



TECHNICAL GUIDE FOR RISK PRODUCTS

March 2023

Notes

- This guide 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 guide, the provisions of the contract documents will prevail.
- Take note that information contained in this technical guide is with regard to the latest versions of the applicable products/benefits. Consult 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.

Technical guide for risk products

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General

Do you hope that your loved ones will be financially independent should you die or become impaired? Do you hope that you will be able to give your loved ones a dignified funeral, with funeral costs settled speedily? Do you hope to have financial peace of mind even if an injury causes you to no longer be able to work?

Our broad range of risk cover solutions can help you achieve what you hope for by offering cover for unexpected events while providing you with the peace of mind that:

- your cover is backed by the financial strength of Sanlam
- you do not have to inform us if you change your occupation or part-time activities, or if you start smoking, or leave South-Africa to visit, work or stay in another country. We will carry the risk of changes in your personal circumstances after your cover has been underwritten.

We offer specific risk cover solutions for each of the following:

- Unexpected death
- Inability to continue working
- Impairment
- Serious illness
- Injury or death as a result of accidents or violent crime.

Our risk cover solutions offer maximum choice and flexibility.

The cover provided by these solutions are suited to people who:

- require large cover amounts to cover claims caused by natural causes and accidents
- require the full cover amount to be available from the date of acceptance should there be a claim
- require a range of risk cover benefits over and above life cover
- want to make the lowest possible payment for cover
- are business owners who require e.g. buy and sell insurance
- require cover for estate planning purposes
- require cover for security for a loan.

A Funeral Expenses (FSC3) benefit is available on our Topcover products, with no medical underwriting, and pays a funeral benefit within 48 hours after we have admitted a claim. This benefit is especially suitable for planholders who want to provide for the cost of their own or their family members' funerals. This benefit can be taken on the same plan as the planholder's other risk benefits.

Our accident benefits are available on our Topcover and Term cover products, with no medical underwriting. These benefits provide cover for claims resulting from accidents only, and are most suitable for people who:

- are young and believe that nothing bad will happen to them unless it is an accident
- are interested in a convenient, simplified application process without medical testing, and who require cover for accidental causes only
- believe they are in good health and want accidental cover now, but intend to purchase fully underwritten cover at a later stage
- do not qualify for other benefits due to poor health.

Product options

Sanlam offers risk cover under 3 different product options:

- Premier
- Classic
- Express.

Premier

Premier is our flagship product option. It is aimed at clients who are looking for maximum flexibility, the best value from a portfolio of Sanlam products and a high level of lifestyle benefits.

The Premier option offers the following:

- All available products (Topcover, Income Protector and Term cover)
- All the segmented product brands (Matrix, Professionals and Graduates)
- All available risk benefits
- All available payment patterns, cover growth options and guarantee periods
- Cover for individual and business insurance purposes
- Cover for HIV positive lives
- Optional Cashback benefit
- Possible integration with Sanlam Reality.

Classic

Classic is aimed at clients who prefer the more traditional type of insurance and provides the more basic product features at a slightly reduced rate.

The Classic option offers the following:

- Only Topcover
- Under the Matrix brand
- Most available risk benefits (Benefits **not** available under Classic are Elite Disability, Accidental Elite Disability, Child: Illness and injury, and future cover benefits.)
- Available payment patterns: Level, Fixed compulsory 5%, Age-related and Aggressive Age-related
- All available cover growth options
- Available guarantee periods: 5 – 10 years
- Optional Cashback benefit
- Cover for individual and business insurance purposes.

Express

Express involves a simplified underwriting process and is ideal for clients who place a premium on their time.

Express offers up to R5 million life, disability and severe illness cover.

The Express option offers the following:

- Only Topcover
- All the segmented product brands (Matrix, Professionals and Graduates)
- A limited range of risk benefits
- Available payment patterns: Level, Fixed compulsory 5% and Age-related
- All available cover growth options
- Guarantee period: 5 years
- Cover for individual insurance purposes only
- Optional Cashback benefit.

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Products

We offer a range of new generation risk products under the Express product option, which enables a life insured to obtain transparent, low-cost risk cover, and offer the required flexibility to accurately address a life insured's requirements for cover.

Limited medical underwriting applies to the Express product option, with a shortened medical questionnaire, which makes this a good option for clients who place a premium on their time.

A separate quotation must be drawn for each of the products in the table below, and a separate plan will be issued for each product.

Product	Product code
Topcover products	
Matrix Express Topcover	
Express Topcover for Professionals	T02W
Express Topcover for Graduates	

Benefits

General

A variety of benefits are available.

When a benefit reaches its cover end date, the total payment of the plan will be reduced by the payment for that benefit at the time.

Business insurance

Express is not available for business insurance.

Benefits for Topcover products

- Up to 10 lives may be insured on a plan, where at least one of these must be the planholder or his/her spouse. It is not compulsory for the planholder to be a life insured on the plan:
 - The planholder and his/her spouse may each have up to 15 benefits
 - The planholder's other family members may each have up to 2 benefits: Funeral Expenses (FSC3) and Cashback (RS).
- The Immediate Expenses benefit (DSF3) and/or Funeral Expenses benefit (FSC3), with or without the Cashback benefit, may not be the only benefits on a plan.
- The Cashback benefit is **not** allowed on its own for a life insured, and can only be taken if the life insured also has other benefits.
- It is compulsory to take the Death benefit for a life insured in order to select an accelerator benefit for that life insured. It is not compulsory to take the Death benefit for a life insured in other instances.
- Cover amounts are subject to new business limits and financial underwriting, and for accelerator benefits the following also applies:
 - The sum of the cover amounts of all **accelerator disability and impairment benefits** on a plan for a life insured may **not** exceed the cover amount of the Death benefit for that life insured.
 - The sum of the cover amounts of all **accelerator dread disease/severe illness benefits** on a plan for a life insured may **not** exceed the cover amount of the Death benefit for that life insured.
- Certain combinations are **not allowed** on the same plan for the same life insured:
 - More than one instance of the same benefit, for example:
 - Two Cancer benefits, where one is with a fixed term and one is with whole life cover. Note, however, that the Cancer and Cancer Plus benefits are different benefits and therefore one of each is allowed for the same life insured on one plan.
 - For benefits other than disability and impairment benefits, accelerator and standalone benefit types of the same benefit are not allowed.
(For disability and impairment benefits it will be allowed to take accelerator and standalone benefits types of the same benefit on the same plan for the same life insured.)
 - The Credit Life benefit in combination with benefits other than the Cashback benefit.
(Only the Cashback benefit and the compulsory Permanent Disability, Temporary Disability and Retrenchment rider benefits are allowed with the Credit Life benefit on the same plan.)

Benefits are grouped together per type of cover, and more information about a specific benefit is available in the applicable chapter with the name of the type of cover, e.g. more information about the Death benefit is available in the *Life cover chapter*.

The type of benefit is indicated by "S", "A" and "AB" in the tables below, where:

- S = Standalone
- A = Accelerator
- AB = Additional benefit.

Benefits for Topcover products		
Benefit	Benefit code	Type of benefit
Life cover		
Death	DS	S
Immediate Expenses	DSF3	S
Estate Expenses	DEC	S
Funeral Expenses	FSC3	S
Accidental death	ASC	S
Disability and impairment benefits		
Comprehensive Disability*	CAR3	A
	CSR3	S
Comprehensive Disability Plus*	CAR4	A
	CSR4	S
Comprehensive Impairment*	OAI	A
	OSI	S
Accidental Comprehensive Disability*	ASO3	S
Accidental Comprehensive Disability Plus*	ASO4	S
Accidental Comprehensive Impairment*	ASI	S
Severe illness benefits		
Cancer*	TAT3	A
	TST3	S
Cancer Plus*	TAT4	A
	TST4	S
Cardiovascular*	TAH3	A
	TSH3	S
Cardiovascular Plus*	TAH4	A
	TSH4	S
Dread disease and injury benefits		
Core dread disease	TAC	A
	TSC	S
Whole life core dread disease	TAC2	A
	TSC2	S
Accidental injury	ASW	S
Credit Life cover		
Credit Life	DSC	S
Cashback		
Cashback	RS	AB

*This benefit is available with fixed term or whole life cover.

Rider benefits with the Credit Life benefit

It is compulsory to take the Permanent Disability, Temporary Disability and Retrenchment rider benefits when the Credit Life benefit is taken for a life insured. (Note however that the Retrenchment rider benefit is not available for self-employed lives insured.)

An additional payment will be charged for each rider benefit.

Refer to the *Credit Life cover chapter* for more information.

General exclusions

In addition to the general exclusions listed in this section, the following applies:

- Exclusions for a specific benefit, if any, are set out in the chapter where the specific benefit is discussed.
- Specific exclusions, if any, are set out in the plan overview, in the special provisions for the life insured concerned.

General

We will not admit a claim if it resulted directly or indirectly from any of the following, where the life insured:

- participates in riot, insurrection, civil commotion, military or hostile action, or an act of terrorism;
- commits or attempts to commit a crime of murder, assault, housebreaking, theft, robbery, kidnapping, a crime involving a sexual act, or a crime of a similar nature to any of these crimes;
- deliberately inflicts an injury on himself or herself;
- takes drugs or medicine not according to medical prescription, or drives any form of motorised vehicle on a public road whilst his or her blood alcohol level exceeds the legal limit;
- is exposed to a nuclear explosion or radio-activity.

The above exclusions **do not apply** to the following benefits:

- Death (DS)
- Immediate Expenses (DSF3)
- Estate Expenses (DEC)
- Funeral Expenses (FSC3)
- Death cover on Credit Life (DSC)

Exclusions for risky activities

We will not admit a claim if the claim event resulted directly or indirectly from any of the following risky activities:

- recurrent (more than once) hang-gliding, paragliding, parasailing, sky-diving, parachuting, sky-surfing or microlight flights.

The above exclusions for risky activities **do not apply** to the following benefits:

- Death (DS)
- Immediate Expenses (DSF3)
- Estate Expenses (DEC)
- Funeral Expenses (FSC3)
- Death cover on Credit Life (DSC)

We will also not admit a claim if the claim event resulted directly or indirectly from any of the following risky activities indicated below. These exclusions **do not apply** to the Funeral Expenses (FSC3) benefit.

- acrobatic flights or BASE jumping;
- cave diving, commercial diving, or the exploration of underwater wrecks for financial gain;
- motorised racing or speed contests;
- professional boxing, professional kick-boxing or professional wrestling.

Exclusion for foreigners

No cover is available to foreigners who do not live in South Africa or who live in South Africa without valid travelling documents.

Cover is available to foreigners who live in South Africa with valid travelling documents, but is restricted to claim events in South Africa only. However, if a life insured at any stage obtains a permanent residence permit, or South African citizenship, the benefits on the plan for that life insured will cover claim events both inside and outside South Africa, excluding those countries where cover is excluded, if applicable.

If a life insured no longer lives in South Africa, it is the planholder's responsibility to request us in writing to end the benefits on the plan for that life insured. We will not refund any payments because of cover being restricted to claim events in South Africa only.

For foreigners with citizenship in Lesotho or Namibia the benefits on the plan will cover claim events both inside and outside South Africa, excluding those countries where cover is excluded, if applicable.

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Products

We offer a range of new generation risk products under the Classic and Premier product options, which enables a life insured to obtain transparent, low-cost risk cover, and offer the required flexibility to accurately address a life insured's requirements for cover.

Full medical underwriting applies to the Classic and Premier product options, except for the Funeral Expenses, accidental and Cashback benefits, where no medical underwriting applies.

A separate quotation must be drawn for each of the products in the table below, and a separate plan will be issued for each product.

The available product options for a specific product are indicated by √ in the table below.

Product	Product code	Product option	
		Classic	Premier
Topcover products			
Matrix Topcover	T02W	√	√
Topcover for Professionals			√
Topcover for Graduates			√
Term cover products			
Matrix Termcover	T02		√
Income protector products			
Matrix Income Protector	T03W		√
Income Protector for Professionals			√
Income Protector for Graduates			√

Benefits

General

A variety of benefits are available. If the benefits selected are for different products, these benefits will be on separate plans. For example, if the Death benefit for a Topcover product is selected in combination with the Extended Income benefit for an Income protector product, separate quotations must be drawn for the Topcover and Income protector products, and a separate plan will then be issued for each of these products.

When a benefit reaches its cover end date, the total payment of the plan will be reduced by the payment for that benefit at the time.

Benefits for Topcover and Term cover products

- Up to 10 lives may be insured on a plan, where each life insured on a plan may have up to 15 benefits.
- Immediate Expenses (DSF3) and Funeral Expenses (FSC3) benefits:
 - The Immediate Expenses benefit (DSF3) and/or Funeral Expenses benefit (FSC3), with or without the Cashback benefit, may not be the only benefits on a plan.
 - The Immediate Expenses benefit is only available for a life insured if there is at least one fully medically underwritten benefit for the same life insured on the same plan, with at least 4 times as much cover as the Immediate Expenses benefit. The Funeral Expenses, Child: Illness and injury, accidental and Cashback benefits do not apply, as they are not fully medically underwritten.
 - The Funeral Expenses benefit can only be added to a plan if the planholder is a life insured on the plan with at least one benefit other than Funeral Expenses and Cashback on his/her own life.
- Waiver of payment benefits:
 - Waiver of payment benefits are only allowed if there are also benefits other than the Cashback benefit on the plan.
 - Only one waiver of payment at death benefit is allowed on a plan. A waiver of payment at death benefit is only allowed if there is more than one life insured on the plan. At least one of the insureds without the waiver of payment at death benefit must have a lump sum benefit other than the Cashback benefit.
 - Only one waiver of payment at disability benefit is allowed on a plan.
 - If a waiver of payment claim is admitted, the total payment of the plan will be waived.
- Cashback benefit:
 - The Cashback benefit is **not** allowed on its own for a life insured, and can only be taken if the life insured also has benefits other than waiver of payment benefits.
 - The Cashback benefit is **not** allowed for the Stepped and Yearly-rated payment patterns.
- It is compulsory to take either a Death or First death benefit for a life insured in order to select an accelerator benefit for that life insured. It is not compulsory to take a Death or First death benefit for a life insured in other instances.
- Cover amounts are subject to new business limits and financial underwriting, and for accelerator benefits the following also applies:
 - The sum of the cover amounts of all **accelerator disability and impairment benefits** on a plan for a life insured may **not** exceed the cover amount of the Death or First death benefit for that life insured.
 - The sum of the cover amounts of all **accelerator dread disease/severe illness benefits** on a plan for a life insured may **not** exceed the cover amount of the Death or First death benefit for that life insured.
- Certain combinations are **not allowed** on the same plan for the same life insured:
 - Death & First death
 - More than one instance of the same benefit, for example:
 - Two Cancer benefits, where one is with a fixed term and one is with whole life cover. Note, however, that the Cancer and Cancer Plus benefits are different benefits and therefore one of each is allowed for the same life insured on one plan.
 - For benefits other than disability and impairment benefits, accelerator and standalone benefit types of the same benefit are not allowed.
(For disability and impairment benefits it will be allowed to take accelerator and standalone benefits types of the same benefit on the same plan for the same life insured.)
 - The Credit Life benefit in combination with benefits other than the Cashback benefit.
(Only the Cashback benefit and the compulsory Permanent Disability, Temporary Disability and Retrenchment rider benefits are allowed with the Credit Life benefit on the same plan.)
 - Waiver of payment with future growth at death & Waiver of payment without future growth at death
 - Waiver of payment with future growth at disability & Waiver of payment without future growth at disability.

The available benefits for a specific product option are indicated by a √ in the tables below. Benefits are grouped together per type of cover, and more information about a specific benefit is available in the applicable chapter with the name of the type of cover, e.g. more information about the Death benefit is available in the *Life cover* chapter.

The type of benefit is indicated by "S", "A" and "AB" in the tables below, where:

- S = Standalone
- A = Accelerator
- AB = Additional benefit.

Benefits for Topcover and Termcover products			Product option		
Benefit	Benefit code	Type of benefit	Classic	Premier	Premier
			Topcover products		Term-cover products
Life cover					
Death	DS	S	√	√	√
First death	DS80	S	√	√	√
Immediate Expenses	DSF3	S	√	√	√
Estate Expenses	DEC	S	√	√	√
Funeral Expenses	FSC3	S	√	√	
Accidental death	ASC	S	√	√	√
Disability and impairment benefits					
Comprehensive Disability*	CAR3	A	√	√	√
	CSR3	S			
Comprehensive Disability Plus*	CAR4	A	√	√	√
	CSR4	S			
Elite Disability*	CAR5	A		√	√
	CSR5	S			
Comprehensive Impairment*	OAI	A	√	√	√
	OSI	S			
Accidental Comprehensive Disability*	ASO3	S	√	√	√
Accidental Comprehensive Disability Plus*	ASO4	S	√	√	√
Accidental Elite Disability*	ASO5	S		√	√
Accidental Comprehensive Impairment*	ASI	S	√	√	√
Severe illness benefits					
Cancer*	TAT3	A	√	√	√
	TST3	S			
Cancer Plus*	TAT4	A	√	√	√
	TST4	S			
Cardiovascular*	TAH3	A	√	√	√
	TSH3	S			
Cardiovascular Plus*	TAH4	A	√	√	√
	TSH4	S			
Comprehensive Severe Illness*	TAW3	A	√	√	√
	TSW3	S			
Comprehensive Severe Illness Plus*	TAW4	A	√	√	√
	TSW4	S			

Benefit	Benefit code	Type of benefit	Benefits for Topcover and Termcover products		
			Topcover		Term-cover
			Product option	Classic	Premier
Dread disease and injury benefits					
Core dread disease	TAC	A	√	√	√
	TSC	S			
Whole life core dread disease	TAC2	A	√	√	
	TSC2	S			
Child: Illness and injury	TSK	S		√	√
Accidental injury	ASW	S	√	√	√
Credit Life cover					
Credit Life	DSC	S	√	√	√
Waiver of payment benefits and FutureCover					
Waiver of payment with future growth at death	DG	AB	√	√	√
Waiver of payment without future growth at death	DP	AB	√	√	√
Waiver of payment with future growth at disability	OGG1	AB	√	√	√
Waiver of payment without future growth at disability	OPG1	AB	√	√	√
FutureCover: Death	FS1	S		√	√
FutureCover: Comprehensive	FS2	S		√	√
Cashback					
Cashback	RS	AB	✗	√	

*This benefit is available with fixed term or whole life cover under Topcover products. Under Term cover products the benefit is available with fixed term cover only.

Rider benefits with the Credit Life benefit

It is compulsory to take the Permanent Disability, Temporary Disability and Retrenchment rider benefits when the Credit Life benefit is taken for a life insured. (Note however that the Retrenchment rider benefit is not available for self-employed lives insured.)

An additional payment will be charged for each rider benefit.

Refer to the *Credit Life cover* chapter for more information.

Benefits for Income protector products

- Only one life may be insured on a plan and this life insured may have up to six of the available benefits, excluding rider benefits.
- The payments of an Income protector plan will automatically be waived if a claim is admitted for any of the benefits on the plan, excluding the Severe Illness Income benefit. The payments of the plan will not be waived if a claim is admitted for a Severe Illness Income benefit.
- The Cashback benefit is **not allowed** on its own for the life insured, and can only be taken if the life insured also has other benefits.
- The following combinations of benefits are **not allowed** on the same plan:
 - More than one instance of the same benefit, for example:
 - More than one Sickness Income benefit. (However, Sickness Income and Sickness Income Plus can be taken together)
 - Two Severe Illness income benefits
 - Sickness Income and Sickness Income Plus benefit together with Temporary Income and Temporary Income Plus.

Benefits are grouped together per type of cover, and more information about a specific benefit is available in the applicable chapter with the name of the type of cover, e.g. more information about the Sickness Income benefit is available in the *Income protection* chapter.

The type of benefit is indicated by "S" and "AB" in the table below, where:

- S = Standalone
- AB = Additional benefit.

Benefits for Income protector products under the Premier product option		
Benefit	Benefit code	Type of benefit
Income protection		
Sickness Income	IS4	S
Sickness Income Plus	IS5	S
Temporary Income	OIT4	S
Temporary Income Plus	OIT5	S
Accidental Temporary Income Plus	AIT	S
Overhead Expenses	OIB4	S
Extended Income*	OIO4	S
Extended Income Plus*	OIO6	S
Accidental Extended Income Plus*	AIO	S
Impairment Income	OII	S
Severe Illness Income*	TIW3	S
Death income*	DI3	S
Cashback		
Cashback	RS	AB

*This benefit is available with different cease ages or whole of life.

Rider benefits for Income protector products

Rider benefits are optional benefits that can be taken with certain main Income protection benefits, and cannot be taken on their own. An additional payment will be charged for a rider benefit.

The following rider benefits are available:

- Spouse protector
- Child protector
- Hospital protector
- Lump sum conversion option

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

Benefits for HIV positive lives

The following benefits, with or without the Cashback benefit, will not be medically underwritten, and are therefore available for HIV positive lives too:

- Funeral Expenses (FSC3)
- Accidental death (ASC)
- Accidental Comprehensive Disability (ASO3)
- Accidental Comprehensive Disability Plus (ASO4)
- Accidental Elite Disability (ASO5)
- Accidental Comprehensive Impairment (ASI)
- Accidental injury (ASW)
- Accidental Temporary Income Plus (AIT)
- Accidental Extended Income Plus (AIO).

The following benefits will be medically underwritten, but may also be available for HIV positive lives (up to certain cover limits) under the Classic and Premier product options, subject to underwriting guidelines and new business rules. If the cover is accepted, the initial guarantee period of the plan, with or without the Cashback benefit, will be limited to five years:

- Death (DS)
- First death (DS80)
- Immediate Expenses (DSF3)
- Estate Expenses (DEC)
- Comprehensive Disability (CAR3/CSR3)*
- Comprehensive Disability Plus (CAR4/CSR4)*
- Comprehensive Impairment (OAI/OSI)*
- Core dread disease (TAC/TSC)*
- Death income (DI3)
- Impairment Income (OII)*.

*This benefit is only available with fixed term cover for HIV positive lives.

General exclusions

In addition to the general exclusions listed in this section, the following applies:

- Exclusions for a specific benefit, if any, are set out in the chapter where the specific benefit is discussed.
- Specific exclusions, if any, are set out in the plan overview, in the special provisions for the life insured concerned.

We will not admit a claim if it resulted directly or indirectly from any of the following, where the life insured:

- participates in riot, insurrection, civil commotion, military or hostile action, or an act of terrorism;
- commits or attempts to commit a crime of murder, assault, housebreaking, theft, robbery, kidnapping, a crime involving a sexual act, or a crime of a similar nature to any of these crimes;
- deliberately inflicts an injury on himself or herself;
- takes drugs or medicine not according to medical prescription, or drives any form of motorised vehicle on a public road whilst his or her blood alcohol level exceeds the legal limit;
- is exposed to a nuclear explosion or radio-activity;
- participates in cave diving, commercial diving, or the exploration of underwater wrecks for financial gain;
- participates in motorised racing, speed contests or acrobatic flights;
- recurrently participates in microlight flights, hang-gliding, paragliding, parasailing, sky-diving, parachuting or sky-surfing;
- participates in professional boxing, professional kick-boxing or professional wrestling.

