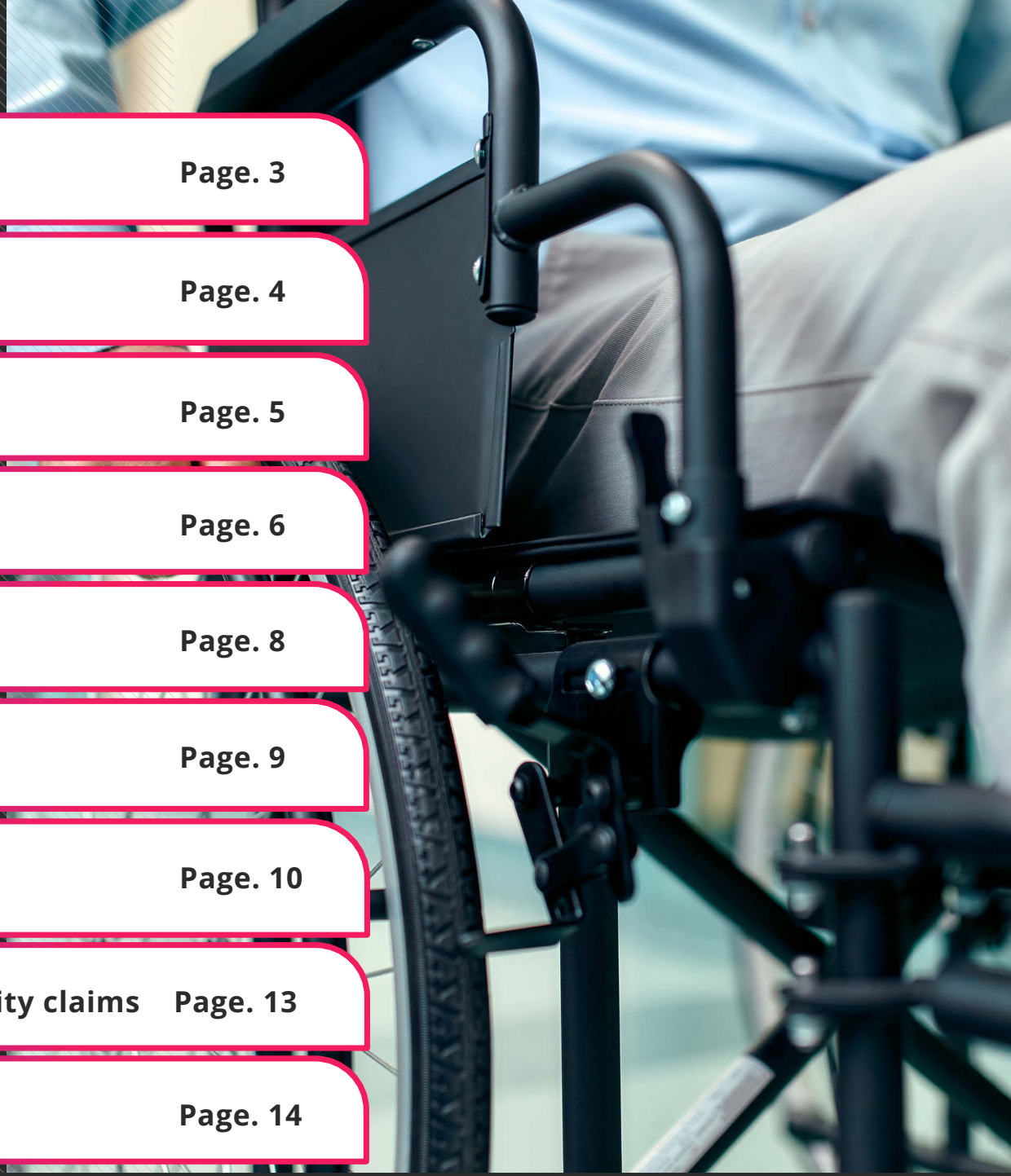
GROUP RISK

Discovery
Corporate and
Employee Benefits

DISABILITY CLAIMS FAQs

Contents



Introduction

WHAT YOU NEED TO KNOW ABOUT DISABILITY CLAIMS

Please read this information together with the Discovery Group Risk Life Plan Guide, as well as any endorsements, arrangements, and benefit selections relating to the specific benefits your employer has in place. If any information in this document is different from the Discovery Group Risk Life Plan Guide, the terms and conditions of the Discovery Group Risk Life Plan Guide will apply.

Glossary

Below are explanations of some of the words and phrases we use in this document.

