DISCLOSURE RELEVANT TO THE SEVERE ILLNESS INSURANCE POLICY – COMPREHENSIVE ILLNESS BENEFIT

ISSUED TO

ERNST & YOUNG INCORPORATED; ERNST & YOUNG ADVISORY SERVICES (PTY) LTD; ERNST & YOUNG SERVICES (PTY) LTD AND EY CATALYST (PTY) LTD

(Policy number 19538887x1)

Policy Section	Description	Reason
General	• Previous Endorsements • Effective 1 November 2024, the removal of Ernst and Young as a signatory.	• All previous endorsements are included in the Policy. • Ernst and Young needed to sign the Policy. However, Ernst and Young have now indicated that their sign-off is not required, so we can proceed with implementing of this Policy.

SEVERE ILLNESS INSURANCE POLICY - COMPREHENSIVE SEVERE ILLNESS BENEFIT

EFFECTED BY

ERNST & YOUNG INCORPORATED; ERNST & YOUNG ADVISORY SERVICES (PTY) LTD; ERNST & YOUNG SERVICES (PTY) LTD AND EY CATALYST (PTY) LTD

Policy number 19538887x1

The provisions of the previous Policy effective from 1 November 2022 are replaced by the provisions of this Policy.

This Policy is effective from 1 November 2024.

Sanlam Life Insurance Limited (Registration no 1998/021121/06) must provide insurance in respect of the EMPLOYEES of certain EMPLOYERS in terms of this Policy (in which the attached SCHEDULES are incorporated), provided that the provisions of the Policy are complied with by the EMPLOYERS. This Policy is issued to the EMPLOYER for the benefit of the persons who are entitled to benefits in terms of the Policy.

Sanlam Life Insurance Limited enters into this Policy on the basis of the information and documents provided to Sanlam Life Insurance Limited relating to the risk relevant to the Policy.

Signed at Bellville on behalf of Sanlam Life Insurance Limited on 12 November 2024.

B. Williams

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SCHEDULE 1 DEFINITIONS

In this Policy, unless the context indicates otherwise,

- the singular also denotes the plural and vice versa; and
- the expressions below have the meanings indicated opposite them.
- the SEVERE ILLNESSES are grouped per CLAIM CATEGORY and are listed under CLAIM CATEGORIES.

The definitions in this SCHEDULE, including but not limited to the definitions of the SEVERE ILLNESS listed in the various categories included under the definition of CLAIM CATEGORIES will together with the provisions of the other SCHEDULES be used to consider a claim.

Some of these SEVERE ILLNESS definitions may include defined parameters to confirm the diagnosis or severity level. If future medical advances find new parameters to replace or add to the ones in our definitions, SANLAM may consider assessing claims on the new parameters, on condition that they are

(i) comparable to the contractual parameters in the context of the specific claim event, in other words, they can confirm the same diagnosis and/or severity level, and

(ii) internationally accepted and used as best practice guidelines by the relevant medical specialists at the time.

ACQUISITION DATE means –

- the date on which an ACQUISITION EMPLOYER becomes part of the Ernst and Young group, including
- an ACQUISITION EMPLOYER who becomes part of the Ernst and Young group as a result of Section 197 transfer.

ACQUISITION EMPLOYER means an EMPLOYER who becomes part of the Ernst and Young group and whose EMPLOYEES have the option to become insured in terms of this Policy.

APPLICABLE LAWS mean

(a) any law, statute, regulation, byelaw or subordinate legislation in force from time to time to which a party is subject and/or in any jurisdiction that the services in terms of the Policy, are provided to or in respect of;

(b) the common law and laws of equity as applicable to the parties from time to time;

(c) any binding court order, judgment or decree;

(d) any applicable industry code, policy or standard; or

(e) any applicable direction, policy, rule or order that is binding on a party and that is made or given by any regulatory body having jurisdiction over a party or any of that party's assets, resources or business.

BENEFIT CESSATION AGE in regard to an INSURED means the day on which he/she attains the age of 65 years.

BENEFIT CESSATION DATE in regard to an INSURED means –

(a) the day on which he/she reaches the NORMAL RETIREMENT DATE; or

(b) the day on which he/she attains the BENEFIT CESSATION AGE; or

whichever occurs first.

BENEFIT ENTITLEMENT in regard to an INSURED means the benefit that would have been provided by SANLAM in regard to him/her in terms of SCHEDULE 3 but for the stipulations in SCHEDULE 4 regarding proof of good health.

BUNDLED CLAIMS in regard to an INSURED means more than one claim originating from the same single event, whether an accident, sickness or injury or other relevant event, which results in the INSURED meeting more than one claim event definition.

CLAIM CATEGORIES are –CANCERS, LEUKAEMIAS, LYMPHOMAS and TUMORS

1. PANCREATIC CANCER STAGE I TO IV

Cancer of stage I, II, III or IV according to the American Joint Committee for Cancer, originating in the pancreas, positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue.

2. OESOPHAGEAL CANCER STAGE I TO IV

Cancer of stage I, II, III or IV according to the American Joint Committee for Cancer, originating in the oesophagus, positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue.

3. STOMACH CANCER STAGE I TO IV

Cancer of stage I, II, III or IV according to the American Joint Committee for Cancer, originating in the stomach, positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue.

4. LUNG CANCER STAGE I TO IV

Cancer of stage I, II, III or IV according to the American Joint Committee for Cancer, originating in the lungs, positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue.

5. LIVER OR BILE DUCT CANCER STAGE I TO IV

Cancer of stage I, II, III or IV according to the American Joint Committee for Cancer, originating in the liver or bile duct, positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue.

6. MESOTHELIOMA STAGE I TO IV

Cancer of the mesothelial tissue (mesothelioma) of stage I, II, III or IV according to the American Joint Committee for Cancer, positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue.

7. TONGUE OR HYPOPHARYNGEAL CANCER STAGE I TO IV

Cancer of stage I, II, III or IV according to the American Joint Committee for Cancer, originating in the tongue or hypopharynx, positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue.

8. RETROPERITONEAL, OMENTAL OR MESENTERIC CANCER STAGE I TO IV

Cancer of stage I, II, III or IV according to the American Joint Committee for Cancer, originating in the retroperitoneal space, omentum or mesentery, positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue.

9. ACUTE LYMPHOBLASTIC LEUKAEMIA

Acute lymphocytic leukaemia in adults, confirmed by bone marrow biopsy.

10. ACUTE MYELOBLASTIC LEUKAEMIA

Acute myeloid leukaemia, confirmed by bone marrow biopsy.

11. BASAL CELL SKIN CARCINOMA OR SQUAMOUS CELL SKIN CARCINOMA (STAGE I OR II) HAVING UNDERGONE A SKIN GRAFT OR SKIN FLAP

Non-melanoma skin cancer, either basal cell carcinoma or squamous cell carcinoma, confirmed histologically as stage I or II, having undergone a skin graft or skin flap.

12. BONE MARROW TRANSPLANT

Any cancer of the blood, bone marrow or lymphatic tissue treated with bone marrow transplant (allogeneic hematopoietic stem cell transplant preceded by total bone marrow ablation). This must be supported with all of the following:

1) Bone marrow biopsy;

2) Laboratory tests.

13. BRAIN TUMOUR (GRADE II ON WHO CLASSIFICATION)

Brain cancer, World Health Organisation (WHO) Grade II, with or without neurological deficit.

14. BRAIN TUMOUR (GRADE III OR IV ON WHO CLASSIFICATION)

Brain cancer, World Health Organisation (WHO) Grade III or IV, confirmed histologically.

15. CARCINOID SYNDROME WITH EVIDENCE OF LIVER METASTASIS OF ATYPICAL CARCINOID TUMOUR

Carcinoid syndrome, confirmed histologically with evidence of liver metastasis of atypical carcinoid tumour.

16. CARCINOID SYNDROME

Carcinoid syndrome, confirmed histologically.

17. CHRONIC LYMPHOCYTIC LEUKAEMIA (STAGE 0 OR I ON THE RAI CLASSIFICATION SYSTEM)

Chronic lymphocytic leukaemia, stage 0 or I on the Rai classification system, confirmed by bone marrow biopsy.

18. CHRONIC LYMPHOCYTIC LEUKAEMIA (STAGE II ON THE RAI CLASSIFICATION SYSTEM)

Chronic lymphocytic leukaemia, stage II on the Rai classification system, confirmed by bone marrow biopsy.

19. CHRONIC LYMPHOCYTIC LEUKAEMIA (STAGE III ON THE RAI CLASSIFICATION SYSTEM)

Chronic lymphocytic leukaemia, stage III on the Rai classification system, confirmed by bone marrow biopsy.

20. CHRONIC LYMPHOCYTIC LEUKAEMIA (STAGE IV ON THE RAI CLASSIFICATION SYSTEM)

Chronic lymphocytic leukaemia, stage IV on the Rai classification system, confirmed by bone marrow biopsy.

21. CHRONIC MYELOID LEUKAEMIA (NO BONE MARROW TRANSPLANT)

Chronic myeloid leukaemia, confirmed by bone marrow biopsy (no bone marrow transplant).

22. CHRONIC MYELOID LEUKAEMIA (WITH BONE MARROW TRANSPLANT)

The undergoing of a bone marrow transplant after diagnosis of chronic myeloid leukaemia, as confirmed by a specialist. This must be supported with all of the following:

1) Bone marrow biopsy;

2) Laboratory tests.

23. HAIRY CELL LEUKAEMIA

Hairy cell leukaemia, confirmed by bone marrow biopsy.

24. HODGKIN'S OR NON-HODGKIN'S LYMPHOMA (STAGE I ON ANN ARBOR CLASSIFICATION SYSTEM)

Hodgkin's or non-Hodgkin's lymphoma, stage I on Ann Arbor classification system, confirmed by bone marrow biopsy.

25. HODGKIN'S OR NON-HODGKIN'S LYMPHOMA (STAGE II ON ANN ARBOR CLASSIFICATION SYSTEM)

Hodgkin's or non-Hodgkin's lymphoma, stage II on Ann Arbor classification system, confirmed by bone marrow biopsy.

26. HODGKIN'S OR NON-HODGKIN'S LYMPHOMA (STAGE III OR IV ON ANN ARBOR CLASSIFICATION SYSTEM)

Hodgkin's or non-Hodgkin's lymphoma, stage III or IV on Ann Arbor classification system, confirmed by bone marrow biopsy.

27. MALIGNANT MELANOMA WITH INVASION BEYOND THE EPIDERMIS OR T1N0M0

Malignant melanoma with invasion beyond the epidermis, histologically classified as T1N0M0.

28. MALIGNANT MELANOMA STAGE II

Malignant melanoma with invasion beyond the epidermis, classified with appropriate evidence by an oncologist as stage II.

29. MALIGNANT MELANOMA STAGE III OR IV

Malignant melanoma, classified with appropriate evidence by an oncologist as stage III or IV.

30. MULTIPLE MYELOMA (STAGE I OR II ON THE DURIE-SALMON SCALE)

Multiple myeloma, stage I or II on the Durie-Salmon scale, confirmed by bone marrow biopsy.

31. MULTIPLE MYELOMA (STAGE III ON THE DURIE-SALMON SCALE)

Multiple myeloma, stage III on the Durie-Salmon scale, confirmed by bone marrow biopsy.

32. MYELODYSPLASTIC SYNDROME

Myelodysplastic syndrome is a group of cancers in which immature blood cells in the bone marrow do not mature or become healthy blood cells. This must be confirmed by bone marrow biopsy.

33. PROSTATE CANCER – T1A-C N0M0, GLEASON SCORE 2-6

Early stage prostate cancer, confirmed histologically as stage I or II, T1a-c N0M0, Gleason score 2-6.

34. PROSTATE CANCER – T1A-C N0M0, GLEASON SCORE ≥7

Early stage prostate cancer, confirmed histologically as stage II, T1a-c N0M0, Gleason score ≥7.

35. PROSTATE CANCER – T2N0M0, GLEASON SCORE 2-6

Prostate cancer, confirmed histologically as stage II, T2N0M0, Gleason score 2-6.

36. PROSTATE CANCER – T2N0M0, GLEASON SCORE ≥7

Prostate cancer, confirmed histologically as stage II, T2N0M0, Gleason score ≥7.

37. PROSTATE CANCER – T3N0M0, GLEASON SCORE 2-6

Prostate cancer, confirmed histologically as stage III, T3N0M0, Gleason score 2-6.

38. PROSTATE CANCER – T3N0M0, GLEASON SCORE ≥7

Prostate cancer, confirmed histologically as stage III, T3N0M0, Gleason score ≥7.

39. PROSTATE CANCER STAGE IV

Prostate cancer, confirmed histologically as stage IV including T4N0M0 with any Gleason score, OR any T, N1 – 3, M0 with any Gleason score, OR any T, any N, M1 with any Gleason score.

40. ANY NON-MELANOMA SKIN CANCER STAGE III

Diagnosis of non-melanoma skin cancer, confirmed histologically as stage III.

41. ANY NON-MELANOMA SKIN CANCER STAGE IV

Diagnosis of non-melanoma skin cancer, confirmed histologically as stage IV.

42. BENIGN BRAIN TUMOUR TREATED SURGICALLY

Benign brain tumour, where a neurosurgeon performs any one of the following procedures:

1) Stereotactic brain ablation;
2) Stimulation;
3) Implantation;
4) Radiosurgery.

43. BRAIN ABSCESS HAVING UNDERGONE SURGICAL DRAINAGE

A brain abscess caused by bacteria or fungi. This must be confirmed by a specialist neurosurgeon with appropriate special investigations such as CT or MRI scan. Treatment must include surgical drainage or intravenous antimicrobial therapy.

44. RECURRENT OR INOPERABLE BENIGN BRAIN TUMOUR SHOWING SYMPTOMS

Benign brain tumour, which returns following optimal medical or surgical treatment or which is irresectable and shows signs of progression, with appropriate clinical signs and symptoms, confirmed by a specialist neurosurgeon.

45. PITUITARY TUMOUR WITH SURGICAL RESECTION

Pituitary tumour, confirmed by radiological evidence, that has undergone surgical excision by a neurosurgeon as a result of one of the following:

1) Failure to suppress excessive hormone production by medication;
2) Signs of raised intracranial pressure;
3) Continued growth of the tumour over time.

46. BENIGN ENDOCRINE TUMOURS HAVING UNDERGONE SURGICAL EXCISION

Benign endocrine tumours: adrenal adenoma, phaeochromocytoma, pancreatic tumour, insulinoma, parathyroid tumour and thyroid adenoma, confirmed by radiological evidence and having undergone surgical excision by an appropriate specialist surgeon.

47. AMYLOIDOSIS

The confirmed diagnosis of amyloidosis in any tissue or organ, confirmed by biopsy. Amyloidosis is a rare disease that occurs when a protein called amyloid builds up in the organs. Amyloid is an abnormal protein that is usually produced in the bone marrow and can be deposited in any tissue or organ.

48. ANY OTHER STAGE I CANCER, UNLESS INCLUDED IN ANY OF THE CRITERIA SET OUT IN ANY OF THE PREVIOUS CLAIM EVENTS

Any other stage I cancer, as per the American Joint Committee for Cancer, positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. This claim event excludes the following conditions:

1) All cancers in situ and all premalignant conditions or conditions with low malignant potential, or classified as borderline malignancy;

2) All tumours of the prostate;

3) All skin cancers. Refer to the "Cancers, tumours, leukaemias and lymphomas" and “Early cancer" claim categories where most of these conditions are covered under other claim events.

49. ANY OTHER STAGE II CANCER, UNLESS INCLUDED IN ANY OF THE CRITERIA SET OUT IN ANY OF THE PREVIOUS CLAIM EVENTS

Any other stage II cancer, as per the American Joint Committee for Cancer, positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. This claim event excludes the following conditions:

1) All cancers in situ and all premalignant conditions or conditions with low malignant potential, or classified as borderline malignancy;

2) All tumours of the prostate;

3) All skin cancers. Refer to the “Cancers, tumours, leukaemias and lymphomas” and “Early cancer" claim categories where most of these conditions are covered under other claim events.

50. ANY OTHER STAGE III OR IV CANCER, UNLESS INCLUDED IN ANY OF THE CRITERIA SET OUT IN ANY OF THE PREVIOUS CLAIM EVENTS

Any other stage III or IV cancer, as per the American Joint Committee for Cancer, positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. This claim event excludes the following conditions:

1) All cancers in situ and all premalignant conditions or conditions with low malignant potential, or classified as borderline malignancy;

2) All tumours of the prostate;

3) All skin cancers. Refer to the “Cancers, tumours, leukaemias and lymphomas” and "Early cancer" claim categories where most of these conditions are covered under other claim events.

*The CLAIM CATEGORY for “CANCERS, LEUKAEMIAS, LYMPHOMAS and TUMORS” includes cancer catch-all claim events. These cancer catch-all claim events will only be considered for a claim, if the condition being claimed for does not result in the INSURED also meeting the claim definition for one of the other listed claim events for this CLAIM CATEGORY.

CARDIOVASCULAR CONDITIONS: HEART, BLOOD VESSELS AND STROKE

1. HEART TRANSPLANT

The actual undergoing of a transplant of one complete human heart as a recipient. This claim event excludes the undergoing of a heart transplant as a result of direct or indirect alcohol or drug abuse.

2. HEART VALVE REPLACEMENT IRRESPECTIVE OF TECHNIQUE

Heart valve replacement, which is performed by a cardiothoracic surgeon or cardiologist.

3. ANY HEART VALVE SURGERY SUCH AS VALVULOPLASTY OR VALVOTOMY IRRESPECTIVE OF TECHNIQUE

Any surgery to the heart valve, such as valvuloplasty or valvotomy, which is performed by a cardiothoracic surgeon or cardiologist.

4. CARDIOMYOPATHY AT CLASS III NYHA AND EF LESS THAN 40% DESPITE OPTIMAL TREATMENT

Definite diagnosis of cardiomyopathy as confirmed by a specialist cardiologist, resulting in permanent and irreversible class III New York Heart Association (NYHA) classification of heart failure, with a permanent left ventricular ejection fraction (EF) of less than 40%, despite optimal treatment.

5. CARDIOMYOPATHY AT CLASS IV NYHA AND EF LESS THAN 30% DESPITE OPTIMAL TREATMENT

Definite diagnosis of cardiomyopathy as confirmed by a specialist cardiologist, resulting in permanent and irreversible class IV New York Heart Association (NYHA) classification of heart failure, with a permanent left ventricular ejection fraction (EF) of less than 30%, despite optimal treatment.

6. TAKOTSUBO CARDIOMYOPATHY

A confirmed diagnosis of Takotsubo cardiomyopathy (TCM) by a cardiologist. This must be supported by all of the following:

1) Raised cardiac markers, specifically troponin I or T;
2) ECG changes showing typical changes such as ST segment elevation in the pre-cordial leads or T wave inversion;
3) Echocardiography demonstrating wall motion abnormalities typically seen in TCM, specifically hypokinesis or akinesis of the midsegment and apical segment of the left ventricle;
4) Findings in support of TCM on cardiac angiography.

7. TRANSCORONARY ABLATION OF SEPTAL HYPERTROPHY

Transcoronary ablation of septal hypertrophy, performed by a cardiothoracic surgeon or cardiologist.

