dysfunction meeting two defined Severity B criteria under two or more body systems due to a connective tissue disease

Severity B
- Definite objective evidence of involvement of two or more organs excluding the skin as an organ
- Permanent inability to perform two Self-care Activities of Daily Living

Severity C
- Joint replacement or fusion or reconstruction because of a listed connective tissue disease (Disc replacements are not considered joint replacements)
- Permanent inability to perform one Self-care Activity of Daily Living

Severity D
- Definite diagnosis of a listed connective tissue disease

Severity E
- Pseudoxanthoma elasticum
- Ehlers-Danlos syndrome
- Behçet's disease

3.7 | UROGENITAL AND KIDNEY BENEFIT

This benefit covers specified conditions of the urogenital tract and kidneys. Surgery for gender reassignment is not covered under this benefit. The claimant must be treated by a specialist nephrologist or urologist registered with the Health Professions Council of South Africa.

The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations such as blood tests, histology or imaging.

Severity A
- Chronic renal failure with ongoing, permanent haemodialysis or a GFR of less than 15 ml/min/1.73m2 according to the internationally recommended GFR equation
- Renal transplant
- Ongoing permanent peritoneal dialysis

Severity B
- Chronic renal failure with a permanent GFR of less than 30 ml/min/1.73m2 and evidence of progressive renal failure as evidenced by sustained decrease of GFR of more than 5 ml/min per year, according to the internationally recommended GFR equation

Severity C
- Acute renal failure requiring more than five treatments of haemodialysis or more than five days of chronic renal replacement therapy (CRRT)
- Any disease or disorder requiring complete nephrectomy (donors excluded)
- Total amputation of the penis
- Any disease or disorder requiring complete cystectomy
- Confirmed gross or confluent renal cortical necrosis involving more than two-thirds of the renal cortex

Severity D
- Partial nephrectomy of at least one-third of the kidney
- Partial cystectomy resulting in a loss of at least one-third of the functional capacity of the bladder
- Partial amputation of the penis (circumcision is excluded)
- Bilateral orchidectomy
- Open kidney surgery for renal or renovascular disease or injury
- Vesicovaginal or rectovaginal fistula

Severity E
- Confirmed diagnosis of nephritic syndrome

- Confirmed diagnosis of nephrotic syndrome with a proteinuria of 3 g per 24 hours and a GFR of <60 ml/min present for six months
- Unilateral orchidectomy

Severity F
- Urethral fistula
- Chronic tubule-interstitial nephritis

Severity G
- Renal abscess
- Surgical repair of a stricture of the ureter or the urethra (one payment only)

3.8 | RESPIRATORY DISEASE BENEFIT

This benefit covers specified conditions of the respiratory system. The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations such as lung function tests, blood tests, histology or imaging.

The claimant must be treated by a pulmonologist registered with the Health Professions Council of South Africa. Lung function tests should be performed by a pulmonologist. The test should include pre- and post-dilatation measurements and show less than 5% variation between three successive FVC or FEV1 readings. Two DCO tests must be done with results within three units. Corrections must be made for anaemia and carboxyhaemoglobin on the DCO test.

Severity A
- Presence of irreversible cor pulmonale
- Confirmed diagnosis of pulmonary hypertension groups 1 to 5, including pulmonary veno-occlusive disease, with a mean pulmonary artery pressure of greater than 30 mmHg
- Lung transplant
- Heart and lung transplant
- Chronic obstructive or restrictive lung disease with a permanent FEV1 or FVC or DCO of 40% or less than predicted
- Pulmonary thromboendarterectomy performed by sternotomy

Severity B
- Requiring removal of more than one lobe of the lung
- Pulmonary venous occlusive disease not specified elsewhere
- Chronic obstructive or restrictive lung disease with a permanent FEV1 or FVC or DCO of 41% to 45% of predicted

Severity C
- Veno-caval filter inserted for recurrent pulmonary emboli
- Chronic obstructive or restrictive lung disease with permanent FEV1 or FVC or DCO of 46% to 49% of predicted

Severity D
- Lung abscess
- Drainage of empyema
- Bronchopleural fistula
- Removal of one lobe of the lung

Severity E
- Confirmed diagnosis of pneumoconiosis
- Confirmed diagnosis of bronchiectasis with at least two impaired lung function readings, taken at least three months apart, with FEV1 of 60% or less
- Pleurectomy
- Decortication
- Idiopathic interstitial pneumonia excluding respiratory bronchiolitis-associated interstitial pneumonia (respiratory bronchiolitis) and bronchiolitis obliterans organising pneumonia (BOOP)
- Pulmonary embolus diagnosed on imaging

Severity F
- Drainage of pleural effusion
- Near drowning requiring full resuscitation with immersion syndrome, hypoxia, acidosis, and pulmonary oedema and ventilatory support

Severity G
- Hyperbaric oxygen therapy for decompression sickness
- Mechanical ventilation for status asthmaticus

3.9 | ADVANCED AIDS/ACCIDENTAL HIV BENEFIT

This benefit covers advanced AIDS and accidental human immunodeficiency virus (HIV) seroconversion as specified below. A positive HIV antibody test and confirmatory polymerase chain reaction test is needed to confirm the diagnosis.