Word/phrase	Explanation
Waiting period	After being continuously disabled due to injury or illness, a member must wait a specified amount of time, from the date of disability, before receiving payment for their income continuation benefit. This period is known as the *"waiting period"* and may be one month, three months, six months or 12 months, depending on what the policyholder selected.
Off-period	The waiting period is waived if a previously disabled member, who has recovered or rehabilitated, claims again from the same cause within 90 days. This is known as the *"off-period".*
Own Job	*"Own job"* refers to an instance where a member is unable to perform any of the functions that are critical to the job they are employed to do because of a medical condition or illness. For example, if the day-to-day job function requires a member to climb stairs and they are unable to do so, they will be considered disabled for the initial period and will be eligible for payment of the benefit for this period.
Own occupation	The assessment used to determine *"own occupation"* will be based on the generic job description in the marketplace. For example, if the generic market job description for an administrator includes 60% typing, 20% filing and 20% general queries, the assessment will not consider the member's individual working conditions if they are unable to climb stairs. Because climbing stairs is not crucial for an administrator's job performance, the member will not be eligible for a claim in this instance.

Notifying Discovery Group Risk of a disability claim

WHEN SHOULD AN EMPLOYER CONSIDER SUBMITTING A NOTIFICATION FOR A DISABILITY CLAIM?

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

HOW CAN DISCOVERY BE NOTIFIED OF A POTENTIAL DISABILITY CLAIM?

The steps below must be followed to notify Discovery of a potential claim:

- Complete and submit the Disability claim - Notification and consent form and send these through to groupriskclaims@discovery.co.za
- Once the Discovery Group Risk Disability Claims team has been notified of the claim, an acknowledgment email will be sent to you. This email will contain information regarding the claim documents which will need to be completed and returned to us. We refer to these as the standard claim documents.
- Complete the relevant forms as requested by us in the email. Send the forms to us as soon as possible. Please attach other documents or information we ask for.

WHY DOES DISCOVERY GROUP RISK NEED TO BE NOTIFIED OF DISABILITY CLAIMS?

- It helps Discovery Group Risk to manage disability claims proactively
- Early notification allows Discovery Group Risk to provide recommendations on the member's medical condition or treatment and ways to accommodate the member within the workplace. This helps create a relationship that benefits Discovery Group Risk, the employer and the employee
- Late notification refers to all claims submitted after three months from the date on which the member was last active at work or the date determined by Discovery Group Risk as the date the member was last able to perform the material and substantial duties of their job due to the medical condition
- If a notification is submitted late, reasons must be given for the late notification

Submitting a claim

WHAT ARE THE STANDARD DISABILITY REQUIREMENTS AND FORMS?

- The *Disability claim - Notification and consent form*
- The Disability claim - Claimant's statement
- The Disability claim - Employer's statement
- A certified copy of the member's identification document
- Leave and attendance records for two years before the date on which the claim is submitted
- The employee's payslip as at the last day the employee was actively at work
- A comprehensive medical report completed by the member's treating doctor
- Copies of all existing medical reports, certificates, file notes, pre- and post-operation reports and treatment records relevant to the condition for which the member is claiming, from all doctors, therapists, pharmacists, clinics and hospitals consulted
- Results of all special investigations and tests, or objective medical evidence such as pathology and radiology reports, lung function test results, etc, as relevant to the member's condition
- A completed Disability claim - Job description (Employer) (only required when submitting a claim for the Income Continuation Benefit).

Important note: Discovery Group Risk should be notified of any potential claim as soon as possible. This can be done by completing and submitting the Notification and Consent Form; the full claim pack is not required.

WITHIN WHAT TIME FRAME DOES A DISABILITY CLAIM HAVE TO BE SUBMITTED?

- You have three months from the last day the employee was at work or performing their material and substantial duties to notify Discovery Group Risk of a potential disability claim.
- 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 the late notification need to be supplied.

You can contact the disability claims department or your financial adviser for assistance with completing the documents for the claim. You can also contact the Disability Claims department on **0860 04 76 87**.

Submitting a claim

WHO PAYS FOR THE MEDICAL EVIDENCE THAT HAS TO BE SUBMITTED FOR A DISABILITY CLAIM?

The member is responsible for paying for all documents, including all medical documents and evidence in support of the disability claim submitted.

WITHIN WHAT TIME FRAME DOES DISCOVERY GROUP RISK RESPOND TO A DISABILITY CLAIM?

- For the Income Continuation Benefit, it takes eight working days from the date we receive all the required claim documents to process a claim
- For the Severe Illness Benefit and Capital Disability Benefit, it takes five working days from the date we receive all the required claim documents to process a claim.

WHAT ARE THE POSSIBLE RESPONSES TO A DISABILITY CLAIM?

