Notes

- This chapter should be read in conjunction with the contract documents. If there is any conflict or inconsistency between the contents of the contract documents and this chapter, the provisions of the contract documents will prevail.
- Take note that information contained in this technical guide is with regards to the latest versions of the applicable products/benefits. Refer to the contract documents for information about the existing products/benefits of a life insured.
- Any reference to "you" or "your" refers to the life insured. Any reference to "we", "us", "our" or "ours" refers to Sanlam Life Insurance Limited (Sanlam Life). Any reference to “plan overview” refers to the plan overview of the contract documents.

Severe illness benefits

Why severe illness benefits?

Any reference to "you" or "your" in this section refers to the life insured.

Serious diseases, like falling victim to cancer, suffering a heart attack, or needing an organ transplant, usually strike without warning. You may perhaps still be medically able to continue working and therefore unable to claim under disability cover, but it is at times like these that extra cash will be needed.

In which ways will a cash payout be essential if you were to suffer a severe illness?

- Additional expenses may have to be covered when you are hospitalised, such as taking care of your children, organising transport, homecare duties, etc.
- Travel expenses may have to be incurred to go for your treatment in major centres, or for your relatives to visit you in your hour of need.
- Delaying your return to work in favour of a speedier recovery might mean a reduction in income, for which you might not have sufficient savings set aside.
- Following an illness like a heart attack, you might decide to reduce your working hours in an attempt to better manage stress. A cash payout can compensate for the likely reduction in your future income.
- Some severe illnesses may leave you uninsurable. Getting a payment after being diagnosed with a severe illness can make up for not being able to obtain additional insurance in future.
- A severe illness may shorten your life expectancy, in which case a benefit payout may enable you to reprioritise your life, like scaling down on business activities or taking more holidays with your family.
- Etc.

Availability of benefits

Individual insurance

All the benefits in this chapter are available for individual insurance.

Business insurance

The benefits in this chapter are not available for business insurance.

Claim categories covered by severe illness benefits

A wide range of claim events are covered, which are grouped into several different claim categories. The claim categories covered by a benefit are indicated by a √ in the table below.

Claim category	Cancer / Cancer Plus	Cardiovascular / Cardiovascular Plus	Comprehensive Severe Illness / Comprehensive Severe Illness Plus / Severe Illness Income
Cancers, tumours, leukaemias, lymphomas	√		√
Early cancer	√		√
Cardiovascular conditions: heart, blood vessels and stroke		√	√
Connective tissue			√
Ear, nose and throat			√
Endocrine system			√
Gastrointestinal system			√
Lymph and blood			√
Musculoskeletal system			√
Nervous system and psychiatric disorders			√
Renal disorders			√
Reproductive system			√
Respiratory disorders			√
Skin and soft tissues			√
Urogenital disorders			√
Vision			√
Infections			√
Injuries, accidents and poison			√
Catch-all*			√

*The Cancer and Cancer Plus benefits do however include cancer catch-all claim events.

Cancer (TAT3, TST3) & Cancer Plus (TAT4, TST4)

These benefits are available under the Express, Classic and Premier product options of our Topcover products and under the Premier product option of our Term cover products.

Benefit description

The Cancer and Cancer Plus benefits cover the same claim events and provide cover against cancers (including early cancers), tumours, leukaemias and lymphomas.

The Cancer benefit, which is a more affordable benefit, will pay less than 100% of the cover amount for lower severities of certain cancers covered by SCIDEP. It will however pay 100% of the cover amount for specified aggressive cancers from stage I. Refer to the SCIDEP table for the Cancer benefit under "Claim events and claim event percentages" for more information.

The Cancer Plus benefit which is a more expensive benefit, will pay 100% of the cover amount for the cancer events covered by SCIDEP, as well as a higher percentage of the cover amount for certain other claim events.

If we admit a claim, we will pay the percentage of the cover amount, linked to the particular claim event as set out in the claim event table under "Claim events and claim event percentages". The amount will be paid as a lump sum. The percentages in this table are the claim event percentages. For multiple claims, we may pay a lower percentage than the claim event percentage, as described under "Multiple claims". For claim events where a maximum rand amount is indicated in the claim event table, we will not pay more than the indicated rand amount.

The cover amount is set out in the plan overview and may change over time as a result of benefit growth, alterations requested by the planholder, and for an accelerator benefit as a result of claims.

Additional features

Additional features are features that are automatically included for a benefit. These features are free of charge. The following additional feature applies:

- Free cover

Refer to the chapter *Payments, payment patterns, guarantees and cover* for more information about Free cover.

Type of benefit

Benefit	Type of benefit	
	Accelerator	Standalone
Cancer (TAT3)	√	
Cancer (TST3)		√
Cancer Plus (TAT4)	√	
Cancer Plus (TST4)		√

When will cover for this benefit end?

Benefits selected with a fixed term

Cover will end

- at midnight before the cover end date set out in the plan overview, or
- if the plan ends for any reason before the cover end date, or
- for an accelerator benefit when the full cover amount has been paid.

Benefits selected with whole life cover

Cover is provided for whole of life. However, the cover will end earlier:

- if the plan ends for any reason before the cover end date, or
- for an accelerator benefit when the full cover amount has been paid.

Cover limits per life insured	Housewives/house husbands, scholars, students, pensioners and unemployed persons (unemployed only under Classic/Premier) may qualify for a limited amount of cover, as described under "Financial underwriting" in the underwriting chapters. Otherwise the limits below apply. Minimum: R50 000 Maximum: • Express product option: R5 000 000* • Classic and Premier product options: R6 000 000* *Subject to financial underwriting The sum of the cover amounts of all **accelerator severe illness/dread disease benefits** on a plan for a life insured may **not** exceed the sum of the cover amounts of the Death or First death benefit for that life insured.

Age limits	**Benefit start age**
	Minimum:
	• Payment patterns other than fixed compulsory growth
	  • 19 next birthday for the Express product option
	  • 15 next birthday otherwise
	• Fixed compulsory growth: 30 next birthday
	Maximum:
	• 5 years before the benefit cease age for benefits selected with a fixed term
	• 65 next birthday for benefits selected with whole life cover
	Benefit cease age
	• 65 next birthday for benefits selected with a fixed term.
	Under Term cover products the term of a benefit is limited to a maximum of the selected term of the plan.
	• At death for benefits selected with whole life cover *(Whole life option only available under Topcover products)*.

Qualifying lives	**Express product option** Only the planholder and his/her spouse may qualify, subject to age limits and underwriting. **Classic and Premier product options** Subject to age limits and underwriting.
Guarantee period	**Express product option** 5 years **Classic and Premier product options** As selected for the plan.

Admittance of a claim

A claim will only be considered if the life insured meets the contractual claim event definition for the particular claim event under "Explanations" and as such, medical evidence will be required where applicable.

Besides the conditions for admittance of a claim set out in the *General information* chapter, we will admit a claim only if the life insured survived more than 14 days from the date the contractual claim event definition has been met.

If we admit a claim and the benefit is an accelerator benefit, we will reduce the cover amount of this benefit for the life insured by the claim amount. Any amount that we pay for a claim event thereafter will be based on the reduced cover amount.

If we admit a claim and the benefit is a standalone benefit, we will not reduce the cover amount of this benefit for the life insured by the claim amount.

Multiple claims

This section applies if more than one claim event is claimed for over the duration of the benefit. The payout percentage, which is the percentage at which we pay out the claim, may then be lower than the claim event percentage in the claim event table.

If a claim is submitted for more than one claim event at the same time, we will first consider the claim event with the highest claim event percentage.

If we admit a claim that is related to previously admitted claims, we will subtract the payout percentages of the previously admitted related claims from the claim event percentage of this claim. We will pay the difference if it is greater than zero.

A claim will be regarded as being related to another claim if a direct causal link to the other claim can be verified objectively from published reputable medical literature. In other words, there must be sufficient published evidence that the claim event occurred as a result of the other claim event, or due to the same disease process, and that the likelihood of the claim event occurring was very low in the absence of the other claim event.

If the claim event is however "partial mastectomy for ductal or lobular carcinoma in situ" and we have not yet paid two claims for this particular claim event, we will not reduce the payout percentage as indicated above. This means that we may pay up to two times for this claim event, even if the two claims are related.

For a standalone benefit we may further reduce the payout percentage in order to ensure that the sum of the payout percentages of related claims is not more than 100%.

Exclusions

Specific exclusions, if any, are set out in the plan overview, in the special provisions for the life insured concerned.

General exclusions are set out in the applicable overview chapter in this technical guide.

Claim events and claim event percentages

The tables below indicate the percentage of the cover amount we will pay for a claim for the severity levels of the following claim events as identified by the Standardised Critical Illness Definitions Project (SCIDEP) of the Association for Savings and Investment South Africa (ASISA). For multiple claims, we may pay a lower percentage than indicated as described under "Multiple claims".

Cancer benefit	Claim event percentage for indicated severity level			
Claim event	Level A Most severe	Level B	Level C	Level D Least severe
Specified aggressive cancers*	100	100	100	100
Other cancers, except cancers excluded by SCIDEP**	100	100	50	25
Coronary artery bypass graft (CABG)	0	0	0	0
Heart attack	0	0	0	0
Stroke resulting in permanent impairment	0	0	0	0

*For the following specified aggressive cancers, we will pay 100% for all SCIDEP severity levels:

- Oesophageal cancer stage I to IV;
- Liver cancer stage I to IV;
- Bile duct cancer stage I to IV;
- Lung cancer stage I to IV;
- Mesothelioma stage I to IV;
- Pancreatic cancer stage I to IV;
- Retroperitoneal cancer stage I to IV;
- Omental cancer stage I to IV;
- Mesenteric cancer stage I to IV;
- Stomach cancer stage I to IV;
- Tongue cancer stage I to IV;
- Hypopharyngeal cancer stage I to IV.

Cancer Plus benefit	Claim event percentage for indicated severity level			
Claim event	Level A Most severe	Level B	Level C	Level D Least severe
Cancer, except cancers excluded by SCIDEP**	100	100	100	100
Coronary artery bypass graft (CABG)	0	0	0	0
Heart attack	0	0	0	0
Stroke resulting in permanent impairment	0	0	0	0

**Stage 0 cancers and certain stage I cancers are excluded by SCIDEP so are not shown in the tables above. Refer to the "Early cancer" and "Cancers, tumours, leukaemias and lymphomas" claim categories in the claim event table for the claim event percentages that apply to the stage 0 and I cancers that are covered by the applicable benefit.

The first column in the table below contains the claim events grouped in claim categories. The contractual claim event definitions are described under "Explanations" and will be used when assessing the validity of a claim. The second and third columns contain the claim event percentages that apply to Cancer and Cancer Plus respectively.

Claim event	Claim event percentage (% of cover amount)	
	Cancer	Cancer Plus
Cancers, tumours, leukaemias and lymphomas		
Pancreatic cancer stage I to IV	100	100
Oesophageal cancer stage I to IV	100	100
Stomach cancer stage I to IV	100	100
Lung cancer stage I to IV	100	100
Liver cancer stage I to IV	100	100
Bile duct cancer stage I to IV	100	100
Mesothelioma stage I to IV	100	100
Tongue cancer stage I to IV	100	100
Hypopharyngeal cancer stage I to IV	100	100
Retroperitoneal cancer stage I to IV	100	100
Omental cancer stage I to IV	100	100
Mesenteric cancer stage I to IV	100	100
Acute lymphoblastic leukaemia	100	100
Acute myeloblastic leukaemia	100	100
Basal cell skin carcinoma or squamous cell skin carcinoma (stage I or II) having undergone a skin graft or skin flap	10	10
Bone marrow transplant	100	100
Brain tumour (Grade II on WHO classification)	50	100
Brain tumour (Grade III or IV on WHO classification)	100	100
Carcinoid syndrome	15	15
Carcinoid syndrome with evidence of liver metastasis of atypical carcinoid tumour	100	100
Chronic lymphocytic leukaemia (stage 0 or I on the Rai classification system)	25	100
Chronic lymphocytic leukaemia (stage II on the Rai classification system)	50	100
Chronic lymphocytic leukaemia (stage III on the Rai classification system)	100	100
Chronic lymphocytic leukaemia (stage IV on the Rai classification system)	100	100
Chronic myeloid leukaemia (no bone marrow transplant)	50	100
Chronic myeloid leukaemia (with bone marrow transplant)	100	100
Hairy cell leukaemia	25	100
Hodgkin's or non-Hodgkin's lymphoma (stage I on Ann Arbor classification system)	25	100
Hodgkin's or non-Hodgkin's lymphoma (stage II on Ann Arbor classification system)	50	100