8. PERICARDIECTOMY IRRESPECTIVE OF TECHNIQUE

A surgical procedure, where all or part of the pericardium is removed to treat fibrosis and scarring of the pericardium which occurred as a result of chronic pericarditis. This must be confirmed by a specialist cardiologist.

9. ARRHYTHMIA HAVING UNDERGONE PATHWAY ABLATION

Any life-threatening variation of the normal rhythm of the heart, confirmed by a cardiologist and documented on Holter ECG, with pathway ablation.

10. ARRHYTHMIA HAVING UNDERGONE A PERMANENT PACEMAKER INSERTION

Any life-threatening variation of the normal rhythm of the heart, confirmed by a cardiologist and documented on Holter ECG, with a permanent pacemaker insertion.

11. ARRHYTHMIA HAVING UNDERGONE A DEFIBRILLATOR INSERTION

Any life-threatening variation of the normal rhythm of the heart, confirmed by a cardiologist and documented on Holter ECG, with permanent defibrillator insertion.

12. PERIPHERAL ARTERIAL DISEASE REQUIRING ANGIOPLASTY, STENT OR BYPASS GRAFT OF ONE PERIPHERAL ARTERY

Peripheral arterial disease, confirmed on Doppler ultra-sound, angiography, CT or MRI, and where a vascular surgeon performs at least one angioplasty, stent or bypass graft in a peripheral artery.

13. PERIPHERAL ARTERIAL DISEASE REQUIRING ANGIOPLASTY, STENT OR BYPASS GRAFT OF MORE THAN ONE PERIPHERAL ARTERY

Peripheral arterial disease, confirmed on Doppler ultra-sound, angiography, CT or MRI, and where a vascular surgeon performs an angioplasty, stent or bypass graft in more than one peripheral artery.

14. LOSS OF USE OF OR LOSS OF ONE FOOT DUE TO PERIPHERAL ARTERIAL DISEASE

Peripheral arterial disease, confirmed on Doppler ultra-sound, angiography, CT or MRI, which results in the loss of use of or loss of one foot at the ankle or below.

15. LOSS OF USE OF OR LOSS OF ONE HAND DUE TO PERIPHERAL ARTERIAL DISEASE

Peripheral arterial disease, confirmed on Doppler ultra-sound, angiography, CT or MRI, which results in the loss of use of or loss of one hand at the wrist or below.

16. ANGIOPLASTY WITH OR WITHOUT STENTING IN ONE CAROTID ARTERY

The undergoing of angioplasty with or without stenting to repair the narrowing or blockage of one carotid artery, as evidenced by angiography or MRI findings.

17. ANGIOPLASTY WITH OR WITHOUT STENTING OF BILATERAL CAROTID ARTERIES

The undergoing of angioplasty with or without stenting to repair the narrowing or blockage of both carotid arteries, as evidenced by angiography or MRI findings.

18. CAROTID ARTERIAL DISEASE: NARROWING OF AT LEAST ONE CAROTID ARTERY REQUIRING EITHER BYPASS GRAFT OR ENDARTERECTOMY

The undergoing of endarterectomy or bypass graft to repair the narrowing or blockage of at least one carotid artery, as evidenced by angiography or MRI findings.

19. ENDOVASCULAR SURGERY OR STENT TO REPAIR ANY THORACIC OR ABDOMINAL AORTIC ANEURYSM

Stenting or endovascular surgery to repair an aneurysm of the thoracic or abdominal aorta, by a specialist vascular surgeon.

20. SURGICAL REPAIR OF AN ILEOFEMORAL ANEURYSM OR STENOSIS

Surgical repair, including bypass graft or keyhole surgery, of an ileofemoral aneurysm or ileofemoral stenosis by a specialist vascular surgeon.

21. SURGICAL REPAIR OF ANY ANEURYSM OR STENOSIS OF MAJOR ARTERIAL BRANCHES OF THE AORTA

Surgical repair, including bypass graft or keyhole surgery, of any aneurysm or stenosis of the following branches of the aorta: subclavian, brachiocephalic, splenic, renal and iliac arteries.

22. MAJOR SURGERY TO DISSECT AND SURGICALLY GRAFT AN AORTIC ANEURYSM

The undergoing of open chest or abdominal surgery to repair an aneurysm in the thoracic or abdominal aorta with a synthetic graft.

23. PRIMARY PULMONARY HYPERTENSION

Primary pulmonary hypertension with mean pulmonary artery pressure exceeding 30 mmHg, and at least class III New York Heart Association (NYHA) classification of cardiac impairment. The diagnosis must be confirmed by a specialist physician.

24. SURGICAL REPAIR OF COARCTATION OF THE AORTA

Any surgical repair of coarctation of the aorta, as confirmed by an appropriate specialist.

25. LEFT VENTRICULAR ANEURYSM REPAIRED SURGICALLY

Surgical repair of the left ventricle for a left ventricular aneurysm by open heart surgery. This must be confirmed by a cardiothoracic surgeon.

26. SURGERY FOR ATRIAL MYXOMA

Surgery for the removal of an atrial myxoma, confirmed by a cardiothoracic surgeon.

27. SUBARACHNOID HAEMORRHAGE WITHOUT NEUROLOGICAL IMPAIRMENT

Subarachnoid haemorrhage bleeding into the subarachnoid space surrounding the brain, with evidence on neuro-imaging investigation, without any permanent neurological deficit. This must be confirmed by a neurosurgeon.

28. ARTERIOVENOUS MALFORMATION TREATED WITH RADIOLOGICAL INTERVENTION

Arteriovenous malformation (AVM) in the brain, treated with radiosurgery or stereotactic radiosurgery.

29. ARTERIOVENOUS MALFORMATION TREATED WITH OPEN SURGERY CRANIOTOMY

Open brain surgery via a craniotomy for repair of arteriovenous malformation, confirmed by a neurosurgeon.

30. ANGIOPLASTY WITH OR WITHOUT STENTING FOR CORONARY ARTERIES

Angioplasty is a surgical procedure performed by a specialist cardiologist to treat blockage or narrowing of one or more coronary arteries, as evidenced by a coronary angiogram.

31. CORONARY ARTERY DISEASE WITH CORONARY ARTERY BYPASS GRAFT FOR UP TO TWO VESSELS

The undergoing of surgery to correct the narrowing of, or blockage to, up to two coronary arteries by means of a bypass graft.

32. CORONARY ARTERY DISEASE WITH CORONARY ARTERY BYPASS GRAFT FOR THREE OR MORE VESSELS

The undergoing of surgery to correct the narrowing of, or blockage to, three or more coronary arteries by means of a bypass graft.

33. MILD HEART ATTACK OF SPECIFIED SEVERITY

This is the death of heart muscle due to inadequate blood supply as evidenced by all three of the criteria below. The evidence must show a definite myocardial infarction. This claim event does not cover other acute coronary syndromes, including but not limited to angina.

1) Compatible clinical symptoms, and
2) Characteristic electrocardiographical (ECG) changes indicative of myocardial ischaemia or myocardial infarction, and
3) Raised cardiac biomarkers.

Characteristic ECG changes indicative of myocardial ischaemia that may progress to myocardial infarction

- with ST segment elevation, are new or presumed new ST segment elevation at the J point in two or more contiguous leads with the cut-off points greater than or equal to 0.2 mV in leads V1, V2 or V3, and greater than or equal to 0.1 mV in other leads. Contiguity in the frontal plane is defined by the lead sequence AVL, I and II, AVF and III.

- without ST segment elevation, are ST segment depression of at least 0.1 mV, or T wave abnormalities only.

Raised cardiac biomarkers, described as one of the following:

- sensitive troponin markers as indicated in the applicable table below, or

- conventional troponin markers as indicated in the applicable table below, or

- non-troponin markers as indicated in the applicable table below.

Sensitive troponin markers		**Value****	
Assay*	**Troponin type**	**Unit (ng/l)**	**Unit (ng/ml)**
Rosche hsTnT	TnT	{sign for GT} 500	{sign for GT} 0.5
Abbott ARCHITECT	TnI	{sign for GT} 1500	{sign for GT} 1.5
Beckman AccuTnI	TnI	{sign for GT} 2500	{sign for GT} 2.5
Siemens Centaur Ultra	TnI	{sign for GT} 3000	{sign for GT} 3.0
Siemens Dimension RxL	TnI	{sign for GT} 3000	{sign for GT} 3.0
Siemens Stratus CS	TnI	{sign for GT} 3000	{sign for GT} 3.0

*Use the relevant manufacturer's assay as it appears on the laboratory report.

**Values represent multiples of the World Health Organisation (WHO) myocardial infarction (MI) rule in levels and not the 99th percentile values (the upper limit of normal) as quoted on the laboratory result.

Conventional troponin markers		**Value**	
Assay	**Troponin type**	**Unit (ng/l)**	**Unit (ng/ml)**

Conventional TnT	TnT	{sign for GT} 500	{sign for GT} 0.5
Conventional AccuTnI or equivalent threshold with other Troponin I methods	TnI	{sign for GT} 250	{sign for GT} 0.25

Non-troponin markers	Value
Raised CK-MB mass	Raised above the upper limit of normal laboratory reference range but not below 2 times the upper limit of normal laboratory reference range in acute presentation phase
Total CPK elevation	Raised above the upper limit of normal laboratory reference range but not below 2 times the upper limit of normal laboratory reference range in acute presentation phase, with at least 6% being CK-MB

Confirmed acute myocardial infarction that has occurred post percutaneous coronary intervention (PCI) with a detection of cardiac biomarkers as indicated in the table below.

Marker	Parameter
Cardiac troponin assay	Raised to the levels of either the sensitive troponin markers or conventional troponin markers listed in the table above
Raised CK-MB mass	Raised above the upper limit of normal laboratory reference range but below 4 times the upper limit of normal laboratory reference range post intervention

Confirmed acute myocardial infarction that has occurred post coronary artery bypass graft (CABG) with a detection of cardiac biomarkers as indicated in the table below.

Marker	Parameter
Cardiac troponin assay	Raised to at least twice the levels of the sensitive troponin markers or conventional troponin markers listed in the table above
Raised CK-MB mass	Raised 4 times or more the upper limit of normal laboratory reference range post intervention

34. MODERATE HEART ATTACK OF SPECIFIED SEVERITY

This is the death of heart muscle due to inadequate blood supply as evidenced by any of the four combinations of criteria below. The evidence must show a definite myocardial infarction. This claim event does not cover other acute coronary syndromes, including but not limited to angina.

1) Compatible clinical symptoms AND raised cardiac biomarkers, or
2) Compatible clinical symptoms AND new pathological Q waves on ECG, or
3) New pathological Q waves on ECG AND raised cardiac biomarkers, or
4) ST segment and T wave changes on ECG indicative of myocardial injury AND raised cardiac biomarkers.

Raised cardiac biomarkers, described as one of the following:

- sensitive troponin markers as indicated in the applicable table below, or
- conventional troponin markers as indicated in the applicable table below, or
- non-troponin markers as indicated in the applicable table below.

Sensitive troponin markers		Value**	
Assay*	**Troponin type**	**Unit (ng/l)**	**Unit (ng/ml)**
Rosche hsTnT	TnT	{sign for GT} 1000	{sign for GT} 1.0
Abbott ARCHITECT	TnI	{sign for GT} 3000	{sign for GT} 3.0
Beckman AccuTnI	TnI	{sign for GT} 5000	{sign for GT} 5.0
Siemens Centaur	TnI	{sign for GT} 6000	{sign for GT} 6.0

Ultra			
Siemens Dimension RxL	TnI	{sign for GT} 6000	{sign for GT} 6.0
Siemens Stratus CS	TnI	{sign for GT} 6000	{sign for GT} 6.0

*Use the relevant manufacturer's assay as it appears on the laboratory report.

**Values represent multiples of the World Health Organisation (WHO) myocardial infarction (MI) rule in levels and not the 99th percentile values (the upper limit of normal) as quoted on the laboratory result.

Conventional troponin markers		**Value**	
Assay	**Troponin type**	**Unit (ng/l)**	**Unit (ng/ml)**
Conventional TnT	TnT	{sign for GT} 1000	{sign for GT} 1.0
Conventional AccuTnI or equivalent threshold with other Troponin I methods	TnI	{sign for GT} 500	{sign for GT} 0.5

Non-troponin markers	**Value**
Raised CK-MB mass	Raised two times or more above the upper limit of normal laboratory reference range in acute presentation phase
Total CPK elevation	Raised two times or more above the upper limit of normal laboratory reference range in acute presentation phase, with at least 6% being CK-MB

New pathological Q waves on ECG are

- any new Q wave in leads V1 through V3,
- a Q wave greater than or equal to 40 ms (0.04 s) in leads I, II, AVL, AVF, V4, V5 or V6. The Q wave changes must be present in any two contiguous leads, and must be greater than or equal to 1 mm in depth,
- the appearance of a new complete bundle branch block.

ST segment and T wave changes on ECG indicative of myocardial ischaemia that may progress to myocardial infarction

- with ST segment elevation, are new or presumed new ST segment elevation at the J point in two or more contiguous leads with the cut-off points greater than or equal to 0.2 mV in leads V1, V2 or V3, and greater than or equal to 0.1 mV in other leads. Contiguity in the frontal plane is defined by the lead sequence AVL, I and II, AVF and III.

- without ST segment elevation, are ST segment depression of at least 0.1 mV, or T wave abnormalities only.

35. HEART ATTACK WITH PERMANENT MILD IMPAIRMENT IN FUNCTION

A heart attack that meets the criteria as described for “Moderate heart attack of specified severity” above, with permanent impairment in one or more of the following functional criteria, as measured 6 weeks after the heart attack:

1) METS 2-7;
2) LVEF 30% to 50%;
3) LVEDD 59 to 72;
4) Ultrasound FS 16% to 25%.

36. HEART ATTACK WITH PERMANENT SEVERE IMPAIRMENT IN FUNCTION

A heart attack that meets the criteria as described for “Moderate heart attack of specified severity” above, with permanent impairment in one or more of the following functional criteria, as measured 6 weeks after the heart attack:

1) Class IV NYHA classification;
2) METS 1 or less;
3) LVEF less than 30%;
4) LVEDD more than 72;
5) Ultrasound FS less than 16%.

37. TAKAYASU'S DISEASE

Takayasu's disease, meeting all diagnostic criteria as defined by The American College of Rheumatology (ACR, 1990):

1) Angiographic criteria must show narrowing or occlusion of the entire aorta, its primary branches, or large arteries in the proximal upper or lower extremities;
2) These changes are not due to arteriosclerosis, fibromuscular dysplasia, or similar causes;
3) Changes are usually focal or segmental. This must be confirmed by a specialist physician.

38. SUPERIOR SAGITTAL SINUS THROMBOSIS

Diagnosis of a superior sagittal sinus thrombosis, confirmed by radiological evidence and a neurosurgeon.

39. CAVERNOUS SINUS THROMBOSIS

Diagnosis of a cavernous sinus thrombosis, confirmed by radiological evidence and a neurosurgeon.

40. PERSISTENT GIANT CELL ARTERITIS DESPITE OPTIMAL THERAPY

Giant cell arteritis, confirmed on biopsy and by a specialist physician, with persistent symptoms and raised inflammatory markers despite optimal therapy.

41. STROKE

The 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. For the stroke claim events the following are not covered:

1) Transient ischaemic attack;
2) Vascular disease affecting the eye or optic nerve;
3) Migraine and vestibular disorders;
4) Traumatic injury to brain tissue or blood vessels.

Severity of the stroke will be assessed by a full neurological examination by a specialist neurologist any time after 3 MONTHS, and will be measured by:

1) The ability to do BASIC and ADVANCED ACTIVITIES OF DAILY LIVING (ADLs), as indicated in the tables "BASIC ACTIVITIES OF DAILY LIVING" and "ADVANCED ACTIVITIES OF DAILY LIVING" at the end of the list of SEVERE ILLNESSES or
2) Whole person impairment (WPI) figures, which will be calculated according to the latest addition of the American Medical Association's Guides to the Evaluation of Permanent Impairment.

42. STROKE WITH FULL RECOVERY

The 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. A full neurological examination by a neurologist after the event must confirm the diagnosis of a stroke and not a transient ischaemic attack (TIA), and that the life insured has recovered fully.

43. STROKE WITH ALMOST FULL RECOVERY

Stroke with almost full recovery, with little residual symptoms or signs, as measured by the ability to do all basic and advanced ADLs, OR a WPI of 10% or less. This definition must be read together with the information under "Stroke" above.

44. STROKE WITH MILD IMPAIRMENT

The life insured can function independently after the stroke, but has impairment as measured by the inability to do three or more advanced ADLs, OR a WPI of 11% to 20%. This definition must be read together with the information under "Stroke" above.

45. STROKE WITH MODERATE IMPAIRMENT

The life insured cannot function independently after the stroke, as measured by the inability to do six or more advanced ADLs, OR a WPI of 21% to 35%. This definition must be read together with the information under "Stroke" above.

46. STROKE WITH SEVERE IMPAIRMENT

The life insured needs constant assistence after the stroke, as measured by the inability to do three or more basic ADLs, OR a WPI of greater than 35%. This definition must be read together with the information under "Stroke" above.

CONNECTIVE TISSUE

1. PROGRESSIVE SYSTEMIC SCLEROSIS (SCLERODERMA)

Systemic sclerosis (scleroderma) with fibrosis of the skin, joints, and at least two internal organs, as diagnosed by an appropriate specialist with all of the following as supporting evidence:

1) Histological evidence confirming the diagnosis;
2) Raised anti-nuclear antibodies;
3) Radiological evidence of joint involvement;
4) Objective evidence of at least two internal organs affected. The disease must be unresponsive to treatment with disease modifying drugs (DMARD) for a continuous period of at least 3 MONTHS.

2. SEROPOSITIVE RHEUMATOID ARTHRITIS

Seropositive rheumatoid arthritis, confirmed by a rheumatologist. This must be confirmed with all of the following:

1) Clinical findings;
2) Laboratory findings.

3. ADVANCED OR PROGRESSIVE RHEUMATOID ARTHRITIS DESPITE OPTIMAL TREATMENT

Seropositive rheumatoid arthritis, confirmed by a rheumatologist. This must be confirmed with all of the following:

1) Clinical findings;
2) Laboratory findings;
3) Radiological evidence of joint destruction and deformity, in at least three large joints (excluding joints in hands or feet). The disease must be unresponsive to treatment with corticosteroids and disease-modifying drugs (DMARD) for a continuous period of at least 3 MONTHS.

4. SYSTEMIC LUPUS ERYTHEMATOSIS (SLE)

The diagnosis of systemic lupus erythematosis (SLE), confirmed by a rheumatologist. This must be supported with all of the following:

1) At least four of the diagnostic criteria as listed in the American College of Rheumatology's SLE classification criteria in 2012;
2) At least one clinical and one immunologic criterion OR biopsy-proven lupus nephritis with ANA or anti-dsDNA antibodies.

5. SYSTEMIC LUPUS ERYTHEMATOSIS WITH MULTIPLE ORGAN IMPAIRMENT

Systemic lupus erythematosis (SLE), confirmed by a rheumatologist. This must be supported with all of the following:

1) At least four of the diagnostic criteria as listed in the American College of Rheumatology's SLE classification criteria in 2012;
2) At least one clinical and one immunologic criterion OR biopsy-proven lupus nephritis with ANA or anti-dsDNA antibodies;
3) Objective evidence of impairment of at least two other organs, besides the kidney.