The diagnosis of the specified AIDS-defining conditions must be supported by compatible signs and symptoms and confirmed by relevant special investigations such as blood tests, antibody tests and histology or imaging.

Severity A
- Advanced AIDS evidenced by positive blood tests as specified above, and a CD4 cell count of less than 50 while on antiretroviral therapy for at least three months
- Advanced AIDS evidenced by positive blood tests as specified above, and a CD4 cell count of less than 200 while on antiretroviral therapy for at least three months, and diagnosis of at least one of the following diseases:
  - Kaposi's sarcoma
  - Pneumocystis jirovecii pneumonia (PJP)
  - Confirmed progressive multifocal leukoencephalopathy
  - Active extra-pulmonary tuberculosis
  - Cryptococcosis infection
  - Disseminated non-tuberculous mycobacteria infection

- Confirmed diagnosis of any other condition as defined as stage 4 on the WHO clinical criteria list
- Advanced AIDS evidenced by positive blood tests as specified above, and a CD4 cell count of less than 200 while on antiretroviral therapy for at least three months, with definite diagnosis of any three conditions defined as stage 3 AIDS on the WHO clinical criteria list
- Accidental HIV because of the following:
  - Accidental needlestick injury while rendering professional duties as a doctor, dentist, paramedic or nurse. A PCR or ELISA test confirming negative HIV status must be done within 24 hours of the needlestick injury
  - A road traffic *accident*
  - The transfusion of infected blood from a transfusion service recognised by *us*
  - Receiving an organ transplant where the organ was previously infected with HIV
- Rape or criminal assault or any other violent crime. The case must have resulted in the opening of a criminal case by the police. A PCR or Elisa test confirming negative HIV status must be done within 24 hours of the assault and a medical examination performed directly after the assault

3.10 | MUSCULOSKELETAL BENEFIT

This benefit covers specified conditions of the muscle, bones, joints and nerves.

The claimant must be treated by a specialist registered with the Health Professions Council of South Africa. The diagnosis must be supported by the relevant investigations and reports.

Severity A

- More than 25% full thickness body surface area burns
- Total and permanent loss of use or amputation of both lower limbs at the level of the ankle or higher (proximal to the ankle)
- Total and permanent loss of use or amputation of both upper limbs at the level of the wrists or higher (proximal to the wrist)
- Total and permanent loss of use or amputation of one upper limb above (proximal to) the wrist and one lower limb above (proximal to) the ankle

Severity B

- Full thickness burns involving 15 to 25% of the body surface area
- Total and permanent loss of use or amputation of a lower limb at the level of the ankle or higher (proximal to the ankle)
- Total and permanent loss of use or amputation of the upper limb above (proximal to) the wrist or higher

Severity C

- Total and permanent loss of use or amputation of a hand below (distal to) the wrist
- More than 10% full thickness body surface area burns

Severity E

- Reattachment surgery for a traumatic amputation of any limb (arm or leg)
- Reconstruction surgery for Le Fort II or III facial fractures or any multiple facial fracture, including the orbit

Severity F

- Chronic osteomyelitis
- Reconstructive surgery to hands or feet involving bone graft and skin flap
- Poliomyelitis resulting in permanent paralysis
- Complete amputation of two or more full fingers or total toes
- Suture of a major nerve to restore function to hand or limb

Severity G

- Emergency spinal surgery or traction for spine instability within seven days of an *accident*
- Complete replacement of any joint due to a chronic disease process (Disc replacements are not considered joint replacements)
- Definite diagnosis of Paget's disease of bone
- Complete amputation of a full finger or total toe
- Osteoporosis resulting in collapse of more than one vertebra or hip fracture in under 65 years old
- Resurfacing of a knee, hip or shoulder joint (one payment only)

3.11 | EYE BENEFIT

This benefit covers specified conditions of the globe, retina, optic nerve, cornea and orbit.

The claimant must be treated by an ophthalmologist registered with the Health Professions Council of South Africa. The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations such as visual acuity tests or imaging.

Severity A

- Complete blindness (no light perception)

Severity B

- Best-corrected binocular Snellen rating of less than 20/125
- Enucleation of eye

Severity C

- Optic nerve atrophy
- Permanent hemianopia
- Complete blindness in one eye

Severity D

- Confirmed diagnosis of retinitis pigmentosa

Severity E

- Corneal transplant
- Optic neuritis (only one payment will be made)
- Permanent visual acuity impairment of 20/200 or worse in one eye

Severity F

- Retinal detachment
- Macular degeneration or dystrophy
- Progressive panuveitis not responsive to pharmacological treatment

Severity G

- Orbital abscess

3.12 | EAR, NOSE AND THROAT BENEFIT

This benefit covers specified conditions of the ear and neural pathways that relate to hearing, as well as specified conditions of the nose, paranasal sinuses, and venous sinuses of the brain.