Cancers, tumours, leukaemias and lymphomas		
Hodgkin's or non-Hodgkin's lymphoma (stage III or IV on Ann Arbor classification system)	100	100
Malignant melanoma with invasion beyond the epidermis or T1N0M0	25	100
Malignant melanoma stage II	50	100
Malignant melanoma stage III or IV	100	100
Multiple myeloma (stage I or II on the Durie-Salmon scale)	50	100
Multiple myeloma (stage III on the Durie-Salmon scale)	100	100
Myelodysplastic syndrome	15	15
Partial mastectomy for ductal or lobular carcinoma in situ	25	50
Total mastectomy for breast pathology	25	50
Prostate cancer – T1a-c N0M0, Gleason score 2-6	10	10
Prostate cancer – T1a-c N0M0, Gleason score ≥7	25	100
Prostate cancer – T2N0M0, Gleason score 2-6	25	100
Prostate cancer – T2N0M0, Gleason score ≥7	50	100
Prostate cancer – T3N0M0, Gleason score 2-6	50	100
Prostate cancer – T3N0M0, Gleason score ≥7	100	100
Prostate cancer stage IV	100	100
Any non-melanoma skin cancer stage III	100	100
Any non-melanoma skin cancer stage IV	100	100
Benign brain tumour treated surgically	25	25
Brain tumour treated with chemotherapy	50	100
Brain tumour treated with radiotherapy	25	25
Recurrent benign brain tumour showing symptoms	50	100
Inoperable benign brain tumour	25	25
Inoperable benign brain tumour with progression	100	100
Brain tumour having undergone open brain surgery	50	100
Brain tumour with permanent neurological deficit	100	100
Acoustic neuroma resulting in neurological deficit	30	30
Pituitary tumour with surgical resection	25	25
Benign endocrine tumours having undergone surgical excision	15	15
Brain abscess having undergone surgical drainage	10	10
Amyloidosis	25	25
Catch-all stage I cancer	25	100
Catch-all stage II cancer	50	100
Catch-all stage III or IV cancer	100	100
Early cancer		
A neuro-endocrine tumour of low malignant potential	5*	5*
Carcinoma in situ of one or both ovaries	5*	5*
Carcinoma in situ of one or both ovaries for which an oophorectomy has been performed	15*	15*
Cervical intraepithelial neoplasia grade III (CIN 3), or carcinoma in situ of the cervix	5*	5*
Cervical intraepithelial neoplasia grade III (CIN 3), or carcinoma in situ of the cervix for which a hysterectomy has been performed	15*	15*
Carcinoma in situ of the larynx	5*	5*
Carcinoma in situ of the larynx for which a total laryngectomy has been performed	15*	15*
Carcinoma in situ of the oesophagus for which surgery to remove the tumour has been performed	15*	15*

Claim event	Claim event percentage (% of cover amount)	
	Cancer	Cancer Plus
Early cancer		
Carcinoma in situ of the stomach	5*	5*
Carcinoma in situ of the stomach for which a partial or total gastrectomy has been performed	15*	15*
Carcinoma in situ of the urinary bladder	15*	15*
Carcinoma in situ of the vagina or vulva	5*	5*
Carcinoma in situ of the vagina or vulva for which surgery defined as a skin flap or skin graft has been performed	15*	15*
Lobular carcinoma in situ or ductal carcinoma in situ of the breast resulting in chemotherapy, lumpectomy or breast conserving surgery	15*	15*
Catch-all carcinoma in situ of any other internal organ or body structure	5*	5*

*For these claim events, the following maximum claim amounts apply:

- For each claim event under the “Early cancer” claim category with a claim event percentage of 5%, we will not pay more than a maximum rand amount of R100 000 per claim event.
- For each claim event under the “Early cancer” claim category with a claim event percentage of 15%, we will not pay more than a maximum rand amount of R300 000 per claim event.

These maximum rand amounts may change from time to time. Refer to “Multiple claims” for the payout percentage that will apply for related claims.

Cardiovascular (TAH3, TSH3) & Cardiovascular Plus (TAH4, TSH4)

These benefits are available under the Express, Classic and Premier product options of our Topcover products and under the Premier product option of our Term cover products.

Benefit description

The Cardiovascular and Cardiovascular Plus benefits cover the same claim events and provide cover for cardiovascular conditions: heart, blood vessels and stroke.

The Cardiovascular benefit, which is a more affordable benefit, will generally pay less than 100% of the cover amount for severities B, C and D of the cardiovascular events covered by SCIDEP. It will however pay 100% of the cover amount for coronary artery bypass graft from Severity B.

The Cardiovascular Plus benefit, which is a more expensive benefit, will pay 100% of the cover amount for the cardiovascular events covered by SCIDEP, as well as a higher percentage of the cover amount for certain other claim events.

If we admit a claim, we will pay the percentage of the cover amount, linked to the particular claim event as set out in the claim event table under "Claim events and claim event percentages". The amount will be paid as a lump sum. The percentages in this table are the claim event percentages. For multiple claims, we may pay a lower percentage than the claim event percentage, as described under "Multiple claims".

The cover amount is set out in the plan overview and may change over time as a result of benefit growth, alterations requested by the planholder, and for an accelerator benefit as a result of claims.

Additional features

Additional features are features that are automatically included for a benefit. These features are free of charge. The following additional feature applies:

- Free cover

Refer to the chapter *Payments, payment patterns, guarantees and cover* for more information about Free cover.

Type of benefit

Benefit	Type of benefit	
	Accelerator	Standalone
Cardiovascular (TAH3)	√	
Cardiovascular (TSH3)		√
Cardiovascular Plus (TAH4)	√	
Cardiovascular Plus (TSH4)		√

When will cover for this benefit end?

Benefits selected with a fixed term

Cover will end

- at midnight before the cover end date set out in the plan overview, or
- if the plan ends for any reason before the cover end date, or
- for an accelerator benefit when the full cover amount has been paid.

Benefits selected with whole life cover

Cover is provided for whole of life. However, the cover will end earlier:

- if the plan ends for any reason before the cover end date, or
- for an accelerator benefit when the full cover amount has been paid.

Cover limits per life insured

Housewives/house husbands, scholars, students, pensioners and unemployed persons (unemployed only under Classic/Premier) may qualify for a limited amount of cover, as described under "Financial underwriting" in the underwriting chapters. Otherwise the limits below apply.

Minimum: R50 000

Maximum:
- Express product option: R5 000 000*
- Classic and Premier product options: R6 000 000*

*Subject to financial underwriting

The sum of the cover amounts of all **accelerator severe illness/dread disease benefits** on a plan for a life insured may **not** exceed the sum of the cover amounts of the Death or First death benefit for that life insured.

Age limits

Benefit start age

Minimum:
- Payment patterns other than fixed compulsory growth
  - 19 next birthday for the Express product option
  - 15 next birthday otherwise
- Fixed compulsory growth: 30 next birthday

Maximum:
- 5 years before the benefit cease age for benefits selected with a fixed term
- 65 next birthday for benefits selected with whole life cover

Benefit cease age

- 65 next birthday for benefits selected with a fixed term.
  Under Term cover products the term of a benefit is limited to a maximum of the selected term of the plan.
- At death for benefits selected with whole life cover *(Whole life option only available under Topcover products)*.

Qualifying lives

Express product option
Only the planholder and his/her spouse may qualify, subject to age limits and underwriting.

Classic and Premier product options
Subject to age limits and underwriting.

Guarantee period

Express product option
5 years

Classic and Premier product options
As selected for the plan.

Admittance of a claim

A claim will only be considered if the life insured meets the contractual claim event definition for the particular claim event under "Explanations" and as such, medical evidence will be required where applicable.

Besides the conditions for admittance of a claim set out in the *General information* chapter, we will admit a claim only if the life insured survived more than 14 days from the date the contractual claim event definition has been met.

If we admit a claim and the benefit is an accelerator benefit, we will reduce the cover amount of this benefit for the life insured by the claim amount. Any amount that we pay for a claim event thereafter will be based on the reduced cover amount.

If we admit a claim and the benefit is a standalone benefit, we will not reduce the cover amount of this benefit for the life insured by the claim amount.

Multiple claims

This section applies if more than one claim event is claimed for over the duration of the benefit. The payout percentage, which is the percentage at which we pay out the claim, may then be lower than the claim event percentage in the claim event table.

If a claim is submitted for more than one claim event at the same time, we will first consider the claim event with the highest claim event percentage.

If we admit a claim that is related to previously admitted claims, we will subtract the payout percentages of the previously admitted related claims from the claim event percentage of this claim. We will pay the difference if it is greater than zero.

A claim will be regarded as being related to another claim if a direct causal link to the other claim can be verified objectively from published reputable medical literature. In other words, there must be sufficient published evidence that the claim event occurred as a result of the other claim event, or due to the same disease process or injury, and that the likelihood of the claim event occurring was very low in the absence of the other claim event.

If the claim event is however any of the claim events listed below, and we have not yet paid two claims for the particular claim event, we will not reduce the payout percentage as indicated above. This means that we may pay up to two times for any of the claim events listed below, even if the two claims are related:

- Any heart valve surgery such as valvuloplasty or valvotomy irrespective of technique*;
- Peripheral arterial disease requiring angioplasty, stent or bypass graft of one peripheral artery;
- Peripheral arterial disease requiring angioplasty, stent or bypass graft of more than one peripheral artery;
- Angioplasty with or without stenting of one or more coronary arteries;
- Angioplasty with or without stenting of one carotid artery;
- Angioplasty with or without stenting of bilateral carotid arteries*;
- Stroke with full recovery.

*Not applicable to Cardiovascular Plus as this benefit already pays 100% for these claim events.

We will also not reduce the payout percentage as indicated above if the claim is part of a bundle of claims. Claims will be regarded as being bundled if the same single accidental or injury cause event results in the life insured meeting more than one claim event definition.

For a **standalone** benefit we may further reduce the payout percentage in order to ensure that

- the sum of the payout percentages of related claims is not more than 100%, and
- the sum of the payout percentages of a bundle of claims is not more than 100%.

Exclusions

Specific exclusions, if any, are set out in the plan overview, in the special provisions for the life insured concerned.

General exclusions are set out in the applicable overview chapter in this technical guide.

Claim events and claim event percentages

The tables below indicate the percentage of the cover amount we will pay for a claim for the severity levels of the following claim events as identified by the Standardised Critical Illness Definitions Project (SCIDEP) of the Association for Savings and Investment South Africa (ASISA). For multiple claims, we may pay a lower percentage than indicated as described under "Multiple claims".

Cardiovascular benefit	Claim event percentage for indicated severity level			
Claim event	Level A Most severe	Level B	Level C	Level D Least severe
Cancer	0	0	0	0
Coronary artery bypass graft (CABG)	100	100	50	50
Heart attack*	100	75	50	35
Stroke resulting in permanent impairment	100	75	50	25

Cardiovascular Plus benefit	Claim event percentage for indicated severity level			
Claim event	Level A Most severe	Level B	Level C	Level D Least severe
Cancer	0	0	0	0
Coronary artery bypass graft (CABG)	100	100	100	100
Heart attack*	100	100	100	100
Stroke resulting in permanent impairment	100	100	100	100

*The “Mild heart attack” claim event is excluded by SCIDEP, so it is not included in the tables above. Refer to the “Cardiovascular conditions: heart, blood vessels and stroke” claim category in the claim event table for the claim event percentages that apply to it.

The first column in the table below contains the claim events grouped in claim categories. The contractual claim event definitions are described under "Explanations" and will be used when assessing the validity of a claim. The second and third columns contain the claim event percentages that apply to Cardiovascular and Cardiovascular Plus respectively.