- *Admit* – This means that the disability claim has been approved and the stipulated benefit amount will be paid.
- *Defer or Request more information* – this may include medical reports, leave records or outstanding standard claim requirements.
- *Decline* – The disability claim may be declined for various reasons, for example, the member is fit to return to work or the medical condition is not severe enough to substantiate a disability claim.
- Admitted Income Continuation Benefit claims may be eligible for a review.

CAN A DISABILITY CLAIM DECISION BE APPEALED?

- Yes, you have 90 days from the date of the decision letter to submit an appeal against our decision on your claim. You will have to provide us with the reasons for disagreeing with our decision and any additional medical evidence you would like us to take into consideration. The aforementioned information can be submitted to:

Discovery Group Risk Claims Review Committee

PO Box 3017, Rivonia 2128
Fax: 011 539 2508
Email: groupriskclaims@discovery.co.za

- If you do not agree with the decision after the above process has been followed, you can file a complaint with the National Financial Ombud Scheme South Africa (NFO).

Factors that can affect a disability claim

WHAT PRE-EXISTING CONDITIONS COULD AFFECT A DISABILITY CLAIM?

Any claim that results directly or indirectly from any pre-existing physical defects, illnesses, bodily injuries or diseases of the member will be excluded in certain circumstances. Pre-existing physical defects, illnesses, bodily injuries or diseases include those the member suffered from, was aware of (or ought reasonably to have been aware of), or had sought medical advice or treatment for before the date of the member joining the plan. The circumstances in which these will be excluded are if such physical defects, illnesses, bodily injuries or diseases would, in the opinion of the medical panel of Discovery Life, have qualified for a claim under the Severe Illness, Cancer Benefit, Income Continuation or Capital Disability Benefits, during the first 12 months of the member joining the plan, whether or not such a claim was submitted.

Other additional exclusions which may apply include:

- Disabilities resulting from intentional self-harm
- Injuries sustained during the participation in riots, civil unrest or unlawful acts
- Consitions not disclosed during underwriting when disclosure was required

This does not apply to Life Cover Benefit and Funeral Cover Benefit claims. Please refer to the Discover Group Risk Life Plan Guide for more information on all the exclusions that may apply.

WHAT IS A MAXIMUM ENTRY AGE?

- If a member was not covered for Capital Disability and Severe Illness Benefits under another compulsory group insurance policy before joining:
  - For Core and Plus Benefits, members must be between the ages of 15 and 65 years.
  - For Flex Benefits, members must be between the ages of 15 and 55.
- The maximum entry age for members who were covered for Capital Disability and Severe Illness Benefits under another compulsory group scheme is the benefit expiry age.

Once the claim has been admitted

WHO RECEIVES PAYMENT OF ADMITTED DISABILITY CLAIMS?

- As the employer is the policyholder, admitted Income Continuation Benefit claims get paid to the employer once a month for as long as the claim is considered to be medically valid. Claim payments can also be made to the account nominated by the employer.
- The lump-sum benefits (Severe Illness Benefit, Cancer Benefit and Capital Disability Benefit) are paid directly into the member's bank account, once such a claim has been admitted or in the case of approved Capital Disability payments, to the retirement fund.

ONCE A CLAIM IS ADMITTED, IS THE MEMBER CONSIDERED PERMANENTLY DISABLED?

- The Discovery Group Risk Life Plan Guide does not cater for permanent disability or medical boarding. Discovery's philosophy is not to classify, a person as temporary or permanently disabled, but rather as a disabled member or not, in terms of the policy for the Income Continuation Benefit. In the case of Lump sum benefits (Capital Disability or Severe Illness Benefit), payment is dependant on criteria being met but does not necessarily mean that the member is classified as permanently disabled.
- Every Income Continuation Benefit claim submitted will be subject to regular reviews at 1, 3, 6, 9 or 12 months depending on the determined plan of management of the case.

Income Continuation Benefit claims

HOW IS THE INCOME CONTINUATION BENEFIT ASSESSED?

- For an initial period of 12, 18 or 24 months of disability (depending on what the policyholder selected). The member will be assessed in terms of the effect the disability has on their functionality and on their regular defined work functions. The assessment will take into account the reasonable continuity by which the member is no longer able to perform the material and substantial duties of their regular job with their own employer or any other suitable job the employer can offer in terms of the principles set out in the Labour Relations Act 66 of 1995.
- Thereafter, Discovery Group Risk will assess the member's disability based on their inability to perform with reasonable continuity the material and substantial duties of their own or any job with their own or any employer (including self-employment), which the member could reasonably be expected to be qualified for or suited to, taking into account the degree of disability as well as the knowledge, training, education, ability, experience and age of the member.

