



HOSPITAL PLAN TERMS AND CONDITIONS

VOLUNTARY ACCIDENT AND ILLNESS INSURANCE POLICY

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Annexure 1

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VOLUNTARY ACCIDENT & ILLNESS INSURANCE

1. BACKGROUND

1.1 The Principal Member named in the Policy Schedule has applied to the Insurer for the insurance as hereinafter set out, the Insurer hereby agrees, subject:

1.1.1 to any proposal or other information supplied by or on behalf of the Insured Person:

1.1.1.1 disclosing all facts and circumstances known to the Insured Person that are material to the assessment of the risks insured hereby, and

1.1.1.2 forming the basis of this Policy, and

1.1.2 to the condition of prior payment of the Premium by or on behalf of the Insured Person and the receipt thereof by or on behalf of the Insurer notwithstanding anything to the contrary set out in this Policy or any section thereof,

to grant such insurance subject to the terms, conditions, provisions and exceptions hereinafter set out or as contained in any endorsement that may be issued in regard thereto.

1.2 This Policy is conditional upon and will only come into effect following payment of the Premium by the Insured Person and the receipt thereof by or on behalf of the Insurer.

2. DEFINITIONS

2.1 In this Policy, unless the context indicates a contrary intention, the following words and expressions bear the meanings assigned to them and cognate expressions bear corresponding meanings -

2.2 "**Accident**" means a sudden, unexpected, unusual, specific event which occurs at an identifiable time and place during the period of the Policy;

- 2.3 **"Admission"** means admission into a Hospital as an Inpatient;
- 2.4 **"ASISA"** means the Association for Savings and Investments South Africa;
- 2.5 **"Bodily Injury"** means Bodily Injury by violent external and visible means caused by an Accident but shall include Bodily Injury caused by starvation, thirst and exposure to the elements as a result of a Road Accident;
- 2.6 **"Benefit"** means the Hospital Cash Back Benefit set out in the Policy Schedule, provided by the Insurer in terms of this Policy;
- 2.7 **"Commencement Date"** means the date specified in the Policy Schedule;
- 2.8 **"Compensation"** means the amount payable to the Insured Person in the event of a Benefit claim;
- 2.9 **"Day"** means 24 consecutive hours from time of Admission;
- 2.10 **"Dependent Child(ren)"** means:
- 2.10.1 a child of a Principal Member under the age of 21 (twenty-one) years, including a stepchild, an illegitimate child or legally adopted child, including a child adopted in terms of a customary adoption under a tradition practiced by the people of Southern Africa provided that the child's natural parents are both

- deceased, or an adoption under the tenets of any religion practiced by the people of Southern Africa provided that the child's natural parents are both deceased;
- 2.10.2 a stillborn child of a Principal Member born after the 28th (twenty-eighth) week of pregnancy or posthumous child;
- 2.10.3 a child of a Principal Member being permanently mentally or physically disabled and totally dependent upon the Principal Member;
- 2.10.4 a child of a Principal Member under the age of 26 (twenty-six) years who is a full time student at any registered university, technikon or tertiary education institution, registered in terms of any legislation in the Republic of South Africa or such other institution as may be approved in Writing by Sanlam, and who is unmarried;
- 2.11 **"Domestic Employee"** means the named individual in the employ of the Principal Member;
- 2.12 **"Dread Disease"** means any of the following:
- Heart Attack:** being a heart attack as defined in the ASISA SCIDEP, set out in clause 2.4 of **Annexure 1**.

Chronic Coronary Heart Disease: Open bypass surgery or surgical treatment of Coronary disease. This excludes angioplasty and / or any similar intra-arterial procedures.

Stroke: being a stroke as defined in terms of the ASISA SCIDEP set out in clause 2.5 of **Annexure 1**.

Cancer: being cancer as defined in ASISA SCIDEP set out in clause 2.3 of **Annexure 1**.

Kidney Failure: means end stage renal failure presenting a chronic irreversible failure of both kidneys to function, as a result of which regular renal dialysis is required on a long-term basis.

Major Organ Transplant: The human to human organ transplant from a donor to the Insured Person of one or more of the following organs:

Kidney, Heart, Lung, Liver, Pancreas or Bone Marrow.

The transplantation of all or other organs, parts of organs or any other tissue transplant is excluded.

Paraplegia: The Insured Person suffers the total and irreversible loss of use of both legs or both arms as a result of an Illness.