Claim event	Claim event percentage (% of cover amount)	
	Cardio-vascular	Cardio-vascular Plus
Cardiovascular conditions: heart, blood vessels and stroke		
Heart transplant	100	100
Heart valve replacement irrespective of technique	100	100
Any heart valve surgery such as valvuloplasty or valvotomy irrespective of technique	50	100
Cardiomyopathy at class III NYHA and EF less than 40%	75	100
Cardiomyopathy at class IV NYHA and EF less than 30%	100	100
Takotsubo cardiomyopathy	25	25
Transcoronary ablation of septal hypertrophy	50	50
Pericardiectomy irrespective of technique	50	100
Arrhythmia having undergone pathway ablation	25	25
Arrhythmia having undergone a permanent pacemaker insertion	25	25
Arrhythmia having undergone a permanent defibrillator insertion	50	100
Peripheral arterial disease requiring angioplasty, stent or bypass graft of one peripheral artery	10	50
Peripheral arterial disease requiring angioplasty, stent or bypass graft of more than one peripheral artery	25	50
Loss of use of or loss of one foot due to peripheral arterial disease	15	15
Loss of use of or loss of one hand due to peripheral arterial disease	50	50
Angioplasty with or without stenting of one carotid artery	25	50
Angioplasty with or without stenting of bilateral carotid arteries	50	100
Carotid arterial disease: narrowing of at least one carotid artery requiring either bypass graft or endarterectomy	75	100
Endovascular surgery or stent to repair any thoracic or abdominal aortic aneurysm	50	100
Surgical repair of an ileofemoral aneurysm or stenosis	50	100
Surgical repair of any aneurysm or stenosis of major arterial branches of the aorta	50	100
Major surgery to dissect and surgically graft an aortic aneurysm	100	100
Primary pulmonary hypertension	100	100
Surgery for atrial septal defects or ventricular septal defects	25	25
Surgical repair of coarctation of the aorta	25	25

Left ventricular aneurysm repaired surgically	100	100
Surgery for atrial myxoma	50	50
Subarachnoid haemorrhage without neurological impairment	25	25
Cardiovascular conditions: heart, blood vessels and stroke		
Arteriovenous malformation treated with radiological intervention	25	25
Arteriovenous malformation treated with open surgery craniotomy	50	100
Angioplasty with or without stenting of one or more coronary arteries	25	25
Coronary artery disease with coronary artery bypass graft for up to two arteries	50	100
Coronary artery disease with coronary artery bypass graft for three or more arteries	100	100
Mild heart attack	25	50
Mild heart attack of specified severity	35	100
Moderate heart attack of specified severity	50	100
Heart attack with permanent mild impairment in function	75	100
Heart attack with permanent severe impairment in function	100	100
Takayasu's disease	25	25
Superior sagittal sinus thrombosis	25	50
Cavernous sinus thrombosis	25	50
Non-healing venous ulcer of more than 3 months duration despite treatment by a vascular surgeon, with documented evidence of deep venous insufficiency	15	15
Post thrombotic leg with syndrome	10	10
Giant cell arteritis	10	10
Persistent giant cell arteritis despite optimal therapy	25	25
Stroke with full recovery	25	25
Stroke with almost full recovery	25	100
Stroke with mild impairment	50	100
Stroke with moderate impairment	75	100
Stroke with severe impairment	100	100

Comprehensive Severe Illness (TAW3, TSW3) & Comprehensive Severe Illness Plus (TAW4, TSW4)

These benefits are available under the Classic and Premier product options of our Topcover products and under the Premier product option of our Term cover products.

Benefit description

The Comprehensive Severe Illness and Comprehensive Severe Illness Plus benefits cover the same claim events. They provide cover for a comprehensive range of severe illnesses as well as cover for various impairments, injuries and infections. They also include a number of catch-all claim events.

The Comprehensive Severe Illness benefit, which is a more affordable benefit, will pay less than 100% of the cover amount for lower severities of certain events covered by SCIDEP. It will however pay 100% of the cover amount for specified aggressive cancers from stage I and 100% of the cover amount for certain other events at lower severities. Refer to the SCIDEP table for the Comprehensive Severe Illness benefit under “Claim events and claim event percentages” for more information.

The Comprehensive Severe Illness Plus benefit, which is a more expensive benefit, will pay 100% of the cover amount for the events covered by SCIDEP, as well as a higher percentage of the cover amount for certain other claim events.

If we admit a claim, we will pay the percentage of the cover amount, linked to the particular claim event as set out in the claim event table under "Claim events and claim event percentages". The amount will be paid as a lump sum. The percentages in this table are the claim event percentages. For multiple claims, we may pay a lower percentage than the claim event percentage, as described under "Multiple claims". For claim events where a maximum rand amount is indicated in the claim event table, we will not pay more than the indicated rand amount.

The cover amount is set out in the plan overview and may change over time as a result of benefit growth, alterations requested by the planholder, and for an accelerator benefit as a result of claims.

Additional features

Additional features are features that are automatically included for a benefit. These features are free of charge. The following additional feature applies:

- Free cover

Refer to the chapter *Payments, payment patterns, guarantees and cover* for more information about Free cover.

Type of benefit

Benefit	Type of benefit	
	Accelerator	Standalone
Comprehensive Severe Illness (TAW3)	√	
Comprehensive Severe Illness (TSW3)		√
Comprehensive Severe Illness Plus (TAW4)	√	
Comprehensive Severe Illness Plus (TSW4)		√

When will cover for this benefit end?	**Benefits selected with a fixed term** Cover will end • at midnight before the cover end date set out in the plan overview, or • if the plan ends for any reason before the cover end date, or • for an accelerator benefit when the full cover amount has been paid. **Benefits selected with whole life cover** Cover is provided for whole of life. However, the cover will end earlier: • if the plan ends for any reason before the cover end date, or • for an accelerator benefit when the full cover amount has been paid.
Cover limits per life insured	Housewives/house husbands, scholars, students, pensioners and unemployed persons (unemployed only under Premier) may qualify for a limited amount of cover, as described under "Financial underwriting" in the underwriting chapters. Otherwise the limits below apply. Minimum: R50 000 Maximum: Classic and Premier product options: R6 000 000* *Subject to financial underwriting The sum of the cover amounts of all **accelerator severe illness/dread disease benefits** on a plan for a life insured may **not** exceed the sum of the cover amounts of the Death or First death benefit for that life insured.
Age limits	**Benefit start age** Minimum: • Payment patterns other than fixed compulsory growth: 15 next birthday • Fixed compulsory growth: 30 next birthday Maximum: • 5 years before the benefit cease age for benefits selected with a fixed term • 65 next birthday for benefits selected with whole life cover **Benefit cease age** • 65 next birthday for benefits selected with a fixed term. Under Term cover products the term of a benefit is limited to a maximum of the selected term of the plan. • At death for benefits selected with whole life cover *(Whole life option only available under Topcover products)*.
Qualifying lives	Subject to age limits and underwriting.
Guarantee period	As selected for the plan.

Admittance of a claim

A claim will only be considered if the life insured meets the contractual claim event definition for the particular claim event under "Explanations" and as such, medical evidence will be required where applicable.

Besides the conditions for admittance of a claim set out in the *General information* chapter, we will admit a claim only if the life insured survived more than 14 days from the date the contractual claim event definition has been met.

If we admit a claim and the benefit is an accelerator benefit, we will reduce the cover amount of this benefit for the life insured by the claim amount. Any amount that we pay for a claim event thereafter will be based on the reduced cover amount.

If we admit a claim and the benefit is a standalone benefit, we will not reduce the cover amount of this benefit for the life insured by the claim amount.

Multiple claims

This section applies if more than one claim event is claimed for over the duration of the benefit. The payout percentage, which is the percentage at which we pay out the claim, may then be lower than the claim event percentage in the claim event table.

If a claim is submitted for more than one claim event at the same time, we will first consider the claim event with the highest claim event percentage.

If we admit a claim that is related to previously admitted claims, we will subtract the payout percentages of the previously admitted related claims from the claim event percentage of this claim. We will pay the difference if it is greater than zero.

A claim will be regarded as being related to another claim if a direct causal link to the other claim can be verified objectively from published reputable medical literature. In other words, there must be sufficient published evidence that the claim event occurred as a result of the other claim event, or due to the same disease process or injury, and that the likelihood of the claim event occurring was very low in the absence of the other claim event.

If the claim event is however any of the claim events listed below, and we have not yet paid two claims for the particular claim event, we will not reduce the payout percentage as indicated above. This means that we may pay up to two times for any of the claim events listed below, even if the two claims are related:

- Partial mastectomy for ductal or lobular carcinoma in situ;
- Any heart valve surgery such as valvuloplasty or valvotomy irrespective of technique*;
- Peripheral arterial disease requiring angioplasty, stent or bypass graft of one peripheral artery;
- Peripheral arterial disease requiring angioplasty, stent or bypass graft of more than one peripheral artery;
- Angioplasty with or without stenting of one or more coronary arteries;
- Angioplasty with or without stenting of one carotid artery;
- Angioplasty with or without stenting of bilateral carotid arteries*;
- Stroke with full recovery;
- Compartment syndrome with permanent motor nerve damage.

*Not applicable to Comprehensive Severe Illness Plus as this benefit already pays 100% for these claim events.

We will also not reduce the payout percentage as indicated above if the claim is part of a bundle of claims. Claims will be regarded as being bundled if the same single accidental or injury cause event results in the life insured meeting more than one claim event definition.

For a standalone benefit we may further reduce the payout percentage in order to ensure that

- the sum of the payout percentages of related claims is not more than 100%, and
- the sum of the payout percentages of a bundle of claims is not more than 100%.

Waiting period for joint replacements

We will not admit a claim for the following claim events under the “Musculoskeletal system” claim category resulting from natural causes within 5 years from the cover start date of the benefit:

- Hip joint replacement;
- Knee joint replacement;
- Ankle joint replacement;
- Shoulder joint replacement.

A claim for any of these claim events, resulting from natural causes, can only be submitted if the claim event occurred after the waiting period of 5 years from the cover start date of the benefit. If the cover amount of the benefit is increased, other than through benefit growth, a waiting period of 5 years from the cover start date of the increase will be applicable to the increase in the cover amount.

The waiting period is not applicable if the claim event results from unnatural causes.

Exclusions

Specific exclusions, if any, are set out in the plan overview, in the special provisions for the life insured concerned.

General exclusions are set out in the applicable overview chapter in this technical guide.

Claim events and claim event percentages

The tables below indicate the percentage of the cover amount we will pay for a claim for the severity levels of the following claim events as identified by the Standardised Critical Illness Definitions Project (SCIDEP) of the Association for Savings and Investment South Africa (ASISA). For multiple claims, we may pay a lower percentage than indicated as described under "Multiple claims".

Comprehensive Severe Illness benefit	Claim event percentage for indicated severity level			
Claim event	Level A Most severe	Level B	Level C	Level D Least severe
Specified aggressive cancers*	100	100	100	100
Other cancers**	100	100	50	25
Coronary artery bypass graft (CABG)	100	100	50	50
Heart attack**	100	75	50	35
Stroke resulting in permanent impairment	100	75	50	25

*For the following specified aggressive cancers, we will pay 100% for all SCIDEP severity levels:

- Oesophageal cancer stage I to IV;
- Liver cancer stage I to IV;
- Bile duct cancer stage I to IV;
- Lung cancer stage I to IV;
- Mesothelioma stage I to IV;
- Pancreatic cancer stage I to IV;
- Retroperitoneal cancer stage I to IV;
- Omental cancer stage I to IV;
- Mesenteric cancer stage I to IV;
- Stomach cancer stage I to IV;
- Tongue cancer stage I to IV;
- Hypopharyngeal cancer stage I to IV.

Comprehensive Severe Illness Plus benefit	Claim event percentage for indicated severity level			
Claim event	Level A Most severe	Level B	Level C	Level D Least severe
Cancer**	100	100	100	100
Coronary artery bypass graft (CABG)	100	100	100	100
Heart attack**	100	100	100	100
Stroke resulting in permanent impairment	100	100	100	100

**Stage 0 cancers and certain stage I cancers are excluded by SCIDEP so are not shown in the tables above. Refer to the "Early cancer" and "Cancers, tumours, leukaemias and lymphomas" claim categories in the claim event table for the claim event percentages that apply to the stage 0 and I cancers that are covered by the applicable benefit. The “Mild heart attack” claim event is excluded by SCIDEP, so it is not included in the tables above. Refer to the “Cardiovascular conditions: heart, blood vessels and stroke” claim category in the claim event table for the claim event percentages that apply to it.

The first column in the table below contains the claim events grouped in claim categories. The contractual claim event definitions are described under "Explanations" and will be used when assessing the validity of a claim. The second and third columns contain the claim event percentages that apply to Comprehensive Severe Illness and Comprehensive Severe Illness Plus respectively.