These general exclusions **do not apply** to the following benefits:

- Death (DS)
- First death (DS80)
- Immediate Expenses (DSF3)
- Estate Expenses (DEC)
- Funeral Expenses (FSC3)
- Death cover on Credit Life (DSC)
- Waiver of payment at death (DG/DP)
- Death income (DI3).

Reality integration with the Premier product option

If a life insured is a member of Reality, and depending on the Reality option and tier that that life insured is on at the time, we may give a discount on the payments for some benefits on the life of that insured. This discount is not guaranteed.

It may take up to ten working days after a life insured has become a Reality member or after the Reality option or tier has changed before any discount will be applied.

Even if a life insured cancels his or her Reality membership or no longer qualifies for a Reality discount, we will never raise the payments to more than what they would have been without the applicable discounts. The amount of cover that a life insured has at the time will also not be affected.

For more information about Reality, their benefits and partners, visit Reality's website at www.sanlamreality.co.za.

Discounts on debit order payments

Reality has four membership options:

- Reality Core
- Reality Plus
- Reality Club
- Reality Health.

The following applies for a life insured to qualify for a discount:

- The life insured must be a **Reality Plus or Reality Health** member
- Only the **Premier product option** of risk products qualifies
- Payments for the plan must be made by **debit order**.

Possible payment discounts for the benefits of a life insured depend on the life insured's Reality tier, and are as follows.

- Bronze: 7.5% discount
- Silver: 15% discount
- Gold: 30% discount.

The following maximums per benefit may qualify for a discount:

- For death-related benefits: The first R3 000 of the monthly payment for the benefit*:
 - Death (DS)
 - First death (DS80)
 - Immediate Expenses (DSF3)
 - Estate Expenses (DEC)
 - Funeral Expenses (FSC3)
 - Accidental death (ASC)
 - Credit Life (DSC)
 - Death income (DI3).
- For other benefits: The first R1 500 of the monthly payment for the benefit*.

*The total monthly payment for a benefit will be used to determine the above maximums, which will include the payments of rider benefits and loadings, if applicable.

Reality discounts are only applied to benefit payments and not to the plan charge.

Short benefit descriptions

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Life cover	3
Death (DS)	3
First death (DS80)	3
Immediate Expenses (DSF3)	3
Estate Expenses (DEC)	3
Funeral Expenses (FSC3)	3
Accidental death (ASC)	3
Disability and impairment benefits	3
Comprehensive Disability (CAR3, CSR3)	3
Comprehensive Disability Plus (CAR4, CSR4)	3
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Short benefit descriptions

Benefits are grouped together per type of cover, and more information about a specific benefit is available in the applicable chapter with the name of the type of cover, e.g. more information about the Death benefit is available in the *Life cover* chapter.

Benefit	Benefit description
Life cover	
Death (DS)	A benefit may be claimed if the life insured dies. If we admit a claim, we will pay the cover amount as a lump sum.
First death (DS80)	This benefit is linked to more than one life insured. A benefit may be claimed at the death of the life insured linked to this benefit, who dies first. If we admit a claim, we will pay the cover amount as a lump sum.
Immediate Expenses (DSF3)	A benefit may be claimed if the life insured dies. If we admit a claim, we will pay the cover amount as a lump sum. We aim to pay the cover amount within 48 hours after receiving the necessary requirements.
Estate Expenses (DEC)	The purpose of this benefit is to make provision for estate costs. A benefit may be claimed at the death of the life insured. If we admit a claim, we will pay the cover amount into the estate of the deceased life insured.
Funeral Expenses (FSC3)	A benefit may be claimed if the life insured dies. If we admit a claim, we will pay the claim amount as a lump sum, subject to legislative limitations. We aim to pay this benefit within 48 hours after receiving the necessary requirements.
Accidental death (ASC)	A benefit may be claimed if the life insured dies and the death resulted directly and solely from a bodily injury. If we admit a claim, we will pay the claim amount as a lump sum.
Disability and impairment benefits	
Comprehensive Disability (CAR3, CSR3)	<p>This benefit provides cover for</p> <ul style="list-style-type: none"> permanent occupational disability up to retirement, age 70 or the cover end date of the benefit, whichever is earlier; and permanent impairment claim events for as long as the benefit is in force. <p>Refer to the "Claim events: List 1" section in the <i>Disability and impairment benefits</i> chapter for information about the claim events and percentages of the cover amount payable.</p> <p>If we admit a claim, we will pay the claim amount as a lump sum.</p> <p>This benefit also includes the following:</p> <ul style="list-style-type: none"> Built-in Future Cover for Young Lives.
Comprehensive Disability Plus (CAR4, CSR4)	<p>This benefit provides cover for</p> <ul style="list-style-type: none"> permanent occupational disability up to retirement, age 70 or the cover end date of the benefit, whichever is earlier; and permanent impairment claim events for as long as the benefit is in force; and accidental claim events for as long as the benefit is in force. <p>Refer to the "Claim events: List 1" section in the <i>Disability and impairment benefits</i> chapter for information about the claim events and percentages of the cover amount payable.</p> <p>If we admit a claim, we will pay the claim amount as a lump sum.</p> <p>This benefit also includes the following:</p> <ul style="list-style-type: none"> Temporary Incapacity Cover for Accidental Causes; and Temporary Incapacity Cover for non-Accidental Causes; and Built-in Future Cover for Young Lives.

Benefit	Benefit description
Disability and impairment benefits	
Elite Disability (CAR5, CSR5)	<p>This benefit provides cover for</p> <ul style="list-style-type: none"> • permanent occupational disability up to retirement, age 70 or the cover end date of the benefit, whichever is earlier; and • permanent impairment claim events for as long as the benefit is in force; and • accidental claim events for as long as the benefit is in force. <p>If we admit a claim, we will pay the claim amount as a lump sum.</p> <p>Refer to the “Claim events: List 1” section in the <i>Disability and impairment benefits</i> chapter for information about the claim events and percentages of the cover amount payable.</p> <p>This benefit also includes the following:</p> <ul style="list-style-type: none"> • Temporary Incapacity Cover for Accidental Causes; and • Temporary Incapacity Cover for non-Accidental Causes; and • A Prosthesis Booster; and • Built-in Future Cover for Young Lives; and • Built-in Child Cover.
Comprehensive Impairment (OAI, OSI)	<p>This benefit provides cover for</p> <ul style="list-style-type: none"> • permanent impairment claim events; and • accidental claim events. <p>If we admit a claim, we will pay the claim amount as a lump sum.</p> <p>Refer to the “Claim events: List 1” section in the <i>Disability and impairment benefits</i> chapter for information about the claim events and percentages of the cover amount payable.</p> <p>This benefit also includes the following:</p> <ul style="list-style-type: none"> • Temporary Incapacity Cover for Accidental Causes; and • Temporary Incapacity Cover for non-Accidental Causes.
Accidental Comprehensive Disability (ASO3)	<p>This benefit provides cover for</p> <ul style="list-style-type: none"> • permanent occupational disability from accidental causes up to retirement, age 70 or the cover end date of the benefit, whichever is earlier; and • permanent impairment claim events from accidental causes for as long as the benefit is in force. <p>If we admit a claim, we will pay the claim amount as a lump sum.</p> <p>Refer to the “Claim events: List 2” section in the <i>Disability and impairment benefits</i> chapter for information about the claim events and percentages of the cover amount payable.</p>
Accidental Comprehensive Disability Plus (ASO4)	<p>This benefit provides cover for</p> <ul style="list-style-type: none"> • permanent occupational disability from accidental causes up to retirement, age 70 or the cover end date of the benefit, whichever is earlier; and • permanent impairment claim events from accidental causes for as long as the benefit is in force; and • other accidental claim events for as long as the benefit is in force. <p>If we admit a claim, we will pay the claim amount as a lump sum.</p> <p>Refer to the “Claim events: List 2” section in the <i>Disability and impairment benefits</i> chapter for information about the claim events and percentages of the cover amount payable.</p> <p>This benefit also includes the following:</p> <ul style="list-style-type: none"> • Temporary Incapacity Cover for Accidental Causes.

Benefit	Benefit description
Disability and impairment benefits	
Accidental Elite Disability (ASO5)	<p>This benefit provides cover for</p> <ul style="list-style-type: none"> • permanent occupational disability from accidental causes up to retirement, age 70 or the cover end date of the benefit, whichever is earlier; and • permanent impairment claim events from accidental causes for as long as the benefit is in force; and • other accidental claim events for as long as the benefit is in force. <p>If we admit a claim, we will pay the claim amount as a lump sum.</p> <p>Refer to the "Claim events: List 2" section in the <i>Disability and impairment benefits</i> chapter for information about the claim events and percentages of the cover amount payable.</p> <p>This benefit also includes the following:</p> <ul style="list-style-type: none"> • Temporary Incapacity Cover for Accidental Causes; and • A Prosthesis Booster.
Accidental Comprehensive Impairment (ASI)	<p>This benefit provides cover for</p> <ul style="list-style-type: none"> • permanent impairment claim events from accidental causes; and • other accidental claim events. <p>If we admit a claim, we will pay the claim amount as a lump sum.</p> <p>Refer to the "Claim events: List 2" section in the <i>Disability and impairment benefits</i> chapter for information about the claim events and percentages of the cover amount payable.</p> <p>This benefit also includes the following:</p> <ul style="list-style-type: none"> • Temporary Incapacity Cover for Accidental Causes.
Temporary Incapacity Cover for Accidental Causes	<p>This cover is automatically included in the following main benefits, if applicable to the life insured:</p> <ul style="list-style-type: none"> • Comprehensive Disability Plus (CAR4/CSR4) • Elite Disability (CAR5/CSR5) • Comprehensive Impairment (OAI/OSI) • Accidental Comprehensive Disability Plus (ASO4) • Accidental Elite Disability (ASO5) • Accidental Comprehensive Impairment (ASI). <p>If we admit a claim, we will pay 10% of the cover amount of the main benefit as a lump sum. The cover amount of the main benefit will be reduced by the claim amount we will pay. We will also reduce the payment of the benefit proportionally.</p> <p>The planholder may claim a benefit if the life insured suffers any bodily injury as a result of an accident and the recovery period for returning to work will be three months or longer, according to the Official Disability Guidelines (ODG) or scientifically accepted equivalent. The life insured does not have to prove any loss of income to qualify for a claim and the injury does not need to result in permanent impairment.</p>

Benefit	Benefit description
Disability and impairment benefits	
Temporary Incapacity Cover for non-Accidental Causes	<p>This cover is automatically included in the following main benefits, if applicable to the life insured:</p> <ul style="list-style-type: none"> • Comprehensive Disability Plus (CAR4/CSR4) • Elite Disability (CAR5/CSR5) • Comprehensive Impairment (OAI/OSI). <p>If we admit a claim, we will pay 10% of the cover amount of the main benefit as a lump sum. The cover amount of the main benefit will be reduced by the claim amount we will pay. We will also reduce the payment of the benefit proportionally.</p> <p>The planholder may claim a benefit if the life insured suffers any of the claim events in the applicable table* in the <i>Disability and impairment benefits</i> chapter and, after the indicated waiting period, the recovery period for returning to work will be two months or longer, according to the Official Disability Guidelines (ODG) or scientifically accepted equivalent. The life insured does not have to prove any loss of income to qualify for a claim and the illness does not need to result in permanent impairment.</p> <p>*Refer to the table in the “Cover description” section for Temporary Incapacity Cover for non-Accidental Causes in the <i>Disability and impairment benefits</i> chapter.</p>
Prosthesis Booster	<p>This Booster is automatically included in the following main benefits, if applicable to the life insured:</p> <ul style="list-style-type: none"> • Elite Disability (CAR5/CSR5) • Accidental Elite Disability (ASO5). <p>If we admit a claim, we will pay a percentage of the cover amount of the main benefit as a lump sum. We will not reduce the cover amount of the main benefit by the claim amount we will pay for this benefit.</p> <p>The claim events and percentages of the cover amount of the main benefit are indicated in the applicable table* in the <i>Disability and impairment benefits</i> chapter. For multiple claims, we may pay a lower percentage than the claim event percentage.</p> <p>If a life insured qualifies for one of the claim events in the applicable table*, he or she will also qualify for the same claim event under the main benefit and may also qualify for the occupational disability claim event under the main benefit. The claim amount for this Prosthesis Booster will however be calculated first, before the cover amount of the main benefit is reduced by the claim under the main benefit. This implies a total payout of up to 250% of the cover amount.</p> <p>All the claim events in the applicable table* will be limited to a maximum payout of R10 million. This maximum may be adjusted from time to time.</p> <p>*Refer to the table in the “Claim event” section for Prosthesis Booster in the <i>Disability and impairment benefits</i> chapter.</p>
Built-in Future Cover for Young Lives	<p>This cover is automatically included in the following standalone main benefits, if applicable to the life insured:</p> <ul style="list-style-type: none"> • Comprehensive Disability (CSR3) • Comprehensive Disability Plus (CSR4) • Elite Disability (CSR5). <p>If the qualifying criteria are met, the planholder has the option to purchase future death cover on the life of an insured without proof of good health. The option expires on the plan anniversary before or on the life insured's 35th birthday and can only be exercised at certain life events.</p> <p>The planholder may purchase cover under one or more of the death benefits available when he or she exercises an option. The list of available benefits will change if we discontinue a benefit, or make other benefits available.</p>

Benefit	Benefit description
Disability and impairment benefits	
Built-in Child Cover	<p>This cover is automatically included in the Elite Disability (CAR5/CSR5) main benefit, if applicable to a life insured.</p> <p>If we admit a claim, we will pay 10% of the cover amount of the main benefit as a lump sum, or a lower percentage if the claim is within the waiting period. We will not reduce the cover amount of the main benefit with the claim amount we will pay.</p> <p>We will pay a maximum of R500 000 per child. If one parent has more than one benefit where this cover is included, we will pay a maximum of R500 000 per child. If more than one parent have benefits where this cover is included, we will pay a maximum of R1 million per child.</p> <p>The planholder may claim a benefit if a child of a life insured on the main benefit suffers any of the illnesses or injuries indicated in the applicable table* in the Disability and impairment benefits chapter.</p> <p>*Refer to the table in the "Claim event" section for Built-in Child Cover in the Disability and impairment benefits chapter.</p>
Severe illness benefits	
Cancer (TAT3/TST3)	<p>The Cancer and Cancer Plus benefits cover the same claim events and provide cover against cancers (including early cancers), tumours, leukaemias and lymphomas.</p> <p>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.</p> <p>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.</p>
Cancer Plus (TAT4/TST4)	<p>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 for these benefits under "Claim events and claim event percentages" in the <i>Severe illness benefits</i> chapter. 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 these benefits. 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.</p>
Cardiovascular (TAH3/TSH3)	<p>The Cardiovascular and Cardiovascular Plus benefits cover the same claim events and provide cover for cardiovascular conditions: heart, blood vessels and stroke.</p> <p>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.</p> <p>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.</p>
Cardiovascular Plus (TAH4/TSH4)	<p>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 for these benefits under "Claim events and claim event percentages" in the <i>Severe illness benefits</i> chapter. 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 these benefits.</p>

Benefit	Benefit description
Severe illness benefits	
Comprehensive Severe Illness (TAW3/TSW3)	<p>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.</p> <p>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.</p>
Comprehensive Severe Illness Plus (TAW4/TSW4)	<p>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.</p> <p>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 for these benefits under "Claim events and claim event percentages" in the <i>Severe illness benefits</i> chapter. 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 these benefits. 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.</p>
Dread disease and injury benefits	
Core dread disease (TAC/TSC)	
Whole life core dread disease (TAC2/TSC2)	<p>This benefit provides cover for dread disease 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 under "Claim events" for this benefit in the <i>Dread disease and injury benefits</i> chapter. The amount will be paid as a lump sum.</p>
Child: Illness and injury (TSK)	<p>This benefit provides cover for illness and accidental injury 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 under "Claim events" for this benefit in the <i>Dread disease and injury benefits</i> chapter. The amount will be paid as a lump sum.</p>
Accidental injury (ASW)	<p>This benefit provides cover for accidental injury 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 under "Claim events" for this benefit in the <i>Dread disease and injury benefits</i> chapter. The amount will be paid as a lump sum.</p>

Benefit	Benefit description
Credit Life cover	
Credit Life (DSC)	<p>A benefit may be claimed if the life insured dies. If we admit a claim, we will pay the cover amount as a lump sum. This benefit and all rider benefits linked to this benefit as well as all other benefits on the life of the insured will then end.</p>
Permanent Disability	<p>This is a compulsory rider benefit that must be taken with the Credit Life benefit. This rider benefit provides cover for permanent occupational disability. In addition to occupational disability, it also provides cover for certain defined recognised and personal disability events. If we admit a claim, we will pay the cover amount of the benefit for which this rider benefit has been chosen. That benefit and all rider benefits linked to that benefit will then end. The amount will be paid as a lump sum.</p>
Temporary Disability	<p>This is a compulsory rider benefit that must be taken with the Credit Life benefit. This rider benefit provides cover for temporary occupational disability. If we admit a claim, we will pay 3.75% of the cover amount of the benefit for which this rider benefit has been chosen. The amount will be paid as a lump sum.</p> <p>A benefit may be claimed if the life insured becomes disabled to the extent that he or she is continuously unable to fulfil the occupational demands of the regular occupation he or she practised for income immediately before the disability.</p> <p>A benefit may be claimed after every three months of continuous disability as described above, with a maximum of four benefit payments for a particular cause of the claim event. The three-month periods may not overlap and the disability must be continuous within each period of three months. Further claims are possible if the cause of the claim event is not related to the cause of a previously admitted claim event.</p> <p>(Note that a claim under this rider benefit will not reduce the cover amount of the benefit for which this rider benefit has been chosen, and also not the cover amounts of any other rider benefits chosen for that benefit.)</p>
Retrenchment	<p>This is a compulsory rider benefit that must be taken with the Credit Life benefit. This rider benefit is however not available for self-employed lives insured.</p> <p>This rider benefit provides cover for up to two retrenchments. If we admit a claim, we will pay 3.75% of the cover amount of the benefit for which this rider benefit has been chosen. The amount will be paid as a lump sum.</p> <p>A benefit may be claimed if the life insured's employment is terminated by the employer as a result of or in anticipation of business conditions, or as a result of any other business decision of the employer resulting in a staff reduction. The date of retrenchment is the date from which the life insured is no longer employed by the employer.</p> <p>A benefit may be claimed on the date of retrenchment and after every three months of continuous unemployment thereafter, with a maximum of four benefit payments for one occurrence of retrenchment. After the life insured has been employed again for at least two years one further benefit with a maximum of four benefit payments as described may be claimed. If the life insured becomes employed again before we have made the maximum of four benefit payments for this second occurrence of retrenchment, it is yourthe planholder's responsibility to request us in writing to cancel this rider benefit.</p> <p>(Note that a claim under this rider benefit will not reduce the cover amount of the benefit for which this rider benefit has been chosen, and also not the cover amounts of any other rider benefits chosen for that benefit.)</p>

Benefit	Benefit description
Waiver of payments and FutureCover	
Waiver of payment with future growth at death (DG)	A benefit may be claimed if the life insured dies.
Waiver of payment without future growth at death (DP)	If we admit a claim, we will waive the payments of the plan. This means we will treat the future payments as having been made when they become due.
Waiver of payment with future growth at disability (OGG1)	This benefit provides cover for occupational disability. In addition to occupational disability, this benefit also provides cover for certain defined recognised and personal disability events.
Waiver of payment without future growth at disability (OPG1)	If we admit a claim, we will waive the payments of the plan. This means we will treat the future payments as having been made when they become due.
FutureCover: Death (FS1)	For certain events the planholder has the option to purchase additional cover on the life of the insured without proof of good health.
FutureCover: Comprehensive (FS2)	The planholder may purchase additional cover under one or more of the benefits available when he or she exercises an option. The list of available benefits will change if we discontinue a benefit, or make other benefits available.
Income protection	
Sickness Income (IS4)	A benefit may be claimed if the life insured is on sick leave. If we admit a claim, we will make a benefit payment of up to 100% of the cover amount. We will continue making monthly benefit payments for as long as the planholder has the right to claim payment.
Sickness Income Plus (IS5)	<ul style="list-style-type: none"> The Sickness Income benefit provides cover for sick leave and severe impairment events. The Sickness Income Plus benefit provides cover for sick leave, severe impairment events and less severe impairment events.
Temporary Income (OIT4)	These benefits provide short term cover for occupational disability resulting in a loss of income and for permanent impairments. Both benefits also include a list of Guaranteed Payment Events, including a catch-all sick leave event, which guarantee payout for a certain period of time without the need to prove loss of income. The benefits are available to employed clients with qualifying occupations.
Temporary Income Plus (OIT5)	<ul style="list-style-type: none"> The Temporary Income benefit provides cover for occupational disability, guaranteed payment events and severe impairment events. The Temporary Income Plus benefit provides cover for occupational disability, guaranteed payment events, severe impairment events and less severe impairment events.
Accidental Temporary Income Plus (AIT)	<p>This benefit provides short term accidental cover for occupational disability resulting in a loss of income and for permanent impairments.</p> <p>It also includes a list of Guaranteed Payment Events, including a catch-all sick leave event, which guarantee payout for a certain period of time without the need to prove loss of income.</p> <p>The benefit is available to employed clients with qualifying occupations, but especially suitable for clients who are not medically insurable.</p> <p>It provides cover for occupational disability, guaranteed payment events, severe impairment events and less severe impairment events, if any of these are from accidental causes.</p>

Benefit	Benefit description
Income protection	
Extended Income (OIO4)	<p>These benefits provide long term cover for occupational disability resulting in a loss of income and for permanent impairments, after a waiting period of 24 months. The whole life options also provide cover for joint replacements and trauma claim events from age 70.</p> <p>The benefit is available to employed clients with qualifying occupations.</p>
Extended Income Plus (OIO6)	<ul style="list-style-type: none"> • The Extended Income benefit covers occupational disability and severe impairment events. • The Extended Income Plus benefit covers occupational disability, severe impairment events and less severe impairment events.
Overheads Expenses (OIB4)	<p>This benefit provides short term occupational disability cover for the business owner or a key person within a business that results in less income being generated in the affected business in order to pay for the overhead expenses.</p> <p>If a 1 month waiting period has been selected, it also includes a list of Guaranteed Payment Events, including a catch-all sick leave event, which guarantee payout for a certain period of time without the need to prove loss of income.</p>
Accidental Extended Income Plus (AIO)	<p>This benefit provides long term accidental cover for occupational disability resulting in a loss of income and for permanent impairments, after a waiting period of 24 months. The whole life option also provides cover for joint replacements and trauma claim events from age 70.</p> <p>The benefit is available to employed clients with qualifying occupations but especially suitable for clients who are not medically insurable.</p> <p>It provides cover for occupational disability, severe impairment events and less severe impairment events, if any of these are from accidental causes.</p>
Impairment Income (OII)	<p>This benefit provides cover for permanent impairments.</p> <p>It does not provide cover for occupational disability, but provides cover for severe impairment events and less severe impairment events.</p>
Hospital Protector	<p>This is an optional rider benefit which can be chosen with the Sickness Income and Sickness Income Plus main benefits, and cannot be purchased on its own. It is only available if the main benefit has a 7 or 14 day waiting period.</p> <p>An additional payment will be charged for this rider benefit.</p>
Spouse protector	<p>This is an optional rider benefit that is available with the Sickness or Temporary disability income benefits.</p> <p>A benefit may be claimed if the spouse of the life insured on the main benefit dies, or is diagnosed with any of the dread diseases as set out under "Claim event" for this rider benefit in the <i>Income protection</i> chapter. The main benefit refers to the benefit for which this rider benefit has been chosen.</p> <p>If we admit a claim, we will make 6 monthly income payments. Each income payment will be equal to the cover amount of the benefit for which this protector rider benefit has been chosen.</p> <p>We will waive the payments for the plan for as long as we make an income payment.</p>