6. SARCOIDOSIS

The diagnosis of sarcoidosis, confirmed by a specialist. This must be confirmed with all of the following:

1) Laboratory tests;
2) Biopsy findings;
3) Imaging.

7. SARCOIDOSIS WITH MULTIPLE ORGAN INVOLVEMENT

Sarcoidosis, confirmed by a specialist. There must be evidence of involvement of at least three of the following:

1) Pulmonary system;
2) Ocular system;
3) Dermatological system;
4) Nervous system;
5) Liver involvement;
6) Kidney involvement.

This must be confirmed with all of the following:

1) Laboratory tests;
2) Biopsy findings;
3) Imaging.

8. POLYARTERITIS NODOSA

Polyarteritis nodosa, confirmed by a specialist.

This must be supported with all of the following:

1) Angiography findings;
2) Biopsy evidence.

9. WEGENER'S GRANULOMATOSIS

Wegener’s granulomatosis, confirmed by a specialist. There must be evidence of respiratory system, kidneys, and skin involvement. This must be supported with all of the following:

1) Biopsy;
2) Imaging;
3) Positive ANCA test result.

EAR, NOSE AND THROAT

1. ACOUSTIC NEUROMA RESULTING IN NEUROLOGICAL DEFICIT

Acoustic neuroma, with hearing loss. This must be confirmed by an Ear, Nose and Throat (ENT) specialist, with all of the following:

1) Radiological evidence;

2) Asymmetrical high frequency hearing loss above 4000 Hz;

3) Loss of balance or vertigo.

2. MASTOIDITIS REQUIRING MASTOIDECTOMY

Chronic mastoiditis with radical mastoidectomy, as confirmed with surgical reports by a specialist.

3. THE TOTAL, PERMANENT AND IRREVERSIBLE LOSS OF HEARING IN ONE EAR

The total, permanent and irreversible loss of hearing in one ear, confirmed by an Ear, Nose and Throat (ENT) specialist. Total deafness means that the average hearing level in the affected ear, tested with hearing aids when applicable, at audible frequencies is more than 90 decibels. For the purpose of this definition audible frequencies mean 500, 1000, 2000 and 3000 Hertz.

4. MORE THAN 60% BINAURAL HEARING LOSS

Permanent binaural hearing loss of more than 60%, confirmed by an Ear, Nose and Throat (ENT) specialist, with supporting audiometric testing. Permanent implies all reasonable treatment should have been undergone.

5. MORE THAN 75% BINAURAL HEARING LOSS

Permanent binaural hearing loss of more than 75%, confirmed by an Ear, Nose and Throat (ENT) specialist, with supporting audiometric testing. Permanent implies all reasonable treatment should have been undergone.

6. TOTAL LOSS OF HEARING IN BOTH EARS

Deafness is the total and permanent loss of hearing in both ears, confirmed by an Ear, Nose and Throat (ENT) specialist. Total deafness means that the average hearing level in the better ear, tested with hearing aids when applicable, at audible frequencies is more than 90 decibels. For the purpose of this definition audible frequencies mean 500, 1000, 2000 and 3000 Hertz.

7. RECIPIENT OF COCHLEAR OR MIDDLE EAR IMPLANT

Cochlear or middle ear implant, confirmed with reports by an Ear, Nose and Throat (ENT) specialist.

GASTROINTESTINAL SYSTEM

1. TRACHEOESOPHAGEAL FISTULA HAVING UNDERGONE SURGERY

Surgical repair of a tracheoesophageal fistula. This must be performed by a specialist surgeon, with surgical reports.

2. CROHN'S DISEASE OR ULCERATIVE COLITIS WITH PROLONGED ADVANCED THERAPY

The unequivocal diagnosis of ulcerative colitis or Crohn's disease by a gastroenterologist. All of the following must be present:

1) Colonoscopy and histopathology findings confirming the diagnosis;
2) Continuous treatment for at least 4 consecutive MONTHS with immunomodulators to control symptoms.

3. CROHN'S DISEASE OR ULCERATIVE COLITIS WITH RECURRENT SURGERY

The unequivocal diagnosis of ulcerative colitis or Crohn's disease by a gastroenterologist. This must have resulted in complications, managed by at least two surgeries to the colon or small intestine.

4. CROHN'S DISEASE OR ULCERATIVE COLITIS WITH A PERMANENT COLOSTOMY OR ILEOSTOMY

The unequivocal diagnosis of ulcerative colitis or Crohn's disease by a gastroenterologist, with a permanent colostomy or ileostomy in place. This must be confirmed by surgical reports.

5. HEMICOLECTOMY

A hemicolectomy, that is as a result of any disease or disorder. This must be confirmed with all of the following:

1) Surgical reports;
2) Objective evidence of disease or disorder of the colon.

6. TOTAL COLECTOMY (REMOVAL OF THE ASCENDING, DESCENDING AND TRANSVERSE COLON)

Any organic disease that results in the surgical removal of the ascending, descending and transverse colon. This must be confirmed with surgical reports by a gastroenterologist.

7. ANY DISEASE OR DISORDER REQUIRING PARTIAL HEPATECTOMY

Any disease or disorder of the liver, with surgical excision of part of the liver. This must be performed by a specialist, with surgical reports.

8. CHRONIC PERSISTENT HEPATITIS CLASSIFIED AS CHILD-PUGH CLASS A OR WORSE

Chronic hepatitis present for at least 6 MONTHS, with liver failure. This must be confirmed by a specialist with all of the following:

1) Biopsy reports;
2) At least Child-Pugh class A liver failure.

9. SCLEROSING CHOLANGITIS CLASSIFIED AS CHILD-PUGH CLASS A OR WORSE

Chronic biliary inflammation present for at least 6 MONTHS, with liver failure. This must be confirmed by a specialist with all of the following:

1) Biopsy reports;
2) At least Child-Pugh class A liver failure.

10. END-STAGE LIVER FAILURE

Any disease or disorder that results in end-stage liver failure. This must be confirmed by a specialist with all of the following:

1) Biopsy reports;

2) At least Child-Pugh class A liver failure.

11. LIVER OR PANCREAS TRANSPLANT

The undergoing, as a recipient, of a complete human liver or pancreas transplant. This must be confirmed with surgical reports by a specialist. This claim event does not cover stem cell therapy.

12. AMYLOIDOSIS OF THE LIVER AND SPLEEN

Amyloidosis of the liver and spleen, confirmed on biopsy.

13. COMPLETE PANCREATECTOMY

The complete surgical removal of the pancreas. This must be confirmed with surgical reports by a specialist.

14. PRIMARY BILIARY CIRRHOSIS CONFIRMED ON A LIVER BIOPSY BY A GASTROENTEROLOGIST

Primary biliary cirrhosis, confirmed by a gastroenterologist with all of the following:

1) Radiological tests;

2) Biopsy findings.

15. LOSS OF MORE THAN ONE THIRD OF THE TONGUE

Any disease or disorder that results in the surgical loss of more than one third of the tongue. This must be confirmed with surgical reports by a surgeon.

LYMPH AND BLOOD

1. CHRONIC BLOOD DISORDERS REQUIRING CONSTANT BLOOD REPLACEMENTS

Any chronic disorder of the blood, where at least four units of blood or blood products has been transfused per month for at least 3 consecutive MONTHS. This must be confirmed by a specialist with all of the following:

1) Clinical records documenting the blood transfusions;

2) Blood counts.

2. SEVERE APLASTIC ANAEMIA

The unequivocal diagnosis of bone marrow failure. This must be confirmed by a specialist, with all of the following:

1) Bone marrow biopsy;

2) Blood tests showing anaemia, neutropenia and thrombocytopenia;

3) Classified as severe aplastic anaemia according to the latest International Aplastic Anaemia Study Group;

4) Treated with at least one of the following: marrow stimulating agents, immunosuppressive agents, or bone marrow transplant. This claim event specifically excludes non-severe aplastic anaemia.

3. A BONE MARROW TRANSPLANT OR STEM CELL TRANSPLANT

The undergoing of a bone marrow transplant after complete bone marrow ablation, as confirmed by a specialist. This must be supported with all of the following:

1) Bone marrow biopsy;

2) Laboratory tests.

MUSCULOSKELETAL SYSTEM

1. HIP JOINT REPLACEMENT

Surgical hip joint replacement with a prosthesis, confirmed by an orthopedic surgeon. This must be supported by surgical reports.

2. KNEE JOINT REPLACEMENT

Surgical knee joint replacement with a prosthesis, confirmed by an orthopedic surgeon. This must be supported by surgical reports.

3. PARAPLEGIA, HEMIPLEGIA, DIPLEGIA OR QUADRIPLEGIA

Paraplegia is the total and permanent loss of muscle function resulting in the loss of use of both legs due to disease of or injury to the spinal cord or brain.

Hemiplegia is the total and permanent loss of muscle function of one side of the body due to disease of or injury to the spinal cord or brain. This claim event does not cover hemiplegia facialis (facial palsy).

Diplegia is the total and permanent loss of muscle function or sensation of both sides of the body due to disease of or injury to the spinal cord or brain.

Quadriplegia is the total and permanent loss of the functioning of both arms and both legs due to disease of or injury to the spinal cord or brain. For all of the conditions above, the following is required:

1) Radiological evidence such as a CT scan or MRI;
2) Must be confirmed by a neurologist or neurosurgeon;
3) The conditions must be medically documented for at least 3 MONTHS.

4. LOSS OF MORE THAN 50% OF HAND FUNCTION AS DEFINED IN AMA'S GUIDES OR ITS EQUIVALENT

The permanent loss of more than 50% of hand function as calculated according to the American Medical Association's (AMA) latest Guides to the Evaluation of Permanent Impairment or its equivalent.

5. LOSS OF USE OF OR LOSS OF ONE FOOT

The irreversible loss of or loss of use of one foot from the ankle. This must be confirmed with supporting evidence by a specialist.

6. LOSS OF USE OF OR LOSS OF ONE HAND

The irreversible loss of or loss of use of one hand from the wrist. This must be confirmed with supporting evidence by a specialist.

7. LOSS OF USE OF OR LOSS OF BOTH FEET

The irreversible loss of or loss of use of both feet, from the ankles. This must be confirmed with supporting evidence by a specialist.

8. LOSS OF USE OF OR LOSS OF ONE HAND AND ONE FOOT

The irreversible loss of or loss of use of one hand from the wrist and one foot from the ankle. This must be confirmed with supporting evidence by a specialist.

9. LOSS OF USE OF OR LOSS OF ONE LIMB

The irreversible loss of or loss of use of one arm from the elbow or one leg from the knee. This must be confirmed with supporting evidence by a specialist.

10. LOSS OF USE OF OR LOSS OF BOTH HANDS

The irreversible loss of or loss of use of both hands from the wrist. This must be confirmed with supporting evidence by a specialist.

11. LOSS OF USE OF OR LOSS OF MORE THAN ONE LIMB

The irreversible loss of or loss of use of two arms from the elbows, or two legs from the knees, or one arm from the elbow and one leg from the knee. This must be confirmed with supporting evidence by a specialist.

NERVOUS SYSTEM AND PSYCHIATRIC DISORDERS

1. CONDITIONS HAVING UNDERGONE OPEN BRAIN SURGERY

Open brain surgery via a craniotomy. This must be supported with surgical reports by a neurosurgeon.

2. GUILLAIN-BARRE WITH PROLONGED RESPIRATORY SUPPORT

The confirmed diagnosis of Guillain-Barre, which results in mechanical ventilation for more than 60 consecutive days. This must be confirmed with reports by a specialist.

3. GUILLAIN-BARRE WITH PERMANENT NEUROLOGICAL DEFICIT

The confirmed diagnosis of Guillain-Barre, which results in permanent neurological deficit, with the complete reliance on an assistive device for ambulation. This will be assessed after 6 MONTHS. This must be confirmed by a neurologist report.

4. PERMANENT AND COMPLETE INABILITY TO COMMUNICATE OR COMPREHEND LANGUAGE SYMBOLS

Aphasia, with a complete inability to speak or comprehend speech or to read or write. This must be as a result of injury or disease of the brain, and confirmed by a neurologist. This claim event does not cover

1) Inability to speak due to psychiatric causes;
2) Inability to speak due to non-neurological disease.

5. A PERMANENT HEMIPARESIS OR PARALYSIS SECONDARY TO TRAUMA OR SURGERY

Brain surgery or an accident that results in permanent hemiparesis or hemiparalysis. This must be confirmed with all of the following:

1) Neuro-imaging;
2) Neurological reports.

Permanence will be established after 3 MONTHS. For this definition, accident means any external, violent and traumatic event. This claim event excludes Bell’s palsy.

6. PERMANENT MODERATE TO SEVERE IMPAIRMENT OF INTELLECTUAL CAPACITY AS A RESULT OF BRAIN INJURY OR SYSTEMIC HYPOXIA

Brain injury or systemic hypoxia that results in permanent moderate to severe impairment of intellectual capacity. This must be evidenced by all of the following:

1) The permanent inability to do six or more ADVANCED ACTIVITIES OF DAILY LIVING (ADLs) as indicated in the table "ADVANCED ACTIVITIES OF DAILY LIVING" at the end of the list of SEVERE ILLNESSES;
2) Neuro-imaging;
3) Confirmation by a neurologist. Permanence will be established after 3 MONTHS.

7. MOTOR NEURON DISEASE

The diagnosis of motor neuron disease, confirmed by a neurologist, with all of the following:

1) Evidence on electromyography and electroneurography;
2) Permanent inability to perform independently at least three BASIC ACTIVITIES OF DAILY LIVING (ADLs) as indicated in the table "BASIC ACTIVITIES OF DAILY LIVING" at the end of the list of SEVERE ILLNESSES. Permanence will be established after 3 MONTHS.

8. DIAGNOSIS OF MUSCULAR DYSTROPHY

Muscular dystrophy, confirmed by a neurologist with all of the following:

1) Characteristic electromyogram;
2) Confirmation on muscle biopsy.

9. PROGRESSIVE MUSCULAR DYSTROPHY

The diagnosis of muscular dystrophy, confirmed by a neurologist with all of the following:

1) Characteristic clinical presentation;
2) Characteristic electromyogram;
3) Clinical suspicion confirmed by muscle biopsy;
4) The disease must result in a permanent inability to perform independently at least three BASIC ACTIVITIES OF DAILY LIVING (ADLs) as indicated in the table "BASIC ACTIVITIES OF DAILY LIVING" at the end of the list of SEVERE ILLNESSES. Permanence will be established after 3 MONTHS.

10. COMA WITH FULL RECOVERY

Coma, where there is a state of unconsciousness not induced by sedation. There must be evidence of all of the following:

1) Glasgow Coma scale reading of 8 or less;
2) No reaction to external stimuli or internal needs;
3) This state must persist continuously for more than 96 hours.

11. COMA RESULTING IN PERMANENT NEUROLOGICAL DEFICIT

Coma, where there is a state of unconsciousness not induced by sedation. There must be evidence of all of the following:

1) Glasgow Coma scale reading of 8 or less;
2) No reaction to external stimuli or internal needs;
3) This state must persist continuously for more than 96 hours, with permanent neurological deficit. Permanence will be established at 3 MONTHS.

12. MULTIPLE SCLEROSIS

The definitive diagnosis of multiple sclerosis, with all of the following:

1) Two separate neurological events resulting in neurological deficit;
2) Appropriate neuro-imaging showing typical pathology;
3) Confirmed by at least two independent neurologists.

13. ADVANCED MULTIPLE SCLEROSIS

The diagnosis of advanced multiple sclerosis, with all of the following:

1) Two separate neurological events resulting in permanent neurological deficit;
2) This permanent neurological deficit must involve at least two of the following three systems: sensory, motor and autonomic;
3) Neurological deficit must be present for a continuous period of at least 6 MONTHS;
4) All of this must be supported by appropriate neuro-imaging and neurological reports.

14. OPTIC NEURITIS WITH DEMYELINATING ON MRI

Optic neuritis where two or more plaques are confirmed as demyelinating on an MRI.

15. PARKINSON'S DISEASE

The diagnosis of Parkinson's disease, confirmed by a neurologist, with all of the following:

1) Appropriate clinical signs and symptoms;
2) Appropriate testing to exclude other causes.

16. ADVANCED PARKINSON'S DISEASE

The diagnosis of Parkinson's disease, confirmed by a neurologist, with all of the following:

1) Appropriate clinical signs and symptoms;
2) Permanent inability to perform independently at least three BASIC ACTIVITIES OF DAILY LIVING (ADLs) as indicated in the table "BASIC ACTIVITIES OF DAILY LIVING" at the end of the list of SEVERE ILLNESSES. Permanence will be assessed after 3 MONTHS.

17. DIAGNOSIS OF MYASTHENIA GRAVIS

The diagnosis of myasthenia gravis by a neurologist with objective evidence supported with all of the following:

1) Appropriate blood tests;
2) Nerve conduction tests;
3) Radio imaging.

18. MYASTHENIA GRAVIS WITH SEVERE PERMANENT IMPAIRMENT

The diagnosis of myasthenia gravis by a neurologist with all of the following objective evidence:

1) Appropriate blood tests;
2) Nerve conduction test;
3) Radio imaging and permanent inability to perform independently at least three BASIC ACTIVITIES OF DAILY LIVING (ADLs) as indicated in the table "BASIC ACTIVITIES OF DAILY LIVING" at the end of the list of SEVERE ILLNESSES, or the need for 24 hour supervision by a caregiver. Permanence will be established after 3 MONTHS.

19. HYDROCEPHALUS WITH THE INSERTION OF A VP SHUNT

The diagnosis of a hydrocephalus, with all of the following:

1) Confirmed by a neurosurgeon;
2) Insertion of a ventikulo peritoneal (VP) shunt;
3) Neurosurgical reports.

Only one payment will be made for this claim event.

20. STEREOTACTIC BRAIN SURGERY

Any brain disease or disorder, for which a neurosurgeon or radiologist performs all of the following:

1) Stereotactic brain ablation, stimulation, implantation;
2) Radiotherapy.

This must be supported by neurosurgical or radiologist reports.

21. IRREVERSIBLE UNILATERAL TRIGEMINAL NERVE PALSY

Damage to the cranial nerve V (trigeminal nerve), with all of the following permanent signs:

1) Loss of facial sensation;
2) Impairment of mastication;
3) Loss of corneal reflex.

This must be confirmed by a neurologist, as well as on neuro-imaging tests.

22. IRREVERSIBLE UNILATERAL FACIAL NERVE PALSY

Damage to the cranial nerve VII (facial nerve), with all of the following permanent signs:

1) No or slight movement of one half of the face with asymmetry at rest;
2) Incomplete or no eyelid closure;
3) Slight or no movement of the mouth.

This must be confirmed by a neurologist, as well as on neuro-imaging tests.

23. IRREVERSIBLE UNILATERAL HYPOGLOSSAL NERVE PALSY

Damage to cranial nerve XII (hypoglossal nerve), with all of the following permanent signs:

1) Moderate to severe dysarthria or dysphagia;
2) Nasal regurgitation;
3) An inability to swallow, or process oral secretions without choking, or aspiration of liquids or semi-solid foods.