Claim event	Claim event percentage (% of cover amount)	
	Compre-hensive Severe Illness	Compre-hensive Severe Illness Plus
Cancers, tumours, leukaemias and lymphomas		
Pancreatic cancer stage I to IV	100	100
Oesophageal cancer stage I to IV	100	100
Stomach cancer stage I to IV	100	100
Lung cancer stage I to IV	100	100
Liver cancer stage I to IV	100	100
Bile duct cancer stage I to IV	100	100
Mesothelioma stage I to IV	100	100
Tongue cancer stage I to IV	100	100
Hypopharyngeal cancer stage I to IV	100	100
Retroperitoneal cancer stage I to IV	100	100
Omental cancer stage I to IV	100	100
Mesenteric cancer stage I to IV	100	100
Acute lymphoblastic leukaemia	100	100
Acute myeloblastic leukaemia	100	100
Basal cell skin carcinoma or squamous cell skin carcinoma (stage I or II) having undergone a skin graft or skin flap	10	10
Bone marrow transplant	100	100
Brain tumour (Grade II on WHO classification)	50	100
Brain tumour (Grade III or IV on WHO classification)	100	100
Carcinoid syndrome	15	15
Carcinoid syndrome with evidence of liver metastasis of atypical carcinoid tumour	100	100
Chronic lymphocytic leukaemia (stage 0 or I on the Rai classification system)	25	100
Chronic lymphocytic leukaemia (stage II on the Rai classification system)	50	100
Chronic lymphocytic leukaemia (stage III on the Rai classification system)	100	100
Chronic lymphocytic leukaemia (stage IV on the Rai classification system)	100	100
Chronic myeloid leukaemia (no bone marrow transplant)	50	100
Chronic myeloid leukaemia (with bone marrow transplant)	100	100
Hairy cell leukaemia	25	100
Hodgkin's or non-Hodgkin's lymphoma (stage I on Ann Arbor classification system)	25	100
Hodgkin's or non-Hodgkin's lymphoma (stage II on Ann Arbor classification system)	50	100
Hodgkin's or non-Hodgkin's lymphoma (stage III or IV on Ann Arbor classification system)	100	100
Malignant melanoma with invasion beyond the epidermis or T1N0M0	25	100
Malignant melanoma stage II	50	100
Malignant melanoma stage III or IV	100	100
Multiple myeloma (stage I or II on the Durie-Salmon scale)	50	100
Multiple myeloma (stage III on the Durie-Salmon scale)	100	100
Myelodysplastic syndrome	15	15

Claim event	Claim event percentage (% of cover amount)	
	Compre-hensive Severe Illness	Compre-hensive Severe Illness Plus
Partial mastectomy for ductal or lobular carcinoma in situ	25	50
Total mastectomy for breast pathology	25	50
Prostate cancer – T1a-c N0M0, Gleason score 2-6	10	10
Prostate cancer – T1a-c N0M0, Gleason score ≥7	25	100
Prostate cancer – T2N0M0, Gleason score 2-6	25	100
Prostate cancer – T2N0M0, Gleason score ≥7	50	100
Prostate cancer – T3N0M0, Gleason score 2-6	50	100
Prostate cancer – T3N0M0, Gleason score ≥7	100	100
Prostate cancer stage IV	100	100
Any non-melanoma skin cancer stage III	100	100
Any non-melanoma skin cancer stage IV	100	100
Benign brain tumour treated surgically	25	25
Brain tumour treated with chemotherapy	50	100
Brain tumour treated with radiotherapy	25	25
Recurrent benign brain tumour showing symptoms	50	100
Inoperable benign brain tumour	25	25
Inoperable benign brain tumour with progression	100	100
Brain tumour having undergone open brain surgery	50	100
Brain tumour with permanent neurological deficit	100	100
Acoustic neuroma resulting in neurological deficit	30	30
Pituitary tumour with surgical resection	25	25
Benign endocrine tumours having undergone surgical excision	15	15
Brain abscess having undergone surgical drainage	10	10
Amyloidosis	25	25
Catch-all stage I cancer	25	100
Catch-all stage II cancer	50	100
Catch-all stage III or IV cancer	100	100
Early cancer		
A neuro-endocrine tumour of low malignant potential	5*	5*
Carcinoma in situ of one or both ovaries	5*	5*
Carcinoma in situ of one or both ovaries for which an oophorectomy has been performed	15*	15*
Cervical intraepithelial neoplasia grade III (CIN 3), or carcinoma in situ of the cervix	5*	5*
Cervical intraepithelial neoplasia grade III (CIN 3), or carcinoma in situ of the cervix for which a hysterectomy has been performed	15*	15*
Carcinoma in situ of the larynx	5*	5*
Carcinoma in situ of the larynx for which a total laryngectomy has been performed	15*	15*
Carcinoma in situ of the oesophagus for which surgery to remove the tumour has been performed	15*	15*
Carcinoma in situ of the stomach	5*	5*
Carcinoma in situ of the stomach for which a partial or total gastrectomy has been performed	15*	15*
Carcinoma in situ of the urinary bladder	15*	15*
Carcinoma in situ of the vagina or vulva	5*	5*

Claim event	Claim event percentage (% of cover amount)	
	Compre-hensive Severe Illness	Compre-hensive Severe Illness Plus
Carcinoma in situ of the vagina or vulva for which surgery defined as a skin flap or skin graft has been performed	15*	15*
Lobular carcinoma in situ or ductal carcinoma in situ of the breast resulting in chemotherapy, lumpectomy or breast conserving surgery	15*	15*
Catch-all carcinoma in situ of any other internal organ or body structure	5*	5*
Cardiovascular conditions: heart, blood vessels and stroke		
Heart transplant	100	100
Heart valve replacement irrespective of technique	100	100
Any heart valve surgery such as valvuloplasty or valvotomy irrespective of technique	50	100
Cardiomyopathy at class III NYHA and EF less than 40%	75	100
Cardiomyopathy at class IV NYHA and EF less than 30%	100	100
Takotsubo cardiomyopathy	25	25
Transcoronary ablation of septal hypertrophy	50	50
Pericardiectomy irrespective of technique	50	100
Arrhythmia having undergone pathway ablation	25	25
Arrhythmia having undergone a permanent pacemaker insertion	25	25
Arrhythmia having undergone a permanent defibrillator insertion	50	100
Peripheral arterial disease requiring angioplasty, stent or bypass graft of one peripheral artery	10	50
Peripheral arterial disease requiring angioplasty, stent or bypass graft of more than one peripheral artery	25	50
Loss of use of or loss of one foot due to peripheral arterial disease	15	15
Loss of use of or loss of one hand due to peripheral arterial disease	50	50
Angioplasty with or without stenting of one carotid artery	25	50
Angioplasty with or without stenting of bilateral carotid arteries	50	100
Carotid arterial disease: narrowing of at least one carotid artery requiring either bypass graft or endarterectomy	75	100
Endovascular surgery or stent to repair any thoracic or abdominal aortic aneurysm	50	100
Surgical repair of an ileofemoral aneurysm or stenosis	50	100
Surgical repair of any aneurysm or stenosis of major arterial branches of the aorta	50	100
Major surgery to dissect and surgically graft an aortic aneurysm	100	100
Primary pulmonary hypertension	100	100
Surgery for atrial septal defects or ventricular septal defects	25	25
Surgical repair of coarctation of the aorta	25	25
Left ventricular aneurysm repaired surgically	100	100
Surgery for atrial myxoma	50	50
Subarachnoid haemorrhage without neurological impairment	25	25
Arteriovenous malformation treated with radiological intervention	25	25
Arteriovenous malformation treated with open surgery craniotomy	50	100
Angioplasty with or without stenting of one or more coronary arteries	25	25
Coronary artery disease with coronary artery bypass graft for up to two arteries	50	100
Coronary artery disease with coronary artery bypass graft for three or more arteries	100	100
Mild heart attack	25	50

Claim event	Claim event percentage (% of cover amount)	
	Compre-hensive Severe Illness	Compre-hensive Severe Illness Plus
Mild heart attack of specified severity	35	100
Moderate heart attack of specified severity	50	100
Heart attack with permanent mild impairment in function	75	100
Heart attack with permanent severe impairment in function	100	100
Takayasu's disease	25	25
Superior sagittal sinus thrombosis	25	50
Cavernous sinus thrombosis	25	50
Non-healing venous ulcer of more than 3 months duration despite treatment by a vascular surgeon, with documented evidence of deep venous insufficiency	15	15
Post thrombotic leg with syndrome	10	10
Giant cell arteritis	10	10
Persistent giant cell arteritis despite optimal therapy	25	25
Stroke with full recovery	25	25
Stroke with almost full recovery	25	100
Stroke with mild impairment	50	100
Stroke with moderate impairment	75	100
Stroke with severe impairment	100	100
Connective tissue		
Progressive systemic sclerosis (scleroderma)	100	100
Seropositive rheumatoid arthritis	25	50
Advanced or progressive rheumatoid arthritis despite optimal treatment	100	100
Systemic lupus erythematosis (SLE)	25	50
Systemic lupus erythematosis with multiple organ impairment	100	100
Sarcoidosis	25	25
Sarcoidosis with multiple organ involvement	100	100
Polyarteritis nodosa	20	20
Wegener's granulomatosis	20	50
Ear, nose and throat		
Mastoiditis requiring mastoidectomy	30	30
Total and permanent loss of hearing in one ear	30	30
Permanent binaural hearing loss of more than 60%	50	50
Permanent binaural hearing loss of more than 75%	70	100
Total and permanent loss of hearing in both ears	100	100
Recipient of cochlear or middle ear implant	20	20
Otosclerosis resulting in hearing loss after failed surgery	10	10
Chronic osteomyelitis of the sinuses	10	10
Endocrine system		
Diagnosis of thyrotoxic crisis	5	5
Diagnosis of acromegaly	5	5
Diagnosis of Addisonian crisis	5	5
Diagnosis of parathyroid tetany	5	5
Diagnosis of Simmonds' disease	5	5
Diagnosis of Conn's syndrome	5	5

Claim event	Claim event percentage (% of cover amount)	
	Compre-hensive Severe Illness	Compre-hensive Severe Illness Plus
Diagnosis of primary Cushing's disease	5	5
Diagnosis of diabetes insipidus	5	5
Diagnosis of type I diabetes	15	15
Diabetes mellitus type II with permanent renal impairment	15	15
Diabetic retinopathy stage III	10	10
Diabetic retinopathy stage IV	15	15
Gastrointestinal system		
Tracheoesophageal fistula having undergone surgery	25	25
Crohn's disease or ulcerative colitis with prolonged advanced therapy	25	25
Crohn's disease or ulcerative colitis with recurrent surgery	50	50
Crohn's disease or ulcerative colitis with a permanent colostomy or ileostomy	75	100
Hemicolectomy	25	25
Total colectomy (removal of the ascending, descending and transverse colon)	50	100
Any disease or disorder requiring partial hepatectomy	25	25
Chronic persistent hepatitis classified as Child-Pugh class A or worse	100	100
Sclerosing cholangitis classified as Child-Pugh class A or worse	100	100
End-stage liver failure	100	100
Liver or pancreas transplant	100	100
Amyloidosis of the liver and spleen	25	25
Complete pancreatectomy	100	100
Primary biliary cirrhosis	50	50
Chronic pancreatitis	30	30
Loss of more than one third of the tongue	20	20
Chronic rectal fistula	10	10
Proven acute peritonitis requiring surgical intervention (excluding appendectomy)	10	10
Irreparable abdominal or inguinal hernia	10	10
Lymph and blood		
Chronic blood disorders requiring constant blood replacements	50	100
Severe aplastic anaemia	50	100
Bone marrow transplant	100	100
Diffuse intravascular clotting	10	10
Idiopathic thrombocytopenic purpura with splenectomy	10	10
Chronic anaemia despite optimal treatment needing blood transfusion every second week	10	10
Autoimmune haemolytic anaemia with splenectomy	10	10
Essential thrombocytosis	10	10
Musculoskeletal system		
Any long-bone chronic osteomyelitis	10	10
Septic arthritis of a major joint	10	10
Hip joint replacement**	15	15
Knee joint replacement**	15	15
Ankle joint replacement**	10	10
Shoulder joint replacement**	10	10

Claim event	Claim event percentage (% of cover amount)	
	Compre-hensive Severe Illness	Compre-hensive Severe Illness Plus
Elbow or wrist joint replacement	10	10
Paraplegia, hemiplegia, diplegia or quadriplegia	100	100
Loss of more than 50% of hand function as defined in AMA's guides or its equivalent	25	25
Loss of use of or loss of one thumb	10*	10*
Loss of use of or loss of three or more fingers on the same hand	10*	10*
Loss of use of or loss of one hand	50	50
Loss of use of or loss of both hands	100	100
Loss of use of or loss of one foot	25	25
Loss of use of or loss of both feet	100	100
Loss of use of or loss of one hand and one foot	75	100
Loss of use of or loss of one limb	50	50
Loss of use of or loss of more than one limb	100	100
Surgical repair of major motor nerve after complete severance	10	10
Confirmed diagnosis of Paget's disease of the bone	10	10
Persistent neurological impairment despite recurrent spinal surgery	10	10
Temperomandibular joint replacement	10	10
Nervous system and psychiatric disorders		
Conditions having undergone open brain surgery via a craniotomy	50	100
Status epilepticus resulting in permanent neurological impairment	100	100
Guillain-Barre with prolonged respiratory support	50	50
Guillain-Barre with permanent neurological deficit	100	100
Permanent and complete inability to communicate or comprehend language symbols	100	100
Permanent hemiparesis or hemiparalysis secondary to trauma or surgery	100	100
Permanent moderate to severe impairment of intellectual capacity as a result of brain injury or systemic hypoxia	50	100
Motor neuron disease	100	100
Diagnosis of muscular dystrophy	50	100
Progressive muscular dystrophy	100	100
Induced coma	25	50
Coma with full recovery	50	100
Coma resulting in permanent neurological deficit	100	100
Multiple sclerosis	25	100
Advanced multiple sclerosis	100	100
Optic neuritis with demyelinating on MRI	25	25
Parkinson's disease	25	25
Advanced Parkinson's disease	100	100
Diagnosis of myasthenia gravis	25	25
Myasthenia gravis with severe permanent impairment	100	100
Hydrocephalus with the insertion of a VP shunt	25	25
Stereotactic brain surgery	25	25
Irreversible unilateral trigeminal nerve palsy	25	25
Irreversible unilateral facial nerve palsy	25	25