Benefit	Benefit description
Income protection	
Child protector	<p>A benefit may be claimed if a child of the life insured on the main benefit suffers any of the illnesses or injuries indicated under "Claim event" for this rider benefit in the <i>Income protection</i> chapter. The main benefit refers to the benefit for which this rider benefit has been chosen.</p> <p>If we admit a claim, we will make 6 monthly income payments. Each income payment will be equal to the cover amount of the benefit for which this protector rider benefit has been chosen.</p> <p>We will waive the payments for the plan for as long as we make an income payment.</p>
Lump Sum Conversion Option	<p>This rider benefit provides the option to convert future income payments on the main benefit to a lump sum amount. If the client exercises the option, we will pay a lump sum amount instead of the monthly income payments. The main benefit refers to the benefit for which this rider benefit has been chosen.</p> <p>The rider benefit also guarantees the receipt of any remaining income payments until the end of a specified period, if the option event occurred but the option was not exercised and the life insured dies before the end of the specified period.</p>
Built-in Future Cover for Young Lives	<p>This cover is automatically included in the following main benefits, if applicable to the life insured:</p> <ul style="list-style-type: none"> • Extended Income (OIO4) • Extended Income Plus (OIO6) <p>If the qualifying criteria are met, the planholder has the option to purchase future death cover on the life of an insured without proof of good health. The option expires on the plan anniversary before or on the life insured's 35th birthday and can only be exercised at certain life events.</p> <p>The planholder may purchase cover under one or more of the death benefits available when he or she exercises an option. The list of available benefits will change if we discontinue a benefit, or make other benefits available.</p>
Severe Illness Income (TIW3)	<p>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.</p> <p>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" for this benefit in the <i>Income protection</i> chapter. 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 this benefit.</p>
Death income (DI3)	<p>A benefit may be claimed at the death of the life insured.</p> <p>If we admit a claim, we will make an income payment equal to the cover amount. We will continue making income payments for as long as an appointed beneficiary has the right to claim payment.</p>

Benefit	Benefit description
	Cashback
Cashback (RS)	<p>We will pay the payments made for a life insured as a Cashback amount for specific events. For the purpose of calculating the Cashback amount, the cover amount of each benefit on the life of an insured is split into layers. The first layer is formed by the cover amount of a benefit on the later of the cover start date of that benefit and the cover start date of the Cashback benefit. Whenever the cover amount of a benefit is increased thereafter, whether due to benefit growth or a requested increase in the cover amount, a new layer is formed by the increased part of the cover amount. However, the Cashback benefit will not apply to a new layer with a remaining duration of less than 15 years. It will also not apply to a new layer that is formed from the plan anniversary before or on the life insured's 60th birthday.</p> <p>A separate Cashback amount is calculated for each layer. The Cashback amount for a layer is calculated as the total payments made for that layer. The payments for the Cashback benefit for that layer as well as any compulsory payment growth linked to that layer are included in the total payments for that layer.</p> <p>If we give a discount on the payments for some benefits because of a life insured's membership of Reality, we will use the discounted payments in the calculation of the Cashback amount.</p> <p>The total Cashback amount to be paid for a specific event is the sum of the Cashback amounts for all the layers with a duration of 15 years and longer.</p>

Payments, payment patterns, guarantees and cover

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Plan benefits

The benefits provided by a plan, are set out in the plan overview. Each benefit annexure sets out when the benefit will be provided.

General conditions under which benefits will not be provided are set out under "General exclusions" in the general plan provisions, and in each benefit annexure. Special provisions for a benefit for a specific life insured, if any, are set out in the plan overview.

The approval of plan benefits and cover amounts will be based on the medical, financial, lifestyle and occupational information provided by the planholder and a life insured. We will use this information in our decision to provide cover, to determine the payments we charge for this cover, and whether or not to add exclusions and/or loadings. It is therefore the responsibility of the planholder and a life insured to ensure that the information provided is correct and complete. If we later determine that there is any information the planholder and a life insured have not provided that might have affected our decision, it may result in exclusions and/or loadings being added to the benefits, or even the benefits being cancelled. The plan benefits may also be reduced or even refused if a claim is submitted in future.

If a fraudulent claim for a benefit is submitted, the plan with all its benefits will be cancelled, and any payments made will be forfeited.

Cover

Cover start date

The cover start date for each benefit will be the later of

- the cover start date for that benefit set out in the plan overview, and
- the date on our letter of acceptance of the planholder's application.

However, Immediate life cover or Free cover may apply from an earlier date.

If the cover amount of or the payment for a benefit is changed, other than through benefit or payment growth, the cover start date for that benefit in the plan overview will be changed to the effective date of the change.

Immediate life cover on the Death (DS), First death (DS80) and Estate Expenses (DEC) benefits

Immediate life cover will be given under these benefits at death, provided that:

- the life insured is not yet aged 60 on the application date; and
- the first payment has been made with the application, or, but for the death of the applicant, a debit order or stop order payment for the first payment would have been honoured.

Immediate life cover will apply from the date we receive the application form, with all questions fully and correctly answered and signed by, if different parties, the life insured and the applicant, until the earliest of:

- the final underwriting decision being made that the application is accepted, declined, or deferred for the life insured;
- 30 days after the signing of the application form;
- us cancelling the cover in writing.

The immediate life cover will apply only in respect of death from unnatural causes (excluding suicide). The normal contractual exclusions will apply. No immediate life cover will be payable if death is directly or indirectly caused by:

- the life insured participating in any dangerous pursuits;
- exposure to risks beyond the borders of South Africa and which are, in our opinion, not generally found in South Africa, or are more severe than corresponding risks in South Africa.

The consideration of a claim will be subject to the then prevailing terms of the type of plan applied for, and our usual practices.

The amount payable will be limited to the smaller of the initial cover amount and R500 000. The amount will be payable to the beneficiary, if any, nominated in the application form.

Free cover

We will give free cover for all benefits that we accept, excluding the Funeral Expenses benefit, provided that:

- the first payment has been made with the application, or satisfactory arrangements have been made for the first payment, and
- the cover start date in the plan overview is not later than the first day of the month following the month of acceptance.

However, if the date of acceptance is within 4 working days* of the end of the month of acceptance, the cover start date can be up to one calendar month later than described above.

For example, if the date of acceptance is 8 March, the cover start date must not be later than 1 April, but if the date of acceptance is 29 March, the cover start date can be up to 1 May in order to qualify for free cover.

*A working day is a day of the week between and including Monday to Friday, excluding public holidays.

If free cover is applicable, it will apply from the date of our acceptance letter, to the day before the actual cover start date. The normal contractual exclusions will apply. If a waiting period applies, the cover amount will only be paid at the end of the waiting period and payments will be payable during the waiting period.

The consideration of a claim is subject to the prevailing terms of the type of plan applied for, and our usual practices. Free cover will not be given if any information which, in our reasonable opinion, and which is relevant to the insurance risk, is not provided completely and correctly.

For the Spouse protector and Child protector rider benefits, free cover only applies to claims due to unnatural causes (excluding suicide). Refer to the *Income protection* chapter for the waiting periods that apply on claims due to natural causes and claims due to suicide.

Example to explain the second bullet above

Refer to the second bullet in the previous section.

Suppose the date of acceptance is 8 March 2020 (which is more than 4 working days from the end of March). The month of acceptance is March. The month following the month of acceptance is April. In order to qualify for free cover, the cover start date in the plan overview must not be later than the first of April 2020. If the date of acceptance was however rather within 4 working days from the end of March (e.g. on the 29th of March), the cover start date can be up to one calendar month later than the first of April, i.e. the cover start date can be up to the 1st of May 2020 in order to qualify for free cover.

Cover for accidental causes on the Funeral Expenses (FSC3) benefit

Cover for claims due to accidental causes, excluding suicide, will start on the "Funeral Expenses issue date" as indicated in the plan overview of the contract documents under the life insured's name.

Refer to the *Life* cover chapter for the waiting periods that apply on claims due to natural causes and claims due to suicide.

What happens at the cover end date?

Cover for a benefit ends at midnight before its cover end date unless it has already ended before the cover end date for any other reason. The plan will come to an end when all benefits have reached their cover end dates or have already ended before that.

Payments

General

The following applies to the payments of a plan:

- The total monthly payment for the plan will be the sum of the monthly payment for each life insured, and the monthly collection payment, if any, and the plan charges.
- Payments must be made in South Africa in South African currency.
- Payments are due in advance. The planholder may select to make the payments monthly or yearly in advance. The payment due dates are indicated in the plan overview of the contract documents. The planholder has 30 days after the date on which each payment is due, to make the payment. If the payment is not made in full within the 30 days, the plan will lapse, and **will provide no further benefits**.
- The planholder may select the debit order or stop order date upfront, where this date may be any day of the month for debit orders and must be on the first of the month for stop orders, also subject to our new business rules. The payment collection dates are indicated in the plan overview of the contract documents.
- Payments for a benefit must be made up to the cover end date, or until a life insured dies, or until a waiver of payment claim is admitted, or until cover for a benefit ends for any other reason.

Payment frequency

Choice between:

- Monthly
- Yearly, where the yearly payment = the monthly payment x 11.4.

Payment method

The first payment of a plan may be made in cash. Thereafter payments must be made by stop order or debit order.

Choice between:

- Stop order (monthly payment frequency only)
- Debit order.

Collection payment for stop order payments

The following applies:

- For the Express product option no collection payment is currently charged for stop order payments.
- For Classic and Premier product options a collection payment is charged for stop order payments. The collection payment is currently calculated as 3.5% of the total monthly payment, excluding the collection payment. We may change this percentage from time to time. If we increase the percentage, the total monthly payment will increase. When payment growth takes place, if any, the collection payment will also increase. NOTE: No payment growth applies to the Level payment pattern without cover growth.

Reality membership for Premier product options

Not applicable to stop order payment methods.

If a life insured is a member of Reality, and depending on the Reality option and tier that that life insured is on at the time, we may give a discount on the payments for some benefits on the life of that insured. This discount is not guaranteed.

It may take up to ten working days after a life insured has become a Reality member or after the Reality option or tier has changed before any discount will be applied.

Minimum payments

The minimum payments per plan are indicated in the table below.

Minimum monthly payment		Minimum yearly payment	
Plans with one life insured	Plans with more than one life insured	Plans with one life insured	Plans with more than one life insured
R100	<p>R100 (R75 for student) plus R75 for every additional life insured, with the following exceptions:</p> <ul style="list-style-type: none"> • If an additional life insured has a Funeral Expenses benefit only OR a Child: Illness and injury benefit only, with or without Cashback, the minimum additional payment for this life insured is R5 • If an additional life insured has a Funeral Expenses benefit PLUS a Child: Illness and injury benefit only, with or without Cashback, the minimum additional payment of this life insured is R10. 	R1 140	<p>R1 140 (R855 for student)plus R855 for every additional life insured, with the following exceptions:</p> <ul style="list-style-type: none"> • If an additional life insured has a Funeral Expenses benefit only OR a Child: Illness and injury benefit only, with or without Cashback, the minimum additional payment for this life insured is R57 • If an additional life insured has a Funeral Expenses benefit PLUS a Child: Illness and injury benefit only, with or without Cashback. the minimum additional payment of this life insured is R114.

Plan charge

For Topcover and Term cover products the plan charge is currently R20 per month.

For Income protector products the plan charge is currently zero.

Without cover growth

Level and Stepped payment patterns

The plan charge will remain unchanged.

Fixed compulsory 5% and Fixed compulsory 7% payment patterns

Each year when the payment is increased, the plan charge will be increased at the same rate.

Age-related and Aggressive age-related payment patterns

Each year when the payment is increased, the plan charge will be increased according to the inflation rate.

Yearly-rated payment pattern

The plan charge will remain unchanged when the payment is increased each year.

With cover growth

All payment patterns, except Yearly-rated

Each year when the payment is increased, the plan charge will be increased according to the inflation rate.

Yearly-rated payment pattern

The plan charge will remain unchanged when the payment is increased each year.

Payment patterns, initial guarantee periods and optional cover growth

The planholder has a choice between different payment patterns and initial guarantee periods. Optional cover growth with accompanying payment growth may be added to a plan. The payment pattern, initial guarantee period and cover growth percentage are selected per plan and will apply to all the benefits on the plan.

If the payments are made as set out in the plan overview, we will not increase the payments during a guarantee period, other than through contractual payment growth.

Available payment patterns and initial guarantee periods

Product option	Payment pattern*	Initial guarantee period**
Topcover products		
Express	<ul style="list-style-type: none"> • Level • Fixed compulsory 5% • Age-related 	5 years
Classic	<ul style="list-style-type: none"> • Level • Fixed compulsory 5% • Age-related • Aggressive age-related 	5 to 10 years
Premier	<ul style="list-style-type: none"> • Level • Stepped • Fixed compulsory 5% • Fixed compulsory 7% • Age-related • Aggressive age-related • Yearly-rated**** 	<ul style="list-style-type: none"> • Fixed compulsory 7%: Whole life*** • Stepped: 10, 15, 20 or 25 years • Yearly-rated: 1 year • All other payment patterns: 5 to 15 years
Termcover products****		
Premier	<ul style="list-style-type: none"> • Level • Fixed compulsory 5% 	5 to 25 years
Income protector products		
Premier	<ul style="list-style-type: none"> • Level • Fixed compulsory 5% • Age-related 	5 years

*The minimum benefit start age for the Fixed compulsory 5% and Fixed compulsory 7% payment patterns is 30 next birthday. This age limitation does, however, not apply to the Funeral Expenses (FSC3) and Child: Illness and injury (TSK) benefits.

**The maximum initial guarantee period that may be chosen for a plan with any of the following benefits is 10 years. (If the planholder wants to take other benefits in combination with any of these benefits and he/she requires an initial guarantee period of longer than 10 years for these other benefits, the other benefits must be taken on a separate plan.):

- Funeral Expenses
- Child: Illness and injury
- Disability and impairment benefits, but only if the benefit is selected with whole life cover:
 - Comprehensive Disability
 - Comprehensive Disability Plus
 - Elite Disability
 - Comprehensive Impairment
 - Accidental Comprehensive Disability
 - Accidental Comprehensive Disability Plus
 - Accidental Elite Disability
 - Accidental Comprehensive Impairment.

We have various benefits available under the Classic and Premier product options for HIV positive lives, subject to underwriting guidelines. The initial guarantee period for some of these benefits will be limited to 5 years. If the planholder wants to take other benefits in combination with any of these benefits and he/she requires an initial guarantee period of longer than 5 years for these other benefits, the other benefits must be taken on a separate plan. Refer to the *Overview of Classic and Premier* chapter for more information.

***For Fixed compulsory 7% with the whole life guarantee, the payment for a benefit is guaranteed not to increase up to the end of a benefit, other than through contractual payment growth.

****Because the benefit cease age for a Child: Illness and injury benefit is 20 next birthday, the term until the benefit cease age becomes less than 5 years if the inception age of the life insured is older than 15 next birthday. If this benefit is the only benefit on a plan, the term of the plan will therefore also be less than 5 years. The Yearly-rated payment pattern will then be the only available payment pattern for the plan, as this is the only payment pattern with a guarantee period of less than 5 years.

*****For Termcover products the term of a plan will be the same as the selected initial guarantee period.

Working of the different payment patterns

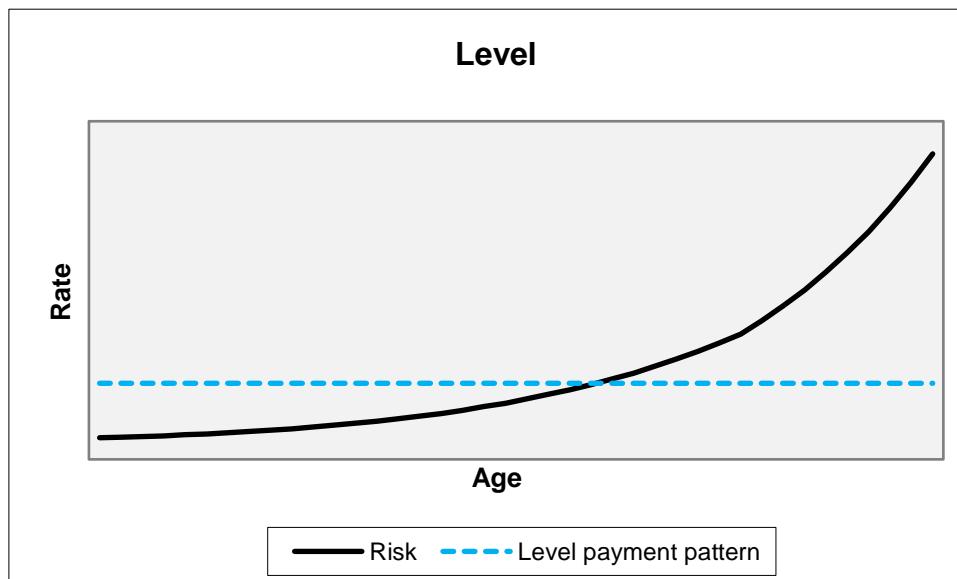
Level

With the Level payment pattern the payments for a benefit will remain the same for a **level amount of cover** until the end of a guarantee period.

Optional cover growth may be added to a plan. Whenever the cover amount of a benefit is increased, the payment for the benefit will be increased at the same time with the amount needed to pay for this additional amount of cover. Thereafter the payments for this additional amount of cover will remain the same until the end of a guarantee period.

When the payment of another benefit is increased, the payment for a waiver of payment benefit, if any, will also be increased.

Payments are initially more than the cost of the underlying risk but become less later on, as indicated in the graph below.



Stepped

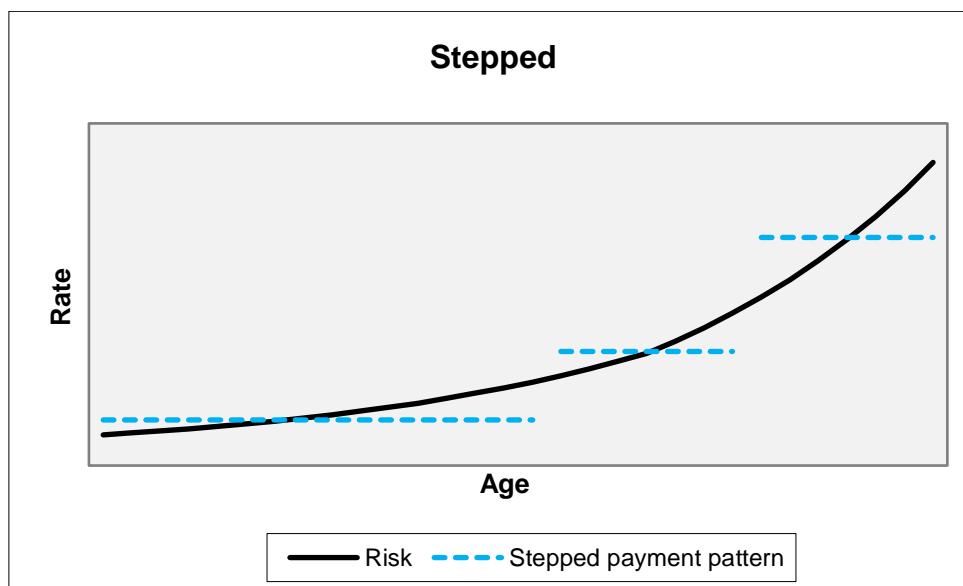
With the stepped payment pattern the plan provides cover for as long as a benefit allows, but a **level amount of cover** is initially priced for a guarantee period of 10, 15, 20 or 25 years, according to the choice of the planholder. At the end of this period, the plan is automatically extended for a new guarantee period and the payment will be recalculated for this next period. We will then increase the payment because a life insured will be older at that time. We may also adjust the payment to reflect, if applicable, changes in our assumptions of claims and other factors.

The insurability of the life insured is guaranteed for the full duration of the contract and no underwriting or intervention by the planholder is required at the end of a guarantee period.

Optional cover growth may be added to a plan. Whenever the cover amount of a benefit is increased, the payment for the benefit will be increased at the same time with the amount needed to pay for this additional amount of cover. Thereafter the payment for this additional amount of cover will remain the same until the end of a guarantee period.

When the payment of another benefit is increased, the payment for a waiver of payment benefits, if any, will also be increased.

During a guarantee period, the payments are initially more than the cost of the underlying risk and less later, as indicated in the graph below.



Fixed compulsory growth

A fixed compulsory payment pattern offers a cheaper initial payment for a level amount of cover than the level payment pattern, but gets more expensive over time.

With the Fixed compulsory 5% payment pattern the payments for a benefit will be increased by 5% per year **for a level amount of cover** until the end of a guarantee period.

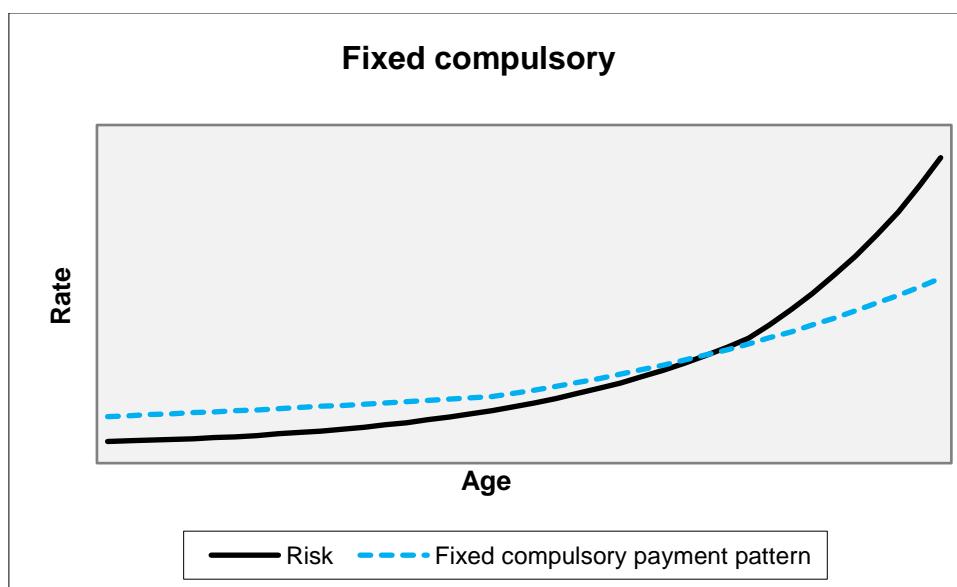
With the Fixed compulsory 7% payment pattern the payments for a benefit will be increased by 7% per year **for a level amount of cover**. As a whole life guarantee applies for this payment pattern, no other increases will be made.