Blindness: The Insured Person suffers the total and irrecoverable sudden loss of vision in both eyes as a result of an Illness;

(excluding mental illness) which requires Admission to Hospital, and which was not a Pre-Existing Condition (unless otherwise provided for herein). A recurrence of any illness will only be considered a separate illness if 6 (six) months have elapsed from the date of onset of the preceding illness;

- 2.17 **"Insured Persons"** means the Principal Member as named on the Policy Schedule and their named Spouse and Dependent Children and Domestic Employee (where applicable);
- 2.18 **"Insurer"** means Sanlam Developing Markets Limited, registration number 1911/003818/06, a long-term insurance company with limited liability, having its registered address at Sanlam Business Park, 9 West Street, Houghton;
- 2.19 **"Insuring Section"** means the Benefits payable and types of insurance cover granted to the Insured Person as more fully set out in clause 7;
- 2.20 **"Permanent Total Disability"** means Permanent and total loss of or use of:
- | | |
|--|------|
| Speech | 100% |
| Hearing in both ears | 100% |
| Any limb | 100% |
| by physical separation at or above wrist or ankle of one or more limbs | 100% |
| One or both eyes | 100% |
| sight in one or both eyes | 100% |
- 2.21 **"the / this Policy"** means this insurance agreement concluded between the Insurer and the

- Principal Member in respect of the Benefits underwritten by the Insurer;
- 2.22 **"Policy Schedule"** means the long-term insurance policy schedule issued to the Principal Member in terms of section 48 of the Long-term Insurance Act;
- 2.23 **"Pre-Existing Condition"** means any Bodily Injury or Illness or Dread Disease for which the Insured Person received medical advice and or treatment in the 12 (twelve) months prior to the Commencement Date stated in the Policy Schedule (unless otherwise provided for herein);
- 2.24 **"Premium"** means the premium payable to the Insurer on a monthly basis in terms of this Policy in order to secure the Benefits;
- 2.25 **"Principal Member"** means the person who applies for Insurance Cover under this Policy;
- 2.26 **"Professional Sport"** means a sporting activity in which an Insured Person engages and from which such Insured Person derives the majority of their monthly income;
- 2.27 **"SCIDEP"** means the ASISA Standardised Critical Illness Definitions Project;
- 2.28 **"Spouse"** means the named Spouse of a Principal Member. Not more than one Spouse shall be covered in respect of each Principal Member;
- 2.29 **"Temporary Total"**

- Disability"** means the Insured Person being admitted to Hospital as an in Disability patient;
- 2.30 **"Territorial Limits"** means the Republic of South Africa, Namibia, Lesotho, Botswana, Swaziland, Zimbabwe and Mozambique; and
- 2.31 **"Writing"** (or words of similar meaning) means legible writing and in English and excludes any form of electronic communication contemplated in the Electronic Communications and Transactions Act, 25 of 2002.
- 2.32 Any reference to the singular includes the plural and vice versa; and
- 2.33 any reference to a gender includes the other gender.
- 2.34 The clause headings in this Policy have been inserted for convenience only and shall not be taken into account in its interpretation.
- 2.35 If any provision in a definition is a substantive provision conferring rights or imposing obligations on any party, effect shall be given to it as if it were a substantive clause in the body of the Policy, notwithstanding that it is only contained in the interpretation clause.
- 2.36 This Policy shall be governed by, construed and interpreted in accordance with the law of the Republic of South Africa.

3. GENERAL PROVISIONS

It is declared and agreed that:

- 3.1 once any Insured Person has been Insured under this Policy for a period of 24 (twenty four) consecutive months any Pre-Existing Condition shall no longer apply;
- 3.2 the age of the Principal Member cannot exceed 55 years when first acceding to this Policy (unless otherwise provided for herein);

- 3.3 an Insured Person may not be covered for more than one Policy under this Insurance;

4. PAYMENT OF PREMIUM

- 4.1 Premiums shall be payable monthly in advance on the first day of the month. In the event of non-payment of the Premium on the due date, and subject to the provision of a 15 (fifteen) day grace period to pay the Premium in arrears, insurance cover in respect of the Insured Person shall lapse after written notification of the non-payment by the Insurer.

- 4.2 Premiums shall be payable by means of a debit order from a bank account nominated by the Principal Member. All costs associated in respect thereof shall be borne by the Principal Member.