Claim event	Claim event percentage (% of cover amount)	
	Compre-hensive Severe Illness	Compre-hensive Severe Illness Plus
Irreversible unilateral hypoglossal nerve palsy	25	100
Irreversible cerebellum dysfunction	50	100
Alzheimer's disease	100	100
Schizophrenia	25	100
Anorexia nervosa with BMI less than 16 for 6 consecutive months	25	25
Medically certified institutionalisation for a mental and behavioural disorder for at least 6 months continuously	100	100
Renal disorders		
Chronic nephrotic syndrome	10	10
Nephrotic syndrome with renal artery or renal vein thrombosis	25	25
Chronic tubulointerstitial disease	10	10
Primary amyloidosis of the kidney	25	25
Nephrectomy as kidney donor, meeting ethical and legal requirements	10	10
Partial or total nephrectomy	25	25
Renal cortical necrosis	25	25
Moderate progressive chronic kidney disease with decline in function	50	50
Severe progressive chronic kidney disease with decline in function	75	75
Chronic, irreversible kidney failure requiring and already having undergone regular dialysis treatment	100	100
Kidney transplant	100	100
Polycystic kidney disease	25	25
Documented renal vein thrombosis	25	25
Open kidney surgery, not for diagnostic purposes	10	10
Reproductive system		
Eclampsia	10	10
Amniotic fluid pulmonary embolism	10	10
Diffuse intravascular clotting in pregnancy	10	10
Acute renal failure in pregnancy	20	20
Ectopic pregnancy	10	10
Intrauterine death after 12 weeks and up to and including 24 weeks gestation	5	5
Intrauterine death after 24 weeks gestation	10	10
Uterus rupture	20	20
Sheehan syndrome post-partum	5	5
Hydatidiform mole	10	10
Respiratory disorders		
Confirmed diagnosis of interstitial lung disease	10	10
Severe status asthmaticus	10	10
Pulmonary embolism	25	25
Recurrent pulmonary embolism, with associated pulmonary hypertension	100	100
Chronic irreversible lung disease with moderate impairment	50	50
Chronic irreversible lung disease with severe impairment	100	100
Removal of two or more lobes of a lung	25	25
Removal of a lung	50	50

Claim event	Claim event percentage (% of cover amount)	
	Compre-hensive Severe Illness	Compre-hensive Severe Illness Plus
Lung or heart-lung transplant	100	100
Any chronic lung disease with pleurectomy or decortication	15	15
Chronic sarcoidosis not responding to optimal treatment	50	50
Pulmonary fibrosis	50	50
Pulmonary alveolar proteinosis	50	50
Repair of bronchopleural fistula	10	10
Skin and soft tissues		
Pemphigus vulgaris	10	10
Stevens-Johnson syndrome	10	10
Toxic epidermal necrolysis	50	50
Psoriasis of more than 20% skin involvement plus nail and joint involvement	20	20
Discoid lupus	10	10
Compartment syndrome with permanent motor nerve damage	10	10
Scleroderma	10	10
CREST syndrome	10	10
Urogenital disorders		
Vesicovaginal or rectovaginal fistula having undergone surgery	10	10
Partial amputation of the penis	25	25
Total amputation of the penis	50	50
Partial cystectomy (removal of at least 50% of the urinary bladder)	25	25
Radical cystectomy resulting in a need for an external bag or catheterisation	50	50
Unilateral orchidectomy	10	10
Bilateral orchidectomy	25	25
Vision		
Macular degeneration	15	15
Retinal detachment requiring corrective laser therapy or that is inoperable	10	10
Corneal transplant	10	10
Optic neuritis	10	10
Enucleation of one eye	40	40
Retinitis pigmentosa	25	100
Total and permanent loss of sight in one eye	25	50
Total and permanent loss of sight in both eyes	100	100
Irreversible hemianopia in one eye	30	30
Irreversible hemianopia in both eyes	75	100
Infections		
Accidental HIV infection	100	100
Clinical manifestation of Aids supported by a positive HIV test result	100	100
Cerebral malaria	25	25
Cerebral malaria resulting in permanent neurological impairment	100	100
Bacterial meningitis	10	10
Injuries, accidents and poison		
Full thickness burns involving more than 30% of one hand or more than 30% of the head	25	25

Claim event	Claim event percentage (% of cover amount)	
	Compre-hensive Severe Illness	Compre-hensive Severe Illness Plus
Grade II partial thickness burns involving more than 20% of the body surface area	25	25
Full thickness burns involving more than 10% but less than or equal to 20% of the body surface area	50	50
Full thickness burns involving more than 20% but less than or equal to 30% of the body surface area	75	75
Full thickness burns involving more than 30% of the body surface area	100	100
Spinal fusion	10	10
Decompression laminectomy or decompression laminotomy	10	10
Drainage via burr hole	10	10
Emergency tracheostomy or cricothyrotomy	10	10
ICU admission with mechanical ventilation for at least 96 hours	25	25
Traumatic injuries resulting in a comatose state requiring mechanical ventilation persistent for longer than 96 hours	100	100
Spinal injury resulting in paraplegia, diplegia, hemiplegia, quadriplegia or cauda equina syndrome	100	100
Objective radiological evidence of a fracture dislocation of the spine	10	10
Penetrating stab wound or gunshot wound	25	25
Loss of bowel or bladder function, with permanent stoma or indwelling catheter	25	25
Fat embolism of the lungs	10	10
Skull fracture requiring reconstruction	20	20
Dog bite to the face requiring primary suturing under general anaesthetic by a plastic surgeon	10	10
Dog bite to the face requiring primary suturing, followed by multiple sessions of repair by a plastic or reconstructive surgeon	20	20
Blunt injury to the abdomen resulting in rupture of the liver or spleen, or injury to the kidney, necessitating emergency exploration	25	25
Brachial plexus injury with permanent neurological impairment	50	50
Radial, ulnar or median nerve injury, with loss of function of the hand	25	25
Plateau fracture of the tibia	10	10
Open fracture of the tibia	15	15
Open fracture of the femur	15	15
Lead or mercury poisoning	10	10
Venomous snake bite necessitating anti-venom administration and ICU admission requiring mechanical ventilation	15	15
Traumatic event resulting in ICU admission of more than 5 weeks with assisted mechanical ventilation for at least 3 of those weeks	50	50
Reconstructive surgery for multiple facial fractures	30	30
Occupational toxin exposure which necessitated supportive therapy in ICU for at least 48 hours	10	10
Near drowning requiring post resuscitation mechanical ventilation in ICU for at least 48 hours	10	10
Hyperbaric therapy for decompression sickness	10	10
Orbital fracture requiring surgical correction	10	10
Le Fort II or III facial injuries	10	10
Catch-all* **		
General catch-all	100	100
Terminal illness catch-all	100	100

*For these claim events, the following maximum claim amounts apply:

- For each claim event under the “Early cancer” claim category with a claim event percentage of 5%, we will not pay more than a maximum rand amount of R100 000 per claim event.
- For each claim event under the “Early cancer” claim category with a claim event percentage of 15%, we will not pay more than a maximum rand amount of R300 000 per claim event.
- For the two claim events which involve the loss of a thumb or fingers under the “Musculoskeletal system” claim category, we will not pay more than a maximum rand amount of R600 000 per claim event.

These maximum rand amounts may change from time to time. Refer to “Multiple claims” for the payout percentage that will apply for related claims.

**These joint replacement claim events under the “Musculoskeletal system” claim category are subject to a waiting period as described under "Waiting period for joint replacements".

***The "Catch-all" claim category will only be considered for a claim if the condition being claimed for does not result in the life insured also meeting the contractual claim event definition of a claim event in another claim category.

Severe Illness Income (TIW3)

This benefit is available under the Premier product option of our Income protector products.

Benefit description

The Severe Illness Income benefit provides cover for a comprehensive range of severe illnesses as well as cover for various impairments, injuries and infections. It also includes a number of catch-all claim events.

If we admit a claim, we will make 12 monthly income payments. Each payment will be equal to the percentage of the cover amount linked to the particular claim event as set out in the claim event table under "Claim events and claim event percentages". The percentages in this table are the claim event percentages. For multiple claims, we may pay a lower percentage than the claim event percentage, as described under "Multiple claims".

The cover amount is set out in the plan overview and may change over time as a result of benefit growth or alterations requested by the planholder. The cover amount will not be reduced as a result of claims.

If we admit a claim, the planholder must continue to make payments for this benefit, as set out in the plan overview. We will not waive the payments for the plan while we make income payments.

Refer to the *Income protection* chapter for more information.

Explanations

Layman's terms

The explanations in this section are the contractual definitions of the claim events that will be used to consider a claim. For a better understanding of the claim events they have also been described in layman's terms which are not to be used in the legal interpretation of the claim events. The layman's terms are available on the Sanlam website at www.sanlam.co.za.

Future medical advances

Some claim event 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, we will consider assessing claims on the new parameters, on condition that they are

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

Cancers, tumours, leukaemias and lymphomas

This claim category is only applicable to the Cancer, Cancer Plus, Comprehensive Severe Illness, Comprehensive Severe Illness Plus and Severe Illness Income benefits.

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.

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.

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.

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.

Liver 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, positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue.

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 bile duct, positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue.

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.

Tongue 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, positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue.

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 hypopharynx, positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue.

Retroperitoneal 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, positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue.

Omental cancer stage I to IV

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

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 mesentery, positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue.

Acute lymphoblastic leukaemia

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

Acute myeloblastic leukaemia

Acute myeloid leukaemia, confirmed by bone marrow biopsy.

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.

Bone marrow 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.

Brain tumour (Grade II on WHO classification)

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

Brain tumour (Grade III or IV on WHO classification)

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

Carcinoid syndrome

Carcinoid syndrome, confirmed histologically.

Carcinoid syndrome with evidence of liver metastasis of atypical carcinoid tumour

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

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.

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.

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.

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.

Chronic myeloid leukaemia (no bone marrow transplant)

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

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.

Hairy cell leukaemia

Hairy cell leukaemia, confirmed by bone marrow biopsy.

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.

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.

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.

Malignant melanoma with invasion beyond the epidermis or T1N0M0

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

Malignant melanoma stage II

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

Malignant melanoma stage III or IV

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

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.

Multiple myeloma (stage III on the Durie-Salmon scale)

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

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.

Partial mastectomy for ductal or lobular carcinoma in situ

Partial or total mastectomy, unilateral or bilateral, for the diagnosis of ductal or lobular carcinoma in situ of the breast. The diagnosis must be supported by histological evidence and confirmed by an appropriate specialist. This claim event excludes lumpectomy and quadrantectomy.

Total mastectomy for breast pathology

The undergoing of a prophylactic total mastectomy, unilateral or bilateral, due to:

- fibrocystic disease requiring mastectomy, or
- familial fibrocystic disease requiring mastectomy, or
- genetic mutation markers indicative of significantly increased cancer risk.

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.

Prostate cancer – T1a-c N0M0, Gleason score ≥7

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

Prostate cancer – T2N0M0, Gleason score 2-6

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

Prostate cancer – T2N0M0, Gleason score ≥7

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

Prostate cancer – T3N0M0, Gleason score 2-6

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

Prostate cancer – T3N0M0, Gleason score ≥ 7

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

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.

Any non-melanoma skin cancer stage III

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

Any non-melanoma skin cancer stage IV

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

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. This must be confirmed with a clinical report from the treating specialist, with copies of all surgical or radiological procedure reports.

Brain tumour treated with chemotherapy

A brain tumour that is treated with chemotherapy. This must be confirmed by a specialist with supporting evidence of the clinical need for chemotherapy.

Brain tumour treated with radiotherapy

A brain tumour that is treated with radiotherapy. This must be confirmed by a specialist with supporting evidence of the clinical need for radiotherapy.

Recurrent benign brain tumour showing symptoms

Benign brain tumour which recurs following optimal medical or surgical treatment. This must be confirmed by a specialist neurosurgeon and supported with radiological evidence of recurrence of the tumour.

Inoperable benign brain tumour

Benign brain tumour that is irresectable, with appropriate clinical signs and symptoms. This must be confirmed by a specialist neurosurgeon.

Inoperable benign brain tumour with progression

Benign brain tumour that is irresectable with evidence of the following: 1) Signs of raised intracranial pressure; 2) Continued growth of the tumour over time. This must be confirmed by a specialist neurosurgeon.