The payment growth is compulsory to maintain the contractual cover amount of a benefit. If the payment growth is cancelled, skipped or lowered, the cover amount of a benefit will be reduced.

Optional cover growth may be added to a plan. Whenever the cover amount of a benefit is increased, the payment will be increased at the same time with the amount needed to pay for this additional amount of cover. Thereafter the payment for this additional amount of cover will continue to increase with the fixed percentage as described above.

When the payment of another benefit is increased, the payment for a waiver of payment benefit, if any, will also be increased.

Payments are initially more than the cost of the underlying risk, and less later. The increasing payments roughly imitate the risk curve as indicated in the graph below.



Age-related and Aggressive Age-related

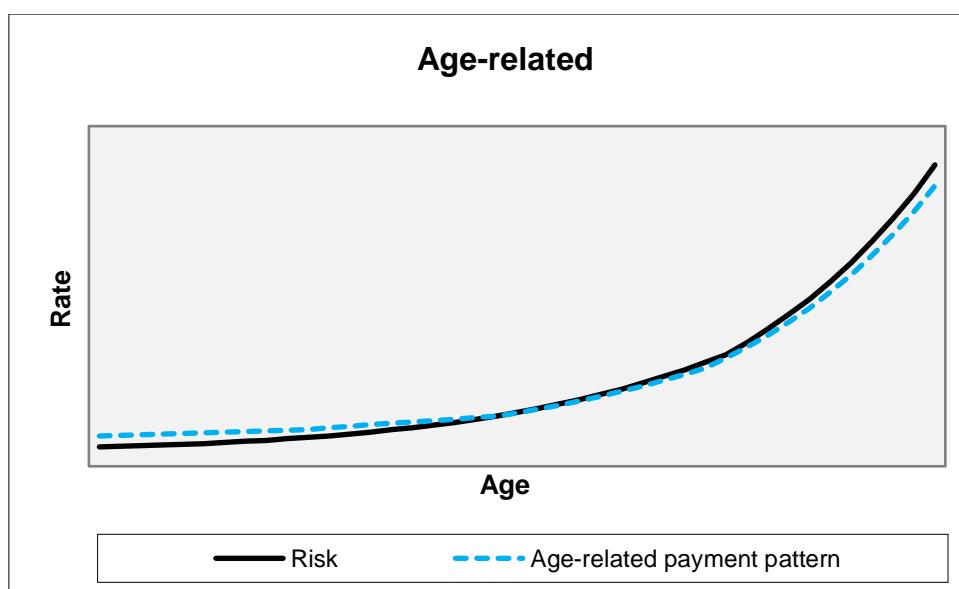
Like fixed compulsory growth, an age-related compulsory payment pattern offers a cheaper initial payment for a level amount of cover than the level payment pattern, and also gets more expensive over time. The compulsory yearly payment increases required to **Maintain a level amount of cover** are predetermined for the duration of the plan and the percentage for a specific increase will depend on the age of a life insured at the time of the increase.

The payment growth is compulsory to maintain the contractual cover amount of a benefit. If the payment growth is cancelled, skipped or lowered, the cover amount of a benefit will be reduced.

Optional cover growth may be added to a plan. Whenever the cover amount of a benefit is increased, the payment will be increased at the same time with the amount needed to pay for this additional amount of cover. Thereafter the payment for this additional amount of cover will continue to increase with the predetermined percentages as described above.

When the payment of another benefit is increased, the payment for a waiver of payment benefit, if any, will also be increased.

The increasing payments follow the risk curve closely as indicated in the graph below.



Age-related and Aggressive Age-related payment patterns: Payment growth for Topcover products

Plan anniversary before or on a life insured's indicated birthday	Topcover products	
	Age-related payment pattern	Aggressive age-related payment pattern
up to 25	0	3
26 to 28	1	3
29 to 30	2	4
31 to 32	3	5
33 to 34	3	6
35 to 36	4	7
37 to 38	5	8
39 to 40	5	9
41 to 43	6	10
44 to 47	7	10
48 to 55	8	10
56 to 60	9	10
61 and older	10	10

Age-related payment pattern: Payment growth for Income protector products

Plan anniversary before or on a life insured's indicated birthday	Income protector products	
	Age-related payment pattern	Yearly payment growth % for a level cover amount
up to 29		4
30 to 34		5
35 to 39		6
40 to 44		7
45 to 56		8
57		6
58		4
59		2
60 and older		0

Yearly-rated

For this payment pattern the payment for a benefit will be recalculated on each plan anniversary, using our payment rates for new business and the age of a life insured at the time. Our payment rates for new business may change in future and can be higher or lower than on the effective date. This recalculation of the payment is compulsory to **maintain a level amount of cover**. If the planholder requests us to continue with the payment as before the increase, the cover amount of a benefit will be reduced.

Optional cover growth may be added to a plan. Whenever the cover amount of a benefit is increased, the payment will be increased at the same time with the amount needed to pay for this additional amount of cover. Thereafter the payments for this additional amount of cover will continue to increase as described above.

When the payment of another benefit is increased, the payment for a waiver of payment benefit, if any, will also be increased.

Cover growth

Optional cover growth with accompanying payment growth may be added to a plan.

Optional cover growth choices

The cover growth choices are indicated in the table below. Payment growth is not specified upfront for cover growth, and the increase in payment required to pay for an increase in cover will be determined when the cover growth takes place. These payment increases will be in addition to any compulsory payment increases on the plan (according to the selected payment pattern), as discussed under "Working of the different payment patterns" in the previous section.

Payment pattern	Optional cover growth (Payment growth is NOT specified upfront)
Topcover products	
Express product option	
Level, Fixed compulsory 5% and Age-related*	3.5% per year 5% per year According to the inflation rate**
Classic product option	
Level, Fixed compulsory 5%, Age-related and Aggressive age-related*	3.5% per year 5% per year According to the inflation rate**
Premier product option	
Level, Stepped and Yearly-rated	3.5% per year (the 3.5% cover growth choice is NOT available for Stepped or Yearly-rated) 5% per year 10% per year According to the inflation rate** According to the change in the rand/US dollar exchange rate over the plan year*** According to the change in the rand/pound sterling exchange rate over the plan year*** According to the change in the rand/euro exchange rate over the plan year***
Fixed compulsory 5%, Fixed compulsory 7%, Age-related and Aggressive age-related*	3.5% per year 5% per year According to the inflation rate**
Term cover products	
Premier product option	
Level	5% per year 10% per year According to the inflation rate** According to the change in the rand/US dollar exchange rate over the plan year*** According to the change in the rand/pound sterling exchange rate over the plan year*** According to the change in the rand/euro exchange rate over the plan year***
Fixed compulsory 5%*	3.5% per year 5% per year According to the inflation rate**
Income protector products	
Premier product options	
Level, Fixed compulsory 5% and Age-related*	5% per year According to the inflation rate**

*The minimum benefit start age for the Fixed compulsory 5% and Fixed compulsory 7% payment patterns is 30 next birthday.

**Cover growth according to the inflation rate: When we determine the inflation rate, we will take into account the change in the South African consumer price index, or any other commonly accepted method of measuring South African inflation that may apply at the time. The inflation rate used will not be less than 0%, and not more than 15%. We may change this minimum and maximum from time to time.

***Cover growth according to exchange rate movements: The minimum increase in the cover amount each year will be equal to the change in the South African consumer price index, or any other commonly accepted method of measuring South African inflation that may apply at the time, and the maximum will be 35% in South African monetary terms. We may change this maximum from time to time. If we admit a claim to waive payments under our waiver of payment benefits, the cover amount will not continue to be increased according to the change in the rand/US dollar/pound sterling/euro exchange rate over the plan year. Instead, the cover amount will be increased according to the change in the South African consumer price index, or any other commonly accepted method of measuring South African inflation that may apply at the time. The minimum increase each year will be 0%, and the maximum 15%. We may change this minimum and maximum from time to time.

Cover growth on Level and Stepped payment patterns

The cover amount of a benefit will be increased as indicated under "Optional cover growth choices" on each plan anniversary, according to the choice made by the planholder.

The payment will be increased at the same time. The payment increase will depend on the increase in the cover amount of a benefit and the age of a life insured at the time of the cover increase. As a life insured grows older, the payment increase will grow gradually.

The yearly cover growth is optional and may be cancelled without affecting the cover amount of a benefit or the payment at that time. The yearly cover growth for any year may also be skipped, resulting in no increase in the cover amount of a benefit and the payment for that year.

Cover growth on Fixed Compulsory 5%, Fixed Compulsory 7%, Age-related and Aggressive age-related payment patterns

The cover amount of a benefit will be increased as indicated under "Optional cover growth choices" on each plan anniversary, according to the choice made by the planholder.

The payment will be increased at the same time. The payment increase will depend on the increase in the cover amount of a benefit and the age of a life insured at the time of the cover increase. As a life insured grows older, the payment increase will grow gradually.

This payment increase is in addition to the compulsory payment growth for the payment pattern.

The yearly cover growth is optional and may be cancelled without affecting the cover amount of a benefit or the payment at that time. The yearly cover growth for any year may also be skipped, resulting in no increase in the cover amount of a benefit and also no additional payment increase for that year.

Cover growth on Yearly-rated payment pattern

The cover amount of a benefit will be increased as indicated under "Optional cover growth choices" on each plan anniversary, according to the choice made by the planholder.

At the same time, the payment will be recalculated because of the increase in the cover amount of a benefit. For this recalculation we will use our payment rates for new business and the age of a life insured at the time of the cover increase. Our payment rates for new business may change in future and can be higher or lower than on the effective date.

This recalculation of the payment is in addition to the compulsory recalculation for the payment pattern.

The yearly cover growth is optional. If the planholder requests us to continue with the payment as before the increase in the cover amount of a benefit, the cover growth will be cancelled.

What happens at the end of a guarantee period?

Not applicable to a Fixed compulsory 7% payment pattern with a whole life guarantee.

Level, Fixed compulsory 5%, Age-related and Aggressive age-related

As the initial guarantee period of a **Term cover product** is for the full term of the plan, the plan will end when the guarantee period ends.

For **other products** the initial payment will be calculated for the full term of the benefits and will be based on our best estimate assumptions of claims and other factors. When a guarantee period ends, a new guarantee period of 5 years will start. At the end of each guarantee period, we will review the payment. We may then adjust it, but only if our assumptions of claims and other factors have changed and not because a life insured is older at that time.

When we review our assumptions, we look at the expected experience relating to claims, investment returns on payment income, the incidence of taxation, the cost of reinsurance, and lapses. We will analyse our actual experience as well as industry experience of these factors for similar plans, the expected impact of future medical advances and practices, and other trends and/or practices that are expected to influence these factors. We will then compare the assumptions applicable at the time of the payment review with those that were previously used and, by reference to that comparison, use a fair and reasonable method of calculating any adjustment to the payment.

The payment may increase at each payment review as a result of the revised assumptions. An adjustment to the payment will not depend on the individual circumstances of a life insured, for example his or her health, at the time of the payment review. If an adjustment is made at the end of the first guarantee period and the payment is increased, the increase in the payment will not be more than the percentage indicated in the table below. This increase applies in addition to any contractual payment growth on the same date. We do not guarantee a maximum increase at the end of subsequent guarantee periods.

Initial guarantee period in years	Maximum % increase in payment
5	20
6	21
7	22
8	23
9	24
10	25
11	26
12	27
13	28
14	29
15	30

Any adjustment to the payment as a result of a review will become effective from the end of a guarantee period. We will notify the planholder in writing at least two months before the adjustment. If the payment increases as a result of a review, the planholder can choose to continue paying the amount before the increase, instead of the increased amount. We will then reduce the cover amount of a benefit proportionally.

Stepped

The initial payment has been calculated for the guarantee period only, and is based on our best estimate assumptions of claims and other factors. When a guarantee period ends, a new guarantee period of 5 years will start. At the end of each guarantee period, we will review the payment. We will then increase the payment because a life insured will be older at that time. We may also adjust the payment to reflect, if applicable, changes in our assumptions of claims and other factors.

When we review our assumptions, we look at the expected experience relating to claims, investment returns on payment income, the incidence of taxation, the cost of reinsurance, and lapses. We will analyse our actual experience as well as industry experience of these factors for similar plans, the expected impact of future medical advances and practices, and other trends and/or practices that are expected to influence these factors. We will then compare the assumptions applicable at the time of the payment review with those that were previously used and, by reference to that comparison, use a fair and reasonable method of calculating any adjustment to the payment.

The increase in the payment will depend on the age of a life insured at the time of the payment review, and not on his or her individual circumstances, for example his or her health. There will be no limit to the increase. This increase applies in addition to any contractual payment growth on the same date.

The increase in the payment as a result of a review will become effective from the end of a guarantee period. We will notify the planholder in writing at least 2 months before the increase. The planholder can choose to continue paying the amount before the increase. We will then reduce the cover amount of a benefit proportionally.

If we admit a waiver of payment claim, we will not increase the payment at the end of a guarantee period because a life insured is older. However, if a waiver of payment claim continues after the end of a guarantee period, we may reduce the cover amount of a benefit instead of increasing the payment.

If the planholder resumes payments after the waiver of payment claim has ended, we will adjust the payment at the end of a future guarantee period only if our assumptions of claims and other factors have changed, and not because a life insured is older at that time.

Yearly-rated

The calculation of the initial payment is based on our best estimate assumptions of claims and other factors. Each year on the plan anniversary we will recalculate the payment using our new business payment rates which will change as our assumptions of claims and other factors change. We may then increase the payment because a life insured will be older at that time. The recalculation of the payment to maintain the contractual cover amount of a benefit is compulsory.

The increase in the payment will depend on the age of a life insured at the time of the payment review, and not on his or her individual circumstances, for example his or her health. There will be no limit to the increase.

General

Contract documents

The plan, which is a contract between the planholder and us, consists of the following documents:

- the quotation
- the planholder's application for the plan, whether separate or included in the planholder's application for the plan
- the declaration form, if applicable
- our acceptance of the planholder's application
- the plan overview
- the accompanying general plan provisions
- the accompanying benefit annexure(s)
- other documents, correspondence and information, if any, that by implication form part of the contract.

The plan overview contains a summary of a plan, while the general plan provisions provide more detail of the plan. Each benefit is described in a separate benefit annexure.

Cooling-off period

Not applicable to re-issues.

If a planholder does not wish to continue with a plan he or she applied for, or with an alteration to a plan that was done at his or her request, the planholder may cancel it by notifying us in writing within 31 days (the cooling-off period) of receiving the contract documents. The planholder must also return the contract documents to us.

We will then refund any payments made for the new plan, or increase in payments made for the alteration. If an alteration was done, we will reinstate the plan to what it was before the alteration. However, the planholder may not cancel an alteration if the cancellation would make a claim possible that would not have been possible before the cancellation.

The cooling-off period also applies to the replacement of existing insurance with us or other insurers.

The planholder cannot borrow against a plan

A plan provides risk benefits only, and as such, provides benefits only for the claim events described in the benefit annexures. The planholder therefore cannot borrow against a plan.

Business insurance

The need, problem and solution, as well as the tax implications and the structure are discussed for each of the business insurance needs below. An example is also included to demonstrate the practical application.

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Business insurance needs

Contingent liability

The need

When a business borrows money from the bank, the bank will require one or more of the owners to sign surety for that loan in their personal capacity. The bank may call up the surety if the business owner is unable to repay the loan as a result of death or permanent disability.

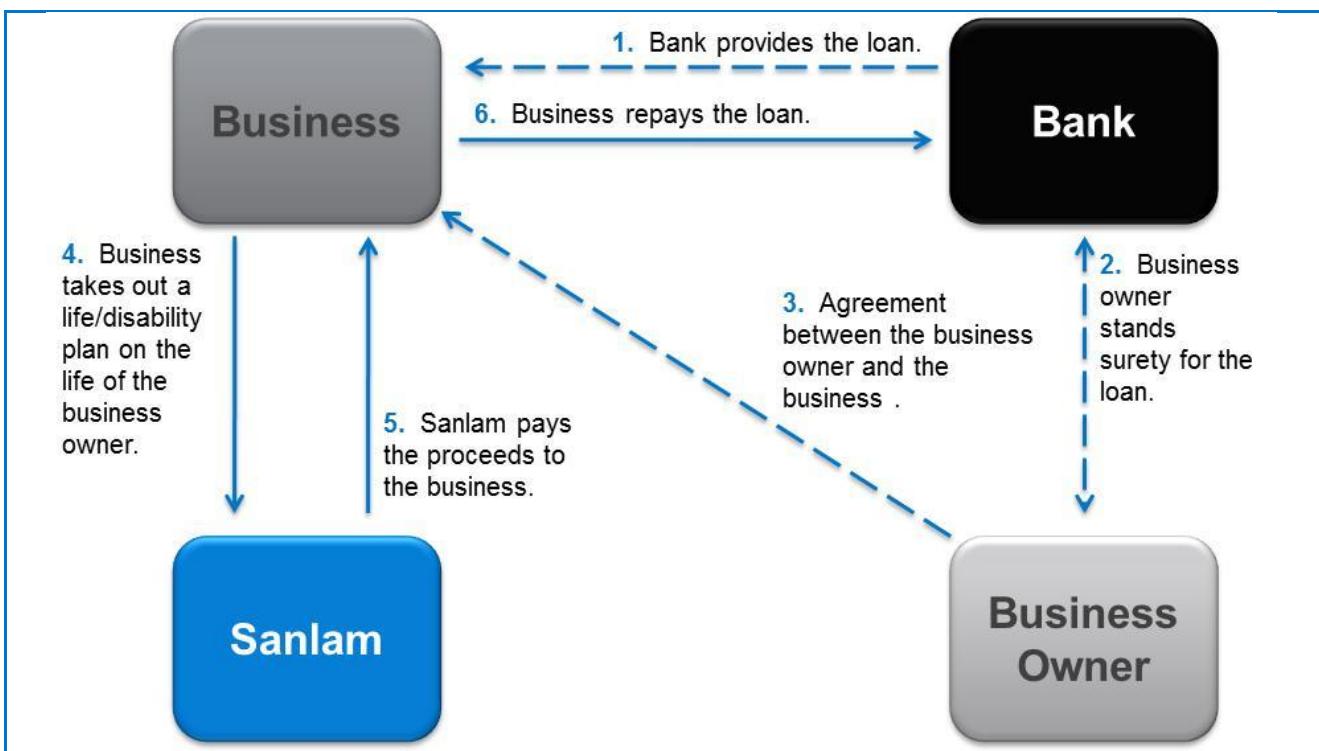
The solution

A contingent liability insurance plan, taken out by the business on the life of the business owner who signed surety, is used to overcome such a dilemma.

The tax implications

Tax implications	
Income tax	<ul style="list-style-type: none">There is no tax deduction for payments made by the business.
Estate duty	<ul style="list-style-type: none">Plans on the life of a deceased, owned by a third party, are deemed to be property in the estate of the deceased (section 3(3)(a) of the Estate Duty Act).Proceeds of a contingent liability plan will not be deemed to be property in the deceased's estate if the requirements of section 3(3)(a)(ii) are met.
Capital gains tax	<ul style="list-style-type: none">A plan ceded as security does not become a second-hand plan.A pure risk plan (with no cash or surrender value) will also not become a second-hand plan if ceded outright to anyone (paragraph 55(1)(e) of the 8th Schedule to the Income Tax Act).

Structure



Example

Move It (Pty) Ltd borrowed R1 million from ABC Bank to fund the purchase of new trucks for their transport business. The three shareholders, John, Jack and Jill, were required to sign surety on behalf of the business.

The business takes out a pure risk plan on the life of each of the shareholders for an amount equal to the value of the debt guaranteed, and enters into an agreement with the shareholders compelling the business to settle the debt with the bank on the death or permanent disability of any of the shareholders.

Credit loan account

The need

The capital structure of a business usually includes a loan, also known as a credit loan, from the business owner. In the event of the owner's death or permanent disability, the business could face financial distress as it may not be in a position to repay the loan.

The solution

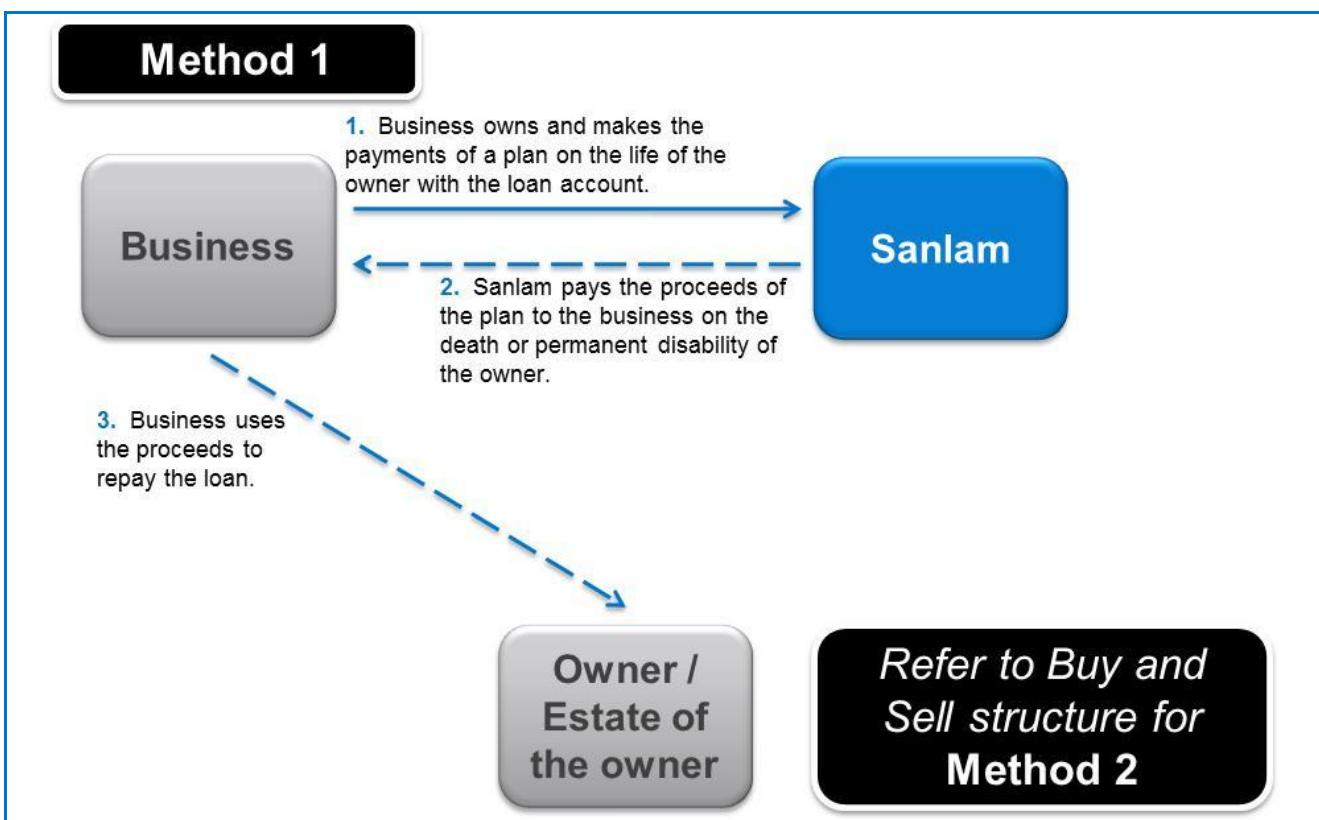
The credit loan can be covered by an insurance plan that includes a death and/or permanent disability benefit. The structure used to cover the loan can either be a plan owned by the business or the loan can be included in the Buy and Sell agreement, resulting in the capital structure of the business being protected.