This must be confirmed by a neurologist, as well as on neuro-imaging tests.

24. IRREVERSIBLE CEREBELLUM DYSFUNCTION

Irreversible cerebellum dysfunction, resulting in the permanent inability to walk without total dependence on assistive devices. This must be confirmed by a neurologist, as well as on neuro-imaging tests.

25. ALZHEIMER'S DISEASE

The diagnosis of Alzheimer’s disease (pre-senile dementia), confirmed by a neurologist or psychiatrist. There must be evidence of all of the following:

1) Typical findings in cognitive tests according to the latest Diagnostic and Statistical Manual for Mental Disorders (DSM) criteria;
2) Supportive findings on neuro-imaging;
3) Permanent inability to perform independently at least three BASIC ACTIVITIES OF DAILY LIVING (ADLs) as indicated in the table "BASIC ACTIVITIES OF DAILY LIVING" at the end of the list of SEVERE ILLNESSES, or the need for 24 hour supervision by a caregiver.

Permanence will be established after 3 MONTHS.

26. MEDICALLY CERTIFIED INSTITUTIONALISATION FOR A MENTAL AND BEHAVIOURAL DISORDER FOR AT LEAST 6 MONTHS CONTINUOUSLY

The diagnosis of a psychiatric disorder, according to the latest Diagnostic and Statistical Manual for Mental Disorders (DSM) classification, with all of the following:

1) Institutionalisation in a registered psychiatric facility for more than 6 consecutive MONTHS with appropriate medical certification;
2) Undergoing of constant supervision, with a permanent caregiver;
3) Global Assessment Function (GAF) score of 30 or less.

This must be confirmed by at least two independent psychiatric reports.

RENAL DISORDERS

1. PRIMARY AMYLOIDOSIS OF THE KIDNEY

The confirmed diagnosis of primary amyloidosis of the kidney, by biopsy.

2. PARTIAL OR TOTAL NEPHRECTOMY

Nephrectomy, with the surgical report confirming the removal of part of one kidney (partial nephrectomy) or one whole kidney (total nephrectomy).

3. RENAL CORTICAL NECROSIS

Renal cortical necrosis, confirmed by a nephrologist with radiological evidence or renal biopsy.

4. NEPHROTIC SYNDROME WITH RENAL ARTERY OR RENAL VEIN THROMBOSIS

Confirmed diagnosis of nephrotic syndrome, with documented renal artery or renal vein thrombosis, confirmed by a nephrologist, with supporting imaging results.

5. MODERATE PROGRESSIVE CHRONIC KIDNEY DISEASE WITH DECLINE IN FUNCTION

Progressive chronic kidney disease as evidenced by all of the following despite optimal therapy:

1) Renal function tests that show a decline in the glomerular filtration rate (GFR) of more than 5 ml/min over the past 12 MONTHS;
2) Last GFR 50 ml/min or less; 3) Persistent proteinuria (1+ or more on dipstick).

This must be confirmed by a nephrologist.

6. SEVERE PROGRESSIVE CHRONIC KIDNEY DISEASE WITH DECLINE IN FUNCTION

Progressive chronic kidney disease as evidenced by all of the following despite optimal therapy:

1) Renal function tests that show a decline in the glomerular filtration rate (GFR) of more than 5 ml/min over the past 12 MONTHS;
2) Last GFR 30 ml/min or less;
3) Persistent proteinuria (1+ or more on dipstick).

This must be confirmed by a nephrologist.

7. CHRONIC, IRREVERSIBLE KIDNEY FAILURE REQUIRING AND ALREADY HAVING UNDERGONE REGULAR DIALYSIS TREATMENT

Chronic, end-stage kidney failure that is irreversible, with regular dialysis instituted.

8. A KIDNEY TRANSPLANT

Undergone a complete human kidney transplant.

9. DOCUMENTED RENAL VEIN THROMBOSIS

Renal vein thrombosis, confirmed by a nephrologist or urologist, with confirmatory investigations and imaging.

RESPIRATORY DISORDERS

1. PULMONARY EMBOLISM

The diagnosis and treatment of a pulmonary embolism (PE) following a deep vein thrombosis (DVT). This must be confirmed by a specialist and must include all of the following:

1) A ventilation-perfusion (VQ) scan or reports of the latest radiological imaging technique;
2) Treatment record of use of anticoagulant drugs.

2. CHRONIC IRREVERSIBLE LUNG DISEASE WITH SEVERE IMPAIRMENT

Chronic irreversible lung disease, confirmed by a pulmonologist, resulting in irreversible respiratory impairment of FEV1 ≤40% or FVC ≤40%, or DCO ≤40% on at least three occasions at least 1 month apart.

3. REMOVAL OF A LUNG

The surgical removal of one lung, confirmed with surgical reports by an appropriate specialist.

4. RECURRENT PULMONARY EMBOLISM, WITH ASSOCIATED PULMONARY HYPERTENSION

Recurrent pulmonary embolism despite optimal treatment, resulting in pulmonary hypertension, where the mean pulmonary artery pressure is more than 40 mmHg. This must be confirmed by a specialist.

5. A LUNG OR HEART-LUNG TRANSPLANT

Complete lung or heart-lung transplant. This must be confirmed with surgical reports by a cardiothoracic surgeon.

6. ANY CHRONIC LUNG DISEASE WITH PLEURECTOMY OR DECORTICATION

Any chronic lung disease, with pleurectomy or decortication. This must be confirmed with surgical reports by a specialist.

7. CHRONIC SARCOIDOSIS NOT RESPONDING TO OPTIMAL TREATMENT

Definitive diagnosis of chronic pulmonary sarcoidosis, which is not responding to optimal medical therapy. This must be evidenced by three lung function tests, each performed at least 1 month apart, and confirmed by a specialist.

8. PULMONARY ALVEOLAR PROTEINOSIS

Definitive diagnosis of pulmonary alveolar proteinosis, with at least three lung function tests, each performed at least 1 month apart, showing a DCO of less than 50%. This must be confirmed by a specialist.

9. REMOVAL OF TWO OR MORE LOBES OF A LUNG

The surgical removal of two or more lobes of a lung by an appropriate specialist, with surgical reports.

UROGENITAL DISORDERS

1. TOTAL AMPUTATION OF THE PENIS

Any physical disease or injury of the penis that results in total amputation of the penis. This must be performed by a surgeon, and confirmed with surgical reports. Amputation due to gender dysphoria or for gender reassignment purposes is not covered.

2. PARTIAL CYSTECTOMY (REMOVAL OF AT LEAST 50% OF THE URINARY BLADDER)

The surgical removal of at least 50% of the urinary bladder by a specialist, confirmed by surgical reports.

3. RADICAL CYSTECTOMY RESULTING IN A NEED FOR AN EXTERNAL BAG OR CATHETERISATION

The surgical removal of the whole urinary bladder by a specialist, confirmed by surgical reports.

4. BILATERAL ORCHIDECTOMY

Bilateral orchidectomy that is medically necessary. This must be confirmed with surgical reports by a specialist. This claim event does not cover bilateral orchidectomy for gender dysphoria or for gender reassignment purposes.

VISION

1. ENUCLEATION OF ONE EYE

Traumatic or surgical enucleation of one eye, confirmed with supporting reports by an ophthalmologist.

2. RETINITIS PIGMENTOSA

Retinitis pigmentosa, confirmed with supporting reports by an ophthalmologist.

3. TOTAL, PERMANENT AND IRREVERSIBLE LOSS OF SIGHT IN ONE EYE

The total, permanent and irreversible loss of sight in one eye, with all of the following:

1) Sharpness of vision of 6/60 or worse when measured with the use of visual aids;
2) Reports by an ophthalmologist.

4. IRREVERSIBLE HEMIANOPIA IN ONE EYE

Irreversible loss of half of the visual field (left or right) of one eye, as confirmed by an ophthalmologist. This must be supported with all of the following:

1) Radiological evidence;
2) Visual tests.

5. IRREVERSIBLE LOSS OF SIGHT IN BOTH EYES WITH BEST CORRECTED BILATERAL VISUAL ACUITY OF 6/30 OR WORSE

The total and permanent loss of sight in both eyes, with all of the following:

1) Visual acuity of 6/30 or worse for both eyes when measured with the use of visual aids;
2) Reports by an ophthalmologist.

6. IRREVERSIBLE HEMIANOPIA IN BOTH EYES

Irreversible loss of either the left or right half of the visual field in both eyes, as confirmed by an ophthalmologist. This must be supported with all of the following:

1) Radiological evidence;
2) Visual tests.

INFECTIONS

1. ACCIDENTAL HIV INFECTION

Infection by the Human Immunodeficiency Virus or the diagnosis of immunodeficiency syndrome.

The infection must be proved to our satisfaction as being due to one of the following:

- the transfusion of infected blood or blood products from a transfusion service that we recognise, on or after the cover start date;

- an accidental needlestick injury or cut in the execution of the life insured's duties as a full time medical student, or normal professional duties as a medical or dental practitioner or nurse, registered with the Health Professions Council of South Africa (HPCSA), or the South African Nursing Council. The incident must have been recorded in writing in the workplace, for example with the Superintendent if in a hospital. An HIV test must have been performed within 24 hours to confirm the HIV negative status of the life insured at the time of the incident, as well as the HIV status of the patient with whom the incident took place. There must be proof that the life insured has been started on a course of anti-retroviral drugs. A subsequent HIV test must have been performed within 6 MONTHS after the incident to confirm the change in the life insured's HIV status from negative to positive;

- receiving a transplanted organ where the organ has previously been infected with the HI virus;

- any other medical or dental procedure, recognised by the HPCSA, performed on the life insured by a medical or dental practitioner, registered with the HPCSA. An HIV test must have been performed, but not longer than 12 MONTHS before the medical or dental procedure, to confirm the HIV negative status of the life insured at the time of the incident. A subsequent HIV test must have been performed within at least 12 MONTHS after the incident to confirm the change in the life insured's HIV status from negative to positive;

- rape or indecent assault. The offence must have been reported to the South African Police Services (SAPS) and a case number and/or a criminal case must have been opened. An HIV test must have been performed within 24 hours to confirm the HIV negative status of the life insured at the time of the assault. A medical examination must have been performed within 24 hours after the incident, confirming the rape or indecent assault. There must be proof that the life insured has been started on a course of anti-retroviral drugs. A subsequent HIV test must have been performed within 6 MONTHS after the incident to confirm the change in the life insured's HIV status from negative to positive;

- a violent crime. The offence must have been reported to the SAPS and a case number and/or criminal case must have been opened. A medical examination must have been performed within 24 hours after the incident, confirming the crime. Medically documented proof of acute trauma and suspicion of HIV infection must have been submitted, as well as an HIV test that proves that the life insured was HIV negative at the time of the crime. There must be proof that the life insured has been started on a course of anti-retroviral drugs. A subsequent HIV test must have been performed within 6 MONTHS after the incident to confirm the change in the life insured's HIV status from negative to positive;

- a road traffic accident. The accident must have been reported to the SAPS and a case number and/or criminal case must have been opened. A medical examination must have been performed within 24 hours after the incident, confirming the accident. Medically documented proof of acute trauma and suspicion of HIV infection must have been submitted, as well as an HIV test that proves that the life insured was HIV negative at the time of the accident. There must be proof that the life insured has been started on a course of anti-retroviral drugs. A subsequent HIV test must have been performed within 6 MONTHS after the incident to confirm the change in the life insured's HIV status from negative to positive. If the accidental HIV infection is a result of emergency assistance at the

scene of the accident, an affidavit by the SAPS or an eyewitness to prove the assistance of the life insured must have been submitted.

2. CEREBRAL MALARIA

Confirmed diagnosis of cerebral malaria with all of the following:

1) Blood tests showing parasitaemia count of more than 5%;
2) Permanent neurological deficit, as measured by a whole person impairment (WPI) of 1 to 10% according to the latest American Medical Association's Guides to the Evaluation of Permanent Impairment.

This will be measured after 3 MONTHS.

3. CEREBRAL MALARIA RESULTING IN PERMANENT NEUROLOGICAL IMPAIRMENT

Confirmed diagnosis of cerebral malaria with all of the following:

1) Blood tests showing parasitemia count of more than 5%;
2) Permanent neurological deficit, as measured by a whole person impairment (WPI) of 11% or more according to the latest American Medical Association's Guides to the Evaluation of Permanent Impairment.

This will be measured after 3 MONTHS.

INJURIES, ACCIDENTS AND POISON

1. **FULL THICKNESS BURNS INVOLVING MORE THAN 30% OF ONE HAND OR MORE THAN 30% OF THE HEAD**

   Full thickness burns involving more than 30% of the surface area of one hand or more than 30% of the surface area of the head, as measured by the Lund and Browder Chart or equivalent, confirmed by a specialist.

2. **GRADE II PARTIAL THICKNESS BURNS INVOLVING MORE THAN 20% OF THE BODY SURFACE AREA**

   Partial thickness or second degree burns involving more than 20% of the body surface area, as measured by the Lund and Browder Chart or equivalent. This must be confirmed by a specialist.

3. **FULL THICKNESS BURNS INVOLVING MORE THAN 10% BUT LESS THAN OR EQUAL TO 20% OF THE BODY SURFACE AREA**

   Full thickness burns involving more than 10% but less than or equal to 20% of the body surface area, as measured by the Lund and Browder Chart or equivalent.

4. **FULL THICKNESS BURNS INVOLVING MORE THAN 20% BUT LESS THAN OR EQUAL TO 30% OF THE BODY SURFACE AREA**

   Full thickness burns involving more than 20% but less than or equal to 30% of the body surface area, as measured by the Lund and Browder Chart or equivalent.

5. **FULL THICKNESS BURNS INVOLVING MORE THAN 30% OF THE BODY SURFACE AREA**

   Full thickness burns involving more than 30% of the body surface area, as measured by the Lund and Browder Chart or equivalent.

6. **TRAUMATIC INJURIES RESULTING IN A COMATOSE STATE REQUIRING MECHANICAL VENTILATION PERSISTENT FOR LONGER THAN 96 HOURS**

   Traumatic injuries resulting in a comatose state requiring mechanical ventilation persistent for longer than 96 hours, not induced by sedation. There must be evidence of all of the following:

   1) Glasgow Coma scale reading of 8 or less;
   2) No reaction to external stimuli or internal needs;
   3) This state must persist continuously for more than 96 hours.

7. **SPINAL INJURY RESULTING IN PARAPLEGIA, DIPLEGIA, HEMIPLEGIA, QUADRIPLEGIA OR CAUDA EQUINA SYNDROME**

   Traumatic event to the spinal cord, resulting in permanent paraplegia, diplegia, hemiplegia, quadriplegia or cauda equina syndrome (permanent loss of bowel or bladder function or paraplegia).

8. **LOSS OF BOWEL OR BLADDER FUNCTION, WITH PERMANENT STOMA OR INDWELLING CATHETER**

   A traumatic injury to the spinal cord resulting in permanent bladder incontinence with a permanent indwelling catheter or bowel incontinence with a permanent colostomy.

9. **SKULL FRACTURE REQUIRING RECONSTRUCTION**

   Any traumatic event which causes a depressed skull fracture that has undergone reconstructive surgery. This must be confirmed by radiological evidence and by a specialist.

10. **DOG BITE TO THE FACE REQUIRING PRIMARY SUTURING, FOLLOWED BY MULTIPLE SESSIONS OF REPAIR BY A PLASTIC OR RECONSTRUCTIVE SURGEON**

    A dog bite to the face, with primary suturing followed by at least one revision of the scar and reconstruction by a plastic or reconstructive surgeon. Only one payment for this claim event.

11. BRACHIAL PLEXUS INJURY WITH PERMANENT NEUROLOGICAL IMPAIRMENT

Brachial plexus injury, with permanent irreversible paralysis of the entire arm. This must be supported by neurophysiological tests, and confirmed by a specialist.

12. RADIAL, ULNAR OR MEDIAN NERVE INJURY, WITH LOSS OF FUNCTION OF THE HAND

Radial, ulnar or median nerve injury, with permanent loss of function of the hand in the area innervated by the affected nerve. This must be supported by neurophysiological tests, and confirmed by a specialist.

13. LEAD OR MERCURY POISONING

Acute lead or mercury poisoning with all of the following:

1) Evidence on laboratory markers;
2) Appropriate signs and symptoms;
3) Confirmation by a specialist.

14. VENOMOUS SNAKE BITE NECESSITATING ANTI-VENOM ADMINISTRATION AND ICU ADMISSION REQUIRING MECHANICAL VENTILATION

Snake bite, which results in the administration of anti-venom and intensive care unit (ICU) admission with mechanical ventilation.

15. TRAUMATIC EVENT RESULTING IN ICU ADMISSION OF MORE THAN 5 WEEKS WITH ASSISTED MECHANICAL VENTILATION FOR AT LEAST 3 OF THOSE WEEKS

A traumatic injury or event that results in intensive care unit (ICU) admission of more than 5 weeks, with assisted mechanical ventilation for at least 3 weeks.

16. RECONSTRUCTIVE SURGERY FOR MULTIPLE FACIAL FRACTURES

Multiple facial fractures that result in two or more craniofacial surgeries, where medically necessary realignment of the bone segments and fixation are performed. This must be performed by a reconstructive or maxillofacial surgeon. This claim event does not cover cosmetic surgery.

17. BASIC ACTIVITIES OF DAILY LIVING

Bathing	The ability to wash or bathe oneself independently
Transferring	The ability to move oneself from a bed to a chair or from a bed to a toilet independently
Dressing	The ability to take off and put on one's clothes independently
Eating	The ability to feed oneself independently. This does not include the making of food
Toileting	The ability to use a toilet and cleanse oneself thereafter, independently
Locomotion on a level surface	The ability to walk on a flat surface, independently
Locomotion on an incline	The ability to walk up a gentle slope, or a flight of steps independently

18. ADVANCED ACTIVITIES OF DAILY LIVING

Driving a car	The ability to open a car door, change gears or use a steering wheel
Medical care	The ability to prepare and take the correct medication
Money management	The ability to do one's own banking and to make rational financial decisions
Communicative activities	The ability to communicate either verbally or written
Shopping	The ability to choose and lift groceries from shelves as well as carry them in bags
Food preparation	The ability to prepare food for cooking as well as using kitchen utensils
Housework	The ability to clean a house or iron clothing
Community ambulation with or without assistive device, but not requiring a mobility device	The ability to walk around in public places using only a walking stick if necessary
Moderate activities	Activities like moving a table, pushing a vacuum cleaner, bowling, golf
Vigorous activities	Able to partake in running, heavy lifting, sports

COMMENCEMENT DATE means 1 November 2022.

COMPLAINT means a complaint or request relating to either party's obligations under DATA PRIVACY LAWS in terms of the Policy, including any compensation claim from a DATA SUBJECT or any notice, investigation or other action from a SUPERVISORY AUTHORITY.

CONSUMER PRICE INDEX means the "consumer price index for all urban areas" supplied by Statistics South Africa from time to time.