5. GENERAL EXCLUSIONS AND LIMITATIONS

The Insurer shall not be liable to pay Compensation for Bodily Injury or Illness or Dread Disease in respect of any Insured Person:

- 5.1 caused by suicide, or self-injury or intentional exposure to obvious risk of Injury (unless in an attempt to save human life);
- 5.2 caused by a Pre-Existing Condition (unless otherwise provided for herein);
- 5.3 over 65 years of age (unless otherwise provided herein);
- 5.4 caused by or as a result of the influence of alcohol, drugs or narcotics upon such Insured Person unless administered by or prescribed by and taken in accordance with the instructions of a member of the medical profession (other than himself);
- 5.5 caused by or arising from exposure to or contamination by atomic energy and/or nuclear fission or reaction;

- 5.6 whilst travelling by air other than as a passenger and not as a member of the crew nor for the purpose of any trade or technical operation thereon or therein;
- 5.7 whilst participating in any riot or civil commotion or public disorder or active involvement in war, acts of terrorism, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection or political risk of any kind;
- 5.8 whilst participating in a Professional Sport;
- 5.9 for any mental and/or nervous disorders, other than those caused by Accident as defined in this Insurance;
- 5.10 who is in employment or service in the permanent force of the South African National Defence Force, South African Police Service or any other armed forces;
- 5.11 for any claims for mountaineering or rock climbing necessitating the use of ropes or guides, potholing, hang gliding, sky diving, riding or driving in a race or rally, underwater activities involving the use of artificial breathing apparatus unless the Insured Person has an open water diving certificate or is diving with a qualified instructor to a depth no greater than 30 meters and/or similar activities, unless agreed by Insurer;
- 5.12 for any claim arising whilst the Insured Person is perpetrating an intentional unlawful act in terms of South African Law;
- 5.13 caused by any gradually operating cause of which the Insured Person is aware.
- 5.14 for pregnancy or childbirth unless the mother has been insured under this Policy for more than 12 (twelve) consecutive months nor for any congenital abnormalities;

- 5.15 for claims in respect of expenses arising out of regular medical treatments on an ongoing basis;
- 5.16 for elective, elective cosmetic, corrective optical and laser surgery or treatment and costs resulting therefrom;
- 5.17 for treatment, directly or indirectly arising from, or connected with male and female birth control, infertility and any form of assisted reproduction;
- 5.18 for any newborn children where the Illness or Dread Disease was known by the Principal Insured Person prior to the birth of that Dependent Child;
- 5.19 in respect of premature childbirth unless the expected date of birth is later than 12 (twelve) consecutive months after inception of insurance;
- 5.20 the Insured Persons shall take all reasonable precautions to prevent Accidents and to comply with all statutory requirements and regulations;
- 5.21 if the consequences of an Accident shall be aggravated by any condition or physical disability of the Insured Person which existed before the Accident occurred, the amount of any compensation payable under this Insurance in respect of the consequences of the Accident shall be the amount which it is reasonably considered would have been payable if such consequences had not been so aggravated.
- 5.22 if at the time of any Insured Event, giving rise to a Medical Expenses claim under this policy, an Insurance or Medical Aid Scheme exists with any other Insurers or Medical Aid covering the Insured Person against the defined events, the Company shall be liable to make good only a rateable proportion of the amount payable by or to or on behalf of the Insured Person in respect of such Insured Event. Where Insurers have invoked this provision the daily in hospital benefit will be limited to actual medical expenses up to a maximum of such daily in

hospital benefit. The actual medical expenses to be applied will be those not paid by any other Insurer and or Medial Aid Scheme.

6. GENERAL CONDITIONS

- 6.1 Insurance cover shall commence on the Commencement Date subject to receipt of the first Premium by the Insurer.
- 6.2 This Policy and the Policy Schedule shall be read together as one contract and any word or expression to which a specific meaning has been attached in any part of this Policy or the Policy Schedule shall bear specific meaning wherever it may appear.
- 6.3 This Policy may be cancelled at any time by the Insurer giving 30 (thirty) days' notice in writing (or such other period as may be mutually agreed).
- 6.4 This Policy is not assignable. Compensation shall be payable only to the Insured Person or their estate whose receipt shall effectually discharge the Insurer.
- 6.5 This Policy shall be voidable in the event of misrepresentation, mis-description or non-disclosure by or on behalf of an Insured Person of any particular material fact to this Insurance.
- 6.6 Notice must be given to the Insurer in writing as soon as practicable of any occurrence which may give rise to a claim under this Insurance, but in any event within 6 months of such occurrence, failing which the claim will not be entertained.
- 6.7 In the event that the Insurer repudiates liability for any claim under the Policy, the claimant shall have 90 (ninety) days from the date of notice of the repudiation within which to make representations to the Insurer disputing the repudiation of the claim. If the claimant concerned does not, in respect of the subject matter of such claim, within 12 (twelve) months, after the 90 (ninety) day period to make representations, commence legal proceedings in a competent court and prosecute

such proceedings to final judgment, any liability of the Insurer shall be extinguished and no benefits shall be payable in respect of such claim and/or the insured event concerned.