Brain tumour having undergone open brain surgery

The removal of a brain tumour via open brain surgery (craniotomy). This must be supported with surgical reports by a neurosurgeon.

Brain tumour with permanent neurological deficit

A brain tumour that causes permanent neurological impairment, excluding cognitive impairment. This must be confirmed with appropriate clinical signs and symptoms, by a specialist neurosurgeon.

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.

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.

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.

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.

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.

Catch-all stage I cancer

Any stage I cancer, unless covered by any of the previous claim events, 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.

Catch-all stage II cancer

Any stage II cancer, unless covered by any of the previous claim events, 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.

Catch-all stage III or IV cancer

Any stage III or IV cancer, unless covered by any of the previous claim events, 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.

Early cancer

This claim category is only applicable to the Cancer, Cancer Plus, Comprehensive Severe Illness, Comprehensive Severe Illness Plus and Severe Illness Income benefits.

A neuro-endocrine tumour of low malignant potential

A neuro-endocrine tumour of low malignant potential, confirmed histologically.

Carcinoma in situ of one or both ovaries

Carcinoma in situ of one or both ovaries, confirmed histologically.

Carcinoma in situ of one or both ovaries for which an oophorectomy has been performed

Carcinoma in situ of one or both ovaries, confirmed histologically, for which an oophorectomy has been performed.

Cervical intraepithelial neoplasia grade III (CIN 3), or carcinoma in situ of the cervix

Cervical intraepithelial neoplasia grade III (CIN 3), or carcinoma in situ of the cervix, confirmed histologically.

Cervical intraepithelial neoplasia grade III (CIN 3), or carcinoma in situ of the cervix for which a hysterectomy has been performed

Cervical intraepithelial neoplasia grade III (CIN 3), or carcinoma in situ of the cervix, confirmed histologically, for which a hysterectomy has been performed. This claim event excludes all other forms of treatment including trachelectomy (removal of the cervix), loop excision, laser surgery, conisation and cryosurgery.

Carcinoma in situ of the larynx

Carcinoma in situ of the larynx, confirmed histologically.

Carcinoma in situ of the larynx for which a total laryngectomy has been performed

Carcinoma in situ of the larynx, confirmed histologically, for which a total laryngectomy has been performed.

Carcinoma in situ of the oesophagus for which surgery to remove the tumour has been performed

Carcinoma in situ of the oesophagus, confirmed histologically, for which surgery to remove the tumour has been performed. This claim event excludes treatment by any other method.

Carcinoma in situ of the stomach

Carcinoma in situ of the stomach, confirmed histologically as an intraepithelial tumour without invasion of the lamina propria.

Carcinoma in situ of the stomach for which a partial or total gastrectomy has been performed

Carcinoma in situ of the stomach, confirmed histologically as an intraepithelial tumour without invasion of the lamina propria, for which a partial or total gastrectomy has been performed.

Carcinoma in situ of the urinary bladder

Carcinoma in situ of the urinary bladder, confirmed histologically as Tis. This claim event excludes non-invasive papillary carcinoma or stage Ta bladder cancer.

Carcinoma in situ of the vagina or vulva

Carcinoma in situ of the vagina or vulva, confirmed histologically.

Carcinoma in situ of the vagina or vulva for which surgery defined as a skin flap or skin graft has been performed

Carcinoma in situ of the vagina or vulva, confirmed histologically, for which surgery defined as a skin flap or skin graft has been performed.

Lobular carcinoma in situ or ductal carcinoma in situ of the breast resulting in chemotherapy, lumpectomy or breast conserving surgery

Histological confirmation of lobular or ductal carcinoma in situ of the breast, resulting in chemotherapy, lumpectomy or breast conserving surgery.

Catch-all carcinoma in situ of any other internal organ or body structure

Carcinoma in situ of an internal organ or body structure, unless covered by any of the previous claim events in the “Early cancer” claim category, confirmed histologically. This claim event excludes carcinoma in situ of the skin which is not an internal organ.

Cardiovascular conditions: heart, blood vessels and stroke

This claim category is only applicable to the Cardiovascular, Cardiovascular Plus, Comprehensive Severe Illness, Comprehensive Severe Illness Plus and Severe Illness Income benefits.

Heart transplant

The undergoing of a complete heart transplant, human or mechanical, as a recipient, or confirmation of being on a recognised national South African transplant waiting list, awaiting a complete human heart transplant. This must be confirmed by a specialist with supporting evidence.

Heart valve replacement irrespective of technique

Heart valve replacement, which is performed by a cardiothoracic surgeon or cardiologist. This must be supported with a detailed report by a specialist, including copies of the operation reports.

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. This must be supported with a detailed report by a specialist, including copies of the operation reports.

Cardiomyopathy at class III NYHA and EF less than 40%

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.

Cardiomyopathy at class IV NYHA and EF less than 30%

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.

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.

Transcoronary ablation of septal hypertrophy

Transcoronary ablation of septal hypertrophy, performed by a cardiothoracic surgeon or cardiologist. This must be supported with a detailed report by a specialist, including copies of the procedure reports.

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.

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.

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.

Arrhythmia having undergone a permanent defibrillator insertion

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

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 an angioplasty, stent or bypass graft of one peripheral artery.

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 of more than one peripheral artery.

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.

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.

Angioplasty with or without stenting of 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.

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.

Carotid arterial disease: narrowing of at least one carotid artery requiring either bypass graft or endarterectomy

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

Endovascular surgery or stent to repair any thoracic or abdominal aortic aneurysm

Endovascular surgery or stenting to repair an aneurysm of the thoracic or abdominal aorta, by a specialist vascular surgeon. This must be supported with a detailed report by a surgeon, including copies of the operation reports.

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. This must be supported with a detailed report by a surgeon, including copies of the operation reports.

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. This must be supported with a detailed report by a surgeon, including copies of the operation reports.

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. This must be supported with a detailed report by a surgeon, including copies of the operation reports.

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.

Surgery for atrial septal defects or ventricular septal defects

Any symptomatic atrial or ventricular septal defect with surgical closure, as confirmed by an appropriate specialist.

Surgical repair of coarctation of the aorta

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

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.

Surgery for atrial myxoma

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

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.

Arteriovenous malformation treated with radiological intervention

Arteriovenous malformation (AVM) in the brain, treated with radiosurgery or stereotactic radiosurgery. This must be supported with a detailed report by a surgeon, including copies of the operation reports or radiological procedure reports.

Arteriovenous malformation treated with open surgery craniotomy

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

Angioplasty with or without stenting of one or more coronary arteries

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

Coronary artery disease with coronary artery bypass graft for up to two arteries

The undergoing of surgery to correct the narrowing of, or blockage to, up to two coronary arteries by means of a bypass graft. This must be supported with a detailed report by a cardiothoracic surgeon, including copies of the operation reports.

Coronary artery disease with coronary artery bypass graft for three or more arteries

The undergoing of surgery to correct the narrowing of, or blockage to, three or more coronary arteries by means of a bypass graft. This must be supported with a detailed report by a cardiothoracic surgeon, including copies of the operation reports.

Mild heart attack

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

1. Raised cardiac biomarkers AND one of the following:
2. Compatible clinical symptoms, OR
3. Characteristic electrocardiographical (ECG) changes indicative of myocardial ischaemia or myocardial infarction.

Post procedure myocardial infarction is included, provided it meets the above requirements.

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.

Post procedure myocardial infarction is included, provided it meets the above requirements.

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.

Sensitive troponin markers		Value**	
Assay*	Troponin type	Unit (ng/l)	Unit (ng/ml)
Rosche hsTnT	TnT	> 500	> 0.5
Abbott ARCHITECT	TnI	> 1500	> 1.5
Beckman AccuTnI	TnI	> 2500	> 2.5
Siemens Centaur Ultra	TnI	> 3000	> 3.0
Siemens Dimension RxL	TnI	> 3000	> 3.0
Siemens Stratus CS	TnI	> 3000	> 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	> 500	> 0.5
Conventional AccuTnI or equivalent threshold with other Troponin I methods	TnI	> 250	> 0.25

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

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

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.

Post procedure myocardial infarction is included, provided it meets the above requirements.

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

Sensitive troponin markers		Value**	
Assay*	Troponin type	Unit (ng/l)	Unit (ng/ml)
Rosche hsTnT	TnT	> 1000	> 1.0
Abbott ARCHITECT	TnI	> 3000	> 3.0
Beckman AccuTnI	TnI	> 5000	> 5.0
Siemens Centaur Ultra	TnI	> 6000	> 6.0
Siemens Dimension RxL	TnI	> 6000	> 6.0
Siemens Stratus CS	TnI	> 6000	> 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	> 1000	> 1.0
Conventional AccuTnI or equivalent threshold with other Troponin I methods	TnI	> 500	> 0.5

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.

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%.

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%.

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.

Superior sagittal sinus thrombosis

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

Cavernous sinus thrombosis

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

Non-healing venous ulcer of more than 3 months duration despite treatment by a vascular surgeon, with documented evidence of deep venous insufficiency

Non-healing venous ulcer of more than 3 months duration despite optimum treatment by a vascular surgeon, with documented evidence of deep venous insufficiency by duplex ultrasonography or venography.

Post thrombotic leg with syndrome

The confirmed diagnosis of a post phlebitic leg swelling, by a vascular surgeon. There must be a history of a deep vein thrombosis (DVT), plus swelling in the affected limb to be at least 5 cm greater in diameter than the unaffected limb, persisting at least 1 month after the DVT.

Giant cell arteritis

Giant cell arteritis, confirmed on biopsy and specialist physician report.

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.

Stroke

The death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in neurological deficit, 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.

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). These ADLs are indicated in the tables "Basic activities of daily living for severe illness benefits" and "Advanced activities of daily living for severe illness benefits" at the end of this chapter; OR 2) Whole person impairment (WPI) figures, which will be calculated according to the latest edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment.

Stroke with full recovery

The death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in neurological deficit, 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.

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.

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.

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.

Stroke with severe impairment

The life insured needs constant assistance 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

This claim category is only applicable to the Comprehensive Severe Illness, Comprehensive Severe Illness Plus and Severe Illness Income benefits.

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.

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.

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.

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.

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.

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.

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.

Polyarteritis nodosa

Polyarteritis nodosa, confirmed by a specialist. This must be supported with all of the following: 1) Angiography findings; 2) Biopsy evidence.

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

This claim category is only applicable to the Comprehensive Severe Illness, Comprehensive Severe Illness Plus and Severe Illness Income benefits.

Mastoiditis requiring mastoidectomy

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

Total and permanent loss of hearing in one ear

The total and permanent loss of hearing in one ear, confirmed by an Ear, Nose and Throat (ENT) specialist, with supporting audiometric testing. Total loss of hearing 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. Permanent implies all reasonable treatment should have been undergone.

Permanent binaural hearing loss of more than 60%

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.

Permanent binaural hearing loss of more than 75%

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.

Total and permanent loss of hearing in both ears

The total and permanent loss of hearing in both ears, confirmed by an Ear, Nose and Throat (ENT) specialist, with supporting audiometric testing. Total loss of hearing 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. Permanent implies all reasonable treatment should have been undergone.

Recipient of cochlear or middle ear implant

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

Otosclerosis resulting in hearing loss after failed surgery

Otosclerosis, with hearing loss, that persists following failed surgery. This must be confirmed by an Ear, Nose and Throat (ENT) specialist, supported with all of the following: 1) Audiometric tests showing conductive patterns hearing loss; 2) Acoustic test reflex.

Chronic osteomyelitis of the sinuses

Chronic osteomyelitis of the sinuses, confirmed by a specialist. This must be confirmed with appropriate radiological evidence.

Endocrine system

This claim category is only applicable to the Comprehensive Severe Illness, Comprehensive Severe Illness Plus and Severe Illness Income benefits.

Diagnosis of thyrotoxic crisis

Confirmed diagnosis of thyrotoxic crisis by an endocrinologist. This must be supported by appropriate investigations.

Diagnosis of acromegaly

Confirmed diagnosis of acromegaly by an endocrinologist. This must be supported by appropriate investigations.

Diagnosis of Addisonian crisis

Confirmed diagnosis of Addisonian crisis by an endocrinologist. This must be supported by appropriate investigations.

Diagnosis of parathyroid tetany

Confirmed diagnosis of parathyroid tetany by an endocrinologist. This must be supported by appropriate investigations.

Diagnosis of Simmonds' disease

Confirmed diagnosis of Simmonds' disease by an endocrinologist. This must be supported by appropriate investigations.

Diagnosis of Conn's syndrome

Confirmed diagnosis of Conn's syndrome by an endocrinologist. This must be supported by appropriate investigations.

Diagnosis of primary Cushing's disease

Confirmed diagnosis of primary Cushing's disease by an endocrinologist. This must be supported by appropriate investigations.