The claimant must be treated by a specialist ear, nose and throat surgeon, registered with the Health Professions Council of South Africa.

The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations such as blood tests, histology or imaging.

Severity A

- Hearing loss of 90 dB or more in both ears, measured over the frequencies 500 Hz, 1,000 Hz, 2,000 Hz and 3,000 Hz in two measurements six months apart, with a hearing aid

Severity B

- Binaural hearing loss of more than 75% (as defined by the AMA guide)
- Hearing loss of 70 dB in both ears, measured over the frequencies 500 Hz, 1,000 Hz, 2,000 Hz, 3,000 Hz in two measurements six months apart, with a hearing aid

Severity C

- Aby dural sinus thrombosis

Severity D

- Acoustic neuroma
- Cortical mastoidectomy
- Binaural hearing loss of more than 60% (as defined by the AMA guide)
- Cochlear implant

Severity E

- Chronic petrositis
- Osteomyelitis of sinuses

Severity F

- Tympanosclerosis with hearing loss of 70 dB in one ear, measured over the frequencies 500 Hz, 1,000 Hz, 2,000 Hz, 3,000 Hz in two measurements six months apart, with a hearing aid
- Hearing loss of 70 dB in one ear, measured over the frequencies 500 Hz, 1,000 Hz, 2,000 Hz, 3,000 Hz in two measurements six months apart, with a hearing aid
- Otosclerosis

Severity G

- Nose reconstruction because of a disease (trauma and cosmetic procedures excluded)

3.13 | ENDOCRINE AND METABOLIC DISEASES BENEFIT

This benefit covers specified conditions of the thyroid, pituitary or adrenal gland. Only one payment will be made for each disease.

The claimant must be treated by a specialist endocrinologist or surgeon registered with the Health Professions Council of South Africa.

The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations such as blood tests, histology or imaging.

Severity D

- ICU or high-care admission for treatment of a thyroid storm
- Hypophysectomy

Severity E

- Diabetes insipidus
- Acute adrenal crisis or diagnosis of Addison's disease
- Sheehan's syndrome or Simmond's disease

Severity F

- Diabetic coma (one event only)
- Conn's syndrome
- Cushing's syndrome
- Phaeochromocytoma or insulinoma
- Glycogen storage disease
- Lipid storage disease
- Surgical removal of a benign neuroendocrine tumour
- Adrenalectomy
- Confirmed amyloidosis of any of the following organs: heart, kidneys, liver, spleen, tongue

Severity G

- Acromegaly
- Parathyroid tetany

3.14 | *CHILD* SEVERE ILLNESS BENEFIT

This benefit covers the specified conditions affecting *children* under 18 years of *age*, as well as the specified conditions under the main Severe Illness Benefit. The claimant must be treated by a paediatrician or paediatric surgeon registered with the Health Professions Council of South Africa.

The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations such as blood tests, histology or imaging.

Childhood cancers must be diagnosed by a specialist and confirmed by the relevant investigations, for example, blood tests, histology or imaging, and treated with accepted oncology modalities, for example, surgery, chemotherapy, bone marrow transplant or radiotherapy.

Severity A

- Childhood cancer
- Diagnosis of a condition resulting in global developmental delay, confirmed by poor performance in two or more of the the below developmental domains. Poor performance is defined as two standard deviations below the norm or equivalent:
  - Motor
  - Speech and language
  - Cognition and personal
  - Social and daily living skills
- Autism spectrum disorder with intellectual impairment
  - Diagnosis and assessment of Autism Level 3 (requiring very substantial support) in social communication or interaction
  - Severe impairments in functioning, very limited initiation of social interactions, minimal response to social overtures from others
  - **Examples include:**
- Non-existent communication, no attempts to share thoughts or interests or make requests
- Communication consists only of physical gestures with no eye contact or spoken language
- Communications that consists of words that are repeated from other contexts for example echolalia

AND

- Repetitive or restrictive behaviour that requires very substantial support
- Behaviours significantly interfere with function in all spheres, extreme difficulty coping with changes, great distress or difficulty changing focus or action.
- **Examples include:**
  - Rocking or spinning the body, objects, flapping hands
  - Engaging in unusual sensory exploration such as sniffing or mouthing objects
  - Rigid adherence to routines that interferes with functional activities
- The diagnosis and assessment of the severity level must be confirmed by a *child* neurologist, *child* psychiatrist or development paediatrician.