- 6.8 If any amount payable in terms of this Policy is not claimed in accordance with the provisions of this Policy within 3 (three) years from the date on which it became due for payment, all rights and claims in respect thereof shall prescribe and no further claim whatsoever shall be valid against the Insurer pursuant to this Policy.
- 6.9 All certificates, information and evidence required by the Insurer shall be furnished in the form prescribed and without expense to the Insurer. The Insured Person shall submit to medical examination on behalf of and at the expense of the Insurer as often as shall be required in connection with any claim.
- 6.10 Qualified medical advice shall be sought and followed promptly on the occurrence of any Bodily Injury, Dread Disease or Illness and the Insurer shall not be liable for any part of any claim which in the opinion of the medical adviser arises from the unreasonable or wilful neglect or failure of an Insured Person to seek and remain under the care of a qualified member of the medical profession.
- 6.11 The Insured Person must notify ER 24 at least 48 (forty eight) hours prior to being hospitalised and give full particulars of the hospitalisation to ER 24 at the contact number as provided on the membership card. Failure to do so will result in the non-payment of claims. Where it is not possible to notify ER 24 prior to Hospitalisation due to an emergency this condition will not apply, subject to notification to ER 24 within 48 hours after Admission provided that the Insured Person is physically able to do so.
- 6.12 If any claim under this Insurance be in any respect fraudulent or intentionally exaggerated or if any fraudulent means or devices are used by Insured Person or anyone acting on his behalf to obtain any

benefit under this Insurance all benefit hereunder shall be forfeited and no Premiums shall be refunded.

6.13 It is a condition precedent to Insurer's liability to pay Benefits on behalf of an Insured Person that all medical records, notes and correspondence referring to the subject of a claim or a related Pre Existing Condition shall be made available to any medical or other advisor appointed by Insurer and such advisor or advisors shall, for the purpose of reviewing the claim, be allowed so often as may be deemed necessary to make examination of the Insured Person or any other record pertaining to the claim. The conditions listed are:

- 6.13.1 Kaposi's Sarcoma;
- 6.13.2 Pneumocystis carinii;
- 6.13.3 Tuberculosis;
- 6.13.4 CMV;
- 6.13.5 Cryptococcal meningitis;
- 6.13.6 Cryptosporidium;
- 6.13.7 Disseminated Herpes/Shingles.

7. INSURING SECTION

The following Insurance Cover and Benefits shall be available to the Insured Persons as follows:

BENEFITS	AMOUNT PAYABLE
1 st Day in Hospital (subject to a 90 day waiting period unless by specific agreement)	R6 500
2 nd Day in Hospital (subject to a 90 day waiting period unless by specific agreement)	R4 500

3 rd Day in Hospital (subject to a 90 day waiting period unless by specific agreement)	R4 500
Every subsequent day thereafter (subject to a 90 day waiting period unless by specific agreement)	R1 500
Maximum Benefit payable for a 21 Day period	R47000
Dread Disease amount per day in Hospital	R9000

7.1 **Illness Top up**

7.1.1 An Illness Protection Benefit payable per annum up to a maximum of **R25,000** per Single Member and a maximum of **R40,000** per Family. The Illness Protection Benefit is payable in instances where the daily cash benefit defined in clause 8 is insufficient to cover the Hospital Cost related to the illness admission as defined in the Benefit Rules. The Illness Protection Benefit has a 90 day waiting period and requires pre-authorization in addition to an excess payment of R2,000 (unless by specific agreement) payable by the Policyholder each and every event up to the annual limit payable.

7.2 **Accident Permanent Disability Cover**

7.2.1 If during the period of the Policy the Insured Person, within the Territorial Limits, sustains Bodily Injury which directly and independently of all other causes results within twenty four calendar months of the Accident, in Permanent Disability as specified in the circumstances set out in the Insuring Section to this Policy, the Insurer agree to pay to the Insured Person or his estate the Compensation stated in the Insuring Section.