Diagnosis of diabetes insipidus

Confirmed diagnosis of diabetes insipidus by an endocrinologist. This must be supported by appropriate investigations.

Diagnosis of type I diabetes

The diagnosis of type I diabetes by an endocrinologist, which is treated with daily insulin. This must be supported by appropriate investigations. This claim event does not cover type II diabetes or gestational diabetes.

Diabetes mellitus type II with permanent renal impairment

Type II diabetes mellitus, with a GFR less than 60 ml/min/1.73 m2 for 3 months or more and evidence of diabetic retinopathy. This must be confirmed by the relevant specialist reports with objective tests.

Diabetic retinopathy stage III

Type II diabetes mellitus, with severe nonproliferative retinopathy. This must be confirmed with reports by an ophthalmologist.

Diabetic retinopathy stage IV

Proliferative type II diabetes mellitus, with severe proliferative retinopathy. This must be confirmed with reports by an ophthalmologist.

Gastrointestinal system

This claim category is only applicable to the Comprehensive Severe Illness, Comprehensive Severe Illness Plus and Severe Illness Income benefits.

Tracheoesophageal fistula having undergone surgery

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

Crohn's disease or ulcerative colitis with prolonged advanced therapy

The unequivocal diagnosis of Crohn's disease or ulcerative colitis 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.

Crohn's disease or ulcerative colitis with recurrent surgery

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

Crohn's disease or ulcerative colitis with a permanent colostomy or ileostomy

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

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.

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.

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.

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.

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.

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.

Liver or pancreas transplant

The undergoing of a complete liver or pancreas transplant as a recipient, or confirmation of being on a recognised national South African transplant waiting list, awaiting a complete liver or pancreas transplant. This must be confirmed by a specialist with supporting evidence. This claim event does not cover stem cell therapy.

Amyloidosis of the liver and spleen

Amyloidosis of the liver and spleen, confirmed on biopsy.

Complete pancreatectomy

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

Primary biliary cirrhosis

Primary biliary cirrhosis, confirmed by a gastroenterologist with all of the following: 1) Radiological tests; 2) Biopsy findings.

Chronic pancreatitis

Chronic pancreatitis, confirmed by a gastroenterologist. There must be evidence of all of the following: 1) Chronic malabsorption as evidenced by appropriate blood tests; 2) Diagnosis of diabetes mellitus, evidenced by blood tests, which occurred as a result of the pancreatitis; 3) Pancreatic calcification on abdominal x-ray.

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.

Chronic rectal fistula

The first surgical repair of a chronic rectal fistula. This must be confirmed with surgical reports by a surgeon.

Proven acute peritonitis requiring surgical intervention (excluding appendectomy)

Acute peritonitis, with emergency surgical intervention. This must be confirmed by all of the following: 1) Appropriate laboratory markers; 2) Surgical reports. This claim event does not cover an appendectomy for appendicitis.

Irreparable abdominal or inguinal hernia

Irreparable abdominal or inguinal hernia where surgery is specifically contraindicated, as confirmed by a surgeon. There must be documented evidence in the history of at least one of the following complications: 1) Strangulation; 2) Obstruction; 3) Ischaemia; 4) Gangrene.

Lymph and blood

This claim category is only applicable to the Comprehensive Severe Illness, Comprehensive Severe Illness Plus and Severe Illness Income benefits.

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.

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.

Bone marrow 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.

Diffuse intravascular clotting

Diffuse intravascular clotting (DIC), confirmed by a specialist. This must be supported with all of the following: 1) Laboratory tests; 2) Score of at least 5 according to the International Society on Thrombosis and Haemostasis (ISTH).

Idiopathic thrombocytopenic purpura with splenectomy

Idiopathic thrombocytopenic purpura with splenectomy, confirmed by a specialist. This must be supported with all of the following: 1) Platelet count below 10 × 109/L; 2) Surgical reports.

Chronic anaemia despite optimal treatment needing blood transfusion every second week

Chronic anaemia despite optimal oral treatment, where there is evidence of blood transfusions every second week, occurring for at least 3 consecutive months. This must be confirmed by a specialist, with all of the following supporting evidence: 1) Clinical records documenting the blood transfusions; 2) Blood counts

Autoimmune haemolytic anaemia with splenectomy

Autoimmune haemolytic anaemia with splenectomy, confirmed by a specialist. This must be supported with all of the following: 1) Laboratory tests; 2) Surgical reports.

Essential thrombocytosis

Essential thrombocytosis, confirmed by a specialist. This must be supported with all of the following: 1) Laboratory tests; 2) Bone marrow biopsy.

Musculoskeletal system

This claim category is only applicable to the Comprehensive Severe Illness, Comprehensive Severe Illness Plus and Severe Illness Income benefits.

Any long-bone chronic osteomyelitis

Any long-bone chronic osteomyelitis, confirmed by an orthopaedic surgeon. This must be supported with all of the following: 1) Radiological findings; 2) Confirmed by biopsy; 3) Must be present for at least 6 months.

Septic arthritis of a major joint

Septic arthritis of a major joint, confirmed by an orthopaedic surgeon. This must be supported with all of the following: 1) Radiological findings; 2) Confirmed by joint fluid analysis and culture.

Hip joint replacement

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

Knee joint replacement

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

Ankle joint replacement

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

Shoulder joint replacement

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

Elbow or wrist joint replacement

Surgical elbow or wrist joint replacement with a prosthesis, confirmed by an orthopaedic surgeon. This must be supported by surgical reports.

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.

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.

Loss of use of or loss of one thumb

Irreversible loss of or loss of use of one thumb. This must be confirmed with supporting evidence by a specialist.

Loss of use of or loss of three or more fingers on the same hand

Irreversible loss of or loss of use of three or more fingers on the same hand. This must be confirmed with supporting evidence by a specialist.

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.

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.

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.

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.

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.

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.

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.

Surgical repair of major motor nerve after complete severance

Surgical repair of major motor nerve after complete severance. This must be confirmed with surgical reports by a surgeon.

Confirmed diagnosis of Paget's disease of the bone

Confirmed diagnosis of Paget's disease of the bone, by a specialist. All of the following must be present: 1) Radiological evidence; 2) Blood tests consistent with Paget's disease.

Persistent neurological impairment despite recurrent spinal surgery

Persistent documented neurological impairment despite two or more completely separate spinal procedures, performed within a 5-year period. Spinal procedures may include any of the following individually or in combination:
1) Laminectomy; 2) Discectomy; 3) Fusion; 4) Surgical motion preserving technologies such as discarthroplasty or dynamic stabilisation techniques. This must be confirmed with surgical reports for each procedure by a specialist.
Permanent neurological impairment must be confirmed by all of the following: 1) Persistent clinical signs and symptoms; 2) Imaging; 3) Electrodiagnostic studies.

Temperomandibular joint replacement

Surgical replacement of the temporomandibular joint (TMJ) with a total joint prosthesis. This must be confirmed with surgical reports by a specialist.

Nervous system and psychiatric disorders

This claim category is only applicable to the Comprehensive Severe Illness, Comprehensive Severe Illness Plus and Severe Illness Income benefits.

Conditions having undergone open brain surgery via a craniotomy

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

Status epilepticus resulting in permanent neurological impairment

In spite of sustained optimal treatment and documented compliance of treatment, there must be at least three documented episodes of status epilepticus within the last 12 months, or 12 or more grand mal seizures per month, in the past 4 consecutive months. This will be assessed by all of the following evidence: 1) Electro-encephalograms (EEG); 2) Drug serum levels which must show compliance; 3) Documented evidence of epileptic attacks on clinical records; 4) Evidence of emergency treatment administered.

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.

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.

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.

Permanent hemiparesis or hemiparalysis 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.

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). These ADLs are indicated in the table "Advanced activities of daily living for severe illness benefits" at the end of this chapter; 2) Neuro-imaging; 3) Confirmation by a neurologist. Permanence will be established after 3 months.

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). These ADLs are indicated in the table "Basic activities of daily living for severe illness benefits" at the end of this chapter. Permanence will be established after 3 months.

Diagnosis of muscular dystrophy

Muscular dystrophy, confirmed by a neurologist with all of the following: 1) Characteristic electromyogram; 2) Confirmation on muscle biopsy.

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). These ADLs are indicated in the table "Basic activities of daily living for severe illness benefits" at the end of this chapter. Permanence will be established after 3 months.

Induced coma

Admission to an intensive care unit (ICU) for a medical emergency where sedation is required for intubation and mechaical ventilation for at least 96 hours. This must be confirmed with clinical reports by the relevant treating specialist.

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.

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.

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.

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.

Optic neuritis with demyelinating on MRI

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

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.

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). These ADLs are indicated in the table "Basic activities of daily living for severe illness benefits" at the end of this chapter. Permanence will be assessed after 3 months.

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.

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 tests; 3) Radio imaging and permanent inability to independently perform at least three basic activities of daily living (ADLs), or the need for 24 hour supervision by a caregiver. These ADLs are indicated in the table "Basic activities of daily living for severe illness benefits" at the end of this chapter. Permanence will be established after 3 months.

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 ventriculo peritoneal (VP) shunt; 3) Neurosurgical reports. Only one payment will be made for this claim event.

Stereotactic brain surgery

Any brain disease or disorder, for which a neurosurgeon or radiologist performs any of the following: 1) Stereotactic brain ablation, stimulation, implantation; 2) Radiotherapy. This must be supported by neurosurgical or radiologist reports.

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.

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.

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.

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.

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), or the need for 24 hour supervision by a caregiver. These ADLs are indicated in the table "Basic activities of daily living for severe illness benefits" at the end of this chapter. Permanence will be established after 3 months.

Schizophrenia

The confirmed diagnosis of schizophrenia by at least two independent psychiatrists. There must be collaborated evidence from both reports according to the Diagnostic and Statistical Manual for Mental Disorders (DSM), confirming all of the following: 1) Loss of intellectual capacity due to irreversible global failure of brain functioning; 2) Reduction in executive functions such as abstract thinking, judgment and problem solving; 3) Requirement for a permanent caregiver.

Anorexia nervosa with BMI less than 16 for 6 consecutive months

The diagnosis of anorexia nervosa, with body mass index (BMI) less than 16 for 6 consecutive months, despite optimal treatment. There must be evidence of all of the following: 1) Hospital admission for cardiac dysrhythmias, metabolic abnormalities or re-feeding; 2) Inpatient admission under psychiatric supervision; 3) Confirmation by a physician and psychiatric reports.

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

This claim category is only applicable to the Comprehensive Severe Illness, Comprehensive Severe Illness Plus and Severe Illness Income benefits.

Chronic nephrotic syndrome

Confirmed diagnosis of nephrotic syndrome by a nephrologist, with all of the following supportive evidence: 1) Laboratory investigation; 2) Renal imaging; 3) Biopsy.

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.

Chronic tubulointerstitial disease

Chronic tubulointerstitial disease must be confirmed by a renal biopsy. The term tubulointerstitial is used to broadly refer to chronic kidney diseases that involve tubules and/or the interstitium of the kidney, but not the glomeruli.

Primary amyloidosis of the kidney

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

Nephrectomy as kidney donor, meeting ethical and legal requirements

Nephrectomy as kidney donor within South Africa, that conforms to all ethical and legal requirements of South Africa. This must be supported with operation reports.

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).

Renal cortical necrosis

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

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.

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.

Chronic, irreversible kidney failure requiring and already having undergone regular dialysis treatment

Chronic, end-stage kidney failure that is irreversible, with regular dialysis instituted. This must be supported with a report from the treating nephrologist.

Kidney transplant

The undergoing of a complete kidney transplant as a recipient, or confirmation of being on a recognised national South African transplant waiting list, awaiting a complete kidney transplant. This must be confirmed by a specialist with supporting evidence.

Polycystic kidney disease

Confirmed diagnosis of polycystic kidney disease by a nephrologist, with supportive evidence on laboratory investigation and renal imaging.

Documented renal vein thrombosis

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

Open kidney surgery, not for diagnostic purposes

Open kidney surgery that is performed for treatment of a renal disorder or injury. This must be supported with surgical reports. This claim event does not cover any surgery purely for diagnostic reasons.

Reproductive system

This claim category is only applicable to the Comprehensive Severe Illness, Comprehensive Severe Illness Plus and Severe Illness Income benefits.

Eclampsia

The diagnosis of eclampsia during pregnancy or in the 6-week post-partum period, with one of the following: 1) New onset of grand mal seizures; 2) Unexplained coma. This must be confirmed by an obstetrician-gynaecologist.

Amniotic fluid pulmonary embolism

The diagnosis of amniotic fluid embolism (AFE) which results in an allergic-like reaction during labour. There must be signs of one or more of the following: 1) Cardiovascular instability; 2) Respiratory distress; 3) Coagulopathy; 4) Coma/seizures. The diagnosis must be confirmed by a specialist, with the exclusion of all other causes.