Severity C

- Surgical correction of congenital heart disease

Severity E

- Surgical repair of a congenital anomaly
- Rheumatic fever with cardiac complications
- Type 1 diabetes mellitus

Severity F

- Poliomyelitis with permanent paralysis

Severity G

- Juvenile rheumatoid arthritis, septic arthritis, osteomyelitis
- Hirschsprung's disease
- Surfactant therapy
- Cleft lip or palate repair
- Disorders of amino acid metabolism

4.1 | GENERAL PROVISIONS

- The life-changing event must have occurred after the start of the benefit.
- Symptoms and signs must be compatible with the diagnosis. The relevant specialist investigations (including blood tests, imaging, histology and other tests) must confirm the diagnosis.
- Major organ transplant claims include being on an official South African or international transplant waiting list for the relevant transplant.
- Specialist reports are required to assess all claims. A specialist is a medical practitioner registered as a specialist with the Health Professions Council of South Africa. Reports and notes from traditional and cultural healers not registered with the Health Professions Council of South Africa will not be considered valid and will not be used in the assessment of any claim.
- The claims definitions in the Discovery Group Risk Severe Illness Benefit are compliant with the ASISA Standard on Disclosures for Critical Illness Products. The document is available at www.asisa.org.za.

The Discovery Group Risk Disclosure Grid (referred to in the ASISA Standard on Disclosures for Critical Illness Products) is:

- Severity A – 100%
- Severity C – 50%
- Severity D – 25%
- Severity E – 15%
- Severity G – 5%

Note that the percentages shown above relate to the percentages of the benefit payment, payable under each severity level as per the ASISA Standard on Disclosures for Critical Illness Products, and so give a mapping of our severity levels to those of ASISA. See clause How the severity levels affect benefit payments for more details on how severity levels affect benefit payments.

Note that claims relating to conditions that may have been identified because of screening tests (for example, genetic tests), but where there are no medical symptoms of the disease, will not be covered under these definitions.

4.2 | CANCER CONDITIONS COVERED

Cancer is a malignant tumour characterised by the uncontrolled growth of cells, invasion of normal tissue and spread to distant organs. The term malignant tumour includes leukaemia, lymphoma and sarcoma.

Pre-malignancy and carcinoma in situ tumours, except for carcinoma in situ of the breast treated by mastectomy, are not covered under this benefit. However, a list of in situ cancers are covered, as set out in Appendix 5: Early Cancer Benefit assessment.

A current internationally recognised staging system will be used to assess the claim. A report from the treating specialist, including the histology and stage of the cancer, the relevant imaging reports and other tests, must confirm the diagnosis. A liquid biopsy and cell free DNA without histological evidence of invasive cancer cannot be considered for a claim. A specialist is a person registered with the Health Professions Council of South Africa in a relevant specialty.

Once a payment for a cancer listed under a Severity A cancer has been made, further cancer claims will only be considered for unrelated cancers. An unrelated cancer is a cancer that is not regarded as being of the same tissue and the same organ. The unrelated cancer will be considered as a new life-changing event.

Multiple cancer claims for related cancers will be assessed as progressive claims. A related cancer is regarded as cancer of the same tissue type and organ, for example breast cancer progressing from stage 1 to stage 2. There is no time limit on this.
Transformation of a cancer or heterogeneity of a tumour on molecular grounds will not be regarded as an unrelated cancer.

Where stem cell or bone marrow transplants are performed as treatment for cancer, only one Severity A claim will be paid. Only one bone marrow or stem cell transplant will be paid for during the lifetime of the *Plan*.

If two cancers of two different tissue types are present and have manifested independently of each other, then each cancer will be considered as a separate life-changing event. The two claims will be regarded as claims within the same body system.

Brain tumours are assessed according to the World Health Organization's grading. Pituitary microadenomas are specifically excluded under this benefit.

Where a claim is defined for both the condition and its treatment, only the claim with the higher applicable severity pay out percentage will be paid.

Severity A (100%)

- Stage IV cancer
- Stage III cancer
- Acute myelocytic leukaemia
- Chronic lymphocytic leukaemia: Stage III or IV on the Rai staging system
- Chronic myelocytic leukaemia
- Acute lymphoblastic leukaemia
- Bone marrow transplant or stem cell transplant
- Severe aplastic anaemia as defined by the International Aplastic Anaemia Study Group
- Multiple myeloma: Stage III on the Durie-Salmon scale or equivalent on an appropriate international staging system

- Hodgkin's or non-Hodgkin's lymphoma: Stage III or IV on the Ann Arbor staging system or equivalent on an appropriate staging system
- Prostate cancer T4N0M0 or with affected lymph nodes or distant metastases
- Malignant melanoma stage III or IV
- Neuroendocrine tumour stage III or IV
- Carcinoid syndrome with evidence of liver metastasis
- Borderline ovarian tumours stage III and IV
- Pseudomyxoma peritonei with disseminated peritoneal adenomucinosis
- Post-transplant lymphoproliferative disorders
- Gastrointestinal stromal tumours stage III and IV
- Dermatofibrosarcoma protuberans stage III and IV
- WHO grade III and IV brain tumours (currently in nervous system for SIB)

Severity C (50%)

- Stage II cancer unless specified elsewhere
- Chronic lymphocytic leukaemia: Stage II on the Rai staging system
- Multiple myeloma: Stage 1 or 2 on the Durie-Salmon scale or equivalent on an appropriate international staging system
- Hodgkin's or non-Hodgkin's lymphoma: Stage II on the Ann Arbor staging system or equivalent on an appropriate staging system
- Prostate cancer T3N0M0
- Malignant melanoma stage II
- Basal cell carcinoma and Squamous cell carcinoma stage III
- Neuroendocrine tumour stage II
- Hairy cell leukaemia with myelofibrosis transformation
- Borderline ovarian tumours Stage II
- Gastrointestinal stromal tumours stage II
- Dermatofibrosarcoma protuberans stage II
- WHO grade II brain tumours (currently in nervous system for SIB)