7.2.2 The following percentage shall be payable in the event of Bodily Injury resulting in Permanent Total Disability – 100% (one hundred percent).

- 7.2.3 In the event of Compensation being due under more than one of the benefits referred to above as a consequence of any one Accident to any one Insured Person the maximum amount payable shall not exceed 100% (one hundred percent) in total under Permanent Total Disability Benefits.
- 7.2.4 For Permanent Disability, the compensation shall be limited to an amount of R250 000.

7.3 Accident Stated Benefit for Hospital Stay Cover

For an Accident resulting in Hospitalisation, the compensation shall be limited to an amount of R125,000 per Insured Person per Accident and R250,000 per Family per Accident.

7.4 Temporary Total Disability (Illness) in Hospital Cover

- 7.4.1 For Temporary Total Disability (Illness), the compensation shall be R1 500 per Insured Person per day for a period not longer than 21 Days from the date of the onset of any Illness.
- 7.4.2 The Insurance Cover afforded any Insured Person for Temporary Total Disability will only come into effect 90 (Ninety) days after the Commencement Date.
- 7.4.3 If during the period of the Policy any Insured Person, within the Territorial Limits, sustains an Illness which first manifests itself after 90 (ninety) days from the Commencement Date stated in the Policy Schedule which directly and independently of all other causes results within fourteen days of the onset of such Illness, as defined, in Hospitalisation, the Insurer agrees to pay to the Insured Person the compensation stated in the Insuring Section.
- 7.4.4 The Compensation specified for Temporary Total Disability shall cease as soon as the Insured Person has been discharged from Hospital.

7.5 **Dread Disease**

- 7.5.1 If during the Period of Insurance any Insured Person, within the Territorial Limits, be diagnosed as suffering from a Dread Disease, symptoms of which were not present in the Insured Person in the 24 months prior to the inception of the Policy Schedule and which symptoms first manifested itself after 90 days from the Commencement Date stated in the Policy Schedule, the Insurer agree to pay the Insured as Compensation the sum stated in the Schedule of Compensation.
- 7.5.2 Upon discharge from the Hospital and after the Insured Person has survived for a period of 30 (thirty) days from the date of diagnosis the amount of Compensation specified in the Schedule less any amounts that have been paid shall be paid to the Insured Person upon request. In the event that the amount paid reaches R185,000 no further benefit shall be payable in respect of any Dread Disease of any Insured person for a period of 12 (twelve) months from the date that the Insured Person was diagnosed of such Dread Disease for which benefit has been paid.
- 7.5.3 It is declared that upon payment of 100% of the Compensation for any one claim under Dread Disease in respect of any Insured Person, all cover provided shall be terminated and cannot be reinstated in respect of the Dread Disease Benefit that has been paid for that Insured Person.
- 7.5.4 Compensation under Dread Disease shall not be in addition to Temporary Total Disability Illness in Hospital.
- 7.5.5 Insurance Cover afforded any Insured person in terms of the Dread Disease will only come into effect 90 (ninety) days after the Commencement Date stated in the Policy Schedule.

8. DISPUTE RESOLUTION

- 8.1 Should any dispute, disagreement or claim arise between the parties concerning this Policy ("**the Dispute**"), the parties shall endeavour to resolve the Dispute referring the Dispute to the Arbitration Foundation of Southern Africa ("**AFSA**") for final resolution by way of arbitration in accordance with the rules of AFSA by an arbitrator or arbitrators appointed by AFSA.
- 8.2 Unless otherwise agreed in writing by the parties, any such arbitration shall be held in Johannesburg.
- 8.3 Each Party to this Policy irrevocably:
- 8.3.1 consents to any arbitration in terms of the aforesaid rules being conducted as a matter of urgency; and
- 8.3.2 authorises the others to apply, on behalf of the parties to such Dispute, in writing to the secretariat of AFSA in terms of the aforesaid rules for any such arbitration to be conducted as a matter of urgency, provided that the party which intends so applying first notifies the other parties in writing of its intention to do so.
- 8.4 The provisions of this clause 8 shall not preclude a party from seeking urgent interim relief from the appropriate court of law.
- 8.5 For the purposes of clause 8 and for the purposes of having any award made by the arbitrator(s) being made an order of court, each of the parties hereby submits itself to the South Gauteng High Court of South Africa or its successor in title.
- 8.6 This clause 8 constitutes an irrevocable consent by each of the parties to any proceedings in terms hereof, is severable from the rest of the Policy and shall, notwithstanding the termination of this Policy, remain in full force and effect.