DATA PRIVACY LAWS mean any APPLICABLE LAWS relating to the processing, privacy, and use of PERSONAL INFORMATION, as applicable to SANLAM and the EMPLOYER in terms of the Policy, including:

(a) in Republic of South Africa:

(i) the POPIA including any regulations promulgated pursuant thereto; and/or

(ii) any other statute dealing with data privacy; and

(b) any judicial or administrative interpretation of any of the above, any guidance, guidelines, codes of practice, approved codes of conduct or approved certification mechanisms issued by any relevant SUPERVISORY AUTHORITY.

DATA SUBJECT means a person to whom personal information relates.

DATE OF WITHDRAWAL means the date on which the INSURED ceases to be an INSURED, or the earlier of the day on which he/she reaches the BENEFIT CESSATION DATE and the last day of the MONTH in which he/she attains the age of 65 years if he/she continues his/her service with the EMPLOYER thereafter.

DEPENDANT in regard to an INSURED means-

(a) a person who, in the opinion of SANLAM, is in fact dependent on the INSURED for maintenance; or

(b) a person with whom the INSURED is joined in marriage; or

(c) a child of the INSURED, including an adopted child and an illegitimate child.

EMPLOYEE means a person who is in the service of the EMPLOYER including a person on a fixed term contract of employment with the EMPLOYER, provided that the fixed term contract is not for less than three months.

EMPLOYER means the PRINCIPAL EMPLOYER and any subsidiary of the PRINCIPAL EMPLOYER that participates in the Policy with the prior written consent of SANLAM and the PRINCIPAL EMPLOYER, provided that the EMPLOYER is registered in the Republic of South Africa.

With regard to an EMPLOYEE, EMPLOYER means that EMPLOYER by whom the EMPLOYEE is or was last employed.

The term EMPLOYER includes an ACQUISITION EMPLOYER.

INSURED means a person who is insured in terms of this Policy by virtue of being an EMPLOYEE.

LABOUR RELATIONS ACT means the Labour Relations Act (Act No.66 of 1995), as amended, and the regulations made in terms of it, or any substituting statutory measures.

MEDICAL PROOF FREE LIMIT in regard to an INSURED means that part of the BENEFIT ENTITLEMENT regarding which proof of good health does not have to be submitted, as laid down from time to time by SANLAM and conveyed in writing to the EMPLOYER.

MONTH means any of the twelve periods in which a year is divided.

MULTIPLE CLAIMS in regard to an INSURED means that a claim for more than 1 SEVERE ILLNESS may be submitted while he/she is an INSURED.

NORMAL RETIREMENT AGE means such age as specified in the EMPLOYEE'S employment contract conditions of service, with a maximum of 65 years.

NORMAL RETIREMENT DATE in regard to an INSURED means the last day of the MONTH in which he/she reaches the NORMAL RETIREMENT AGE.

PERSONAL INFORMATION means personal information as defined in POPIA and special personal information as defined in POPIA.

PERSONAL INFORMATION BREACH means any breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, any PERSONAL INFORMATION.

POPIA means the Protection of Personal Information Act, 4 of 2013.

PRINCIPAL EMPLOYER means Ernst & Young Incorporated; Ernst & Young Advisory Services (Pty) Ltd; Ernst & Young Services (Pty) Ltd and EY Catalyst (Pty) Ltd.

RELATED CLAIMS in regard to an INSURED means a claim which is related to another claim in terms of the Policy on the basis that –

(a) there is a direct causal link to the other claim that can be verified objectively; and

(b) there are sufficient published medical evidence that the SEVERE ILLNESS occurred as a result of the other SEVERE ILLNESS, or due to the same disease process or injury, and that the likelihood of the SEVERE ILLNESS occurring was very low in the absence of the other SEVERE ILLNESS.

RISK SALARY in regard to an INSURED means the total of

(a) the amount of the basic cash remuneration the INSURED receives from the EMPLOYER, plus

(b) any amount determined by the EMPLOYER in terms of its human resources policy, and that is agreed to by the EMPLOYER and SANLAM,

provided that –

- unless the EMPLOYER and SANLAM agree otherwise, the annual RISK SALARY of an INSURED with a variable income is limited to the income which he/she received from the EMPLOYER during the 12 MONTHS immediately preceding the date on which the RISK SALARY is determined or, if less than 12 MONTHS, to his/her average monthly income during the number of MONTHS in which he/she received an income from the EMPLOYER multiplied by twelve; and

- the total of the INSURED's RISK SALARY may not exceed the total cost incurred (either conditionally or not) by the EMPLOYER in respect of the INSURED's service with the EMPLOYER.

However, if in terms of the EMPLOYER'S human resources policy, the benefits and premiums in terms of this Policy in regard to an INSURED is based on 80% of the INSURED's Total Cost Package therefore,

- the applicable salary to be used must be advised to SANLAM by the EMPLOYER and accepted by SANLAM in writing for the purposes of the Policy; and

- the percentage must apply to all EMPLOYEES who are insured in terms of this Policy per defined categories; and

- SANLAM must be advised in writing if the applicable percentage has changed before the date that the change becomes applicable; and

- individual choices per INSURED will not be allowed, unless agreed otherwise between the EMPLOYER and SANLAM.

RESPONSIBLE PARTY means a public or private body or any other person which, alone or in conjunction with others, determines the purpose of and means for processing PERSONAL INFORMATION.

REVIEW DATE means 1 November of each year, the date on which the premium rate and underwriting conditions will be reviewed.

REVIEW PERIOD means a period starting on the REVIEW DATE in any year and ending immediately before the next REVIEW DATE. For purposes of this definition, the period from COMMENCEMENT DATE up to 31 October 2023, will be regarded as the first review period.

SANLAM means Sanlam Life Insurance Limited.

SEVERE ILLNESS means any illness, injury or condition listed in any of the various categories under the definition of CLAIM CATEGORIES.

SUM INSURED in regard to an INSURED means an amount equal to 1 times but not more than the smaller of 3 times the INSURED's annual RISK SALARY immediately before he/she contracted the SEVERE ILLNESS and R2,800,000, or any other maximum amount determined by SANLAM. The SUM INSURED applicable to the INSURED will not be reduced with the amount(s) of the SEVERE ILLNESS claim(s) that has been admitted.

SUPERVISORY AUTHORITY means any local, national or multinational agency, department, official, parliament, public or statutory person or any government or professional body, regulatory or supervisory authority, board or other body responsible for administering DATA PRIVACY LAWS.

SURVIVAL PERIOD means a period of 14 days immediately following the date of contracting the SEVERE ILLNESS, where the date of contracting is the date as contemplated in clause 3.5.

UNRELATED CLAIMS in regard to an INSURED means that a claim will be regarded as being unrelated to another claim if it does not meet the definition for RELATED CLAIMS.

WAITING PERIOD FOR JOINT REPLACEMENTS in regard to an INSURED means a period of 5 years during which the INSURED will not qualify for a HIP and/or KNEE JOINT REPLACEMENT. This period will commence on the latest date on which the insurance of the benefit or an increase in the benefit by virtue of an amendment to the Policy, as the case may be, becomes applicable to the INSURED.

SCHEDULE 2 PARTICIPATION

2.1 INSURED

2.1(1) Every EMPLOYEE qualifies to become an INSURED in terms of this Policy, provided that -

(a) he/she has already reached the age of 15 years; and

(b) he/she has not reached the NORMAL RETIREMENT AGE.

2.1(2) An EMPLOYEE who entered the service of the EMPLOYER before the COMMENCEMENT DATE and has since then remained in the EMPLOYER'S service without interruption, may become an INSURED on or after the date on which he/she qualifies for the insurance by applying for it.

2.1(3) If an EMPLOYEE referred to in sub-clause (2) above applies in writing to become an INSURED more than 3 MONTHS after the date of qualification such EMPLOYEE can only become an INSURED with the approval of SANLAM and subject to the terms and conditions SANLAM may lay down in terms of the specific case at that time. Please refer to clause 3.6(1) In this regard.

2.1(4) An EMPLOYEE who is in the service of an ACQUISITION EMPLOYER, who on the ACQUISITION DATE has an option to become an INSURED and who-

(a) apply in writing to become an INSURED withing three MONTHS of the ACQUISITION DATE, may become an INSURED with the approval of SANLAM, subject to clause 4.1(2); or

(b) apply in writing to become an INSURED more than three MONTHS after the date of qualification, will not qualify to become an INSURED. However, such an EMPLOYEE may become an INSURED with the approval of SANLAM, provided that the EMPLOYEE submits proof of good health in terms of clause 4.1(3).

2.1(5) The insurance of an EMPLOYEE who is insured in accordance with the preceding sub-clause 2.1(3) and 2.1(4), commences on the first day of the MONTH following the date on which SANLAM approves the insurance and subject to the terms and conditions SANLAM may lay down in the terms of the specific case at that time.

2.1(6) Every EMPLOYEE who qualifies for this insurance on or after the COMMENCEMENT DATE, automatically and without any specific application is insured in terms of this Policy from the date on which he/she qualifies for the insurance.

2.1(7) The requirements referred to in the preceding sub-clause must be laid down by the EMPLOYER as a condition of employment of its EMPLOYEES.

2.2 Termination of participation of an INSURED

An INSURED ceases to be an INSURED -

(a) at the INSURED's death; or

(b) as soon as the INSURED, after he/she has ceased to be an EMPLOYEE, ceases to be entitled to a benefit in terms of the Policy; or

(c) as soon as the contract with the EMPLOYER expires in the case of an INSURED who is on a fixed term contract with the EMPLOYER; or

(d) at the cancellation of the insurance in terms of the provisions of the Policy; or

(e) if the EMPLOYER ceases to carry on business,

whichever event occurs first.

SCHEDULE 3 SEVERE ILLNESS INSURANCE - COMPREHENSIVE SEVERE ILLNESS BENEFIT

3.1 Benefit

3.1(1) If an INSURED contracts a SEVERE ILLNESS while being an EMPLOYEE before the BENEFIT CESSATION DATE and does not die before the end of the SURVIVAL PERIOD, SANLAM pays the SUM INSURED, subject to -

- the proof of good health requirements stipulated in SCHEDULE 4
- the reappointment provisions stipulated in SCHEDULE 8
- the INSURED satisfies the conditions pertaining to the definition of the SEVERE ILLNESS described in the CLAIM CATEGORIES in SCHEDULE 1.

3.1(2) The benefit is determined according to the payout percentage linked to the particular SEVERE ILLNESS, as indicated in Table A of the SUM INSURED and is subject to the conditions and limitations regarding MULTIPLE CLAIMS as stipulated in clause 3.2. This means that for MULTIPLE CLAIMS we may pay a lower percentage than the payout percentage of the SUM INSURED.

Table A

The first column in Table A below contains the SEVERE ILLNESSES grouped and listed in CLAIM CATEGORIES. Refer to SCHEDULE 1 for the definitions of the SEVERE ILLNESS listed in the various categories included under the definition of CLAIM CATEGORIES that will together with the provisions of the other SCHEDULES be used to consider a claim.

The second column contain the percentages of the SUM INSURED that apply to each SEVERE ILLNESS.

If SANLAM admits a claim, SANLAM will pay a percentage of the SUM INSURED that applies to the particular SEVERE ILLNESS as set out in Table A below. For MULTIPLE CLAIMS, SANLAM may pay a lower percentage than the percentage as indicated in Table A, as described in clause 3.2.

* These SEVERE ILLNESSES include any stage I –IV cancer not covered under the SEVERE ILLNESS definitions in the CLAIM CATEGORIES defined in SCHEDULE 1, excluding cancers of the prostate and skin. Specified cancers of the prostate and skin are covered under the definitions of SEVERE ILLNESS in SCHEDULE 1.

** These joint replacement SEVERE ILLNESSES under the MUSCULOSKELETAL SYSTEM CLAIM CATEGORY are subject to a **WAITING PERIOD FOR JOINT REPLACEMENTS** as described in SCHEDULE 1.

Table A

SEVERE ILLNESS	**Payout percentage of the SUM INSURED**
CANCERS, LEUKAEMIAS, LYMPHOMAS AND TUMOURS	
PANCREATIC CANCER STAGE I TO IV	100

SEVERE ILLNESS	Payout percentage of the SUM INSURED
OESOPHAGEAL CANCER STAGE I TO IV	100
STOMACH CANCER STAGE I TO IV	100
LUNG CANCER STAGE I TO IV	100
LIVER OR BILE DUCT CANCER STAGE I TO IV	100
MESOTHELIOMA STAGE I TO IV	100
TONGUE OR HYPOPHARYNGEAL CANCER STAGE I TO IV	100
RETROPERITONEAL, OMENTAL OR MESENTERIC CANCER STAGE I TO IV	100
ACUTE LYMPHOBLASTIC LEUKAEMIA	100
ACUTE MYELOBLASTIC LEUKAEMIA	100
BASAL CELL SKIN CARCINOMA OR SQUAMOUS CELL SKIN CARCINOMA (STAGE L OR II) HAVING UNDERGONE A SKIN GRAFT OR SKIN FLAP	10
BONE MARROW TRANSPLANT	100
BRAIN TUMOUR (GRADE II ON WHO CLASSIFICATION)	50
BRAIN TUMOUR (GRADE III OR IV ON WHO CLASSIFICATION)	100
CARCINOID SYNDROME WITH EVIDENCE OF LIVER METASTASIS OF ATYPICAL CARCINOID TUMOUR	100
CARCINOID SYNDROME	15
CHRONIC LYMPHOCYTIC LEUKAEMIA (STAGE 0 OR I ON THE RAI CLASSIFICATION SYSTEM)	25
CHRONIC LYMPHOCYTIC LEUKAEMIA (STAGE II ON THE RAI CLASSIFICATION SYSTEM)	50
CHRONIC LYMPHOCYTIC LEUKAEMIA (STAGE III ON THE RAI	100

SEVERE ILLNESS	Payout percentage of the SUM INSURED
CLASSIFICATION SYSTEM)	
CHRONIC LYMPHOCYTIC LEUKAEMIA (STAGE IV ON THE RAI CLASSIFICATION SYSTEM)	100
CHRONIC MYELOID LEUKAEMIA (NO BONE MARROW TRANSPLANT)	50
CHRONIC MYELOID LEUKAEMIA (WITH BONE MARROW TRANSPLANT)	100
HAIRY CELL LEUKAEMIA	25
HODGKIN'S OR NON-HODGKIN'S LYMPHOMA (STAGE I ON ANN ARBOR CLASSIFICATION SYSTEM)	25
HODGKIN'S OR NON-HODGKIN'S LYMPHOMA (STAGE II ON ANN ARBOR CLASSIFICATION SYSTEM)	50
HODGKIN'S OR NON-HODGKIN'S LYMPHOMA (STAGE III OR IV ON ANN ARBOR CLASSIFICATION SYSTEM)	100
MALIGNANT MELANOMA WITH INVASION BEYOND THE EPIDERMIS OR T1N0M0	25
MALIGNANT MELANOMA STAGE II	50
MALIGNANT MELANOMA STAGE III OR IV	100
MULTIPLE MYELOMA (STAGE I OR II ON THE DURIE-SALMON SCALE)	50
MULTIPLE MYELOMA (STAGE III ON THE DURIE-SALMON SCALE)	100
MYELODYSPLASTIC SYNDROME	15
PROSTATE CANCER – T1A-C N0M0, GLEASON SCORE 2-6	10
PROSTATE CANCER – T1A-C N0M0, GLEASON SCORE ≥7	25
PROSTATE CANCER – T2N0M0, GLEASON SCORE 2-6	25
PROSTATE CANCER – T2N0M0, GLEASON SCORE ≥7	50

SEVERE ILLNESS	Payout percentage of the SUM INSURED
PROSTATE CANCER – T3N0M0, GLEASON SCORE 2-6	50
PROSTATE CANCER – T3N0M0, GLEASON SCORE ≥7	100
PROSTATE CANCER STAGE IV	100
ANY NON-MELANOMA SKIN CANCER STAGE III	100
ANY NON-MELANOMA SKIN CANCER STAGE IV	100
BENIGN BRAIN TUMOUR TREATED SURGICALLY	25
BRAIN ABSCESS HAVING UNDERGONE SURGICAL DRAINAGE	10
RECURRENT OR INOPERABLE BENIGN BRAIN TUMOUR SHOWING SYMPTOMS	25
PITUITARY TUMOUR WITH SURGICAL RESECTION	25
BENIGN ENDOCRINE TUMOURS HAVING UNDERGONE SURGICAL EXCISION	15
AMYLOIDOSIS	25
*ANY OTHER STAGE I CANCER, UNLESS INCLUDED IN ANY OF THE CRITERIA SET OUT IN ANY OF THE PREVIOUS CLAIM EVENTS	25
*ANY OTHER STAGE II CANCER, UNLESS INCLUDED IN ANY OF THE CRITERIA SET OUT IN ANY OF THE PREVIOUS CLAIM EVENTS	50
*ANY OTHER STAGE III OR IV CANCER, UNLESS INCLUDED IN ANY OF THE CRITERIA SET OUT IN ANY OF THE PREVIOUS CLAIM EVENTS	100
CARDIOVASCULAR CONDITIONS: HEART, BLOOD VESSELS AND STROKE	
HEART TRANSPLANT	100
HEART VALVE REPLACEMENT IRRESPECTIVE OF TECHNIQUE	100
ANY HEART VALVE SURGERY SUCH AS VALVULOPLASTY OR VALVOTOMY IRRESPECTIVE OF TECHNIQUE	50

SEVERE ILLNESS	Payout percentage of the SUM INSURED
CARDIOMYOPATHY AT CLASS III NYHA AND EF LESS THAN 40% DESPITE OPTIMAL TREATMENT	75
CARDIOMYOPATHY AT CLASS IV NYHA AND EF LESS THAN 30% DESPITE OPTIMAL TREATMENT	100
TAKOTSUBO CARDIOMYOPATHY	25
TRANSCORONARY ABLATION OF SEPTAL HYPERTROPHY	50
PERICARDIECTOMY IRRESPECTIVE OF TECHNIQUE	50
ARRHYTHMIA HAVING UNDERGONE PATHWAY ABLATION	25
ARRHYTHMIA HAVING UNDERGONE A PERMANENT PACEMAKER INSERTION	25
ARRHYTHMIA HAVING UNDERGONE A DEFIBRILLATOR INSERTION	50
PERIPHERAL ARTERIAL DISEASE REQUIRING ANGIOPLASTY, STENT OR BYPASS GRAFT OF ONE PERIPHERAL ARTERY	10
PERIPHERAL ARTERIAL DISEASE REQUIRING ANGIOPLASTY, STENT OR BYPASS GRAFT OF MORE THAN ONE PERIPHERAL ARTERY	25
LOSS OF USE OF OR LOSS OF ONE FOOT DUE TO PERIPHERAL ARTERIAL DISEASE	15
LOSS OF USE OF OR LOSS OF ONE HAND DUE TO PERIPHERAL ARTERIAL DISEASE	50
ANGIOPLASTY WITH OR WITHOUT STENTING IN ONE CAROTID ARTERY	25
ANGIOPLASTY WITH OR WITHOUT STENTING OF BILATERAL CAROTID ARTERIES	50
CAROTID ARTERIAL DISEASE: NARROWING OF AT LEAST ONE CAROTID ARTERY REQUIRING EITHER BYPASS GRAFT OR ENDARTERECTOMY	75
ENDOVASCULAR SURGERY OR STENT TO REPAIR ANY THORACIC OR ABDOMINAL AORTIC ANEURYSM	50