Severity D (25%)

- Stage 1 cancer unless specified elsewhere
- Chronic lymphocytic leukaemia: Stage 0 or I on the Rai staging system
- Moderate chronic aplastic anaemia as defined by the International Aplastic Anaemia Study Group
- Hodgkin's or non-Hodgkin's lymphoma: Stage I on the Ann Arbor staging system or equivalent on an appropriate staging system
- Prostate cancer T1N0M0 with Gleason score higher than 6
- Prostate cancer T2N0M0
- Malignant melanoma stage I
- Mastectomy for carcinoma in situ
- Prophylactic mastectomy
- Hairy cell leukaemia
- Neuroendocrine tumour stage I
- Borderline ovarian tumours stage I
- Gastrointestinal stromal tumours stage I
- WHO grade I brain tumours (currently in nervous system for SIB)
- Pituitary macroadenomas bigger than 10 mm or hypophysectomy (currently in nervous system for SIB)
- Acoustic neuroma (currently in Ear nose and throat system for SIB)

Severity E (15%)

- Myelodysplastic syndrome
- Myelofibrosis
- Overlap myelodysplastic/myeloproliferative neoplasms according to WHO classification

Severity G (5%)

- Basal cell carcinoma stage I or II treated with skin graft or skin flap or greater than 2 cm (only one payment)
- Squamous cell carcinoma stage I or II treated with skin graft or skin flap or greater than 2 cm (only one payment)
- Prostate cancer T1N0M0 with Gleason score of 6 or lower
- Myeloproliferative disorders: Polycythaemia vera, essential thrombocytosis

4.3 | *CHILD* CANCER BENEFIT

This benefit covers the specified conditions affecting *children* under 18 years of age, as well as the specified conditions under the main Cancer Benefit. The claimant must be treated by a paediatrician or paediatric surgeon registered with the Health Professions Council of South Africa.

The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations such as blood tests, histology or imaging.

Childhood cancers must be diagnosed by a specialist and confirmed by the relevant investigations, for example, blood tests, histology or imaging, and treated with accepted oncology modalities, for example, surgery, chemotherapy, bone marrow transplant or radiotherapy.

The positive diagnosis with histological confirmation of the following is covered under this benefit:

Severity E

- Lobular carcinoma in situ of the breast with chemotherapy, lumpectomy or breast-conserving surgery
- Ductal carcinoma in situ of the breast with chemotherapy, lumpectomy or breast-conserving surgery
- Excision of recurrent (more than one clinical event) carcinoma in situ of the cervix, which includes cervical intraepithelial neoplasia III
- Carcinoma in situ of the ovary with excision
- Carcinoma in situ of the testis (intratubular germ cell neoplasia) with unilateral orchidectomy
- Carcinoma in situ or high-grade dysplasia of the oesophagus with excision, oesophagectomy or endoscopic (including ablation) therapy
- Bladder carcinoma in situ (Tis) with excision or partial or total cystectomy
- Carcinoma in situ of the stomach (intraepithelial tumour without invasion of the lamina propria) with radiotherapy, chemotherapy, excision or gastrectomy

Severity G

- Bladder carcinoma in situ (Tis) treated with intravesical Bacillus Calmette-Guérin (BCG) treatment
- Carcinoma in situ of the uterus with excision or hysterectomy
- Carcinoma in situ of the fallopian tubes with excision
- Carcinoma in situ of the vagina or vulva with excision
- Carcinoma in situ of the testis (intratubular germ cell neoplasia) with chemotherapy radiotherapy or excision
- Histological presence of both high-grade prostate intraepithelial neoplasia (HGPIN) and atypical small acinar proliferation (ASAP)
- Carcinoma in situ of the penis with excision
- Carcinoma in situ of the lung with excision
- Carcinoma in situ of the kidney with excision
- Colon adenoma with increasing polyp size > 1 cm or high-grade dysplasia, treated with polypectomy or surgery
- Carcinoma in situ of the larynx with radiotherapy or excision
- Carcinoma in situ of the pharynx with radiotherapy or excision
- Carcinoma in situ of the nasal cavity with radiotherapy or excision
- Carcinoma in situ of the thyroid with radiotherapy or excision
- Melanoma in situ with excision
- Carcinoma in situ of the salivary glands or adenoid cystic carcinoma of salivary gland with excision
- Dermatofibrosarcoma protuberans (complete excision with clear margins would be considered as one event). Later events will be subject to multiple claims rules.