9. NEW LAWS

If, at any time after the Commencement Date, any legislation, rulings or regulations (including any taxation laws) applying to this Policy, comes into operation, the Insurer shall be entitled on a 3 (three) months prior written notice to the Principal Member, to change, amend or alter any terms or conditions of this Policy in order to comply with such legislation, rulings or regulations (including any tax laws) or otherwise to be placed in the same position it would have been was it not for the legislation, rulings or regulations becoming applicable.

10. DOMICILIUM

10.1 The *domicilium citandi et executandi* address of a Principal Member shall be the address set out in the application form or such later address as notified in writing.

10.2 For purposes of this Policy, the Insurer's addresses shall be 9 West Street, Sanlam Business Park, Houghton; +27 11 441 2385 (facsimile), for the attention of the Company Secretary.

10.3 Any notice given in terms of this Policy shall be in writing and shall -

10.3.1 if delivered by hand be deemed to have been duly received by the addressee on the date of delivery;

10.3.2 if posted by prepaid registered post be deemed to have been received by the addressee on the 8th (eighth) day following the date of such posting;

10.3.3 if transmitted by facsimile be deemed to have been received by the addressee on the day following the date of dispatch,

unless the contrary is proved.

10.4 Notwithstanding anything to the contrary contained or implied in the Policy, a written notice or communication actually received by the Insurer or a member from the other as the case may be, including by

way of facsimile transmission shall be adequate written notice or communication to such party.

11. GENERAL

- 11.1 This Policy constitutes the entire insurance policy and that no other conditions, stipulations, warranties and representations whatsoever, have been made by any party or that party's agent, other than as specifically included herein.
- 11.2 No latitude, extension of time or other indulgence which may be given or allowed by either party to the other in respect of any payment provided for in the Policy or the performance of any other obligation shall under any circumstances be construed to be an implied consent by such party or operate as a waiver or a novation of or otherwise affect any of the third party's rights in terms of or arising from the Policy, or prevent such party from importing, at any time and without notice, strict and punctual compliance with each and every provision or term hereof.
- 11.3 No amendment or cancellation of the Policy shall be of any force and effect unless such amendment or cancellation is in writing and signed by the Insurer.
- 11.4 This Policy does not accumulate cash or surrender value and may not be converted into a paid up policy. The Insurer specifically determines that no loans will be allowed in terms of the Policy.
- 11.5 Statements made by the Insured Person relating to the Policy will be deemed to be true and incontestable.
- 11.6 The parties consent to the jurisdiction of the South Gauteng Division of the High Court of South Africa, to hear and determine any action or proceeding which may result from or arises from the Policy.

Signed at

on

2011

Witness

for **SANLAM SKY**

.....

.....

duly authorised and warranting such
authority

DEFINITIONS OF HEART ATTACK, STROKE AND CANCER

1 BACKGROUND

- 1.1 The Policy together with this **Annexure 1** constitutes an indivisible agreement between the parties.
- 1.2 All words and expressions defined in the Policy shall have a similar meaning in this **Annexure 1** unless expressly stipulated otherwise or inconsistent with, or otherwise indicated by the context.

2 SCIDEP DEFINITIONS

- 2.1 For purposes of this Policy, the Dread Diseases shall bear the meanings as assigned to it in the Policy or this **Annexure 1**, which ever applicable, which definitions are prescribed in terms of the SCIDEP definitions.
- 2.2 For the sake of convenience, a layman's definition is included herein due to the complexity of the medical definitions of Dread Diseases.
- 2.3 **Cancer**
 - 2.3.1 Cancer is an uncontrolled growth that spreads into the normal tissue surrounding the organ where the cancer originates. The diagnosis must be supported by tests where a pathologist confirms the presence of cancer using a microscope. Some cancers have been specifically excluded because the long term outcome is good and the effect on quality of life is minimal; and treatment is neither expensive nor extensive.
 - 2.3.2 There are specific exclusions to this definition that include:
 - 2.3.2.1 Cancerous cells that have not invaded the surrounding or underlying tissue;
 - 2.3.2.2 Early cancer of the prostate gland and breast; and
 - 2.3.2.3 All cancers of the skin except cancerous moles that have invaded underlying tissue.

2.3.3 Staging of cancer:

2.3.3.1 As a general rule there are four stages of cancer. Stage 1 cancer is defined by an invasive cancer confined to the tissue or organ of origin. Stage 2 cancer is defined by the involvement of adjacent structures or organs. Stage 3 cancer involves spreading to regional lymph nodes. Stage 4 cancer is characterized by distant metastasis.