The tax implications

Tax implications	
Income tax	<ul style="list-style-type: none">There is no tax deduction for payments made.
Estate duty	<ul style="list-style-type: none">Plans on the life of a deceased, owned by a third party, are deemed to be property in the estate of the deceased (section 3(3)(a) of the Estate Duty Act).Proceeds of a company-owned plan will not be deemed to be property in the deceased's estate if the requirements of section 3(3)(a)(ii) are met.Proceeds of a Buy and Sell plan (i.e. where a credit loan is included) will not be deemed to be property in the deceased's estate if the requirements of section 3(3)(a)(iA) are met.
Capital gains tax	<ul style="list-style-type: none">A plan ceded as security does not become a second-hand plan.A pure risk plan (with no cash or surrender value) will also not become a second-hand plan if ceded outright to anyone (paragraph 55(1)(e) of the 8th Schedule to the Income Tax Act).

Structure

"Owner" refers to the business owner and not the planholder.



Example

After 20 years of formal employment, John used the proceeds of his provident fund to start his own business, Move It (Pty) Ltd, a transport business.

To ensure that the business is in a position to repay the start-up capital on John's death or permanent disability, a pure risk plan equal to the total amount owed to John is taken out by the business. John also has the option of including the loan made to the business in a Buy and Sell agreement.

Buy and Sell agreement

The need

The death or permanent disability of a co-owner in the business could jeopardise the existence of the business as the remaining owners may be unable to purchase the deceased owner's equity in the business.

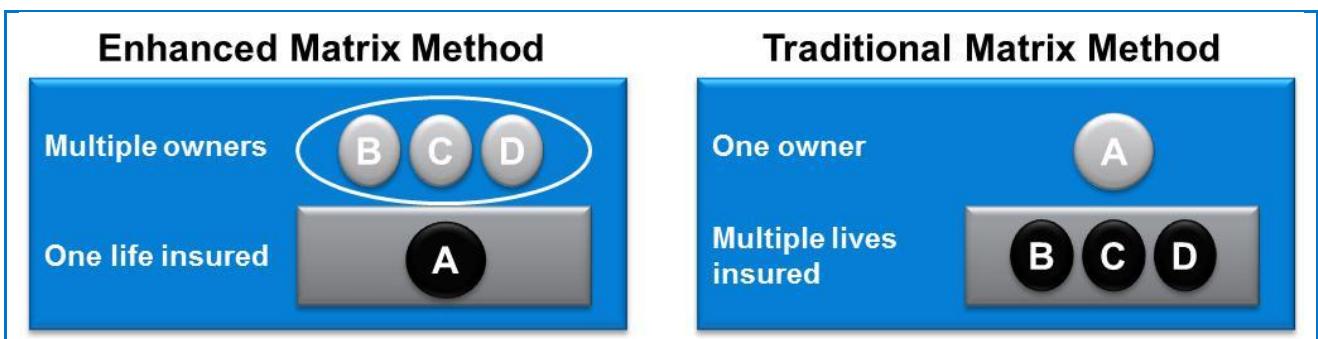
The solution

A Buy and Sell solution presents a smooth exit to a co-owner of a business in the event of death or permanent disability, ensuring continuity of the business. The Buy and Sell arrangement can be structured using the Traditional or Enhanced Matrix Method.

The tax implications

Tax implications	
Income tax	<ul style="list-style-type: none">There is no tax deduction for the payments made by each co-owner of the business.
Estate duty	<ul style="list-style-type: none">Plans on the life of a deceased, owned by a third party, are deemed to be property in the estate of the deceased (section 3(3)(a) of the Estate Duty Act).Proceeds of a Buy and Sell plan will not be deemed to be property in the deceased's estate if the requirements of section 3(3)(a)(iA) are met.
Capital gains tax	<ul style="list-style-type: none">Plans ceded to the respective lives insured will not become second-hand plans by virtue of the exemption as per paragraph 55(1)(c) of the 8th Schedule to the Income Tax Act.A pure risk plan (with no cash or surrender value) will also not become a second-hand plan if ceded outright to anyone (paragraph 55(1)(e) of the 8th Schedule to the Income Tax Act).

Structure



Example

Move It (Pty) Ltd has three shareholders: John, Jack and Jill, with shareholdings of 50%, 30% and 20% respectively. The business is valued at R1 000 000. To ensure continuity in the business the shareholders take out a pure risk plan on the life of each co-owner in proportion to their share of the business as set out in the Buy and Sell agreement. Note: A permanent disability benefit can also be included.

The plan contracts can be structured as indicated in the tables below.

Enhanced Matrix Method (multiple owners, one life insured) ¹			
Contracts	Plan contract 1	Plan contract 2	Plan contract 3
Applicants	Applicants as per Plan Note 1 (John and Jack)	Applicants as per Plan Note 2 (John and Jill)	Applicants as per Plan Note 3 (Jack and Jill)
Life insured	Jill (Cover amount: R200 000)	Jack (Cover amount: R300 000)	John (Cover amount: R500 000)
Percentage ownership of cover amount and payment payable	John: 50/80 x 100 = 63% Jack: 30/80 x 100 = 37%	John: 50/70 x 100 = 71% Jill: 20/70 x 100 = 29%	Jack: 30/50 x 100 = 60% Jill: 20/50 x 100 = 40%

Traditional Matrix method (one owner, multiple lives insured) ¹			
Contracts	Plan contract 1	Plan contract 2	Plan contract 3
Applicants	John	Jack	Jill
Life insured	Jack and Jill	John and Jill	John and Jack
Ownership on each life insured	Jack: R214 286 (50/70 x 300 000) Jill: R125 000 (50/80 x 200 000)	John: R300 000 (30/50 x 500 000) Jill: R75 000 (30/80 x 200 000)	John: R200 000 (20/50 x 500 000) Jack: R85 714 (20/70 x 300 000)

¹ A *Sanlam business insurance calculator* has been developed to calculate the ownership percentage based on the Enhanced Matrix Method and the Traditional Matrix Method respectively. It can be downloaded from the "Tools & Calculators" portal on SanPort.

Key person insurance

The need

The sudden loss of expertise due to death or permanent disability could have a devastating impact on a business in the short to medium term. High replacement costs, in addition to a slowdown in turnover, could further strain the cash flow position of the business.

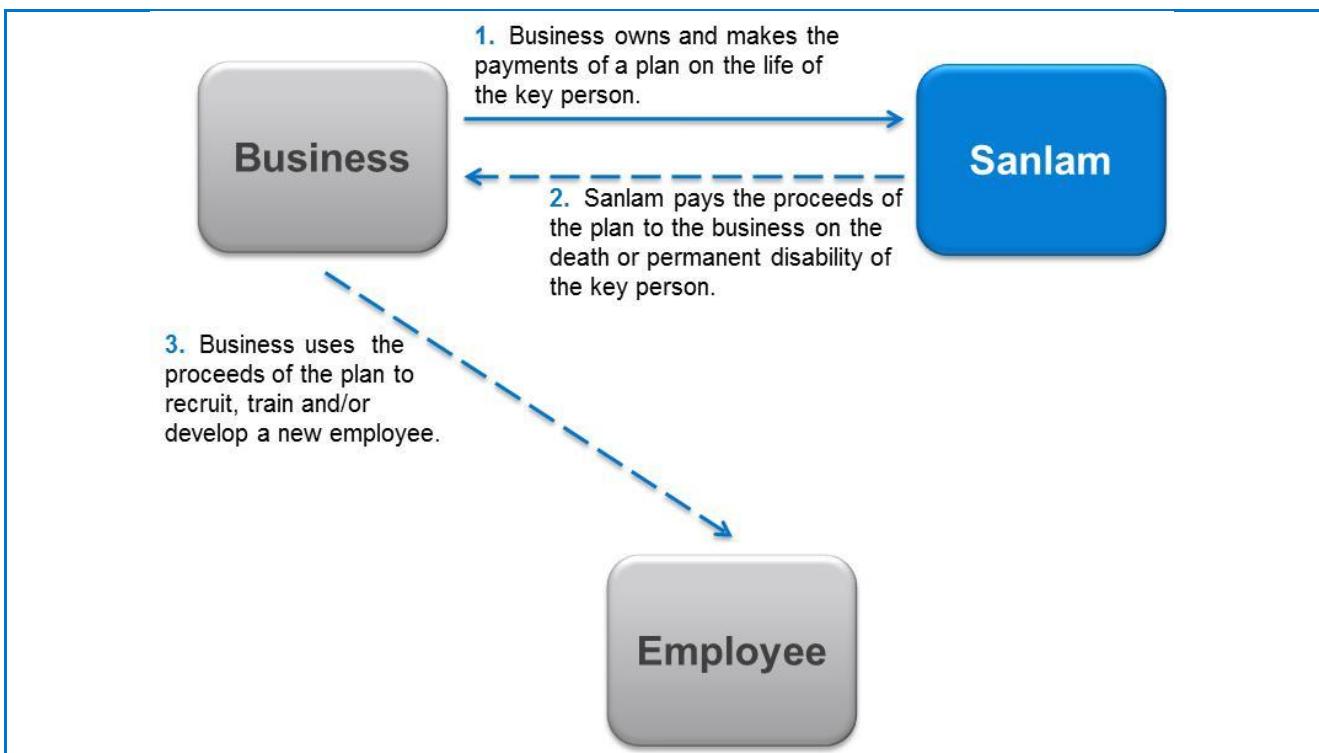
The solution

Key person insurance provides the business with the necessary funds to sustain the business while a suitable replacement is being found.

The tax implications

Tax implications	
Income tax	<ul style="list-style-type: none">Payments – If the requirements of section 11(w)(ii) are met, then the business has a choice regarding the tax deductibility of the payment.Proceeds – If no election was made to comply with the requirements of section 11(w)(ii), then the proceeds of the plan for the business will be exempt from tax in terms of section 10(1)(gh).
Estate duty	<ul style="list-style-type: none">Plans on the life of a deceased, owned by a third party, are deemed to be property in the estate of the deceased (section 3(3)(a) of the Estate Duty Act).Proceeds of a Key person plan will not be deemed to be property in the deceased's estate if the requirements of section 3(3)(a)(ii) are met.
Capital gains tax	<ul style="list-style-type: none">Plans ceded to the respective lives insured will not become second-hand plans by virtue of the exemption as per paragraph 55(1)(b) of the 8th Schedule to the Income Tax Act if deducted in terms of section 11(w).A pure risk plan (with no cash or surrender value) will also not become a second-hand plan if ceded outright to anyone (paragraph 55(1)(e) of the 8th Schedule to the Income Tax Act).

Structure



Example

Matrix Hills (Pty) Ltd is a small wine-making company. John is the winemaker and is considered to be the key person because of his specialist wine-making skill.

The owners of Matrix Hills (Pty) Ltd have therefore insured John as their key person. The proceeds of the insurance will be used to upskill or find a suitable replacement for John on his death or permanent disability. The business also has the option to insure itself against the loss of a key person in a tax-effective manner.

Debit loan account

The need

A business sometimes lends money to its owner, also known as a debit loan. The business therefore faces a risk that the loan may not be repaid on the death or permanent disability of the owner, leading to consequential losses for the remaining owners.

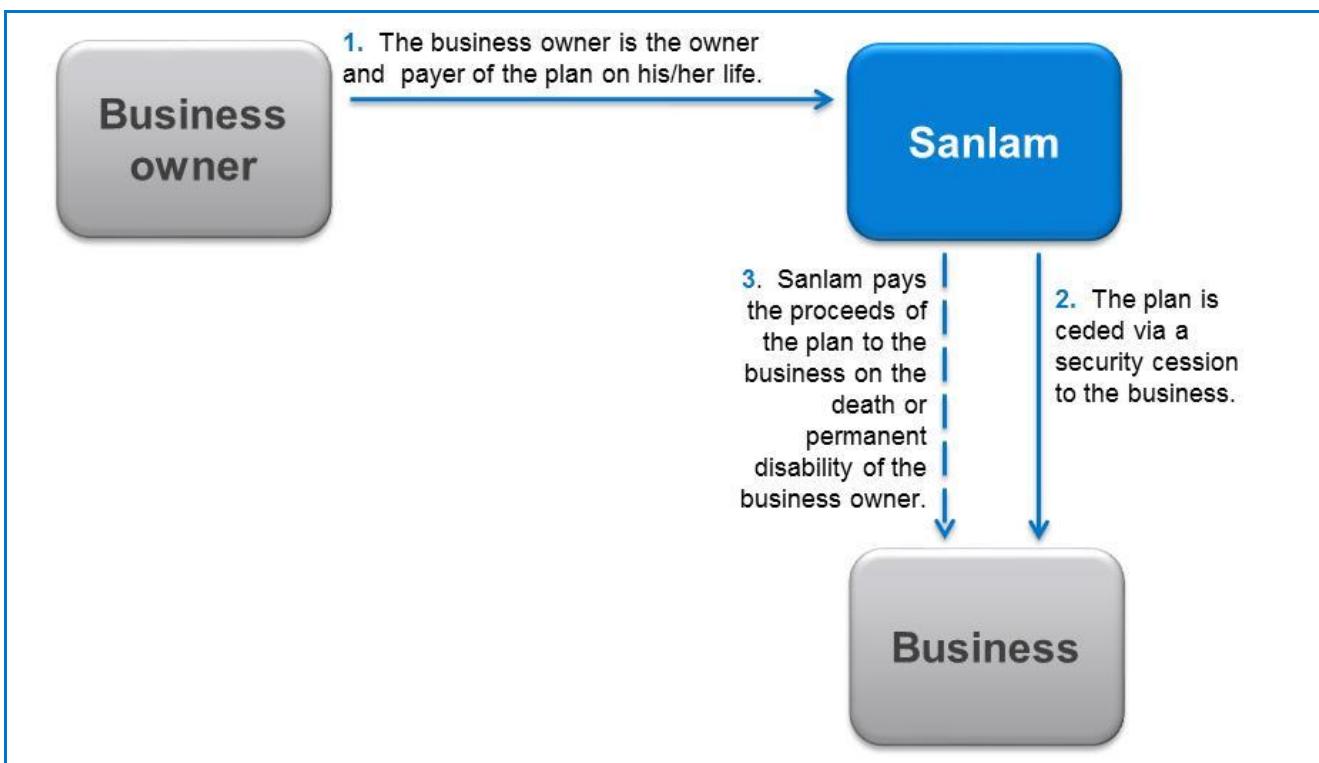
The solution

The debit loan can be covered with an insurance plan that includes a death and/or permanent disability benefit. The business owner is the owner and payer of the plan on his/her life.

The tax implications

Tax implications	
Income tax	<ul style="list-style-type: none">There is no tax deduction for payments made.
Estate duty	<ul style="list-style-type: none">Plans on the life of a deceased, owned by the deceased but for the benefit of a third party, are deemed to be property in the estate of the deceased (section 3(3)(a) of the Estate Duty Act).
Capital gains tax	<ul style="list-style-type: none">There are no CGT implications.

Structure



Example

Business owner John needed to build a wall around his personal property to ensure the safety of his family. As he did not have the means to fund it himself, he borrowed R100 000 from the business.

To ensure that he can repay the business the outstanding debt on his death or permanent disability, he effects a plan on his life equal to the outstanding amount and cedes it via a security cession to the business. Should John die or become permanently disabled, the outstanding debt will be settled.

Business overhead protection

Lump sum payment

The need

The unexpected death of the business owner or one of its co-owners may temporarily affect the business and its cash flow position to such an extent that the business may not be in a position to pay its overheads.

The solution

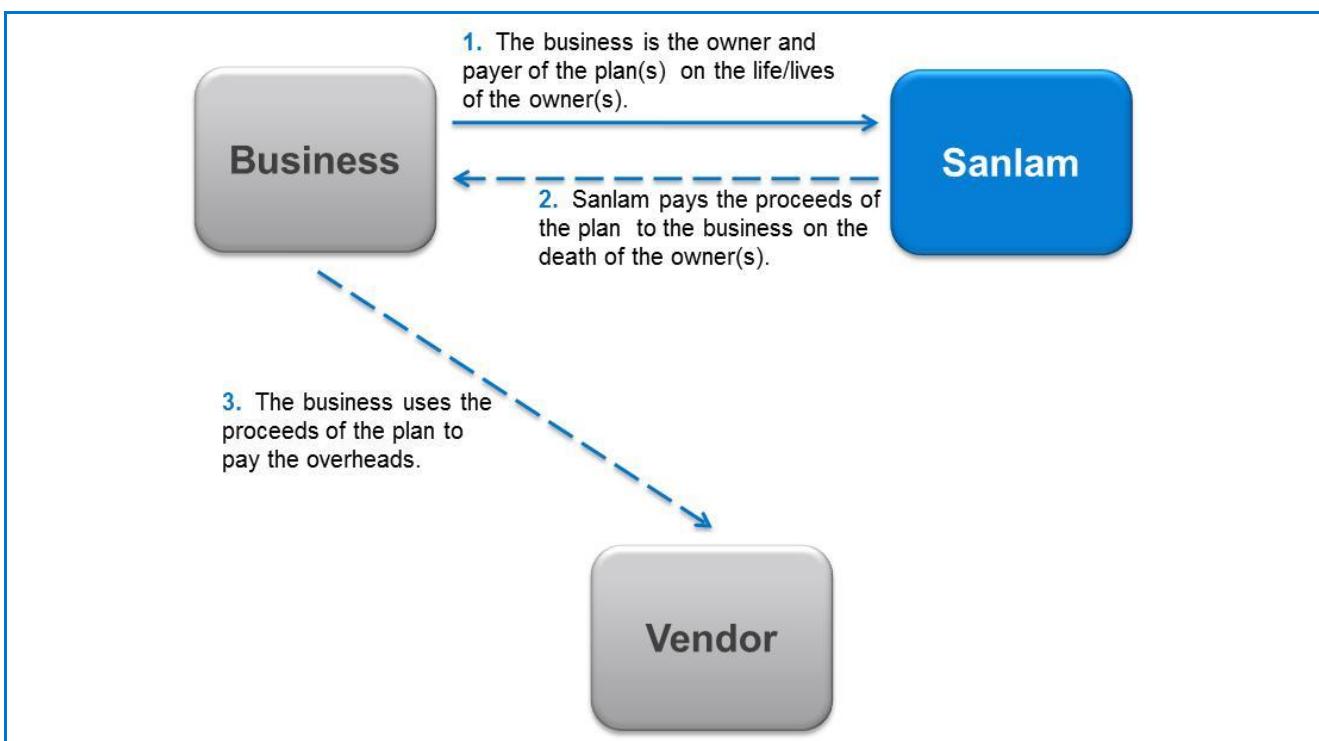
A lump sum business overhead protection benefit provides the business with the necessary funds to satisfy its business overhead commitments after the unexpected death of a business owner.

The tax implications

Tax implications	
Income tax	<ul style="list-style-type: none">Payments – If the requirements of section 11(w)(ii) are met, then the business has a choice regarding the tax deductibility of the payment.Proceeds – If no election was made to comply with the requirements of section 11(w)(ii), then the proceeds of the plan for the business will be exempt from tax in terms of section 10(1)(gh).
Estate duty	<ul style="list-style-type: none">Plans on the life of a deceased, owned by a third party, are deemed to be property in the estate of the deceased (section 3(3)(a) of the Estate Duty Act).Proceeds of a business overhead protection plan will not be deemed to be property in the deceased's estate if the requirements of section 3(3)(a)(ii) are met.
Capital gains tax	<ul style="list-style-type: none">Plans ceded to the respective lives insured will not become second-hand plans by virtue of the exemption as per paragraph 55(1)(b) of the 8th Schedule to the Income Tax Act if deducted in terms of section 11(w).A pure risk plan (with no cash or surrender value) will also not become a second-hand plan if ceded outright to anyone (paragraph 55(1)(e) of the 8th Schedule to the Income Tax Act).

Structure

"Owner" refers to the business owner and not the planholder.



Example

Move It (Pty) Ltd has signed various long-term business overhead commitments (e.g. lease of their business premises). The co-owners of Move It (Pty) Ltd were concerned that their long-term business overhead commitments would not be covered in the event of the death of one or more of the co-owners, as they signed jointly and severally.

To prevent this, Move It (Pty) Ltd insures the lives of the co-owners for an amount equal to the total long-term business overhead commitments, giving them peace of mind should a co-owner die. The business also has the option to insure itself against the loss of contributions towards business overhead commitments in a tax-effective manner.

Replacement of income at death

Lump sum payment

The need

The unexpected death of a business owner, who may also be the breadwinner in the family, could seriously expose his/her family to financial distress, forcing the family to adjust their lifestyle.

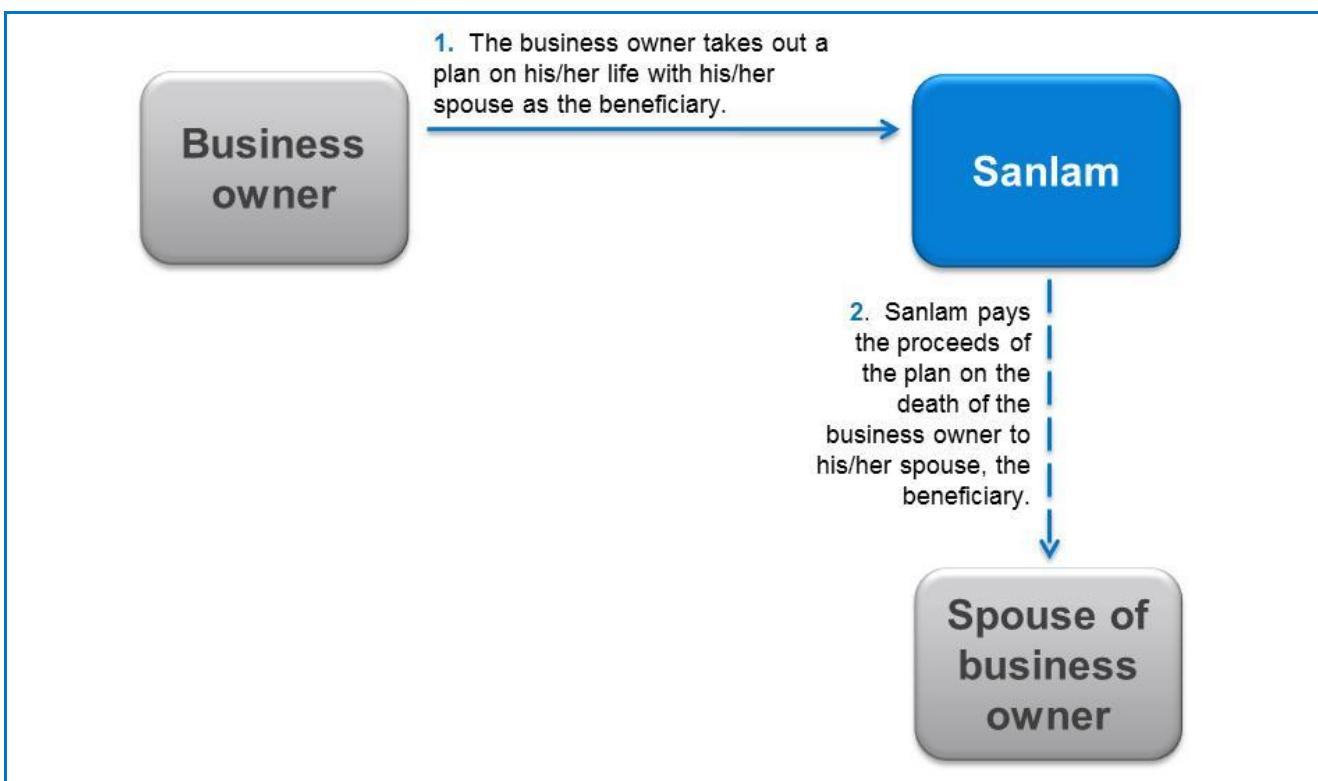
The solution

Replacing the business owner's income with a lump sum benefit on death will minimise the financial impact on the family, allowing them to maintain the lifestyle they were used to before the breadwinner died.