SEVERE ILLNESS	Payout percentage of the SUM INSURED
SURGICAL REPAIR OF AN ILEOFEMORAL ANEURYSM OR STENOSIS	50
SURGICAL REPAIR OF ANY ANEURYSM OR STENOSIS OF MAJOR ARTERIAL BRANCHES OF THE AORTA	50
MAJOR SURGERY TO DISSECT AND SURGICALLY GRAFT AN AORTIC ANEURYSM	100
PRIMARY PULMONARY HYPERTENSION	100
SURGICAL REPAIR OF COARCTATION OF THE AORTA	25
LEFT VENTRICULAR ANEURYSM REPAIRED SURGICALLY	100
SURGERY FOR ATRIAL MYXOMA	50
SUBARACHNOID HAEMORRHAGE WITHOUT NEUROLOGICAL IMPAIRMENT	25
ARTERIOVENOUS MALFORMATION TREATED WITH RADIOLOGICAL INTERVENTION	25
ARTERIOVENOUS MALFORMATION TREATED WITH OPEN SURGERY CRANIOTOMY	50
ANGIOPLASTY WITH OR WITHOUT STENTING FOR CORONARY ARTERIES	25
CORONARY ARTERY DISEASE WITH CORONARY ARTERY BYPASS GRAFT FOR UP TO TWO VESSELS	50
CORONARY ARTERY DISEASE WITH CORONARY ARTERY BYPASS GRAFT FOR THREE OR MORE VESSELS	100
MILD HEART ATTACK OF SPECIFIED SEVERITY	35
MODERATE HEART ATTACK OF SPECIFIED SEVERITY	50
HEART ATTACK WITH PERMANENT MILD IMPAIRMENT IN FUNCTION	75
HEART ATTACK WITH PERMANENT SEVERE IMPAIRMENT IN FUNCTION	100

SEVERE ILLNESS	Payout percentage of the SUM INSURED
TAKAYASU'S DISEASE	25
SUPERIOR SAGITTAL SINUS THROMBOSIS	25
CAVERNOUS SINUS THROMBOSIS	25
PERSISTENT GIANT CELL ARTERITIS DESPITE OPTIMAL THERAPY	25
STROKE WITH FULL RECOVERY	25
STROKE WITH ALMOST FULL RECOVERY	25
STROKE WITH MILD IMPAIRMENT	50
STROKE WITH MODERATE IMPAIRMENT	75
STROKE WITH SEVERE IMPAIRMENT	100
CONNECTIVE TISSUE	
PROGRESSIVE SYSTEMIC SCLEROSIS (SCLERODERMA)	100
SEROPOSITIVE RHEUMATOID ARTHRITIS	25
ADVANCED OR PROGRESSIVE RHEUMATOID ARTHRITIS DESPITE OPTIMAL TREATMENT	100
SYSTEMIC LUPUS ERYTHEMATOSIS (SLE)	25
SYSTEMIC LUPUS ERYTHEMATOSIS WITH MULTIPLE ORGAN IMPAIRMENT	100
SARCOIDOSIS	25
SARCOIDOSIS WITH MULTIPLE ORGAN INVOLVEMENT	100
POLYARTERITIS NODOSA	20
WEGENER'S GRANULOMATOSIS	20

SEVERE ILLNESS	Payout percentage of the SUM INSURED
EAR, NOSE AND THROAT	
ACOUSTIC NEUROMA RESULTING IN NEUROLOGICAL DEFICIT	30
MASTOIDITIS REQUIRING MASTOIDECTOMY	30
THE TOTAL, PERMANENT AND IRREVERSIBLE LOSS OF HEARING IN ONE EAR	30
MORE THAN 60% BINAURAL HEARING LOSS	50
MORE THAN 75% BINAURAL HEARING LOSS	70
TOTAL LOSS OF HEARING IN BOTH EARS	100
RECIPIENT OF COCHLEAR OR MIDDLE EAR IMPLANT	20
GASTROINTESTINAL SYSTEM	
TRACHEOESOPHAGEAL FISTULA HAVING UNDERGONE SURGERY	25
CROHN'S DISEASE OR ULCERATIVE COLITIS WITH PROLONGED ADVANCED THERAPY	25
CROHN'S DISEASE OR ULCERATIVE COLITIS WITH RECURRENT SURGERY	50
CROHN’S DISEASE OR ULCERATIVE COLITIS WITH A PERMANENT COLOSTOMY OR ILEOSTOMY	75
HEMICOLECTOMY	25
TOTAL COLECTOMY (REMOVAL OF THE ASCENDING, DESCENDING AND TRANSVERSE COLON)	50
ANY DISEASE OR DISORDER REQUIRING PARTIAL HEPATECTOMY	25
CHRONIC PERSISTENT HEPATITIS CLASSIFIED AS CHILD-PUGH CLASS A OR WORSE	100
SCLEROSING CHOLANGITIS CLASSIFIED AS CHILD-PUGH CLASS A OR WORSE	100

SEVERE ILLNESS	Payout percentage of the SUM INSURED
END-STAGE LIVER FAILURE	100
LIVER OR PANCREAS TRANSPLANT	100
AMYLOIDOSIS OF THE LIVER AND SPLEEN	25
COMPLETE PANCREATECTOMY	100
PRIMARY BILIARY CIRRHOSIS CONFIRMED ON A LIVER BIOPSY BY A GASTROENTEROLOGIST	50
LOSS OF MORE THAN ONE THIRD OF THE TONGUE	20
LYMPH AND BLOOD	
CHRONIC BLOOD DISORDERS REQUIRING CONSTANT BLOOD REPLACEMENTS	50
SEVERE APLASTIC ANAEMIA	50
A BONE MARROW TRANSPLANT OR STEM CELL TRANSPLANT	100
MUSCULOSKELETAL SYSTEM	
**HIP JOINT REPLACEMENT	15
**KNEE JOINT REPLACEMENT	15
PARAPLEGIA, HEMIPLEGIA, DIPLEGIA OR QUADRIPLEGIA	100
LOSS OF MORE THAN 50% OF HAND FUNCTION AS DEFINED IN AMA'S GUIDES OR ITS EQUIVALENT	25
LOSS OF USE OF OR LOSS OF ONE FOOT	25
LOSS OF USE OF OR LOSS OF ONE HAND	50
LOSS OF USE OF OR LOSS OF BOTH FEET	100
LOSS OF USE OF OR LOSS OF ONE HAND AND ONE FOOT	75

SEVERE ILLNESS	Payout percentage of the SUM INSURED
LOSS OF USE OF OR LOSS OF ONE LIMB	50
LOSS OF USE OF OR LOSS OF BOTH HANDS	100
LOSS OF USE OF OR LOSS OF MORE THAN ONE LIMB	100
NERVOUS SYSTEM AND PSYCHIATRIC DISORDERS	
CONDITIONS HAVING UNDERGONE OPEN BRAIN SURGERY	50
GUILLAIN-BARRE WITH PROLONGED RESPIRATORY SUPPORT	50
GUILLAIN-BARRE WITH PERMANENT NEUROLOGICAL DEFICIT	100
PERMANENT AND COMPLETE INABILITY TO COMMUNICATE OR COMPREHEND LANGUAGE SYMBOLS	100
A PERMANENT HEMIPARESIS OR PARALYSIS SECONDARY TO TRAUMA OR SURGERY	100
PERMANENT MODERATE TO SEVERE IMPAIRMENT OF INTELLECTUAL CAPACITY AS A RESULT OF BRAIN INJURY OR SYSTEMIC HYPOXIA	50
MOTOR NEURON DISEASE	100
DIAGNOSIS OF MUSCULAR DYSTROPHY	50
PROGRESSIVE MUSCULAR DYSTROPHY	100
COMA WITH FULL RECOVERY	50
COMA RESULTING IN PERMANENT NEUROLOGICAL DEFICIT	100
MULTIPLE SCLEROSIS	25
ADVANCED MULTIPLE SCLEROSIS	100
OPTIC NEURITIS WITH DEMYELINATING ON MRI	25

SEVERE ILLNESS	Payout percentage of the SUM INSURED
PARKINSON’S DISEASE	25
ADVANCED PARKINSON’S DISEASE	100
DIAGNOSIS OF MYASTHENIA GRAVIS	25
MYASTHENIA GRAVIS WITH SEVERE PERMANENT IMPAIRMENT	100
HYDROCEPHALUS WITH THE INSERTION OF A VP SHUNT	25
STEREOTACTIC BRAIN SURGERY	25
IRREVERSIBLE UNILATERAL TRIGEMINAL NERVE PALSY	25
IRREVERSIBLE UNILATERAL FACIAL NERVE PALSY	25
IRREVERSIBLE UNILATERAL HYPOGLOSSAL NERVE PALSY	25
IRREVERSIBLE CEREBELLUM DYSFUNCTION	50
ALZHEIMER'S DISEASE	100
MEDICALLY CERTIFIED INSTITUTIONALISATION FOR A MENTAL AND BEHAVIOURAL DISORDER FOR AT LEAST 6 MONTHS CONTINUOUSLY	100
RENAL DISORDERS	
PRIMARY AMYLOIDOSIS OF THE KIDNEY	25
PARTIAL OR TOTAL NEPHRECTOMY	25
RENAL CORTICAL NECROSIS	25
NEPHROTIC SYNDROME WITH RENAL ARTERY OR RENAL VEIN THROMBOSIS	25
MODERATE PROGRESSIVE CHRONIC KIDNEY DISEASE WITH DECLINE IN FUNCTION	50

SEVERE ILLNESS	Payout percentage of the SUM INSURED
SEVERE PROGRESSIVE CHRONIC KIDNEY DISEASE WITH DECLINE IN FUNCTION	75
CHRONIC, IRREVERSIBLE KIDNEY FAILURE REQUIRING AND ALREADY HAVING UNDERGONE REGULAR DIALYSIS TREATMENT	100
A KIDNEY TRANSPLANT	100
DOCUMENTED RENAL VEIN THROMBOSIS	25
RESPIRATORY DISORDERS	
PULMONARY EMBOLISM	25
CHRONIC IRREVERSIBLE LUNG DISEASE WITH SEVERE IMPAIRMENT	100
REMOVAL OF A LUNG	50
RECURRENT PULMONARY EMBOLISM, WITH ASSOCIATED PULMONARY HYPERTENSION	100
A LUNG OR HEART-LUNG TRANSPLANT	100
ANY CHRONIC LUNG DISEASE WITH PLEURECTOMY OR DECORTICATION	15
CHRONIC SARCOIDOSIS NOT RESPONDING TO OPTIMAL TREATMENT	50
PULMONARY ALVEOLAR PROTEINOSIS	50
REMOVAL OF TWO OR MORE LOBES OF A LUNG	25
UROGENITAL DISORDERS	
TOTAL AMPUTATION OF THE PENIS	50
PARTIAL CYSTECTOMY (REMOVAL OF AT LEAST 50% OF THE URINARY BLADDER)	25
RADICAL CYSTECTOMY RESULTING IN A NEED FOR AN EXTERNAL BAG OR CATHETERISATION	50

SEVERE ILLNESS	Payout percentage of the SUM INSURED
BILATERAL ORCHIDECTOMY	25
VISION	
ENUCLEATION OF ONE EYE	25
RETINITIS PIGMENTOSA	25
TOTAL, PERMANENT AND IRREVERSIBLE LOSS OF SIGHT IN ONE EYE	25
IRREVERSIBLE HEMIANOPIA IN ONE EYE	30
IRREVERSIBLE LOSS OF SIGHT IN BOTH EYES WITH BEST CORRECTED BILATERAL VISUAL ACUITY OF 6/30 OR WORSE	100
IRREVERSIBLE HEMIANOPIA IN BOTH EYES	75
INFECTIONS	
ACCIDENTAL HIV INFECTION	100
CEREBRAL MALARIA	25
CEREBRAL MALARIA RESULTING IN PERMANENT NEUROLOGICAL IMPAIRMENT	100
INJURIES, ACCIDENTS AND POISON	
FULL THICKNESS BURNS INVOLVING MORE THAN 30% OF ONE HAND OR MORE THAN 30% OF THE HEAD	25
GRADE II PARTIAL THICKNESS BURNS INVOLVING MORE THAN 20% OF THE BODY SURFACE AREA	25
FULL THICKNESS BURNS INVOLVING MORE THAN 10% BUT LESS THAN OR EQUAL TO 20% OF THE BODY SURFACE AREA	50
FULL THICKNESS BURNS INVOLVING MORE THAN 20% BUT LESS THAN OR EQUAL TO 30% OF THE BODY SURFACE AREA	75
FULL THICKNESS BURNS INVOLVING MORE THAN 30% OF THE BODY SURFACE AREA	100

SEVERE ILLNESS	Payout percentage of the SUM INSURED
TRAUMATIC INJURIES RESULTING IN A COMATOSE STATE REQUIRING MECHANICAL VENTILATION PERSISTENT FOR LONGER THAN 96 HOURS	100
SPINAL INJURY RESULTING IN PARAPLEGIA, DIPLEGIA, HEMIPLEGIA, QUADRIPLEGIA OR CAUDA EQUINA SYNDROME	100
LOSS OF BOWEL OR BLADDER FUNCTION, WITH PERMANENT STOMA OR INDWELLING CATHETER	25
SKULL FRACTURE REQUIRING RECONSTRUCTION	20
DOG BITE TO THE FACE REQUIRING PRIMARY SUTURING, FOLLOWED BY MULTIPLE SESSIONS OF REPAIR BY A PLASTIC OR RECONSTRUCTIVE SURGEON	20
BRACHIAL PLEXUS INJURY WITH PERMANENT NEUROLOGICAL IMPAIRMENT	50
RADIAL, ULNAR OR MEDIAN NERVE INJURY, WITH LOSS OF FUNCTION OF THE HAND	25
LEAD OR MERCURY POISONING	15
VENOMOUS SNAKE BITE NECESSITATING ANTI-VENOM ADMINISTRATION AND ICU ADMISSION REQUIRING MECHANICAL VENTILATION	15
TRAUMATIC EVENT RESULTING IN ICU ADMISSION OF MORE THAN 5 WEEKS WITH ASSISTED MECHANICAL VENTILATION FOR AT LEAST 3 OF THOSE WEEKS	50
RECONSTRUCTIVE SURGERY FOR MULTIPLE FACIAL FRACTURES	30

3.1(3) The benefit payable in the event of a SEVERE ILLNESS is limited so that the aggregate amount which is paid in terms of similar benefits from all sources regarding the INSURED does not exceed R7,500,000.

3.2 Conditions regarding payment of MULTIPLE CLAIMS in respect of an INSURED

3.2(1) An INSURED may submit MULTIPLE CLAIMS while he/she remains an INSURED.

3.2(2) If a claim is submitted for more than one SEVERE ILLNESS at the same time, SANLAM will first consider the SEVERE ILLNESS with the highest payout percentage.

3.2(3) There is no limitation on the number of MULTIPLE CLAIMS that an INSURED may submit on condition that the claims are not RELATED CLAIMS.

3.2(4) If SANLAM admits a RELATED CLAIM, SANLAM will reduce the payout percentage of the RELATED CLAIM with the payout percentage of all the previously RELATED CLAIMS that have been admitted. SANLAM will pay the difference if it is greater than zero.

3.2(5) There is no limitation on the number of BUNDLED CLAIMS that an INSURED may submit.

3.2(6) Notwithstanding anything to the contrary contained in the Policy, SANLAM may reduce the payout percentage in order to ensure that the sum of the payout percentages of a BUNDLED CLAIM or RELATED CLAIM is not more than 100% of the SUM INSURED.

3.2(7) The payout percentage of the SUM INSURED for any of the SEVERE ILLNESSES listed below, will only be reduced after the second claim for that SEVERE ILLNESS has been paid. This means that SANLAM will pay for 2 SEVERE ILLNESS claims listed below, even if the 2 claims are RELATED CLAIMS. Each claim is subject to the payout percentage of the SUM INSURED as indicated in Table A.

(a) ANY HEART VALVE SURGERY SUCH AS VALVUPLASTY OF VALVOTOMY IRRESPECTIVE OF THE TECHNIQUE;

(b) PERIPHERAL ARTERIAL DISEASE REQUIRING ANGIOPLASTY, STENT OR BYPASS GRAFT OF ONE PERIPHERAL ARTERY;

(c) PERIPHERAL ARTERIAL DISEASE REQUIRING ANGIOPLASTY, STENT OR BYPASS GRAFT OF MORE THAN ONE PERIPHERAL ARTERY;

(d) ANGIOPLASTY WITH OR WITHOUT STENTING IN ONE CAROTID ARTERY;

(e) ANGIOPLASTY WITH OR WITHOUT STENTING OF BILATERAL CAROTID ARTERIES;

(f) ANGIOPLASTY WITH OR WITHOUT STENTING FOR CORONARY ARTERIES;

(g) STROKE WITH FULL RECOVERY.

3.3 Payment of benefit

The benefit is paid in accordance with the payment provisions stipulated in SCHEDULE 7.

3.4 Exclusions and limitations

Notwithstanding any provision to the contrary in this Policy, the insurance in terms of this SCHEDULE in regard to an INSURED is subject to –

(a) the proof of good health requirements as stipulated in SCHEDULE 4; and

(b) the exclusions and/or limitations as set out in SCHEDULE 5; and

(c) the reappointment provisions stipulated in SCHEDULE 8.

3.5 Time of contracting a SEVERE ILLNESS

The date of contracting the SEVERE ILLNESS is taken as the date of the first diagnosis thereof.

3.6 Commencement of SANLAM's liability

3.6(1) The benefit described in this SCHEDULE, or any increase in it by virtue of an amendment to the Policy, is not provided regarding an INSURED if the INSURED had the option of becoming an INSURED and a claim for the benefit arises before SANLAM has received full particulars regarding him/her and the terms and conditions that SANLAM has laid down in terms of that specific case at that time for participation have been satisfied.

3.6(2) A claim for a HIP JOINT REPLACEMENT or a KNEE JOINT REPLACEMENT that forms part of the MUSCULOSKELETAL SYSTEM CLAIM CATEGORY described in this Policy, is not payable in regard to an INSURED if he/she contracts that SEVERE ILLNESS as a result of natural causes within the WAITING PERIOD FOR JOINT REPLACEMENTS.

3.7 Cancellation

3.7(1) If the insurance described in this Policy is cancelled for a group of INSURED, SANLAM's liabilities in terms of this SCHEDULE regarding each of those INSURED lapses, unless -

(a) the INSURED has contracted a SEVERE ILLNESS before the date of cancellation; and

(b) SANLAM is notified of a claim for this benefit in terms of the notification provisions in SCHEDULE 6; and

(c) the claim referred to is submitted to SANLAM before or within 6 MONTHS of the date of cancellation; and

(d) the SURVIVAL PERIOD expires before the date of cancellation; and

(e) the WAITING PERIOD FOR JOINT REPLACEMENTS expires before the date of cancellation; and

(f) the claim referred to has been or is admitted by SANLAM.

3.7(2) SANLAM will not be liable for any RELATED CLAIM that an INSURED contracts after the date of cancellation.