2.3.3.2 However, each type of cancer is staged specifically by the American Joint Committee for Cancer (AJCC). This staging is based on the outcome of the specific cancer and does not always follow the general rule as stated above.

2.4 Heart Attack

Four levels of severity of heart attacks are defined:

2.4.1 Level D is the mildest and Level A the most severe;

2.4.2 In both Levels C and D the patient recovers fully and the heart function returns to normal;

2.4.3 In Levels A and B, more permanent damage has resulted, which means the heart function is less than 100% after recovery;

2.4.4 The effect of the heart attack on heart function should be measured 6 weeks after the heart attack.

2.4.5 Level A: Heart attack severe impairment in function

2.4.5.1 These are heart attacks where a significant proportion of the heart muscle was damaged. The same tests are used to measure the damage as under Level B but the results would show a more serious level of impaired function.

2.4.5.2 This person will have difficulty coping with normal activities of daily living, and will most likely not be able to work.

2.4.6 Level B: Heart attack with mild permanent impairment in function

2.4.6.1 This is usually a heart attack that does not recover 100% of normal function. The degree of permanent damage can be measured by a

heart sonar, an exercise tolerance test or a measurement of physical abilities. These measurements should be performed 6 weeks after the heart attack.

2.4.6.2 A person with this level of heart damage should still be able to manage normal daily activities and even his/her occupation, if the occupation does not involve strenuous physical work. However, this person's insurability will be adversely affected, and the future risk for a repeat cardiac event is high. Significant life-style adaptation and risk factor modification are indicated.

2.4.7 Level C: Moderate heart attack of specified severity

2.4.7.1 In this case damage to the heart muscle is more than in Level D. In some cases a cardiologist will intervene early and reverse the potential damage. This intervention may include administration of drugs to dissolve the blood clot in the coronary artery(ies), balloon stretching of the coronary artery, with or without a stent.

2.4.7.2 Because the clinical methods of diagnosing this level of heart attack are unambiguous, only two of the three criteria are required:

2.4.7.3 Typical chest pain or other symptoms typically associated with a heart attack;

2.4.7.4 Certain defined ECG changes. At this level the changes are more marked and more specific to a heart attack;

2.4.7.5 Elevated blood test results greater than required for Level D.

2.4.8 Level D: Mild heart attack with full recovery

This is a heart attack where the ECG changes and blood test results are mildly abnormal. Therefore, all three criteria are required, e.g. Typical chest pain or other symptoms associated with a heart attack; and certain defined ECG changes; and an elevation in certain blood test results.

2.5 **Stroke**

2.5.1 A stroke occurs when the blood supply to a portion of the brain is obstructed and this part of the brain tissue dies. It can also happen when

there is bleeding into the brain tissue due to a weakening or abnormality of the blood vessel wall. A common cause of the rupture of a brain blood vessel is longstanding uncontrolled high blood pressure.

2.5.2 The result of a stroke is usually paralysis of an arm and leg, sometimes with one half of the face affected as well. In some cases people also lose their ability to speak. The paralysis can recover to varying degrees. Some recover fully, whereas others may retain permanent weakness of a limb(s).

2.5.3 A Transient Ischaemic Attack (TIA) occurs when the blood supply is momentarily interrupted, but restored before any permanent damage can occur. It usually results in one or more of the following symptoms:

2.5.3.1 A loss of sensation;

2.5.3.2 Dizziness;

2.5.3.3 Lameness of a limb;

2.5.3.4 Loss of speech,

which only occur for a few minutes to hours and recovery is quick and spontaneous.

POLICY SCHEDULE

INSURED PERSON: The Principal Member as named on the Policy Certificate and their named spouse and Dependent Children.