The Activities of Daily Living (ADLs) is an internationally used scoring system that assesses the functional ability of a person, including their physical, cognitive and interactive abilities. *We* use the ADLs to assess functioning for both the Severe Illness and Capital Disability Benefits when objective criteria of impairment are needed – for example, when neurological and connective tissue diseases, as specified in Appendix 2: Disablilty benefits assessment and Appendix 3: Severe illness benefit assessment, are assessed. Changes to the ADLs must be permanent, must have occurred after the start date of the *Plan*, and must be due to the condition, illness or event that is being claimed for.

We reserve the right to request an occupational therapist's or neuropsychologist's assessment of ADL functioning, using standardised assessment methods.

6.1 | THE SIX CATEGORIES OF ADLS

- Self-care
- Communication
- Physical Activity
- Sensory Function
- Hand Function
- Advanced Activities

6.2 | SCORING OF THE CATEGORIES

The terms 'no impairment,' 'moderately impaired,' 'severely impaired' and 'very severely impaired' are used in the Advanced Activities category. The terms 'independent', 'impaired' and 'unable' are used in all the other categories. These terms are defined in the ADL Score Sheet at the end of this appendix.

6.3 | SELF-CARE

- If a person is unable to do one activity within this category, it is scored as the inability to perform the Self-care category of the ADL Score Sheet.
- If a person is impaired in doing two activities within this category, it is scored as the inability to perform the Self-care category of the ADL Score Sheet.

6.4 | COMMUNICATION

- If a person is unable to do one activity within this category, it is scored as the inability to perform the Communication category of the ADL Score Sheet.
- If a person is impaired in doing two activities within this category, it is scored as the inability to perform the Communication category of the ADL Score Sheet.

6.5 | PHYSICAL ACTIVITY

- If a person is unable to do three activities within this category, it is scored as the inability to perform the Physical Activity category of the ADL Score Sheet.
- If a person is impaired in doing six activities within this category, it is scored as the inability to perform the Physical Activity category of the ADL Score Sheet.

6.6 | SENSORY FUNCTION

- If a person is unable to do one activity within this category, it is scored as the inability to perform the Sensory Function category of the ADL Score Sheet.
- If a person is impaired in doing two activities within this category, it is scored as the inability to perform the Sensory Function category of the ADL Score Sheet.

6.7 | HAND FUNCTION

- If a person is unable to do one activity within this category, it is scored as the inability to perform the Hand Function category of the ADL Score Sheet.
- If a person is impaired in doing two activities within this category, it is scored as the inability to perform the Hand Function category of the ADL Score Sheet.

6.8 | ADVANCED ACTIVITIES

It is scored as the inability to perform the Advanced Activity category if:

- A person is moderately impaired in all four areas
- A person is severely impaired in two of the four areas
- A person is very severely impaired in one of the four areas.

6.9 | ADL SCORE SHEET

SELF-CARE			
ACTIVITY	**INDEPENDENT**	**IMPAIRED**	**UNABLE**
Bathing	No help is needed. OR The client can bath or shower independently with the aid of handrails and a non-slip bathmat.	Hands-on help is needed. OR Assistive devices such as electronic bath benches are needed when getting in or out of the tub or shower. OR The client generally baths themselves but needs some help with cleaning hard-to-reach areas.	The client is totally dependent on others in all areas of bathing; the client would be at risk if left alone.
Grooming	No help is needed.	Hands-on help is needed with some activities of personal hygiene.	The client is totally dependent on others in all areas of grooming.
Dressing	No help is needed. OR The client can dress with an adapted method (such as sitting to dress lower limbs).	Hands-on help is needed with some activities. OR The client is unable to dress themselves completely (for example, tying shoes, zipping, or buttoning) without the help of another person.	The client is totally dependent on others in all areas of dressing.
Eating and feeding	No help is needed. OR The client can do the activity independently with the aid of modified cutlery.	Hands-on help is needed, for example, help with cutting up food or pushing food within reach, or help with applying an assistive device (such as a universal cuff).	The client is totally dependent on others in all areas of eating.
Toilet use and continence	No help is needed with toilet use, and the client has no incontinence.	Hands-on help is needed with some activities, for example, transferring onto the toilet, but the constant presence of another person while toileting is not necessary OR The client uses an intermittent catheter.	The client is totally dependent on others in all areas of toileting. OR The client has no control of bowel or bladder. OR The client uses a permanent catheter or has had a permanent colostomy.
Mobility in home	The client goes about the home independently.	Walking and transferring requires the help of another person, or a railing, cane, walker or wheelchair.	The client sits unsupported in a chair or wheelchair but cannot propel themselves alone or transfer from bed to chair alone. The client is bedridden.

COMMUNICATION			
ACTIVITY	**INDEPENDENT**	**IMPAIRED**	**UNABLE**
Listening	The client can understand verbal communication in their first language.	The client is significantly impaired to understand verbal communication in their first language.	The client is permanently unable to understand verbal communication in their first language.
Speaking	The client is functionally able to communicate verbally in their first language.	The client is significantly impaired to communicate verbally in their first language.	The client is permanently unable to communicate verbally in their first language.
Reading	The client can understand written language in their first language.	The client is significantly impaired to understand written language in their first language.	The client is permanently unable to understand written language in their first language.
Writing	The client can complete personal information documents in their first language independently.	The client needs help when completing forms in their first language.	The client is permanently unable to write in their first language.
Keyboard use	The client can use a cellphone, keyboard, ATM and credit card machine independently.	The client needs help when using a cellphone, keyboard, ATM or credit card machine.	The client is permanently unable to use a cellphone, keyboard, ATM or credit card machine.