HOW IS THE DATE OF DISABILITY DETERMINED FOR THE INCOME CONTINUATION BENEFIT?

The date of disability is defined as the date on which the member was last able to perform with reasonable continuity the material and substantial duties of their regular job.

Income Continuation Benefit claims

WHAT IS A REVIEW IN RELATION TO MY INCOME CONTINUATION BENEFIT?

- To monitor the ever-changing needs of our members, to proactively manage our claims, and ensure that we offer appropriate assistance where indicated, it is our policy that all Income Continuation Benefit claims are reviewed once a claim has been admitted. Many factors are taken into consideration when determining the review date, and the length of time between reviews may therefore vary from time to time. Please be sure to check the review date carefully on all letters communicating decisions regarding a claim. Failure to comply with review requirements may result in suspension of a member's benefit. Extensions to review dates may be granted on request and at Discovery Group Life's sole discretion.
- Discovery Group Life covers the cost of medical reports requested by us to review a claim. However, we do not cover the cost of the appointments the member attends in order for a report to be written. This is on the premise that the member should be receiving regular medical treatment if they are not able to work on the basis of a medical condition. Once all the claim documents have been received, it takes eight working days before we will communicate our decision.

  If Discovery Group Risk refers the member for an appointment by an independent medical specialist we choose, we will cover the costs of the medical report as well as the appointment. However, if the member misses the scheduled appointment without cancelling the appointment beforehand, the member will be responsible for any missed appointment/cancellation costs incurred.
- The member is responsible for ensuring that they meet their review appointments.
- The member must notify Discovery Group Risk of any income received or income received from any other insurer for income benefit purposes.

Income Continuation Benefit claims

WHAT IS CASE MANAGEMENT AS DEFINED BY DISCOVERY GROUP RISK IN RELATION TO THE INCOME CONTINUATION BENEFIT?

- The Discovery Group Risk Life plan guide states that Discovery Group Risk can use their discretion on whether a member can be rehabilitated or not. If they perceive that a member can be rehabilitated then they can request that a member undergoes a case management programme.
- The purpose of the case management programme is to assist the member to achieve a level of performance to enable them to perform any gainful employment or occupation. This case management programme does not replace medical aid schemes and primary rehabilitation offered in clinics, hospitals and homes. Discovery Group Risk may ask for frequent case management reports.
- A board of medical professionals appointed by Discovery Group Risk will determine the feasibility of the case management programme. On acceptance of the programme, the claimant and the employer will be required to sign a written undertaking to indicate the claimant's genuine intent to follow the case management programme.
- Discovery Group Risk will pay the cost of the case management programme directly to the service provider, and it will be limited to a maximum amount determined by Discovery Group Risk from time to time (see general benefit limits). This benefit will end on the occurrence of:
  - The claimant being considered rehabilitated by Discovery Group Risk.
  - The claimant failing to comply with the requirements detailed in the case management programme.
  - Discovery Group Risk deciding at its own discretion that the case management programme is not effective.
- To remove any doubt, this case management 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 will pay for short courses (for example, short admin or computer courses) designed to assist a claimant in achieving a minimum level of functionality, which enables them to gain suitable employment.

WHEN CAN INCOME CONTINUATION BENEFIT PAYMENTS END?

- The payment or partial payment of the Income Continuation Benefit will end if the claimant:
  - No longer meets the applicable definition of disability.
  - Earns an income that is equal to or more than their pre-disability income level, despite their injury or illness.
  - Does not tell us about any income earned while they are classified as a disability claimant and are still receiving Income Continuation Benefit payments.
  - Is a contractor or a temporary worker and their contract with the employer ends.
  - Unreasonably refuses to undergo recommended medical treatment or case management programme to reduce their disability or illness.
  - Fails or refuses to provide Discovery Group Risk with satisfactory proof of their disability or medical evidence within 30 days of being requested to do so, and fail to undergo a physical examination and tests, at Discovery Group Risk's request and expense.
  - Reaches the benefit expiry age as shown in the client benefit schedule.
  - Reached the end of the benefit term.
  - Dies.