The tax implications

Tax implications	
Income tax	<ul style="list-style-type: none">There is no tax deduction for payments made.
Estate duty	<ul style="list-style-type: none">There are no estate duty implications if the spouse is the beneficiary on the plan.
Capital gains tax	<ul style="list-style-type: none">There are no CGT implications.

Structure



Example

John, the owner of a small business, was concerned that the business would close down or that his family would not be able to harvest the true value of the business on his death.

To avoid the financial shock for his family should he die, John effects a plan on his life to replace the income he drew from the business. This is achieved by capitalising his existing income and funding it with life insurance. On John's death the capital amount will provide the family with an income.

Overhead Expenses benefit

Monthly payment

The need

An unexpected illness or accident involving the business owner or its co-owners could temporarily impact the business and its cash flow position to such an extent that the business may not be in a position to pay its monthly business overheads.

The solution

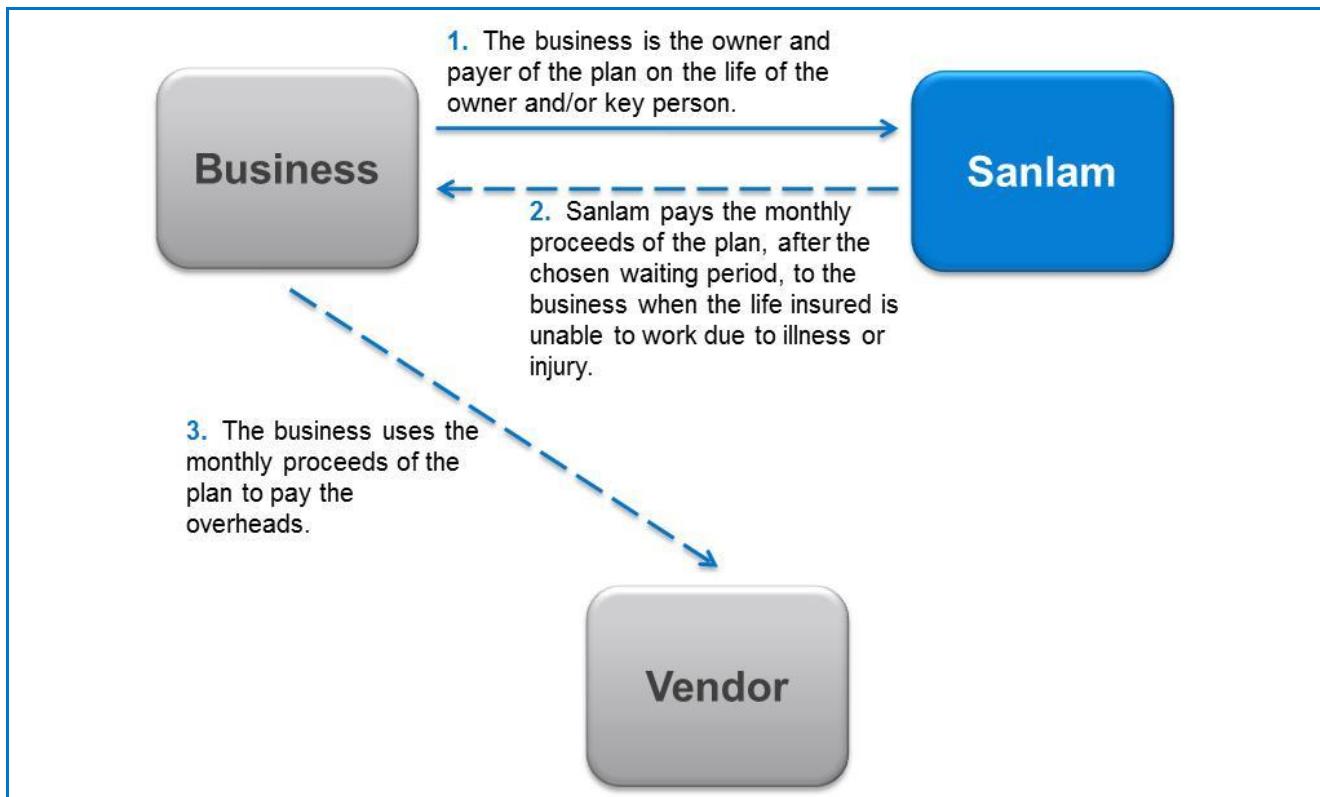
An Overhead Expenses benefit provides the business owner(s) with limited monthly payments, based on their contribution towards turnover, to meet their business overhead commitments while the business owner(s) or a key member of their staff is temporarily unable to contribute to the funding of the running costs of the business.

The tax implications

Tax implications	
Income tax	<ul style="list-style-type: none">Payments – If the requirements of section 11(w)(ii) are met, then the business has a choice regarding the tax deductibility of the payment.Proceeds – If no election was made to comply with the requirements of section 11(w)(ii), then the proceeds of the plan for the business will be exempt from tax in terms of section 10(1)(gH).
Estate duty	<ul style="list-style-type: none">Not applicable.
Capital gains tax	<ul style="list-style-type: none">Not applicable.

Structure

"Owner" refers to the business owner and not the planholder.



Business overhead expenses	
Include the following	Exclude the following
<ul style="list-style-type: none"> • Rent for the business premises • Water, electricity, telephone • Regular maintenance services • Property taxes and mortgage interest for the business premises • Equipment leasing costs • Insurance payments • Accounting fees • Salaries of employees • Other normal and necessary expenses 	<ul style="list-style-type: none"> • Depreciation • Cost of goods or merchandise or additions to inventory • Cost of furniture or equipment • Capital payments on outstanding debt • Expenditure on assets • Fees on current accounts • Expenses that are remunerable under any other disability insurance • Business rationalisation costs, e.g. retrenchment • Any remuneration or other consideration to the life insured, the planholder, associates in the affected business, and any other person who shares directly or indirectly in the profit of the affected business.

Example

The business was concerned that it would not be able to cover the business overheads of its small to medium enterprise should John be unable to work due to illness or injury.

To ensure that its valued employees and creditors would not be disadvantaged financially as a result of John's temporary absence from the business, the business insures his life with Sanlam's Overhead Expenses benefit. This benefit gives the business peace of mind when the life insured is forced out of the daily running of the business by illness or injury, allowing the life insured to fully focus on the rehabilitation process without having to worry about ongoing administrative expenses of the business. The business also has the option to insure the other key person(s) in his business with this benefit.

Sickness benefit for Key person insurance

Monthly payment

The need

The ongoing administrative expense of a professional practice is a function of the income generated by the professional. The absence of the professional would therefore put strain on the cash flow and running costs of the practice.

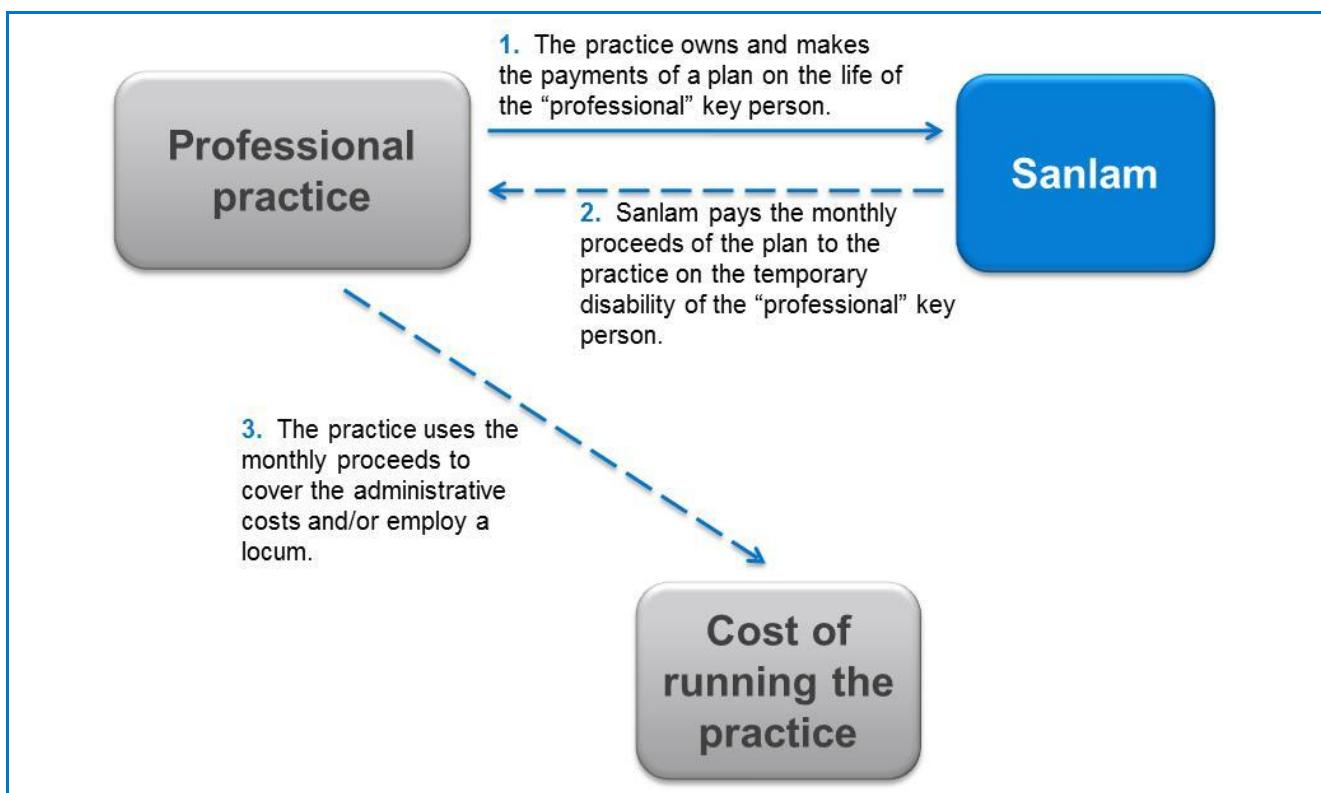
The solution

The Sickness benefit for Key person insurance partially protects the income of the practice should a professional key person be temporarily unable to work due to sickness or injury.

The tax implications

Tax implications	
Income tax	<ul style="list-style-type: none">Payments – If the requirements of section 11(w)(ii) are met, then the business has a choice regarding the tax deductibility of the payment.Proceeds – If no election was made to comply with the requirements of section 11(w)(ii), then the proceeds of the plan for the business will be exempt from tax in terms of section 10(1)(gh).
Estate duty	<ul style="list-style-type: none">Not applicable
Capital gains tax	<ul style="list-style-type: none">Not applicable

Structure



Example

Jabo is a qualified doctor and a member of an incorporated practice. He makes a significant contribution to the funding of the running costs and profit of the practice.

To ensure that the incorporated practice is not out of pocket when Jabo is temporarily unable to fulfil his duties due to sickness or injury, the practice insured his life for the Sliding scale percentage* of his contribution to the income generated by the practice.

*Refer to the *Underwriting for Classic and Premier* chapter for the Sliding scale percentage.

Calculating the cover required where estate duty and/or income tax is applicable

If the proceeds of the plan are subject to estate duty and/or income tax, then the cover amount must be increased to provide for the estate duty and/or income tax payable. The formulae indicated in the table below can be used to calculate the cover amount required.

Cover required		
	For estate duty ¹ only	For income tax ² only
Step 1	<u>Initial cover required</u> 1 - Estate duty rate	<u>Initial cover required</u> 1 - Income tax rate
Step 2	<u>100 000</u> 1 - 0.20	<u>100 000</u> 1 - 0.28
Cover required	R125 000	R138 889

Cover required for estate duty ¹ and income tax ²		
	The long method	The short method
Step 1	<u>Initial cover required</u> 1 - Estate duty rate	<u>Initial cover required</u> 0.576
Step 2	<u>100 000 = R125 000</u> 1 - 0.20	<u>100 000</u> 0.576
Step 3	<u>Adjusted cover</u> 1 - Income tax rate	
Step 4	<u>125 000</u> 1 - 0.28	
Cover required	R173 611	R173 611

The formula for "Cover required for estate duty¹ and income tax²" takes into account the fact that, in practice, SARS allows the estate duty attracted by the plan as a deduction against the proceeds before income tax is levied.

¹ Estate duty is levied on the dutiable value of an estate at a rate of 20% on the first R30 million and at a rate of 25% on the amount above R30 million..

For this example an estate duty rate of 20% is assumed . It is also assumed that the estate duty exemption has been utilised in full.

² It is assumed that the employer tax rate is 28%.

1-2-3 of Business

The 1-2-3 of Business is a web-based analysis instrument for the financial intermediary specialising in business insurance. It is a system by which business insurance needs are identified, quantified and prioritised using the unique Allegiance Risk Type Classification™ (ARTC™) system. The analysis instrument addresses the following business insurance needs:

- ARTC™ 1 – Contingent liability
- ARTC™ 2 – Credit loan account
- ARTC™ 3 – Buy and Sell
- ARTC™ 4 – Key person insurance
- ARTC™ 5 – Debit loan account
- ARTC™ 6 – Business overhead protection (lump sum payment)
- ARTC™ 7 – Replacement of income (lump sum payment)

The 1-2-3 of Business process

- Gather the relevant information using the *1-2-3 of Business questionnaire*. This questionnaire can be downloaded from SanPort or the 1-2-3 of Business website.
- Populate the 1-2-3 of Business with the information gathered:
 - **Option 1 – Assistance Required**
 - Forward the completed questionnaire to Sanlam Legal Consultants.
 - **Option 2 – Self-Service**
 - Access the 1-2-3 of Business analysis tool on SanPort via the Secure Access Portal.
- The analysis tool generates a 1-2-3 of Business Report. The intermediary has the option of requesting a comprehensive, short or customised report.

Allegiance Risk Type Classification™ (ARTC™)

Prioritising the business insurance needs using the ARTC™

A number of risks are attached to the owners and other persons that could have a serious impact on the future wealth of the owners and the sustainability of the business. It is important to understand that the risks vary in impact and to the respective stakeholders.

The financial planning risks that face a business owner are classified in terms of Sanlam's unique Allegiance Risk Type Classification™ (ARTC™).

Allegiance Risk Type Classification™						
Allegiance Risk Type Classification	Business insurance solution	Impact on			Priority group	
		Business	Affected owner	Remaining owners		
ARTC™ 1	Third party creditor risk	Contingent liability	High	High	High	1
ARTC™ 2	Unrecovered capital risk	Credit loan account solution	High	High	High	1
ARTC™ 3	Unrealised wealth risk	Buy and Sell solution	High	High	High	1
ARTC™ 4	Key person risk	Key person insurance	High	N/A	Medium	2
ARTC™ 5	Debit loan account	Debit loan account solution	Medium	High	Medium	2
ARTC™ 6	Overhead risk	Overhead	High	N/A	Medium	2
ARTC™ 7	Replacement of income (Supplementary to Buy and Sell with single owner)	Income replacement plan	N/A	High	N/A	(2, if applicable)

All business insurance needs should be covered, but we suggest that the needs be addressed in the following priority:

- First cover the third party creditor risk (ARTC™ 1) - Contingent liability.
- Secondly, cover the unrecovered capital risk (ARTC™ 2) - Credit loan account.
- Thirdly, cover the unrealised wealth risk (ARTC™ 3) - Buy and Sell arrangement.
- Then address Priority Group 2.

The classification of risk is based on the impact of the type of risk on three stakeholders in the business, i.e.

- the business,
- the affected owner and
- the remaining owners.

The "business" as the stakeholder represents the collective interest of the future owners, employees, the suppliers of the business and the clients of the business.

See a detailed account of the risk classification on the next page.

Allegiance Risk Type Classification™					
Risk	Subject of the risk	Risk relevant to the applicable owner/person	Remaining owner	Business	Solution
ARTC™ 1 Exposure to 3rd Party Creditors	Suretyship that the owner signed for the business.	The creditor may call up the suretyship, exposing the estate of the owner.	If surety is called up against the estate of the deceased estate, it will result in a claim against the business, ultimately affecting the funding structure of the business.	Long-term and short-term funding structure may be exposed. Third-party creditors may withdraw finance or may increase cost of finance.	This risk can be addressed with a contingent liability solution.
ARTC™ 2 Unrecovered Capital	The capital, time and expertise spent on the business are the subject of this risk.	The loan account may never be recovered.	The risk of having to raise a large amount of capital to repay the loan account.	Capital structure of the business is exposed. Risk of not being able to replace the capital. Business may be sued for the loan account.	This risk can be addressed with a loan account solution.
ARTC™ 3 Unrealised Capital (Wealth)	The equity in the business is the subject of this risk.	The risk that the equity in the business may never be sold.	Risk of having to seek funding to purchase shares or face "foreign" partners.	Risk of foreign partners that may adversely affect the future management of the business.	This risk can be addressed with a Buy and Sell solution.
ARTC™ 4 Key Person	A person with special skills to the business is the subject of this risk.	N/A in business insurance context. The risks facing this person can be identified with an estate and financial plan.	Indirectly the wealth of the remaining owners might be at risk because the business's operations may be exposed as a result of a loss of particular skills.	The business is at risk to suffer a loss if a skilled person is lost to the operations of the business. The loss could be the replacement cost, or a direct loss of sales and profit	Key person insurance is a simple and effective solution to this risk.
ARTC™ 5 Debit Loan Account	The money that the owner borrowed from the business is the subject of this risk.	The loan may not be recovered, and the estate of the owner might be sued in an attempt to recover the loans.	Indirectly – If the business cannot recover the loan, then the owner loses some value.	The business may not be able to recover the capital from the owner.	Insure the owner for the debit loan account .
ARTC™ 6 Overheads Risk	Funds to continue paying overheads in the business is the subject of this risk.	This risk may be very relevant with a single shareholder where the estate of the shareholder may be attacked for severance pay of employees (if the business does not continue after the death of the owner).	Indirectly the remaining owners are stuck with the business and its overheads, while the ability of the business to pay the overheads may be challenged with the loss of a co-owner.	The business is directly affected by the loss of an owner, but will have to continue paying overheads irrespective of its performance.	The overhead benefit creates a buffer for the business enabling the business to continue smooth operations in the event of the death of an owner.
ARTC™ 7 Loss of Income Risk	The income of the affected shareholder is the subject of this risk.	The income that the owner is drawing from the business ceases in the event of death or disability. (very pertinent with single owner businesses).	Not really applicable to the remaining owners.	Not really applicable to the business	This risk can be addressed by capitalising the income need and providing for it in the event of death or disability.

Benefits to satisfy business insurance needs

The benefits which are available for a business insurance need are indicated by the product option(s) in the table below.
 NOTE: The Express product option is currently not available for business insurance.

The benefits which are not listed in this table, are not available for business insurance.

S = Standalone A = Accelerator AB = Additional Benefit C = Classic product option P = Premier product option	Type of benefit	Contingent liability	Credit loan account	Buy and Sell	Key person	Debit loan account	Business overhead protection	Replacement of income
Life cover								
Death (DS)	S	C / P	C / P	C / P	C / P	C / P	C / P	C / P
First death (DS80)	S	C / P						
Accidental death (ASC) ¹	S	C / P	C / P	C / P	C / P	C / P	C / P	C / P
Disability and impairment cover								
Comprehensive Disability (CAR3) (fixed term options only)	A	C / P	C / P	C / P	C / P	C / P	C / P	C / P
Comprehensive Disability Plus (CAR4) (fixed term options only)	A	C / P	C / P		C / P	C / P	C / P	C / P
Accidental Comprehensive Disability (ASO3) (fixed term options only) ¹	S	C / P	C / P	C / P	C / P	C / P	C / P	C / P
Accidental Comprehensive Disability Plus (ASO4) (fixed term options only) ¹	S	C / P	C / P		C / P	C / P	C / P	C / P
Dread disease cover								
Core dread disease (TAC)	A				C / P			
Whole life core dread disease (TAC2)	A				C / P			
Credit Life cover								
Credit Life (DSC)	S	C / P						
Future needs cover								
Future cover: Death (FS1)	S	P	P	P	P	P	P	P
Future cover: Comprehensive (FS2)	S	P	P	P	P	P	P	P
Waiver of payment with future growth at disability (OGG1)	AB	C / P	C / P	C / P	C / P	C / P	C / P	C / P
Waiver of payment without future growth at disability (OPG1)	AB	C / P	C / P	C / P	C / P	C / P	C / P	C / P
Sickness and income/Business overhead protection cover								
Sickness (IS4) and Sickness Income Plus (IS5)	S				P			
Temporary Income (OIT4) and Temporary Income Plus (OIT5)	S				P			
Overhead Expenses (OIB4)	S				P			
Cashback								
Cashback (RS)	AB	P	P	P	P	P	P	P

¹ If uninsurable due to medical reasons (*applicable benefits only available with a special quotation*).

² Please engage your Sanlam legal consultant where this benefit is selected to satisfy a business insurance need (i.e. partial disability benefits).

Financial underwriting for business insurance

Responsibility of Sanlam Individual Life

Sanlam Individual Life must always protect their own interests and the interests of their intermediaries and clients. In order to do this, on behalf of Sanlam Individual Life, the underwriters of Sanlam Individual Life must ensure that:

- the solutions offered to clients by intermediaries comply with regulations, for example PPR and FAIS rules, and
- the insurable interest between an applicant and a life insured is acceptable, and
- a life insured is not over-insured.

Responsibility of intermediary

Intermediaries are responsible to:

- market life insurance products within the stipulations of their contracts with Sanlam Individual Life, and
- comply with regulations, for example Policy protection rules and FAIS rules, and
- do comprehensive needs analyses for clients, and
- offer the best possible solutions to clients.

Ensuring that financial underwriting runs smoothly

To limit the need to request more information and to ensure that financial underwriting runs smoothly, the intermediary must:

- ensure that the reason for insurance is clearly explained in the application documents, and
- attach copies of relevant documentation, such as needs analyses and 1-2-3 of Business documents, letters from banks confirming loan acceptances, audited financial statements, etc., and
- clearly indicate the methods used for calculations.

Valuing the business from an underwriting perspective

Business valuations are very subjective. Applying the "normal" formulae may therefore not always be appropriate. The valuation methods below could be used taking into account the following considerations:

- the industry in which the business operates;
- the period that the business has been in operation;
- the type of business, e.g., service orientated, etc.