Diffuse intravascular clotting in pregnancy

The diagnosis of diffuse intravascular clotting (DIC) during pregnancy or in the 6 week post-partum period. There must be evidence on relevant blood tests and the diagnosis must be confirmed by a specialist.

Acute renal failure in pregnancy

Renal cortical necrosis that occurs during pregnancy. This must be confirmed by a nephrologist with all of the following: 1) Radiological evidence; 2) Renal biopsy.

Ectopic pregnancy

The diagnosis of an ectopic pregnancy, with imaging, that results in medical or surgical intervention. This must be confirmed by an obstetrician-gynaecologist.

Intrauterine death after 12 weeks and up to and including 24 weeks gestation

Any intrauterine death that has occurred after 12 weeks and up to and including 24 weeks of gestation. The gestational age must be confirmed with supporting evidence by the treating obstetrician-gynaecologist. This claim event does not cover any induced termination.

Intrauterine death after 24 weeks gestation

Any intrauterine death that has occurred after 24 weeks of gestation. The gestational age must be confirmed with supporting evidence by the treating obstetrician-gynaecologist. This claim event does not cover any induced termination.

Uterus rupture

Acute rupture of the uterus during vaginal delivery, resulting in an emergency hysterectomy. This must be confirmed with surgical reports by the treating obstetrician-gynaecologist.

Sheehan syndrome post-partum

The diagnosis of Sheehan syndrome, that occurs within the 6 week post-partum period, as a result of documented post-partum haemorrhage. This must be supported with all of the following: 1) Blood tests; 2) MRI scan. This must be confirmed by a neurologist.

Hydatidiform mole

Hydatidiform mole or molar pregnancy, as evidenced with all of the following: 1) Quantitative beta-hCG levels greater than 100 000 mIU/ml; 2) Imaging. This must be confirmed by an obstetrician-gynaecologist.

Respiratory disorders

This claim category is only applicable to the Comprehensive Severe Illness, Comprehensive Severe Illness Plus and Severe Illness Income benefits.

Confirmed diagnosis of interstitial lung disease

Interstitial lung disease, which must be confirmed by a pulmonologist, with all of the following: 1) Objective radiological evidence; 2) Biopsy.

Severe status asthmaticus

Status asthmaticus with intubation and intensive care unit (ICU) admission for 48 hours or more. This must be confirmed by a specialist and clinical records.

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.

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.

Chronic irreversible lung disease with moderate impairment

Chronic irreversible lung disease, confirmed by a pulmonologist, resulting in irreversible respiratory impairment of FEV1 ≤50% or FVC ≤50%, or DCO ≤50% on at least three occasions at least 1 month apart.

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.

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.

Removal of a lung

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

Lung or heart-lung transplant

The undergoing of a complete lung or heart-lung transplant as a recipient, or confirmation of being on a recognised national South African transplant waiting list, awaiting a complete lung or heart-lung transplant. This must be confirmed by a specialist with supporting evidence.

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.

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.

Pulmonary fibrosis

Definite diagnosis of pulmonary fibrosis, 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.

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.

Repair of bronchopleural fistula

Surgical repair of a bronchopleural fistula, by a thoracic surgeon, with surgical reports.

Skin and soft tissue

This claim category is only applicable to the Comprehensive Severe Illness, Comprehensive Severe Illness Plus and Severe Illness Income benefits.

Pemphigus vulgaris

Pemphigus vulgaris, confirmed with histopathological evidence by a specialist.

Stevens-Johnson syndrome

The definitive diagnosis of Stevens-Johnson syndrome, confirmed with histopathological evidence by a specialist.

Toxic epidermal necrolysis

The definitive diagnosis of toxic epidermal necrolysis, confirmed with histopathological evidence by a specialist.

Psoriasis of more than 20% skin involvement plus nail and joint involvement

Psoriasis, involving more than 20% skin, with both nail and joint involvement, confirmed by a specialist. This must be supported with all of the following: 1) Evidence of characteristic skin lesions; 2) Radiological evidence.

Discoid lupus

Discoid lupus, confirmed by a specialist with all of the following supportive evidence: 1) Characteristic skin lesions; 2) Biopsy.

Compartment syndrome with permanent motor nerve damage

Definitive history of compartment syndrome with permanent motor nerve damage, confirmed by a specialist. This must be confirmed with all of the following supporting evidence: 1) History and clinical signs of compartment syndrome; 2) Nerve conduction studies.

Scleroderma

Scleroderma, confined to the skin only, confirmed by a specialist. This must be confirmed with all of the following: 1) Histological evidence; 2) Raised anti-nuclear antibodies.

CREST syndrome

The definitive diagnosis of CREST syndrome, by a specialist. This must be confirmed with all of the following supportive evidence: 1) Appropriate laboratory markers; 2) Imaging; 3) Oesophageal motility studies.

Urogenital disorders

This claim category is only applicable to the Comprehensive Severe Illness, Comprehensive Severe Illness Plus and Severe Illness Income benefits.

Vesicovaginal or rectovaginal fistula having undergone surgery

Vesicovaginal or rectovaginal fistula, having undergone surgery by a specialist, confirmed with surgical reports.

Partial amputation of the penis

Any physical disease or injury of the penis that results in partial 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.

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.

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.

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.

Unilateral orchidectomy

Unilateral orchidectomy by a specialist, confirmed by surgical reports. This claim event excludes unilateral orchidectomy for gender dysphoria or for gender reassignment purposes.

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

This claim category is only applicable to the Comprehensive Severe Illness, Comprehensive Severe Illness Plus and Severe Illness Income benefits.

Macular degeneration

Diagnosis of macular degeneration. The definitive diagnosis of macular degeneration must be supported with all of the following: 1) Reports by an ophthalmologist; 2) Objective tests.

Retinal detachment requiring corrective laser therapy or that is inoperable

Retinal detachment requiring corrective laser therapy or that is inoperable, confirmed with appropriate reports by an ophthalmologist.

Corneal transplant

The undergoing of a corneal transplant, as a recipient, confirmed with surgical reports by an ophthalmologist.

Optic neuritis

The confirmed diagnosis of optic neuritis, by an ophthalmologist. Only one payment for this claim event.

Enucleation of one eye

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

Retinitis pigmentosa

Retinitis pigmentosa, confirmed with supporting reports by an ophthalmologist.

Total and permanent loss of sight in one eye

The total and permanent 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. Permanent implies all reasonable treatment should have been undergone.

Total and permanent loss of sight in both eyes

The totaland 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. Permanent implies all reasonable treatment should have been undergone.

Irreversible hemianopia in one eye

Irreversible loss of either the left or right half of the visual field in one eye, as confirmed by an ophthalmologist. This must be supported with all of the following: 1) Radiological evidence; 2) Visual tests.

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

This claim category is only applicable to the Comprehensive Severe Illness, Comprehensive Severe Illness Plus and Severe Illness Income benefits.

Accidental HIV infection

Infection by the Human Immunodeficiency Virus (HIV) 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 on or after the cover start date, where the injury or cut is 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 on or after the cover start date, where the organ has previously been infected with the HI virus;

- rape or indecent assault on or after the cover start date. 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 on or after the cover start date. 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 on or after the cover start date. 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.

Clinical manifestation of Aids supported by a positive HIV test result

A positive Human Immunodeficiency Virus (HIV) antibody test result with all of the following: 1) CD4 count of less than 200 cells/mm³ must be present despite compliance with anti-retroviral treatment; 2) The existence of at least three diseases according to stage III of the latest World Health Organisation (WHO) Clinical Staging, OR alternatively, one AIDS-defining disease according to stage IV of the latest WHO Clinical Classification System.

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.

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.

Bacterial meningitis

A confirmed diagnosis of bacterial meningitis, by an appropriate specialist with appropriate special investigations such as a lumbar puncture. This must cause inflammation of the membranes of the brain or spinal cord and result in permanent neurological deficit.

Injuries, accidents and poison

This claim category is only applicable to the Comprehensive Severe Illness, Comprehensive Severe Illness Plus and Severe Illness Income benefits.

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. This must be confirmed by a specialist.

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.

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. This must be confirmed by a specialist.

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. This must be confirmed by a specialist.

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. This must be confirmed by a specialist.

Spinal fusion

An acute history of a traumatic event, resulting in spinal fusion. This must be confirmed with radiological evidence by a specialist.

Decompression laminectomy or decompression laminotomy

An acute history of a traumatic event, resulting in decompression laminectomy or decompression laminotomy being performed. This must be confirmed by a specialist.

Drainage via burr hole

An acute traumatic brain injury that results in a subdural haematoma, and where drainage is performed via burr hole. This must be confirmed with surgical reports by a neurosurgeon.

Emergency tracheostomy or cricothyrotomy

Any traumatic event that results in an emergency tracheostomy or cricothyrotomy. This must be confirmed by an appropriate specialist.

ICU admission with mechanical ventilation for at least 96 hours

Traumatic event resulting in intensive care unit (ICU) admission, with mechanical ventilation for at least 96 hours. This must be confirmed with clinical reports by a specialist.

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.

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). This must be confirmed by a specialist with copies of all scans.

Objective radiological evidence of a fracture dislocation of the spine

Any acute traumatic event that results in a fracture-dislocation of the spine, with or without neurological deficit. This must be supported by radiological evidence and confirmed by a specialist.

Penetrating stab wound or gunshot wound

Penetration by a bullet or sharp object through the skull or into the chest or abdominal cavities, resulting in surgical exploration of the skull or cavity concerned under general anaesthetic. This must be confirmed by a specialist with an operation report.

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. This must be confirmed by a specialist with copies of all scans.

Fat embolism of the lungs

Fat embolism of the lungs that occurs after one or more major traumatic long-bone fractures. This must be confirmed by radiological evidence and by a specialist physician.

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.

Dog bite to the face requiring primary suturing under general anaesthetic by a plastic surgeon

A dog bite to the face, with primary suturing under general anaesthetic. This must be performed by a plastic surgeon, supported with an operation report.

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, supported with an operation report. Only one payment for this claim event.

Blunt injury to the abdomen resulting in rupture of the liver or spleen, or injury to the kidney, necessitating emergency exploration

Blunt injury to the abdomen, with rupture of the liver or spleen, or injury to the kidney, resulting in surgical exploration, supported with an operation report.

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.

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.

Plateau fracture of the tibia

A tibial plateau fracture. This must be confirmed on imaging.

Open fracture of the tibia

An open fracture of the tibia. This must be confirmed by imaging and clinical reports by an orthopaedic surgeon.

Open fracture of the femur

An open fracture of the femur. This must be confirmed by imaging and clinical reports by an orthopaedic surgeon.

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.

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. This must be supported with a specialist's report.

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. This must be supported with a specialist's report.

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 must be supported with a specialist's report with all operation reports. This claim event does not cover cosmetic surgery.

Occupational toxin exposure which necessitated supportive therapy in ICU for at least 48 hours

The exposure to an occupational toxin, which resulted in intensive care unit (ICU) admission for at least 48 hours. This must be supported with a specialist's report. This claim event does not cover self-inflicted poison ingestion or exposure.

Near drowning requiring post resuscitation mechanical ventilation in ICU for at least 48 hours

Near drowning, which results in mechanical ventilation in an intensive care unit (ICU) for at least 48 hours. This must be supported with a specialist's report.

Hyperbaric therapy for decompression sickness

Hyperbaric therapy for decompression sickness in a registered hospital that has hyperbaric decompression chambers. This must be confirmed by a doctor.

Orbital fracture requiring surgical correction

An orbital fracture, with surgical correction. This must be supported by imaging and specialist reports.

Le Fort II or III facial injuries

Facial fractures, which are classified as severity of at least Le Fort II or III. This must be confirmed by imaging and specialist reports.

Catch-all

This claim category is only applicable to the Comprehensive Severe Illness, Comprehensive Severe Illness Plus and Severe Illness Income benefits.

General catch-all

Any disease or disorder that results in a whole person impairment (WPI) of at least 35% and meets the class 4 impairment criteria specified for the relevant system(s) in the American Medical Association's Guides to the Evaluation of Permanent Impairment or its equivalent, in the opinion of Sanlam's Chief Medical Officer. The functional impairment, and permanence thereof, will be evaluated after the life insured has undergone optimal, reasonable treatment, based on generally accepted medical protocols for treatment of the condition in question at the time of the claim. Treatment undergone, as well as future treatment, will be taken into account.

Terminal illness catch-all

Diagnosis of a terminal illness which is reasonably expected to reduce the life insured's life expectancy to a period of 12 months or less, in the opinion of Sanlam's Chief Medical Officer.

Activities of daily living for severe illness benefits

Basic activities of daily living for severe illness benefits

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

Advanced activities of daily living for severe illness benefits

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