PERIOD OF INSURANCE: Monthly

COMMENCEMENT DATE:

PREMIUMS:

	Premium per month (inclusive of Commission and Fees)
Single member	R313
Single member plus 1 Child	R342
Single member plus 2 Children	R377
Single member plus 3 Children	R411
Single member plus 4 Children	R446
Principal Insured and Spouse	R607
Principal Insured and Spouse plus 1 Child	R641
Principal Insured and Spouse and 2 Children	R676
Principal Insured and Spouse and 3 Children	R710
Principal Insured and Spouse and 4 Children	R745

INSURER: SANLAM DEVELOPING MARKETS LIMITED
Registration number 1911/0038181/06

BROKER: Essmed Medical Cover (trading as Essential Med)

FSB Licence no: 42980

Physical address:
Unit 3, No 4 Nina Street, Springbok Park, Brackenfell, 7560

Postal address:
PO Box 1058, Cape Gate, 7562

Tel: 0861 632 123
Fax: 0865 327 661

IMPORTANT INFORMATION – PLEASE READ CAREFULLY
STATUTORY NOTICE TO POLICY HOLDERS, DISCLOSURE AND OTHER LEGAL REQUIREMENTS

THE INTERMEDIARY

Day1 Health (Pty) Limited

Registration No. 2000/027792/07

FSP License No. 11319

LEGAL STATUS: Administrators for Sanlam Developing Markets Limited

MANAGING DIRECTOR: R.M. Blackman

PHYSICAL ADDRESS:

Block E, Peter Place Office Park, 54 Peter Place, Bryanston, Johannesburg, 2146.

POSTAL ADDRESS:

PO Box 782622, Sandton City, 2146.

TELEPHONE NUMBER: (0861) 113-513

FAX NUMBER: (086) 594-8584

COMPLIANCE OFFICER

Peter Veal
 Email: peter@ice-sa.co.za
 Telephone No. (011) 431-1183/4

Does the Intermediary have any interest in the Insurer or receive more than 30% of its total remuneration from the Insurer? **No**

Does the Intermediary have any interest in the Insurer? **No**

Has the insurer provided the Intermediary with a written mandate to act on its behalf? **Yes**

Does the Intermediary have a Professional Indemnity Policy in place? **Yes**

PREMIUM PAYMENT

Premium is payable in advance by debit order or salary deduction on the first working day of every month. In the event of non-payment a 15 day grace period is allowed in which to pay the premium.

HOW TO INSTITUTE A COMPLAINT

Should you have any complaint about your policy or the service you have received, please contact: Sanlam Sky

If the enquiry is not satisfactory resolved you may contact:

The Ombudsman for Long Term Insurance
 Private Bag x45 Claremont 7735
FAX NUMBER: 021 674 0951

If you are still dissatisfied, you may seek assistance from:

The Registrar of LongTerm Insurance
 The Financial Services Board
 PO Box 35655, Menlo Park, 0102
FAX NUMBER: 012 347 0221

THE INSURER

Sanlam Developing Markets Limited

PHYSICAL ADDRESS: Sanlam Business Park,
 13 West Street, Houghton,
 Johannesburg, 2198

TELEPHONE NUMBER: (0861) 235-433

FAX NUMBER: (011) 388-5084

HOW TO INSTITUTE A CLAIM

- Contact ER 24
- Claim to be reported within 90 days of the event.
- In the event that a claim is repudiated you have 90 days from the date of repudiation to make representation to the Intermediary and 90 days

thereafter to take legal action by the service of summons.

CLAIMS ADMINISTRATORS

Day1 Health (Pty) Ltd

PHYSICAL ADDRESS: Block E, Peter Place Office Park, 54 Peter Place, Bryanston, Johannesburg, 2146

POSTAL ADDRESS: PO Box 782622
Sandton City, 2146

OTHER MATTERS OF IMPORTANCE

- You must be informed of any material changes to the information referred to above
- If the information above was given orally, it must be confirmed in writing in 30 days
- Your Insurer may not cancel your insurance merely by informing your Intermediary. There is an obligation to make sure the notice has been sent to you.
- You are entitled to a copy of the policy free of charge.

WARNING

- | | | |
|---|---|---|
| <p>1. Don't sign any blank or partially completed application form.</p> <p>2. Complete all forms legibly, in ink.</p> | <p>3. Keep all documents handed to you.</p> <p>4. Make a note as to what is said to you.</p> <p>5. Don't be pressurised to buy the product.</p> | <p>6. Incorrect or non-disclosure by you may impact on any claim arising from your contract of insurance.</p> |
|---|---|---|

Duly authorised to market the product. The Intermediary confirms that according to Act No 37 of 2002, par 13.(1)b(i)(aa) and (bb) the Intermediary presenting this product is authorised to do so and the Intermediary accept responsibility within the scope of the accompany product information brochure and policy wording that will be send to the Principal Member within 30 days time. after which the Principal Member have 30 days to cancel this Policy after which we accept that the Main member accept the policy on his/her own accord and whereby the Principal Member confirm that he/she understand the Policy with all its benefits and / or exclusions and where no claim have been submitted.