Valuation methods	
Company	Net profit after tax on income statement \times 5
Own business/Partnership	[Income of owner(s) + Net profit of business + Depreciation on cash flow statement] \times 10
Alternative method	[Net profit after tax \times 5] + Owner's interest on balance sheet + Shareholder loans \times % of Shareholders' interest

Financial underwriting requirements

A signed and fully completed 1-2-3 of Business could assist underwriters to not always insist on the requirements below, or at least to waive some.

It is important to load all financial statements, etc., on the 1-2-3 of Business portal for underwriters to retrieve when needed.

Contingent liability

External funding in whatever form is a normal part of business and its capital structure. The funding may be in the form of an overdraft facility, a term loan or asset finance. In terms of their credit plans, South African banks and other financiers normally require the owners of a business to sign surety for the external funding acquired from the relevant financial institution.

Covering the liability would therefore ensure that the personal assets of the shareholder and/or director are protected. These liabilities are recorded in the balance sheet of the business.

Contingent liability: Financial underwriting requirements	Cover amount per life insured		
	Up to R8m	R8m - R30m	R30m +
Sanlam application form	✓	✓	✓
Letter from the bank/financial institution	✓	✓	✓
<i>Financial questionnaire for business insurance (form AE4022)</i>		✓	✓
Audited financial statements (Business)			✓

Business loans from corporate banks: Financial underwriting requirements	Cover amount per life insured		
	Up to R8m	R8m - R30m	R30m +
Sanlam application form	✓	✓	✓
Letter from the bank/financial institution	✓	✓	✓
<i>Financial questionnaire for business insurance (form AE4022)</i>		✓	✓
Audited financial statements (Business)			✓
Audited financial statements (Personal)			✓
Copy of loan agreement			✓

Buy and Sell

When a co-owner in a business dies or becomes disabled, the deceased owner's estate can be left severely exposed, but the remaining owners could also face potential problems.

The primary purpose of a Buy and Sell arrangement is to provide the surviving partner(s) with cash to purchase the interest of a deceased or disabled partner. A Buy and Sell solution provides a smooth exit for a partner in the event of death or disability. This agreement ensures continuity of the business in the event of the death or disability of an owner.

Buy and Sell arrangements: Financial underwriting requirements	Value of Business		
	Up to R8m	R8m - R30m	R30m +
Traditional Buy and Sell arrangements			
Sanlam application form	✓	✓	✓
<i>Financial questionnaire for business insurance (form AE4022)</i>		✓	✓
Non-traditional Buy and Sell arrangements (e.g. One-sided/Share Buy-back)			
Sanlam application form	✓	✓	✓
<i>Financial questionnaire for business insurance (form AE4022)</i>		✓	✓
Copy of Buy and Sell agreement signed by all parties	✓	✓	✓
Security cession in favour of the life insured (One-sided Buy and Sell agreement where life insured is 100% owner)	✓	✓	✓

Key person insurance

The ongoing profitability and sustainability and, as a result, the capital value of the business are largely reliant on the input of the key employees in the business. The loss of a key person therefore constitutes a risk for the business.

The purpose of the cover is therefore to protect the business from financial hardship caused by the loss of service through the death or permanent disability of an individual who is vital to that business.

Key person insurance: Financial underwriting requirements	Cover amount per life insured		
	Up to R10m	R10m – R16m	R16m +
Sanlam application form	√	√	√
<i>Key person insurance questionnaire</i> (form AE4037)	√	√	√
Audited financial statements (Business)			√

A signed and fully completed 1-2-3 of Business could assist underwriters to not always insist on above requirements, or at least to waive some.

It is important to load all financial statements, etc., on the 1-2-3 of Business portal for underwriters to retrieve when needed.

Start-up businesses

Obtaining reasonable financial data on start-up businesses is always difficult and, as a result, information obtained that may well be sufficient to justify cover in one case may not be enough in another. Furthermore, the "normal" underwriting formulae used will not always give the underwriter the right answer. Each case should therefore be assessed on its own merits.

The following information will help the underwriter quantify the cover required more accurately:

- pro forma statements
- financial projections
- management accounts of the business
- track record (CV) of the insured
- type of business/market
- copy of loan approval papers, etc.

Sanlam Business Market - Support

Contact details	Contact person	Telephone number	e-mail address
Sanlam Business Market			sme@sanlam.co.za
1-2-3 of Business Support	Support Desk: Legal	086 111 3937	legal.support@santam.co.za
Support Desk: Legal	Aidan van der Berg	086 111 3937	legal.support@santam.co.za

Support material	Contingent liability	Credit loan account	Buy and Sell	Key person	Debit loan account	Business overhead protection	Replacement of income	Financial Fitness Analysis	1-2-3 of Business
	(ARTC™ 1)	(ARTC™ 2)	(ARTC™ 3)	(ARTC™ 4)	(ARTC™ 5)	(ARTC™ 6)	(ARTC™ 7)		
Application form	AEB2076	AEB2076	AEB2116 ¹ AEB2076 ²	AEB2076	AEB2076	AEB2076	AEB2076		
Marketing one-pager	✓	✓	✓	✓	✓	✓	✓	✓	✓
Presentation	✓	✓	✓	✓	✓	✓	✓	✓	✓
Podcast ³	✓		✓	✓					
Questionnaire ⁴								✓	✓

¹ Use this application form for the Enhanced Matrix Method (i.e. multiple owners, one life insured).

² Use this application form for the Traditional Matrix Method (i.e. one owner, multiple lives insured).

³ Podcasts can be downloaded from the 1-2-3 of Business website under the "Downloads" section.

⁴ Questionnaires can be downloaded from SanPort or the 1-2-3 of Business website on www.123ob.co.za

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Why life cover?

No one wants to think about death – especially when you’re young and healthy. But think about what would happen if you were to die unexpectedly. Would your family be able to cope without your income? Would there be enough money to:

- Pay for a funeral?
- Pay executor’s fees, estate duty and other costs involved in the administration of an estate?
- Repay any debts?
- Pay for the daily needs of your dependants?

Our life cover allows you to structure a plan to ensure that your death does not mean financial hardship, or even ruin, for your family.

Availability of benefits

Individual insurance

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

Business insurance

Refer to the *Business insurance* chapter for information about availability of benefits. The Express product option is currently not available for business insurance.

Death (DS)

This benefit is 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	A benefit may be claimed at the death of the life insured. If we admit a claim, we will pay the cover amount set out in the plan overview as a lump sum. The conditions for admittance of a claim are set out in the <i>General information</i> chapter.
Additional features	The following additional features apply: <ul style="list-style-type: none"> • Terminal illness • Immediate life cover • Free cover Terminal illness and Immediate life cover are discussed below for this benefit. Refer to the chapter <i>Payments, payment patterns, guarantees and cover</i> for more information about Free cover.
Type of benefit	Standalone If a Death benefit with whole life cover is taken in combination with a Death benefit with term cover, the two benefits must be taken on separate Topcover and Term cover plans.
When will cover for this benefit end?	Topcover products Cover is provided for whole of life. However, the cover will end earlier: <ul style="list-style-type: none"> • if the plan ends for any reason before the cover end date, or • if we admit a claim. Term cover products Cover will end <ul style="list-style-type: none"> • 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 • if we admit a claim.
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. Individual insurance <p>Minimum: R150 000</p> <p>Maximum:</p> <ul style="list-style-type: none"> • Express product option: R5 000 000* • Classic and Premier product options: None* Business insurance under Classic and Premier product options <p>Minimum: R50 000</p> <p>Maximum: None*</p>

*Subject to financial underwriting.

Age limits	<p>Benefit start age</p> <p>Minimum: • Payment patterns other than fixed compulsory growth:</p> <ul style="list-style-type: none"> • 19 next birthday for the Express product option • 15 next birthday otherwise <p>• Fixed compulsory growth: 30 next birthday</p> <p>Maximum: • 80 next birthday</p> <p>• 60 next birthday for Express</p>
	<p>Benefit cease age</p> <p>At death</p> <p>Under Term cover products the term of a benefit is limited to a maximum of the selected term of the plan.</p>
Qualifying lives	<p>Express product option</p> <p>Only the planholder and his/her spouse may qualify, subject to age limits and underwriting.</p>
	<p>Classic and Premier product options</p> <p>Subject to age limits and underwriting.</p>
Guarantee period	<p>Express product option</p> <p>5 years</p>
	<p>Classic and Premier product options</p> <p>As selected for the plan.</p>

Exclusions

We will not admit a claim if death is caused by suicide, also during insanity, committed before or within 24 months from the cover start date of the benefit or the date the plan has been reinstated after an earlier lapse. If the cover amount is increased, other than through benefit growth, this waiting period will also apply to the increase in the cover amount from the effective date of the increase. The claimant must prove that the life insured did not commit suicide.

Other general exclusions, if applicable, are set out in the applicable overview chapter in this technical guide. Specific exclusions, if any, are set out in the plan overview, in the special provisions for the life insured concerned.

What if the life insured is diagnosed with a terminal illness?

If the life insured is diagnosed with a medical condition that, according to our Chief Medical Officer, will result in death within 12 months, the planholder may apply for an early payment of this benefit. We may then pay an early death benefit. The amount of the early payment will be equal to the cover amount of this benefit set out in the plan overview.

We will also consider a claim for a terminal illness payment if the plan has lapsed and the life insured qualified for a claim at the time of the lapse.

After we have made this payment, this benefit as well as all other benefits on the life of the insured will end. However, if the life insured has a waiver of payment at death benefit, we will consider a claim for that benefit as well.

Immediate life cover

Immediate life cover will be given under this benefit at death, provided that:

- the life insured is not yet aged 60 on the application date; and
- the first payment has been made with the application, or, but for the death of the applicant, a debit order or stop order payment for the first payment would have been honoured.

Immediate life cover will apply from the date we receive the application form, with all questions fully and correctly answered and signed by, if different parties, the life insured and the applicant, until the earliest of:

- the final underwriting decision being made that the application is accepted, declined, or deferred for the life insured;
- 30 days after the signing of the application form;
- us cancelling the cover in writing.

The immediate life cover will apply only in respect of death from unnatural causes. The normal contractual exclusions will apply. No immediate life cover will be payable if death is directly or indirectly caused by:

- the life insured participating in any dangerous pursuits;
- exposure to risks beyond the borders of South Africa and which are, in our opinion, not generally found in South Africa, or are more severe than corresponding risks in South Africa.

The consideration of a claim will be subject to the then prevailing terms of the type of plan applied for, and our usual practices.

The amount payable will be limited to the smaller of the initial cover amount and R500 000. The amount will be payable to the beneficiary, if any, nominated in the application form.

Death income (DI3)

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

Benefit description

A benefit may be claimed at the death of the life insured.

If we admit a claim, we will make an income payment equal to the cover amount. We will continue making income payments for as long as the appointed beneficiary has the right to claim payment.

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

First death (DS80)

This benefit is 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	This benefit is linked to more than one life insured. A benefit may be claimed at the death of the life insured linked to this benefit, who dies first. If we admit a claim, we will pay the cover amount set out in the plan overview as a lump sum.
Additional features	<p>The following additional features apply:</p> <ul style="list-style-type: none"> • Terminal illness • Immediate life cover • Free cover <p>Terminal illness and Immediate life cover are discussed below for this benefit. Refer to the chapter <i>Payments, payment patterns, guarantees and cover</i> for more information about Free cover.</p>
Type of benefit	<p>Standalone</p> <p>If a First death benefit with whole life cover is taken in combination with a First death benefit with term cover, the two benefits must be taken on separate Topcover and Termcover plans.</p>
When will cover for this benefit end?	<p>Topcover products Cover is provided for whole of life. However, the cover will end earlier:</p> <ul style="list-style-type: none"> • if the plan ends for any reason before the cover end date, or • if we admit a claim. <p>Term cover products Cover will end</p> <ul style="list-style-type: none"> • 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 • if we admit a claim.
Cover limits per life insured	<p>Housewives/house husbands, scholars, students, pensioners and unemployed persons may qualify for a limited amount of cover, as described under "Financial underwriting" in the underwriting chapters. Otherwise the limits below apply.</p> <p>Individual insurance</p> <p>Minimum: R150 000 Maximum: None*</p> <p>Business insurance</p> <p>Minimum: R50 000 Maximum: None*</p>

*Subject to financial underwriting

Age limits	Benefit start age
Minimum:	<ul style="list-style-type: none"> • Payment patterns other than Fixed compulsory growth: 15 next birthday • Fixed compulsory growth: 30 next birthday
Maximum:	• 80 next birthday
	Benefit cease age
	At the death of the life insured who dies first
	Under Term cover products the term of a benefit is also limited to a maximum of the selected term of the plan.
Qualifying lives	Subject to age limits and underwriting.
Guarantee period	As selected for the plan.

Admittance of a claim

The conditions for admittance of a claim are set out in the *General information* chapter.

We will admit a claim only once for this benefit.

If we admit a claim, this benefit as well as all accelerator benefits for the remaining lives insured linked to this benefit, will end. However, the remaining lives insured linked to this benefit have the option, for only 2 months after we admitted the claim, to take out death cover and accelerator benefits not exceeding the respective cover amounts as at the time of the claim, without proof of good health but subject to our new business requirements.

How a claim for an accelerator benefit affects this benefit

If we admit a claim for an accelerator benefit for a life insured linked to this benefit, we will, despite anything to the contrary in the plan, reduce the cover amount of this benefit for all the lives insured linked to this benefit by the claim amount.

Where the cover amount of an accelerator benefit for any life insured linked to this benefit exceeds the reduced cover amount of this benefit, we will reduce the cover amount of that accelerator benefit so that it is equal to the reduced cover amount of this benefit.

Exclusions

We will not admit a claim if death is caused by suicide, also during insanity, committed before or within 24 months from the cover start date of the benefit or the date the plan has been reinstated after an earlier lapse. If the cover amount is increased, other than through benefit growth, this waiting period will also apply to the increase in the cover amount from the effective date of the increase. The claimant must prove that the life insured did not commit suicide.

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

What if a life insured linked to this benefit is diagnosed with a terminal illness?

If a life insured is diagnosed with a medical condition that, according to our Chief Medical Officer, will result in death within 12 months, the planholder may apply for an early payment of this benefit. We may then pay an early death benefit. The amount of the early payment will be equal to the cover amount of this benefit set out in the plan overview.

We will also consider a claim for a terminal illness payment if the plan has lapsed and the life insured qualified for a claim at the time of the lapse.

After we have made this payment, this benefit as well as all other benefits on the life of the insured with a terminal illness will end. However, if the life insured with a terminal illness has a waiver of payment at death benefit, we will consider a claim for that benefit as well.

For the remaining lives insured linked to this benefit, this benefit as well as all accelerator benefits will end.

Immediate life cover

Immediate life cover will be given under this benefit at death, provided that:

- the life insured is not yet aged 60 on the application date; and
- the first payment has been made with the application, or, but for the death of the applicant, a debit order or stop order payment for the first payment would have been honoured.

Immediate life cover will apply from the date we receive the application form, with all questions fully and correctly answered and signed by, if different parties, the life insured and the applicant, until the earliest of:

- the final underwriting decision being made that the application is accepted, declined, or deferred for the life insured;
- 30 days after the signing of the application form;
- us cancelling the cover in writing.

The immediate life cover will apply only in respect of death from unnatural causes. The normal contractual exclusions will apply. No immediate life cover will be payable if death is directly or indirectly caused by:

- the life insured participating in any dangerous pursuits;
- exposure to risks beyond the borders of South Africa and which are, in our opinion, not generally found in South Africa, or are more severe than corresponding risks in South Africa.

The consideration of a claim will be subject to the then prevailing terms of the type of plan applied for, and our usual practices.

The amount payable will be limited to the smaller of the initial cover amount and R500 000. The amount will be payable to the beneficiary, if any, nominated in the application form.

Immediate Expenses (DSF3)

This benefit is 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	A benefit may be claimed at the death of the life insured. If we admit a claim, we will pay the cover amount set out in the plan overview as a lump sum. We aim to pay the cover amount within 48 hours after receiving the necessary requirements. These requirements are indicated below under "Admittance of a claim" for this benefit.
Additional features	The following additional feature applies: <ul style="list-style-type: none">• Free cover Refer to the chapter <i>Payments, payment patterns, guarantees and cover</i> for more information about Free cover.
Type of benefit	Standalone If an Immediate Expenses benefit with whole life cover is taken in combination with an Immediate Expenses benefit with term cover, the two benefits must be taken on separate Topcover and Term cover plans.
When will cover for this benefit end?	Topcover products Cover is provided for whole of life. However, the cover will end earlier: <ul style="list-style-type: none">• if the plan ends for any reason before the cover end date, or• if we admit a claim. Term cover products Cover will end <ul style="list-style-type: none">• 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• if we admit a claim.
Cover limits per life insured	Minimum: R50 000 Maximum: R150 000* <small>*Subject to financial underwriting</small>
Age limits	Benefit start age Minimum: • Payment patterns other than fixed compulsory growth: <ul style="list-style-type: none">• 19 next birthday for the Express product option• 15 next birthday otherwise • Fixed compulsory growth: 30 next birthday Maximum: • 80 next birthday • 60 next birthday for Express
	Benefit cease age At death Under Term cover products the term of a benefit is limited to a maximum of the selected term of the plan.

Conditions for availability of benefits

The below rules are also subject to age limits and underwriting.

Immediate Expenses benefit (DSF3) and/or Funeral Expenses (FSC3), with or without Cashback, may not be the only benefits on a plan.

In addition to this, the following applies:

Express product option

- The Immediate Expenses benefit is only available to the planholder and spouse.
- For the planholder and spouse the Immediate Expenses and Funeral Expenses benefits may be taken together on the same plan for the same life insured.

Classic and Premier product options

- The Immediate Expenses benefit is only available for a life insured if there is at least one fully medically underwritten benefit for the same life insured on the same plan, with at least 4 times as much cover as the Immediate Expenses benefit. The Funeral Expenses, Child: Illness and injury, accidental and Cashback benefits do not apply, as they are not fully medically underwritten.
- For lives that qualify for the Immediate Expenses benefit, the Immediate Expenses and Funeral Expenses benefits may be taken together on the same plan for the same life insured.

Guarantee period**Express product option**

5 years

Classic and Premier product options

As selected for the plan.

Admittance of a claim

The conditions for admittance of a claim are set out in the *General information* chapter.

We aim to pay this benefit within 48 hours after the following requirements have been received at our head office:

- a certified copy of the death certificate of the deceased life insured, issued by the Department of Home Affairs;
- form BI1663, issued by the doctor who certified the death, that is held on record by the Department of Home Affairs, or any other form that may replace it in future;
- a certified copy of the identity document or passport of the deceased life insured;
- the death claim form, fully completed;
- a declaration by the South African Police Service (SAPS), if the cause of death is unnatural or unknown;
- a certified copy of the identity document or passport of the claimant requesting the payment .

In certain cases we may also require the following:

- a letter of executorship, if the planholder is deceased and no beneficiary has been appointed;
- the name of the guardian or trust and birth certificate of the beneficiary, if the planholder is deceased and the beneficiary is a minor;
- a medical certificate.

If the name, identity number or date of birth of a life insured contained in the above-mentioned requirements differs from the particulars as indicated in the plan overview for that life insured, we may refuse to pay the cover amount.

Exclusions

We will not admit a claim if death is caused by suicide, also during insanity, committed before or within 24 months from the cover start date of the benefit or the date the plan has been reinstated after an earlier lapse. If the cover amount is increased, other than through benefit growth, this waiting period will also apply to the increase in the cover amount from the effective date of the increase. The claimant must prove that the life insured did not commit suicide.

Other general exclusions, if applicable, are set out in the applicable overview chapter in this technical guide. Specific exclusions, if any, are set out in the plan overview, in the special provisions for the life insured concerned.

Estate Expenses (DEC)

This benefit is available under the Express, Classic and Premier product options of our Topcover and Termcover products.

Benefit description	The purpose of this benefit is to make provision for estate costs. A benefit may be claimed at the death of the life insured. If we admit a claim, we will pay the cover amount into the estate of the deceased life insured.
Additional features	<p>The following additional feature applies:</p> <ul style="list-style-type: none"> • Terminal illness • Immediate cover • Free cover <p>Terminal illness and Immediate life cover are discussed below for this benefit. Refer to the chapter <i>Payments, payment patterns, guarantees and cover</i> for more information about Free cover.</p>
Type of benefit	Standalone
When will cover for this benefit end?	<p>It will end</p> <ul style="list-style-type: none"> • 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 • if we admit a claim.
Cover limits per life insured	<p>Minimum: R100 000</p> <p>Maximum:</p> <ul style="list-style-type: none"> • None* • Express product option R5 000 000* <p>*Subject to financial underwriting</p>
Age limits	<p>Benefit start age</p> <p>Minimum:</p> <ul style="list-style-type: none"> • 18 next birthday • 19 next birthday for Express <p>Maximum:</p> <ul style="list-style-type: none"> • 80 next birthday • 60 next birthday for Express <p>Benefit cease age</p> <p>At death</p> <p>Under Term cover products the term of a benefit is limited to a maximum of the selected term of the plan.</p>
Qualifying lives	This benefit is only available for the planholder.
Guarantee period	<p>Express product option 5 years</p> <p>Classic and Premier product options As selected for the plan.</p>

Admittance of a claim

The conditions for admittance of a claim are set out in the *General information* chapter.

Exclusions

We will not admit a claim if death is caused by suicide, also during insanity, committed before or within 24 months from the cover start date of the benefit or the date the plan has been reinstated after an earlier lapse. If the cover amount is increased, other than through benefit growth, this waiting period will also apply to the increase in the cover amount from the effective date of the increase. The claimant must prove that the life insured did not commit suicide.

General exclusions, if applicable, are set out in the general plan provisions.

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

What if the life insured is diagnosed with a terminal illness?

If the life insured is diagnosed with a medical condition that, according to our Chief Medical Officer, will result in death within 12 months, they may apply for an early payment of this benefit. We may then pay an early death benefit. The amount of the early payment will be equal to the cover amount of this benefit set out in the plan overview.

We will also consider a claim for a terminal illness payment if the plan has lapsed and the life insured qualified for a claim at the time of the lapse.

After we have made this payment, this benefit as well as all other benefits on the life of the insured will end. However, if the life insured has a waiver of payment at death benefit, we will consider a claim for that benefit as well.

Immediate life cover

Immediate life cover will be given under this benefit at death, provided that:

- the life insured is not yet aged 60 on the application date; and
- the first payment has been made with the application, or, but for the death of the applicant, a debit order or stop order payment for the first payment would have been honoured.

Immediate life cover will apply from the date we receive the application form, with all questions fully and correctly answered and signed by, if different parties, the life insured and the applicant, until the earliest of:

- the final underwriting decision being made that the application is accepted, declined, or deferred for the life insured;
 - 30 days after the signing of the application form;
- us cancelling the cover in writing.

The immediate life cover will apply only in respect of death from unnatural causes. The normal contractual exclusions will apply. No immediate life cover will be payable if death is directly or indirectly caused by:

- the life insured participating in any dangerous pursuits;
- exposure to risks beyond the borders of South Africa and which are, in our opinion, not generally found in South Africa, or are more severe than corresponding risks in South Africa.