3.7(3) For the purposes of this clause an INSURED is deemed to be a member of a group if he/she was a member of the relevant group immediately prior to contracting a SEVERE ILLNESS.

SCHEDULE 4 PROOF OF GOOD HEALTH

4.1 Proof of good health in regard to an INSURED

4.1(1) The insurance in regard to an INSURED is limited to the MEDICAL PROOF FREE LIMIT, unless proof of good health to the satisfaction of SANLAM regarding that part of his/her BENEFIT ENTITLEMENT exceeding the MEDICAL PROOF FREE LIMIT is submitted to SANLAM in the manner specified by SANLAM from time to time. Such proof of good health is at SANLAM's expense. But the insurance is not limited to the MEDICAL PROOF FREE LIMIT in the following instances –

(a) for the first 3 MONTHS from the date on which the INSURED becomes an INSURED; and

(b) for the first 3 MONTHS from the effective date of an increase in the INSURED's BENEFIT ENTITLEMENT if the MEDICAL PROOF FREE LIMIT is exceeded for the first time as a result of the increase,

provided that-

- the benefit which is provided in the 3 MONTHS referred to in paragraphs (a) and (b) above may not exceed amounts determined by SANLAM from time to time (if applicable); and
- paragraph (a) is not applicable if the INSURED becomes an INSURED as a result of the insurance provided in terms of this Policy replacing other insurance in terms of which the INSURED was insured; and
- if an insured event occurs in respect the INSURED which gives rise to a claim within the 3 MONTHS referred to in paragraphs (a) and (b) above, and SANLAM is satisfied that the cause of the insured event relates to an illness or an injury which occurred within the 6 MONTHS immediately prior to the beginning of the period of 3 MONTHS, the benefit in terms of this Policy will, unless totally excluded in terms of the Policy, be limited to the MEDICAL PROOF FREE LIMIT; and
- the benefit in terms of this Policy will be limited to the MEDICAL PROOF FREE LIMIT if the insured event is directly or indirectly caused by or traceable to attempted suicide which occurs within the 3 MONTHS referred to in paragraphs (a) and (b) above; and
- if the INSURED submits proof of good health to the satisfaction of SANLAM within the 3 MONTHS referred to in paragraphs (a) or (b) above, then the insurance that is agreed by the EMPLOYER and SANLAM in writing is applicable to the INSURED from the moment it is put in writing; and
- for the purposes of this clause 4.1(1) "insured event" means any event in respect of which insurance is provided in terms of this Policy, for a benefit that is subject to proof of good health requirements.

The EMPLOYER must advise SANLAM in writing immediately when an INSURED's BENEFIT ENTITLEMENT exceeds the MEDICAL PROOF FREE LIMIT.

SANLAM will only request proof of good health in respect of an INSURED upon being advised by the EMPLOYER in writing that the INSURED's BENEFIT ENTITLEMENT has exceeded the MEDICAL PROOF FREE LIMIT.

SANLAM will not be liable for any claim in respect of any amount in excess of the MEDICAL PROOF FREE LIMIT where the EMPLOYER did not advise SANLAM in writing that the INSURED's BENEFIT ENTITLEMENT has exceeded the MEDICAL PROOF FREE LIMIT and in respect of whom proof of good health to the satisfaction of SANLAM was not submitted to SANLAM in the manner specified by SANLAM from time to time.

4.1(2) An EMPLOYEE who is in the service of an ACQUISITION EMPLOYER and who has the option of becoming an INSURED, is not insured in terms of this Policy unless if agreed on between the ACQUISITION EMPLOYER and SANLAM, proof of good health is submitted to SANLAM, to the satisfaction of SANLAM and in the manner specified by SANLAM from time to time. Such proof is at such person's own expense.

The EMPLOYER must advise SANLAM in writing of any person who has requested to become an INSURED.

SANLAM will only request proof of good health in respect of such a person upon being advised by the EMPLOYER in writing of such a person's request to become an INSURED.

SANLAM will not be liable for any claim in respect of such a person where the EMPLOYER did not advise SANLAM in writing of such a person's request to become an INSURED and in respect of whom proof of good health to the satisfaction of SANLAM was not submitted to SANLAM in a manner specified by SANLAM from time to time.

4.1(3) If anyone has the option of becoming an INSURED but has failed to become an INSURED within 3 MONTHS of becoming entitled to do so, no insurance is provided in terms of this Policy, unless, if proof of good health was required by SANLAM, such proof was submitted to the satisfaction of SANLAM and in the manner specified by SANLAM from time to time. Such proof is at such person's own expense.

The EMPLOYER must advise SANLAM in writing of any person who has requested to become an INSURED more than 3 MONTHS after becoming entitled to do so.

SANLAM will only request proof of good health in respect of such a person upon being advised by the EMPLOYER in writing of such a person's request to become an INSURED.

SANLAM will not be liable for any claim in respect of such a person where the EMPLOYER did not advise SANLAM in writing of such a person's request to become an INSURED and in respect of whom proof of good health to the satisfaction of SANLAM was not submitted to SANLAM in the manner specified by SANLAM from time to time.

4.1(4) Subject to clause 4.1(6), the benefits in terms of this Policy regarding which proof of good health to the satisfaction of SANLAM has been submitted to SANLAM in the manner specified by SANLAM from time to time, are only provided if the insured event is on or after the date on which SANLAM received the last information taken into account in considering the proof of good health.

4.1(5) Once proof of good health to the satisfaction of SANLAM for that part of an INSURED's insurance exceeding the MEDICAL PROOF FREE LIMIT has been submitted to SANLAM in the manner specified by SANLAM from time to time, subsequent increases in the INSURED's BENEFIT ENTITLEMENT as a result of an increase in the RISK SALARY will, in the following circumstances, apply only if further proof of good health to SANLAM's satisfaction has been provided:

(a) if certain periods determined by SANLAM from time to time have expired; or

(b) if the INSURED reaches a certain age determined by SANLAM from time to time; or

(c) if the benefit(s) exceeds amounts determined by SANLAM from time to time.

4.1(6) In deciding on medical grounds that the proof of good health that has been submitted in a particular case in terms of the preceding sub-clauses is to its satisfaction, SANLAM may -

(a) levy an additional premium (over and above its premium rate for standard lives) for the insurance of that part of the benefits for which the proof has been submitted, and of future increases in the benefits; or

(b) may lay down special conditions regarding the part of the benefits referred to; or

(c) may exclude certain CLAIM CATEGORIES and/or specified SEVERE ILLNESSES

provided that the part of the benefits referred to (including the increases) is only applicable if and after the EMPLOYER and SANLAM have agreed to it in writing.

4.1(7) If SANLAM reduces the MEDICAL PROOF FREE LIMIT at any specific time, the insurance that applied to an existing INSURED before such reduction is not reduced as a result of that, provided that the benefit remains applicable to the INSURED uninterruptedly.

4.1(8) If the insurance in this Policy has ceased to apply to an INSURED temporarily, proof of good health that was submitted in respect of the INSURED before such cessation is, for the purposes of the preceding sub-clauses, deemed null and void.

SCHEDULE 5 EXCLUSIONS, LIMITATIONS AND PRE-EXISTING HEALTH CONDITIONS

5.1 War and Riot exclusion

Notwithstanding any other provision to the contrary in the Policy, no benefit provided in terms of this Policy is paid if the realization of the relevant risk insured against in terms of this Policy -

(a) is a direct or indirect consequence of active participation in

(i) war, invasion, acts of foreign enemies, hostilities, warlike operations (whether war be declared or not), civil war, rebellion, revolution, military or usurped power, insurrection, civil commotion assuming the proportions of or amounting to an uprising; or

(ii) an act of terrorism; or

(iii) a riot; or

(iv) a strike (irrespective of whether the strike is lawful or unlawful), during which the INSURED's conduct gives rise to lives being endangered, public or private property damaged, or an attempt or attempts are made to damage such property; or

(v) any other unlawful act or conduct of whatever nature during which lives are endangered, public or private property damaged, or an attempt or attempts are made to damage such property.

(b) is a direct or indirect consequence of –

(i) any radioactive contamination, including accidental radioactive contamination; or

(ii) the use of nuclear, biological or chemical weapons; or

(iii) attacks on or sabotage of facilities (including, but not limited to, nuclear power plants, reprocessing plants, final repository sites and research reactors) and storage depots, which lead to the release of radioactivity or nuclear, biological or chemical warfare agents,

irrespective whether any of the aforesaid has been performed with the specific use of information technology.

5.2 Additional exclusions

No SEVERE ILLNESS benefit is paid in terms of this Policy if the SEVERE ILLNESS of the INSURED directly or indirectly arises from or is traceable to -

(i) a deliberate unlawful act committed by the INSURED that includes but is not limited to committing or attempting to commit the crime of murder, assault, housebreaking, theft, robbery, kidnapping or the INSURED committing a crime involving a sexual act;

(ii) deliberate self-inflicted injury;

(iii) taking of medicaments by the INSURED, except in accordance with medical prescription;

(iv) the driving of a motorised vehicle on a public road by the INSURED while the alcohol content of his/her blood is more than the legal limit;

(v) participation in –

- cliff diving;
- free diving at depths greater than 25m;
- scuba diving at depths greater than 40m;
- unaccompanied scuba diving;
- cave diving, commercial diving or the exploration of underwater wrecks for financial gain;
- expedition style mountaineering;
- solo climbing mountaineering;
- expedition caving;
- hazardous aviation activities with a fixed-wing aeroplane, including student pilots and acrobatic flights;
- microlight, helicopter or gyrocopter flying;
- recurrent hang-gliding, paragliding, parasailing, sky-diving, parachuting or sky-surfing;
- buildings, antennas, spans and earth (B.A.S.E.) jumping;
- motorized racing, speed contests or acrobatic flights;
- drag powerboat racing, competitive jet-skiing or competitive water skiing;
- professional boxing, professional kick-boxing, professional wrestling, martial arts or combat sports.

5.3 Actively at work condition

The benefit described in this Policy, or any increase in the insurance thereof by virtue of an amendment to the Policy, is not provided regarding an INSURED if, owing to a bodily injury or an illness, the INSURED, in SANLAM's opinion, is incapable of performing his/her normal duties with the EMPLOYER on the latest date on which the insurance of the benefit or the insurance of the increase, as the case may be, has commenced with SANLAM in respect of the INSURED and the realization of the relevant risk insured against in terms of this Policy in respect of the INSURED arises before the INSURED, in the opinion of SANLAM, is capable of performing his/her normal duties and has done so for 20 continuous working days.

5.4 Absence without leave

No claim for the benefit in terms of this Policy is admitted if the realization of the relevant risk insured against in terms of this Policy arises during a period in which the INSURED concerned is deliberately absent from the EMPLOYER's service without permission, unless the EMPLOYER and SANLAM agree otherwise in a particular case.

5.5 Pre-existing health condition in regard to the SEVERE ILLNESS benefit

5.5(1) The SEVERE ILLNESS benefit or any increase in the benefit by virtue of an amendment to the Policy, is not paid for a SEVERE ILLNESS contracted by an INSURED within 24 MONTHS of the latest date on which the insurance of this benefit or the increase, as the case may be, commences with regard to him/her, if that SEVERE ILLNESS –

(a) directly arises from; or

(b) is traceable to; or

(c) is caused by complications after treatment of

a condition of which the INSURED –

(i) was aware of; or

(ii) experienced symptoms of; or

(iii) received which medical treatment,

during the 24 MONTHS immediately before the said date.

5.5(2) The SEVERE ILLNESS benefit or any increase in the benefit by virtue of an amendment to the Policy is not paid for a SEVERE ILLNESS if the INSURED contracted that SEVERE ILLNESS or would have qualified for a SEVERE ILLNESS benefit before the latest date on which the insurance of this benefit or the increase, as the case may be, commences with regard to him/her.

SCHEDULE 6 PROVISIONS REGARDING CLAIMS

6.1 Notification of a claim

SEVERE ILLNESS benefit

When an INSURED has contracted a SEVERE ILLNESS, SANLAM must be notified in writing of the claim for the benefit within 6 MONTHS from the date that the INSURED contracted the particular SEVERE ILLNESS.

6.2 Proof of claims

When a claim for any benefit arises, SANLAM –

(a) may require proof to its satisfaction as to any circumstance which may affect the recognition of the claim; and

(b) will require a diagnosis of the SEVERE ILLNESS that, to SANLAM's satisfaction, complies with the defined parameters, severity level and other requirements as stipulated in the relevant definitions in SCHEDULE 1, where applicable.

Such proof is at the claimant’s expense.

SCHEDULE 7 PAYMENT OF BENEFITS

7.1 Payment of benefit upon the INSURED suffering a SEVERE ILLNESS

SANLAM pays the benefit payable in terms of this Policy to the INSURED.

SCHEDULE 8 OPTION TO APPPLY FOR INDIVIDUAL SEVERE ILLNESS INSURANCE ON OWN LIFE WITHOUT PROOF OF GOOD HEALTH

8.1 Option to apply for individual SEVERE ILLNESS Insurance without proof of good health

An INSURED who ceases to be an INSURED, and an INSURED who continues his/her service with the EMPLOYER after the BENEFIT CESSATION DATE, or his/her DEPENDANT, may, without proof of good health of the INSURED, but subject to SANLAM's other conditions applicable to individual insurance, apply for individual term or whole life SEVERE ILLNESS insurance on the INSURED's life with SANLAM to commence not later than 60 days after the DATE OF WITHDRAWAL.

This option may however only be exercised if -

(a) in the case of an EMPLOYEE who is employed in terms of a fixed term contract, such INSURED has completed a period of twelve MONTHS service or more with the EMPLOYER. This period of twelve MONTHS is determined from the date on which the EMPLOYEE becomes an INSURED up to the date on which the INSURED ceases to be an INSURED and includes previous uninterrupted periods of employment on the permanent staff of the EMPLOYER; and

(b) the SEVERE ILLNESS benefit in terms of the Policy is applicable to the INSURED immediately before the DATE OF WITHDRAWAL; and

(c) the proposal for the insurance is submitted to a SANLAM office within 60 days of the DATE OF WITHDRAWAL; and

(d) the INSURED is a South African citizen, or if the INSURED is not a South African citizen, he/she complies with the conditions under which a person who is not a South African citizen can obtain individual life insurance from SANLAM; and

(e) premiums have been paid up to the DATE OF WITHDRAWAL; and

(f) the INSURED is younger than 66 years.

8.2 Maximum SEVERE ILLNESS benefit

8.2(1) The SEVERE ILLNESS benefit which is provided in terms of the individual SEVERE ILLNESS insurance that may be effected in terms of this SCHEDULE is similar to the SEVERE ILLNESS benefit which is provided in respect of the INSURED in terms of this Policy.

8.2(2) It may, however, not exceed the amount of the SEVERE ILLNESS benefit applicable to the INSURED in terms of the Policy immediately before the DATE OF WITHDRAWAL. Any increase in the SEVERE ILLNESS benefit by virtue of an amendment to the Policy which became effective in the 6 MONTHS immediately preceding the DATE OF WITHDRAWAL is, however, not taken into account to determine the said maximum SEVERE ILLNESS benefit.

8.2(3) If an INSURED in respect of whom individual insurance has been effected in terms of the option in this SCHEDULE, again becomes an EMPLOYEE, the maximum sum insured that may be obtained in terms of this option will be reduced by the sum insured in terms of the previous option on its inception date and by the sums insured in terms of other options similar to the option in this SCHEDULE effected with SANLAM.

8.2(4) Notwithstanding the preceding provisions, the maximum amount that may be obtained in terms of this option may not exceed the maximum benefit normally applicable to similar insurance with SANLAM.

8.3 Premium rates and other provisions of individual insurance

From the inception date of the individual insurance, the premium rates and other provisions that were applicable in respect of the INSURED in terms of this Policy, will no longer be applicable. The individual insurance will be subject to the provisions which are normally applicable to individual insurance with SANLAM. However if, on medical grounds, any special premium rates and other provisions were applicable to the insurance provided in respect of the INSURED in terms of the Policy, adjustments may, to the same extent, be made to the rates and provisions applicable to the individual insurance.

8.4 Contracting a SEVERE ILLNESS within the option period

If an INSURED who qualifies for this option, contracts a SEVERE ILLNESS within 60 days of the DATE OF WITHDRAWAL, an amount equal to the maximum amount of the SEVERE ILLNESS benefit that could be obtained without proof of good health in terms of this option, is paid. Such amount will not be payable if the INSURED or his/her DEPENDANT had effected any individual insurance in terms of this option which had taken effect by the date of contracting a SEVERE ILLNESS.

8.5 Reappointment

If an INSURED in respect of whom individual insurance has been effected in terms of the option in this SCHEDULE, again becomes an INSURED within 12 MONTHS, of the inception date of the individual insurance, and the INSURED contracts a SEVERE ILLNESS due to natural causes within the 12 MONTHS period referred to above, the SEVERE ILLNESS benefit provided in terms of this Policy on his/her life is reduced by the amount of the SEVERE ILLNESS benefit under the individual insurance on its inception date. But this reduction does not apply if the INSURED, during the 12 MONTHS period referred to above, submits proof of good health to the satisfaction of SANLAM after becoming an INSURED again.

8.6 Lapse of option

This option is not available in respect of an INSURED when he/she ceases to be an INSURED as a result of -

- an amendment to the Policy; or
- termination of the EMPLOYER's participation in the Policy; or
- termination of the EMPLOYER's business; or
- him/her being retrenched in circumstances where the EMPLOYER, as part of a retrenchment exercise, retrenches more than the greater of 3 EMPLOYEES and 2% of the total number of EMPLOYEES; or
- the business of the EMPLOYER being transferred to or amalgamated with any other business, company or organisation.

SCHEDULE 9 ABSENCE FROM SERVICE

9.1 Absence with the EMPLOYER's consent

If an INSURED is absent from the service of the EMPLOYER with the EMPLOYER's consent, he/she remains an INSURED as if he/she remains an EMPLOYEE, subject to the following:

(a) During the period of absence, the INSURED's RISK SALARY is deemed to be equal to the RISK SALARY he/she received immediately before the commencement of absence.

(b) The INSURED does not remain an INSURED for longer than 24 MONTHS. Periods of absence that are interrupted by periods of less than 3 MONTHS, are added together to determine whether the period of 24 MONTHS has elapsed or not.

9.2 Absence while on strike

An INSURED will be deemed to be absent with the EMPLOYER's consent while he/she is engaged in a strike that is protected in terms of the LABOUR RELATIONS ACT, subject to clause 5.1 and 5.2.

9.3 Absence without the EMPLOYER's consent

An INSURED ceases to be an INSURED and the INSURED's service with the EMPLOYER is regarded as terminated if and as soon as he/she is absent from the EMPLOYER's service without the EMPLOYER's consent.

9.4 INSURED in receipt of an income disability benefit

9.4(1) An INSURED in receipt of income in accordance with income disability insurance (not comprising the lump sum disability insurance) effected by the EMPLOYER for the benefit of its EMPLOYEES, is deemed to be an EMPLOYEE who is not absent from service and who remains insured for the benefits listed under sub-clause (2) below until the earlier of -

(a) his/her NORMAL RETIREMENT DATE; and

(b) the date on which payment of the income disability benefit ceases; and

(c) the date he/she turns 65; and

(d) the date on which the INSURED's service with the EMPLOYER is terminated; and

(e) with regard to any benefit insured in terms of this Policy, the date on which the insurance of that benefit is cancelled or lapses for the group of which the INSURED was a member immediately before becoming disabled to the extent required for the income disability benefit to become payable.