Severe Illness, Cancer and Capital Disability Benefit claims

HOW MANY BENEFIT PAYMENTS CAN BE MADE UNDER THE CAPITAL DISABILITY, SEVERE ILLNESS OR CANCER BENEFIT (LUMP-SUM BENEFITS)

- Lump-sum benefits might not fall away after the first benefit payment.
- As long as there are enough funds remaining in the Life Fund to fund additional benefit payments, multiple claims are allowed. The member may claim subsequent benefit payments for any life-changing event covered, irrespective of:
  - The body system claims for any previous benefit payments
  - Whether the severity of the subsequent claim is higher, lower or equal to the severity of the previous claim.
- Once the member has satisfied the criteria for another benefit payment, the amount of the benefit payment is determined by whether the illness is of a progressive nature or a new life-changing event, and on the balance of the Life Fund.
- The member and the scheme will need to have remained active with Discovery Group Risk at the date of the event to qualify for further lump-sum benefits.

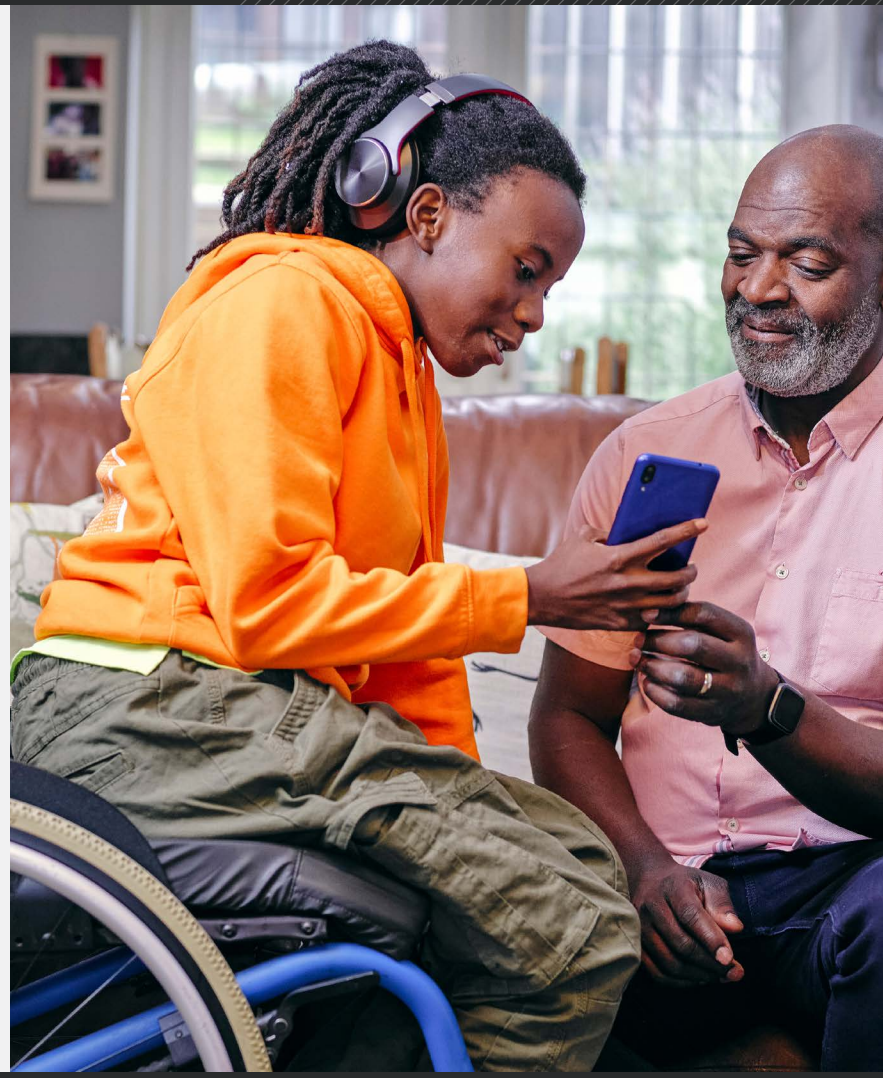
HOW IS THE DATE OF THE EVENT DETERMINED FOR THE SEVERE ILLNESS BENEFIT, CANCER BENEFIT AND CAPITAL DISABILITY BENEFIT?

The date of the event is defined as the date on which the member's condition met the criteria for the applicable benefit and severity level.

A six-month waiting period applies to the Early Cancer Benefit. No claims will be paid for any diagnosis of in situ cancer or other early-stage cancers made within six months of the start or reinstatement of the Severe Illness or Cancer Benefit, or the reinstatement of the Plan.

WHEN DOES THE BENEFIT END?

The benefit ends at the earliest of: the member turning 65, reaching the benefit expiry age, receiving the full benefit payout or fund depletion, losing eligibility, or passing away. Claims are only considered for life-changing events that occurred before the benefit ended.



DISCOVERY GROUP RISK CONTACT INFORMATION

You can contact Discovery using one of the following contact details depending on your requirements:

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