PHYSICAL ACTIVITY			
ACTIVITY	**INDEPENDENT**	**IMPAIRED**	**UNABLE**
Standing	The client can stand independently for longer than 10 minutes.	The client needs external support or assistive devices (such as a walking frame) to stand. OR The client can stand independently, but not for longer than 10 minutes.	The client is unable to stand independently and therefore requires hands-on support when standing; the client would be at risk if unassisted.

PHYSICAL ACTIVITY			
ACTIVITY	**INDEPENDENT**	**IMPAIRED**	**UNABLE**
Sitting	The client can sit independently for longer than 20 minutes.	The client needs support to sit. OR The client can sit independently, but not for longer than 20 minutes.	The client is unable to sit independently.
Walking	The client can walk independently (even though some difficulty or discomfort may be experienced) for six minutes, covering more than 300 metres.	The client needs assistive devices (such as a walking frame) to walk. OR The client can walk independently for six minutes, covering less than 300 metres.	The client is totally dependent on others for walking. OR The client must always be pushed in a wheelchair or gurney.
Crouching	The client can assume and maintain the crouching position independently.	The client needs external support getting in or out of the crouching position, or in maintaining the crouching position.	The client is unable to assume the crouching position.
Squatting	The client can do five repetitive knee squats.	The client can do repetitive knee squats but is unable to perform five. OR The client needs external support when squatting.	The client is unable to perform a knee squat.
Kneeling	The client can assume and maintain the kneeling position independently.	The client needs external support getting in or out of the kneeling position, or in maintaining the kneeling position.	The client is unable to assume the kneeling position.
Reaching	The client can reach to full arm's length (above head height).	The client can reach past eye-level height but is unable to reach to full arm's length.	The client is unable to reach past eye-level height.
Bending	The client can bend forward independently.	The client needs external support when bending forward.	The client is unable to bend forward.
Carrying	The client can carry 4.5 kg for 5 metres with both hands and can carry 2 kg with the left hand for 5metres and can carry 2 kg with the right hand for 5metres.	The client can carry some weight with both hands but is unable to carry 4.5 kg with both hands for 5 metres. OR The client is unable to carry 2 kg with the left hand for 5 metres. OR The client is unable to carry 2 kg with the right hand for 5 metres.	The client is unable to carry any weight.

PHYSICAL ACTIVITY			
ACTIVITY	**INDEPENDENT**	**IMPAIRED**	**UNABLE**
Lifting	The client can lift (from floor to waist) 4.5 kg with both hands and can lift (from floor to waist) 2 kg with the left hand and can lift (from floor to waist) 2 kg with the right hand.	The client can lift some weight with both hands but is unable to lift (from floor to waist) 4.5 kg with both hands. OR The client is unable to lift (from floor to waist) 2 kg with the left hand. OR The client is unable to lift (from floor to waist) 2 kg with the right hand.	The client is unable to lift any weight.
Stair use	The client can climb 20 steps independently, during which a handrail may be used and one step at a time is climbed.	The client needs hands-on help when climbing stairs. OR The client is unable to climb 20 or more steps.	The client is unable to negotiate stairs.
Travel (driving, riding)	The client can drive a vehicle independently. OR The client can use public transport independently.	The client needs help when using public transport. OR The client needs a driver if they had previously been able to drive a motor vehicle independently.	The client is unable to travel.

SENSORY FUNCTION			
ACTIVITY	**INDEPENDENT**	**IMPAIRED**	**UNABLE**
Hearing	The client has functional hearing with or without the use of a hearing aid.	The client's best-corrected, permanent binaural hearing loss exceeds 50%.	The client's best-corrected, permanent hearing loss exceeds 70 dB as measured over the frequencies 500 Hz, 1,000 Hz, 2,000 Hz and 3,000 Hz.
Seeing	The client has normal vision with or without correction.	The client has a permanent visual field defect of 25% or more in one eye due to a scotoma.	The client has a permanent visual field defect of 25% or more in both eyes due to scotomas or permanent quadrantanopia.

SENSORY FUNCTION			
ACTIVITY	**INDEPENDENT**	**IMPAIRED**	**UNABLE**
Tactile sensation	The client has normal sensory function (sensation of the hands is assessed under hand function).	The client has impaired sensory function in a dermatome corresponding with objective pathology (sensation of the hands is assessed under hand function).	The client has complete loss of sensory function in a dermatome corresponding with objective pathology (sensation of the hands is assessed under hand function).
Tasting and smelling	The client has normal ability to taste and smell.	The client has significant impairment to taste or smell because of an injury or disease.	The client is permanently unable to taste, or permanently unable to smell, because of an injury or disease.