9.4(2) The benefit that an INSURED remains insured for is the Comprehensive SEVERE ILLNESS benefit in terms of SCHEDULE 3.

9.4(3) While the INSURED receives such an income, the following apply to the benefits that are continued:

(a) Premiums for the benefits that remain applicable to an INSURED remain payable to SANLAM in terms of the Policy.

(b) The INSURED's REMUNERATION AMOUNT is deemed to be equal to the REMUNERATION AMOUNT he/she received immediately before the commencement of the disability.

(c) The benefits stipulated below are determined as if the INSURED's REMUNERATION AMOUNT, or in the case where the benefits below in respect of an INSURED were

limited to the MEDICAL PROOF FREE LIMIT at the commencement of his/her disability, such restricted benefits, increase(s) every year on a date determined by SANLAM, at a rate of the lesser of -

(i) 10% per annum, compounded annually; and

(ii) the increase in the CONSUMER PRICE INDEX for the year ending 3 MONTHS prior to the increase date; and

(iii) the rate at which the income disability benefit is increased.

The benefit of an INSURED whose benefit was limited to the MEDICAL PROOF FREE LIMIT at the commencement of his/her disability, may due to the aforementioned annual increases, increase to above the MEDICAL PROOF FREE LIMIT.

The benefit is the Comprehensive SEVERE ILLNESS benefit.

(d) The benefits applicable to him/her in terms of the Policy are those that applied immediately before he/she became disabled to the extent required for the income disability benefit to become payable and are calculated on the basis of the Policy provisions that applied at the commencement of his/her disability.

9.4(4) In the preceding sub-clauses the commencement of an INSURED's disability is taken to be the start of any waiting period that is to elapse before the income disability benefit becomes payable.

SCHEDULE 10 PREMIUMS

10.1 Premium rates

10.1(1) For purposes of the calculation of premiums under the Policy, SANLAM determines premium rates which are applicable from the REVIEW DATE, and which SANLAM may revise the premium rates and conditions at each subsequent REVIEW PERIOD by giving at least 31 days written notification to the PRINCIPAL EMPLOYER taking into account the risk profile of the INSUREDS.

10.1(2) Notwithstanding the above, SANLAM may revise the premium rates and conditions at any time during any REVIEW PERIOD if there is a material change in the risk profile of the INSUREDS, which affects the risk under this Policy, subject to at least 31 days written notification to the PRINCIPAL EMPLOYER.

10.1(3) If the PRINCIPAL EMPLOYER does not inform SANLAM in writing before the expiry of the 31 days that the PRINCIPAL EMPLOYER does not accept the revised premium rate it will take effect retrospectively as from the date on which the change referred to in sub-clause 10.1(2) occurred.

10.1(4) If the PRINCIPAL EMPLOYER rejects the amendment, SANLAM may by notice to the PRINCIPAL EMPLOYER terminate the Policy as from the expiry of the notice period referred to in clause 10.1(3).

10.2 Determination of premiums

The monthly premium in respect of all the INSURED is calculated on the total monthly RISK SALARY of all the INSURED who are insured in terms of this Policy as at the end of the relevant MONTH, subject to clause 10.4.

10.3 Payment of premiums and days of grace

10.3(1) The EMPLOYER guarantees to pay the premiums for each MONTH to SANLAM in consideration of SANLAM's obligation in terms of the Policy.

10.3(2) Premiums payable for any particular MONTH must be remitted to SANLAM through one channel and in one amount and are due 15 days after the last day of the relevant MONTH.

10.3(3) If any premium in regard to an INSURED is not paid within the 15 days after the premium was due and in full in terms of the Policy, SANLAM's liability to make any payment or to provide any benefit regarding that INSURED lapses. SANLAM may reinstate its liability regarding the INSURED prior to such lapse on the conditions which it may lay down. If SANLAM and the PRINCIPAL EMPLOYER cannot reach an agreement for the reinstatement, SANLAM will have the right to terminate the Policy as from the expiry of a period of 15 days after which no or insufficient premiums were received by notice to the PRINCIPAL EMPLOYER.

10.3(4) The aforementioned stipulations of this SCHEDULE are subject to the condition that SANLAM may effect alternative arrangements with the EMPLOYER for the payment of premiums or any part thereof to SANLAM.

10.4 When does a premium become payable

10.4(1) If a benefit or an increase in a benefit becomes applicable to an INSURED before the 15th day of a MONTH, a premium is paid for the MONTH concerned as if the benefit or the increase, as the case may be, was applicable to the INSURED for the whole MONTH.

10.4(2) If a benefit or an increase in a benefit becomes applicable to an INSURED on or after the 15thday of a MONTH, then, for the determination of the premium payable for that MONTH, the benefit or increase, as the case may be, is regarded as not being applicable to the INSURED during that whole MONTH.

10.4(3) If a benefit is no longer applicable to an INSURED with effect from the 15th or a later day of a MONTH or if the benefit applicable to an INSURED decreases with effect from the said point in a MONTH, a premium is paid for the MONTH concerned as if the benefit or the benefit before its decrease, as the case may be, was applicable to the INSURED during that whole MONTH.

10.4(4) If a benefit is no longer applicable to an INSURED with effect from the 14th or an earlier day of a MONTH or if the benefit applicable to an INSURED decreases with effect from the said point in a MONTH, then, for the determination of the premiums payable for that MONTH, the benefit or the part by which the benefit decreases, as the case may be, is regarded as not being applicable to the INSURED during that whole MONTH.

SCHEDULE 11 MISCELLANEOUS PROVISIONS

11.1 Currency

All amounts payable to or by the parties in terms of the Policy, are payable in the Republic of South Africa in the currency of the Republic of South Africa.

11.2 Provision of data

11.2(1) The EMPLOYER must provide, in a manner and in the frequency determined by SANLAM, the data which SANLAM may require in relation to the Policy.

SANLAM may act upon the data without further enquiry and is not responsible to anybody for any mis-statements, errors or omissions that may be contained in the data. If it transpires that such data is incorrect or incomplete, SANLAM may in consultation with the EMPLOYER

(a) effect adjustments in the insurance which SANLAM provides in terms of the Policy and to the basis for calculation of the premium of the insurance,

(b) make any adjustments to the benefits provided in terms of this Policy and/or amounts payable in respect of claims, or

(c) cancel the Policy.

These adjustments may only be made to the extent which in SANLAM's opinion is necessitated by the incorrect data.

11.2(2) SANLAM may share such data with any other party that is involved in the insurance in terms of this Policy.

11.2(3) In the case where SANLAM was not provided with the data as required in terms of the Policy to review the premium rate in terms of clause 10.1(1), SANLAM will increase the premium rate with a percentage as decided on by SANLAM at its sole discretion with effect from the date that the premium should have been reviewed as referred to in clause 10.1(1).

11.3 Confidentiality undertaking

SANLAM, the EMPLOYER and the directors, employees or agents of SANLAM and the EMPLOYER undertake to

(a) treat all personal information received from each other with regard to the insurance concerned as confidential; and

(b) use such information only for purposes of enabling it to perform its duties in terms of the Policy and insurance legislation; and

(c) comply with the current and future legislation regarding the protection of personal information.

11.4 Cession

Neither the Policy nor any rights in terms of the Policy or any certificate issued by SANLAM in relation to the Policy, may be transferred or otherwise ceded or pledged.

11.5 Indemnity

SANLAM indemnifies the EMPLOYER against any losses or damages that may result from the negligence, dishonesty or fraud of any of SANLAM's directors, employees or agents. The EMPLOYER also indemnifies SANLAM against any losses or damages that may result from the negligence, dishonesty or fraud of any of the EMPLOYER's directors, employees or agents.

11.6 Alterations to the Policy

11.6(1) Subject to any contrary provision in the Policy, SANLAM may at any time amend any provision of the Policy, provided that SANLAM notifies the PRINCIPAL EMPLOYER in writing of the amendment contemplated at least 31 days before the amendment becomes effective.

11.6(2) If the PRINCIPAL EMPLOYER does not inform SANLAM in writing before the expiry of 31 days that the PRINCIPAL EMPLOYER does not accept the amendment, it will take effect when the 31 days expires.

11.6(3) If the PRINCIPAL EMPLOYER rejects the amendment, SANLAM may by notice to the PRINCIPAL EMPLOYER terminate the Policy as from the expiry of the notice period as referred to in clause 11.6(2) above.

11.6(4) SANLAM may not amend the Policy after the PRINCIPAL EMPLOYER has given notice of cancellation of the whole Policy in terms of clause 11.11.

11.7 Changes by the authorities

In the event of any change to legislation or to comply with any new legally binding rulings of the regulatory authority which may have an impact on SANLAM's position in terms of this Policy, SANLAM, notwithstanding any provision to the contrary, may adjust, in relation to those changes, the provisions of the Policy with effect from the date on which the changes become effective.

11.8 Communication between the parties

The EMPLOYER must represent the INSURED in all aspects regarding the Policy.

11.9 Notifications to and by the parties

For the purposes of the Policy, any notification directed by SANLAM to the person or body appointed by the PRINCIPAL EMPLOYER from time to time to deal with SANLAM on behalf of the PRINCIPAL EMPLOYER, is deemed to have been directed to the PRINCIPAL EMPLOYER. And any notification or instruction directed to SANLAM by any person or body purporting to act for the PRINCIPAL EMPLOYER is deemed to have been directed by the PRINCIPAL EMPLOYER.

11.10 Entry of participating employers

11.10(1) Participation in the Policy of a new EMPLOYER and its EMPLOYEES is subject to the consent of the PRINCIPAL EMPLOYER and SANLAM and also to any special conditions agreed to by the PRINCIPAL EMPLOYER and SANLAM with respect to that subsidiary and its EMPLOYEES.

11.10(2) Subject to the previous sub-clause an EMPLOYEE who is in the service of the subsidiary of the PRICIPAL EMPLOYER that starts participating in this Policy and who remains in the subsidiary's service without interruption, may become an INSURED on or after the date on which he/she qualifies for the insurance by applying for it.

11.10(3) If he/she applies in writing to become an INSURED more than 3 MONTHS after the date of qualification, he/she can only become an INSURED with the approval of SANLAM and subject to the terms and conditions SANLAM may lay down in terms of the specific case at that time.

11.10(4) The date of qualification in regard to an EMPLOYEE who had an option to become insured in terms of the insurance which was replaced by the insurance provided in terms of this Policy, means the date on which the EMPLOYEE qualified for that insurance.

11.11 Cancellation and termination of the Policy

11.11(1) Save for the circumstances provided for in clause 11.11(2) below, the PRINCIPAL EMPLOYER or SANLAM may cancel the Policy at any time by giving the other party at least 31 days written notice.

11.11(2) The PRINCIPAL EMPLOYER may, in the case where no benefit has been paid or claimed, or an event has not yet occurred, cancel this Policy within 31 days of receipt of this Policy in written notification to SANLAM. All premiums paid by the PRINCIPAL EMPLOYER will be refunded by SANLAM, adjusted at SANLAM's discretion.

11.11(3) Any EMPLOYER may cancel its participation at any time by giving SANLAM at least 31 days written notice.

11.11(4) If an EMPLOYER ceases to do business, the part of the Policy pertaining to that EMPLOYER is deemed to be cancelled with effect from the date on which the EMPLOYER thus ceases.

11.11(5) SANLAM may cancel the Policy or the part of the Policy pertaining to an EMPLOYER if any obligation to SANLAM in terms of the Policy is not met.

11.11(6) Furthermore, SANLAM may also cancel the Policy with immediate effect if it is determined by SANLAM that

(a) the Policy or the premium value was concluded as result of fraud, criminal activity, or as a result of material misrepresentation or non-disclosure by the PRINCIPAL EMPLOYER; or

(b) the PRINCIPAL EMPLOYER fails to meet any of the obligations in terms of the Financial Intelligence Centre Act, 2001 (Act No. 38 of 2001).

11.12 Territorial limitations

11.12(1) The insurance provided in terms of the Policy in respect of an INSURED is applicable while he/she is physically present in the Republic of South Africa. If the INSURED is physically outside the Republic of South Africa, the insurance remains applicable in respect of him/her for a maximum period of 6 MONTHS. It is not necessary to inform SANLAM of an INSURED who is physically outside the Republic of South Africa for an uninterrupted period of 6 MONTHS or less.

11.12(2) Before the end of the period of 6 MONTHS referred to in sub-clause (1) and before the end of each period of 12 MONTHS thereafter, the EMPLOYER may request SANLAM in writing to extend the period of insurance. SANLAM will inform the EMPLOYER in writing of its decision in this regard and if any additional conditions will apply in respect of the INSURED. The EMPLOYER must provide SANLAM with the following in respect of the INSURED:

(a) The country in which the INSURED is physically present.

(b) Nature of work responsibilities.

(c) The expected period of stay in the relevant country.

11.12(3) Notwithstanding any provision to the contrary in the Policy, clause 11.12, will also apply to an INSURED who is regarded by the EMPLOYER as mobility assignee and who works outside the Republic of South Africa excluding the Republic of Namibia or Botswana.

11.13 Fraud or dishonesty

11.13(1) SANLAM reserves the right to reject any claim if such claim is found by SANLAM to be based on fraud or dishonesty, including; corruption, cyber-crime, misrepresentation, or providing any deliberate non-disclosure or false information or any attempt to perpetrate any dishonest conduct to claim a benefit by the EMPLOYER, INSURED or any other party who stands to or may benefit from the insurance in terms of the Policy, if it materially affects SANLAM's assessment of a claim submitted for any benefit.

11.13(2) SANLAM shall be entitled to institute an investigation in any circumstances where it suspects fraudulent or dishonest behaviour in relation to a claim. Such investigation may include applying legally compliant techniques, to approach the EMPLOYER, INSURED, family members or relatives of the INSURED and/or any person(s) who may assist in the verification/investigation of a claim and/or have in their possession any information or documentation on the relevant claim.

11.13(3) Depending on the outcome of the investigation, SANLAM reserves the right to:

(a) terminate, suspend or adjust the INSURED's benefit as appropriate in accordance with the relevant provisions of the Policy;

(b) declare all premiums paid by the EMPLOYER in respect of the relevant INSURED forfeited; and/or

(c) report all suspected criminal conduct to the law enforcement authorities for criminal prosecution or other appropriate legal action.

11.13(4) If, after SANLAM paid any claim, it finds that the claim was based on false, dishonest or incomplete information, which materially affects SANLAM's assessment of the claim, all claim payments must be refunded to SANLAM.

11.13(5) Notice of SANLAM's determination of the outcome of the investigation will be communicated to the EMPLOYER.

11.14 Personal Information

11.14(1) The EMPLOYER is a joint RESPONSIBLE PARTY in relation to any PERSONAL INFORMATION it provides to SANLAM as a joint RESPONSIBLE PARTY in terms of the Policy. The PERSONAL INFORMATION of a DATA SUBJECT is collected and shared by the EMPLOYER or service provider appointed by the EMPLOYER in compliance with the APPLICABLE LAWS and/or DATA PRIVACY LAWS.

11.14(2) SANLAM and the EMPLOYER agree that, in relation to a DATA SUBJECT, the PERSONAL INFORMATION relating to the DATA SUBJECT will be processed in accordance with the provisions of DATA PRIVACY LAWS.

11.14(3) SANLAM may use PERSONAL INFORMATION or obtain PERSONAL INFORMATION for the following purposes:

(a) underwriting and providing accurate and effective insurance cover and related value-added services;

(b) member communication;

(c) market research and statistical analysis;

(d) verification of the personal information provided;

(e) to comply with all legal and regulatory requirements, including applicable codes of conduct;

(f) to protect SANLAM's interests; and

(g) any purposes related to the above.

11.14(4) SANLAM may share the EMPLOYER or the DATA SUBJECT'S PERSONAL INFORMATION within the Sanlam Group and/or with other service providers appointed by SANLAM and industry bodies or other insurers where required for any of the purposes listed above, or with third parties where SANLAM is lawfully required to do so.

11.14(5) SANLAM may send the EMPLOYER or the DATA SUBJECT'S PERSONAL INFORMATION to service providers outside the Republic of South Africa for storage or further processing on SANLAM's behalf. SANLAM will not send the PERSONAL INFORMATION to a country that does not have information protection legislation similar to that of the Republic of South Africa, unless SANLAM has a binding agreement with the service provider which ensures that it effectively adheres to the principles for processing of PERSONAL INFORMATION in compliance with the APPLICABLE LAWS or DATA PRIVACY LAWS.

11.14(6) The EMPLOYER or the DATA SUBJECT may request to access, change or correct PERSONAL INFORMATION relating the EMPLOYER or the DATA SUBJECT from

SANLAM's records. If legislation allows, SANLAM may charge an administrative fee subject to prior notice to the EMPLOYER or the DATA SUBJECT of any such cost before executing the request.

11.14(7) All enquiries from the DATA SUBJECT and the Authority concerning the processing of the PERSONAL INFORMATION provided to SANLAM will be responded to by the EMPLOYER within a reasonable time unless SANLAM and the EMPLOYER have agreed otherwise.

11.14(8) SANLAM has implemented appropriate technical and organisational information security measures to keep the PERSONAL INFORMATION secure, accurate, current, and complete. However, SANLAM cannot guarantee the security or accuracy of any information transmitted to SANLAM.

11.14(9) PERSONAL INFORMATION will be held and used for as long as permitted for legal, regulatory, fraud prevention and legitimate business purposes.

11.14(10) SANLAM may contact the EMPLOYER and/or the DATA SUBJECT regarding events, seminars, products, services and content that may be of interest, or invite the EMPLOYER and/or the DATA SUBJECT to participate in research with the aim of improving SANLAM's products and services.

11.15 Breach notification

11.15(1) In respect of any PERSONAL INFORMATION BREACH, the EMPLOYER shall:

(a) notify SANLAM of the PERSONAL INFORMATION BREACH without undue delay (but in no event later than 72 hours after becoming aware of the PERSONAL INFORMATION BREACH); and

(b) provide SANLAM without undue delay (wherever possible, no later than 72 hours after becoming aware of the PERSONAL INFORMATION BREACH) with such details as SANLAM require regarding:

(i) the nature of the PERSONAL INFORMATION BREACH including the categories and approximate numbers of DATA SUBJECTS and protected PERSONAL INFORMATION concerned;

(ii) any investigations into such PERSONAL INFORMATION BREACH;

(iii) the likely consequences of the PERSONAL INFORMATION BREACH; and

(iv) any measures taken, or that the EMPLOYER recommends, to address the PERSONAL INFORMATION BREACH, including to mitigate its possible adverse effects, provided that, (without prejudice to the above obligations) if the EMPLOYER cannot provide all these details within the timeframes set out in this sub-clause (b), it shall (before the end of such timeframes) provide SANLAM with reasons for the delay and when it expects to be able to provide the relevant details (which may be phased), and provide SANLAM with regular updates on these matters.

11.15(2) The EMPLOYER shall promptly (and in any event within 3 Business Days) inform SANLAM if it receives a COMPLAINT and provide SANLAM with full details of such COMPLAINT.