HAND FUNCTION			
ACTIVITY	**INDEPENDENT**	**IMPAIRED**	**UNABLE**
Grasping and holding	The client has grip strength better than two standard deviations below the average age and gender values (according to the Mathiowetz normative data for adults).	The client has grip strength weaker than two standard deviations below average age and gender values (according to the Mathiowetz normative data for adults).	The client is unable to grasp.
Pinching/tip pinch	The client has pinch strength better than two standard deviations below average age and gender values (according to the Mathiowetz normative data for adults)	The client has pinch strength weaker than two standard deviations below average age and gender values (according to the Mathiowetz normative data for adults)	The client is unable to pinch.
Coordination/ dexterity	This is better than two standard deviations below the norm, based on standardised hand coordination tests (for example, the Minnesota Rate of Manipulation).	This is two standard deviations below the norm, based on coordination tests (for example, the Minnesota Rate of Manipulation).	The client is unable to perform percussive movements (finger touching or diadochokinesis).
Sensory discrimination/ tactile sensation	The client has normal sensory function in their hands.	The client has impairment of sensory function, but retained protective sensibility, in their hands.	The client has no sensation in their hands.

6.10 | ADVANCED

The following areas are assessed under this category:

- Concentration
- Memory
- Problem solving, judgement and reasoning
- Executive function, including planning, initiation, organising, error monitoring

The above four areas can be tested by a neuropsychologist and stratified according to percentiles.

ACTIVITY	NO IMPAIRMENT	MODERATELY IMPAIRED	SEVERELY IMPAIRED	VERY SEVERELY IMPAIRED
Memory	Neuropsychological testing results fall above the 30th percentile, or higher than half a standard deviation below the norm.	Neuropsychological testing results fall between the 15th and 30th percentile, or between half and one standard deviation below the norm.	Neuropsychological testing results fall between the 5th and 15th percentile, or between one and two standard deviations below the norm.	Neuropsychological testing results fall below the 5th percentile, or two standard deviations below the norm (or worse).
Concentration	Neuropsychological testing results fall above the 30th percentile, or higher than half a standard deviation below the norm	Neuropsychological testing results fall between the 15th and 30th percentile, or between half and one standard deviation below the norm.	Neuropsychological testing results fall between the 5th and 15th percentile, or between one and two standard deviations below the norm.	Neuropsychological testing results fall below the 5th percentile, or two standard deviations below the norm (or worse).
Problem solving, judgment and reasoning	Neuropsychological testing results fall above the 30th percentile, or higher than half a standard deviation below the norm.	Neuropsychological testing results fall between the 15th and 30th percentile, or between half and one standard deviation below the norm.	Neuropsychological testing results fall between the 5th and 15th percentile, or between one and two standard deviations below the norm.	Neuropsychological testing results fall below the 5th percentile, or two standard deviations below the norm (or worse).
Executive function, including planning, initiation, organising and error monitoring	Neuropsychological testing results fall above the 30th percentile, or higher than half a standard deviation below the norm.	Neuropsychological testing results fall between the 15th and 30th percentile, or between half and one standard deviation below the norm.	Neuropsychological testing results fall between the 5th and 15th percentile, or between one and two standard deviations below the norm.	Neuropsychological testing results fall below the 5th percentile, or two standard deviations below the norm (or worse).

Appendix 7: Excluded medical expenses for PayBack

The expenses below are excluded from the calculation of claims used in *your* personal PayBack matrix, to decide the appropriate claims range *you* fall under:

- Optometry claims (although ophthalmology claims will still be included in the calculation)
- Dentistry claims
- Claims for childbirth
- Claims related to registered counsellors, social workers and dietitians
- Hearing aid acoustician claims
- Podiatry claims
- Speech therapy/audiology claims
- Vitality Health Fitness Assessments
- Blood glucose tests
- Blood pressure tests
- Cholesterol tests
- Body mass index assessments
- Mammograms
- Pap smears
- Prostate-specific antigen tests
- HIV tests
- Flu vaccines
- Lipogram tests
- HBA1C tests
- Mole mapping
- Bone density tests
- One yearly general or routine check-up consultation with a general practitioner per *life assured*
- Colonoscopy claims for lives older than 50 years of *age*
- Shingles and pneumococcal vaccinations

We may from time to time review the claims considered in this calculation and exclude certain claims where it is to *your* benefit.

Appendix 8: Specific international universities recognised for the Global Education Protector

The Global Education Protector covers a comprehensive list of established international universities, renowned for their academic excellence. The international universities are:

- Brown University
- Cambridge University
- Columbia University
- Cornell University
- Dartmouth College
- Ecole Polytechnique
- Harvard University
- Massachusetts Institute of Technology
- National University Singapore
- Oxford University
- Princeton University
- Stanford University
- The Julliard School
- University College London
- University of Amsterdam
- University of Chicago
- University of Pennsylvania
- Yale University

Any overseas facility not on the above list will be covered at the maximum rand amount for South African universities only.

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