The consideration of a claim will be subject to the then prevailing terms of the type of plan applied for, and our usual practices. The amount payable will be limited to the smaller of the initial cover amount and R500 000. The amount will be payable to the beneficiary, if any, nominated in the application form.

Funeral Expenses (FSC3)

This benefit is available under the Express, Classic and Premier product options of our Topcover products.

Benefit description	<p>A benefit may be claimed at the death of the life insured. If we admit a claim, we will pay the cover amount set out in the plan overview as a lump sum, subject to legislative limitations.</p> <p>If a child dies, legislation limits the total amount we are allowed to pay at the death of the child to</p> <ul style="list-style-type: none"> • R20 000 for death before the child's 6th birthday, and • R50 000 for death on or after the child's 6th birthday, but before that child's 14th birthday. <p>When applying the legislative limitations, we will consider all the benefits on which the child is a life insured with us and limit the total amount we pay at the death of the child according to the above-mentioned limits.</p> <p>We aim to pay this benefit within 48 hours after receiving the necessary requirements. These requirements are indicated below under "Admittance of a claim" for this benefit.</p>
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Type of benefit	Standalone
When will cover for this benefit end?	<p>Cover is provided for whole of life. However, the cover will end earlier:</p> <ul style="list-style-type: none"> • if the plan ends for any reason before the cover end date, or • if we admit a claim.
Cover limits per life insured	<p>Minimum: R5 000</p> <p>Maximum:</p> <ul style="list-style-type: none"> • R15 000 before a life insured's 6th birthday* • R30 000 on or after a life insured's 6th birthday, but before that life insured's 14th birthday* • R60 000 on or after a life insured's 14th birthday*
<p>*Subject to financial underwriting</p>	
Age limits	<p>Benefit start age</p> <ul style="list-style-type: none"> • Minimum: 2 next birthday • Maximum: 70 next birthday <p>Benefit cease age</p> <p>At death</p>

Conditions for availability of benefit

The Funeral Expenses benefit is available for lives with the following relationship to the planholder, subject to age limits and underwriting:

- Planholder (on his/her own life)
- Spouse*
- Child*
- Parent*, including parent-in-law
- Grandparent*
- Other family*
- Fiancé*.

*This relationship is described under "Explanations" for this benefit.

Immediate Expenses benefit (DSF3) and/or Funeral Expenses (FSC3), with or without Cashback, may not be the only benefits on a plan.

In addition to this, the following applies:

Express product option

- The planholder can have the Funeral Expenses benefit, with or without Cashback, only in combination with other benefits on his/her own life.
- The spouse can have the Funeral Expenses benefit on its own, or in combination with any of the other available benefits.
- The planholder's child, parent, grandparent, other family members and/or fiancé can only have the Funeral Expenses benefit, with or without the Cashback benefit - no other benefits are allowed for them.
- For the planholder and spouse the Immediate Expenses and Funeral Expenses benefits may be taken together on the same plan for the same life insured.

Classic and Premier product options

- The Funeral Expenses benefit can only be added to a plan if the planholder is a life insured on the plan with at least one benefit other than Funeral Expenses and Cashback on his/her own life.
- The planholder can have the Funeral Expenses benefit, with or without Cashback, only in combination with other benefits on his/her own life. The other lives insured can have the Funeral Expenses benefit on its own or in combination with other benefits.
- For lives that qualify for the Immediate Expenses benefit, the Immediate Expenses and Funeral Expenses benefits may be taken together on the same plan for the same life insured.

Guarantee period**Express product option**

5 years

Classic and Premier product options

The maximum initial guarantee period that may be selected for a plan with a Funeral Expenses benefit is 10 years.

If the planholder wants to take other benefits in combination with the Funeral Expenses benefit and he/she requires an initial guarantee period of longer than 10 years for these other benefits, the other benefits must be taken on a separate plan.

Admittance of a claim

The conditions for admittance of a claim are set out in the *General information* chapter.

We aim to pay this benefit within 48 hours after the following requirements have been received at our head office:

- a certified copy of the death certificate of the deceased life insured, issued by the Department of Home Affairs;
- form BI1663, issued by the doctor who certified the death, that is held on record by the Department of Home Affairs, or any other form that may replace it in future;
- a certified copy of the identity document or passport of the deceased life insured;
- the death claim form, fully completed;
- a declaration by the South African Police Service (SAPS), if the cause of death is unnatural or unknown;
- a certified copy of the identity document or passport of the claimant requesting the payment.

In certain cases we may also require the following:

- a letter of executorship, if the planholder is deceased and no beneficiary has been appointed;
- the name of the guardian or trust and birth certificate of the beneficiary, if the planholder is deceased and the beneficiary is a minor;
- proof of replaced funeral cover, if this benefit has been taken or the cover amount of this benefit has been increased to replace funeral cover that the planholder previously had on the life of the insured. This proof must meet our requirements and be verified by the product provider of the replaced funeral cover.

If the name, identity number or date of birth of a life insured contained in the above-mentioned requirements differs from the particulars as indicated in the plan overview for that life insured, we may refuse to pay the cover amount.

Cover for accidental causes

Cover for death due to accidental causes will start on the "Funeral Expenses issue date" as indicated in the plan overview under the life insured's name. If the cover amount is increased, other than through benefit growth, cover for death due to accidental causes on the increased part of the cover amount will start on the effective date of the increase.

Under this cover, a benefit may be claimed if the life insured dies and the death resulted directly and solely from an accident. An accident is a sudden, unexpected event that occurs at a place and time that is identifiable. It must have been caused by visible, violent, physical and external means, independent of any other cause. Accidental causes exclude suicide.

Waiting period

Waiting period for claims due to natural causes

A waiting period of 6 months applies to claims due to natural causes from the "Funeral Expenses issue date" as indicated in the plan overview under the life insured's name. This means that we will not pay a claim if the life insured dies of natural causes during this period.

The waiting period for claims due to natural causes will however only apply from the "Funeral Expenses issue date" if the first payment for this benefit is paid on time as indicated in the plan overview under "When must the payments be made?". If this first payment is not made on time, the waiting period will apply from the day that the first payment is actually received.

If the cover amount is increased, other than through benefit growth, the waiting period for claims due to natural causes will also apply to the increase in the cover amount from the effective date of the increase.

Waiting period for claims due to suicide

A waiting period of 12 months applies to claims due to suicide, also during insanity, from the "Funeral Expenses issue date" as indicated in the plan overview under the life insured's name. This means that we will not pay a claim if the life insured commits suicide during this period.

The waiting period for claims due to suicide will however only apply from the "Funeral Expenses issue date" if the first payment for this benefit is paid on time as indicated in the plan overview under "When must the payments be made?". If this first payment is not made on time, the waiting period will apply from the day that the first payment is actually received.

If the cover amount is increased, other than through benefit growth, the waiting period for claims due to suicide will also apply to the increase in the cover amount from the effective date of the increase.

Waiting periods reduced or waived

If the planholder can provide us with proof that this benefit has been taken or that the cover amount of this benefit has been increased to replace funeral cover that the planholder previously had on the life of the insured, we may reduce or waive the above-mentioned waiting periods for that life insured. For us to consider such proof, the "Funeral Expenses issue date" as indicated in the plan overview under the life insured's name, or the effective date of the increase in the cover amount, must be before the last date of cover on the replaced funeral cover, or within 31 days from the last date of cover. The proof must meet our requirements and must be verified by the product provider of the replaced funeral cover. It is the planholder's responsibility to inform us of any such replaced funeral cover.

We will not reduce or waive any waiting period if the funeral cover that was planned to be replaced is still in force on the date that the life insured dies.

Exclusions

Countries where cover is excluded

We will not admit a claim for this benefit if a life insured dies in one of the following countries: Afghanistan, Angola: Cabinda Province, Burundi, Central African Republic, Chad, Democratic Republic of the Congo, Iran (Islamic Republic of Iran), Iraq, Lebanon, Libya (Lybian Arab Jamahiriya), Mali, Nigeria: Niger Delta, North Korea, Pakistan, Somalia, South Sudan, Sudan, the Syrian Arab Republic and Yemen. If a life insured lives or plans to live in one of these countries, it is the planholder's responsibility to request us in writing to end this benefit for that life insured. We will not refund any payments because of cover being excluded in these countries.

This list of countries may change in future and if another benefit version was applicable to a life insured in the past, this list of countries may differ from the countries in those list(s). If the cover amount of this benefit is increased, other than through benefit growth, the latest list of countries will apply to the increased part of the cover amount of the benefit. The list(s) of countries that applied to the cover amount before the increase will continue to apply to that part of the cover amount after the increase. Different lists of countries could therefore apply to different parts of the cover amount at the time of a claim.

Exclusion for foreigners

This benefit is not available to foreigners who do not live in South Africa or who live in South Africa without valid travelling documents.

This benefit is available to foreigners who live in South Africa with valid travelling documents, but is restricted to claim events in South Africa only. However, if a life insured at any stage obtains a permanent residence permit, or South African citizenship, this benefit will cover claim events both inside and outside South Africa, excluding those countries where cover for this benefit is excluded.

If a life insured no longer lives in South Africa, it is the planholder's responsibility to request us in writing to end this benefit for that life insured. We will not refund any payments because of cover being restricted to claim events in South Africa only.

For foreigners with citizenship in Lesotho or Namibia this benefit will cover claim events both inside and outside South Africa, excluding those countries where cover for this benefit is excluded.

Explanations

Spouse

A person to whom the planholder is legally married on the date of inclusion as a life insured, or with whom the planholder has concluded an agreement recognised as a marriage in accordance with any law or custom, provided that in the case of a marriage by law or custom, he or she lives with that person as if legally married.

Child

A biological, legally adopted or step child.

Parent

An adult who was a guardian of the planholder or spouse, including a biological, foster or step-parent, who was responsible for the upbringing of the planholder or spouse.

Grandparent

The parent of the "Parent" as described above.

Other family

A relative that is not a spouse, child, parent or grandparent, for example, a brother, sister, nephew, niece, cousin, uncle, aunt.

Fiancé

A person to whom the planholder is engaged to be married.

Accidental death (ASC)

This benefit is 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	A benefit may be claimed if the life insured dies and the death resulted directly and solely from a bodily injury. If we admit a claim, we will pay the cover amount set out in the plan overview as a lump sum. Besides the conditions for admittance of a claim set out in the <i>General information</i> chapter, we will admit a claim only if the life insured dies within 12 months after the bodily injury.
Additional features	The following additional feature applies: <ul style="list-style-type: none">• Free cover Refer to the chapter <i>Payments, payment patterns, guarantees and cover</i> for more information about Free cover.
Type of benefit	Standalone
When will cover for this benefit end?	Cover will end <ul style="list-style-type: none">• 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• if we admit a claim.
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: R2 500 000* *Subject to financial underwriting
Age limits	Benefit start age Minimum: • Payment patterns other than fixed compulsory growth: <ul style="list-style-type: none">• 19 next birthday for the Express product option• 15 next birthday otherwise• Fixed compulsory growth: 30 next birthday Maximum: 60 next birthday
	Benefit cease age 65 next birthday Under Term cover products the term of a benefit is limited to a maximum of the selected term of the plan.

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.

Exclusions

General exclusions are set out in the applicable overview chapter in this technical guide. Specific exclusions, if any, are set out in the plan overview, in the special provisions for the life insured concerned.

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Disability and impairment benefits

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

We have a variety of benefits available to provide cover in the event of your disability or permanent impairment.

You can take benefits on their own or in various combinations to provide cover for your specific needs.

Our disability and impairment benefits

The following benefits are available:

- **Comprehensive Disability:** Provides comprehensive cover for occupational disability and severe impairments. This benefit includes Built-in Future Cover for Young Lives*.
- **Comprehensive Disability Plus:** Provides comprehensive cover for occupational disability, severe impairments as well as cover for less severe events. This benefit includes Built-in Future Cover for Young Lives* and cover for Temporary Incapacity.
- **Elite Disability:** Provides comprehensive cover for occupational disability, severe impairments as well as cover for less severe events. This benefit includes various special features such as Built-in Future Cover for Young Lives* and cover for Temporary Incapacity. It also includes other special features that are unique to this benefit.
- **Comprehensive Impairment:** Provides comprehensive cover for severe impairments as well as cover for less severe events. This benefit includes cover for Temporary Incapacity. Cover for occupational disability is not included.
- **Accidental Comprehensive Disability:** This benefit only covers claim events that are due to accidental causes. It provides cover for occupational disability and severe impairments.
- **Accidental Comprehensive Disability Plus:** This benefit only covers claim events that are due to accidental causes. It provides cover for occupational disability, severe impairments as well as cover for less severe events. This benefit includes Temporary Incapacity Cover for Accidental Causes.
- **Accidental Elite Disability:** This benefit only covers claim events that are due to accidental causes. It provides cover for occupational disability, severe impairments as well as cover for less severe events. This benefit includes various special features such as Temporary Incapacity Cover for Accidental Causes.
- **Accidental Comprehensive Impairment:** This benefit only covers claim events that are due to accidental causes. It provides cover for severe as well as less severe impairments. This benefit includes Temporary Incapacity Cover for Accidental Causes. Cover for occupational disability is not included.

*The Built-in Future Cover for Young Lives only applies for standalone benefits and certain qualification criteria apply.

Comprehensive Disability

This benefit provides cover for:

- Permanent occupational disability (regular occupation)
- Permanent impairment claim events.

The benefit also includes the following special features:

- Extended occupational disability cover
- Built-in Future Cover for Young Lives.

Comprehensive Disability Plus

This benefit provides cover for:

- Permanent occupational disability (regular occupation)
- Permanent impairment claim events
- Accidental claim events that do not necessarily result in permanent impairment.

The benefit also includes the following special features:

- Extended occupational disability cover
- Built-in Future Cover for Young Lives
- Temporary Incapacity Cover for Accidental Causes
- Temporary Incapacity Cover for Non-Accidental Causes.

Elite Disability

This benefit provides cover for:

- Permanent occupational disability (regular occupation)
- Permanent impairment claim events
- Accidental claim events that do not necessarily result in permanent impairment.

The benefit also includes the following special features:

- Extended occupational disability cover
- Built-in Future Cover for Young Lives
- Temporary Incapacity Cover for Accidental Causes
- Temporary Incapacity Cover for Non-Accidental Causes
- Boosted payouts
- A Prosthesis Booster
- Built-in Child Cover.

Comprehensive Impairment

This benefit provides cover for:

- Permanent impairment claim events
- Accidental claim events that do not necessarily result in permanent impairment.

The benefit also includes the following special features:

- Temporary Incapacity Cover for Accidental Causes
- Temporary Incapacity Cover for Non-Accidental Causes.

Accidental Comprehensive Disability

This benefit provides cover for:

- Permanent occupational disability (regular occupation) from accidental causes
- Permanent impairment claim events from other accidental causes.

The benefit also includes the following special feature:

- Extended occupational disability cover.

Accidental Comprehensive Disability Plus

This benefit provides cover for:

- Permanent occupational disability (regular occupation) from accidental causes
- Permanent impairment claim events from other accidental causes
- Other accidental claim events that do not necessarily result in permanent impairment.

The benefit also includes the following special features:

- Extended occupational disability cover
- Temporary Incapacity Cover for Accidental Causes.

Accidental Elite Disability

This benefit provides cover for:

- Permanent occupational disability (regular occupation) from accidental causes
- Permanent impairment claim events from other accidental causes
- Other accidental claim events that do not necessarily result in permanent impairment.

The benefit also includes the following special features:

- Extended occupational disability cover
- Temporary Incapacity Cover for Accidental Causes
- Boosted payouts
- A Prosthesis Booster.

Accidental Comprehensive Impairment

This benefit provides cover for

- Permanent impairment claim events from accidental causes
- Other accidental claim events that do not necessarily result in permanent impairment.

The benefit also includes the following special features:

- Temporary Incapacity Cover for Accidental Causes.

Special features automatically included

To provide even wider cover, certain special features are automatically included in some of our benefits:

- Extended occupational disability cover: If you stop working for any reason other than retirement, for example, taking a sabbatical, becoming a housewife or being retrenched, we will continue to cover you for occupational disability for up to 12 months from the date you stop working, subject to certain terms and conditions.
- Built-in Future Cover for Young Lives: Young lives purchasing standalone disability benefits (that include cover for occupational disability) will have the option to purchase an equivalent amount of life cover before age 35 next birthday, on certain life events. The life cover will be free of medical underwriting or only require a declaration of good health.
- Temporary Incapacity Cover for Accidental Causes: You can claim a benefit if you suffer any bodily injury as a result of an accident that requires a recovery period for returning to work of three months or longer, according to certain guidelines.
- Temporary Incapacity Cover for non-Accidental Causes: You can claim a benefit for certain defined claim events that, after the indicated waiting period, requires a recovery period for returning to work of two months or longer, according to certain guidelines.
- Boosted payouts: Under the Elite Disability and Accidental Elite Disability benefits, various claim events have a higher payout percentage than what is applicable for the other benefits in our range.
- Prosthesis Booster: This booster is included in the Elite Disability and Accidental Elite Disability main benefits. Under this booster, we will pay a percentage of the cover amount of the main benefit for certain amputations, paraplegias and quadriplegias. This is an extra amount and we will not reduce the cover amount of the main benefit by the claim amount we pay under this booster.
- Built-in Child Cover: This feature is exclusive to the Elite Disability benefit. You can claim a benefit if your child suffers any of a number of specified illnesses or injuries. We will not reduce the cover amount of the Elite Disability benefit with the claim amount we will pay.

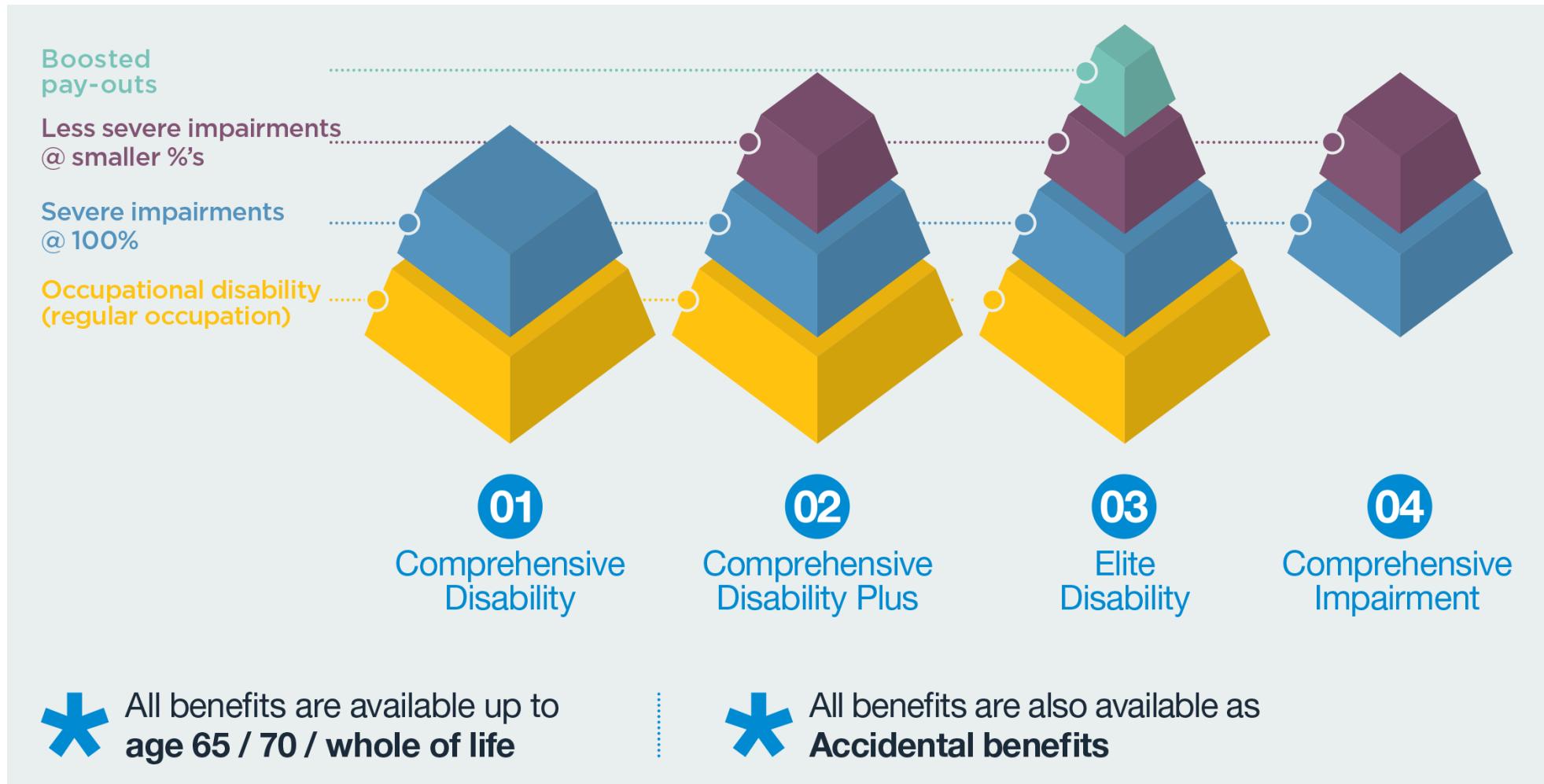
A √ in the table below indicates the special features that apply to a benefit.

Special feature	Benefit							
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment	Accidental Comprehensive Disability	Accidental Comprehensive Disability Plus	Accidental Elite Disability	Accidental Comprehensive Impairment
Extended occupational disability cover	√	√	√		√	√	√	
Built-in Future Cover for Young Lives*	√	√	√					
Temporary Incapacity Cover for Accidental Causes		√	√	√		√	√	√
Temporary Incapacity Cover for Non-Accidental Causes		√	√	√				
Boosted payouts			√				√	
Prosthesis Booster			√				√	
Built-in Child Cover			√					

*The Built-in Future Cover for Young Lives only applies for standalone benefits.

The bigger picture

An illustration of our benefits as discussed above:



Why disability and impairment benefits?

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

If an accident or illness were to leave you unable to work, you could lose your ability to generate an income for you and your family. Adding sufficient disability cover to your plan will relieve you of financial worries while you deal with the challenges of the disability.

With our disability and impairment benefits, we will also pay for certain medical conditions and injuries that cause a significant degree of permanent impairment, even if you are still able to work despite them. For example, if an administrative assistant were to lose the use of both feet, we would still pay 100% of the cover amount, even though the life insured could still be able to carry out his or her occupational duties from a wheelchair.

An injury or illness could also leave you with limitations in performing certain daily activities, even though you might be able to continue working. For example, if you were to partially lose your hearing or develop a serious heart or lung disease, you may still be able to perform your occupational duties but may have to do so with difficulty.

When making a claim against impairment cover, your ability to continue with your job is not taken into consideration, as you are insured against the impairment or loss of function and not against the inability to continue generating an income.

Even though you might still be earning an income after suffering impairment, you and your family may need extra cash to hire help if you are no longer able to perform certain activities.

Our Comprehensive impairment and Accidental Comprehensive Impairment benefits are also available to persons like home executives or students, who do not qualify for disability benefits, but will need their life expenses covered if they were to become impaired.

Impairment cover can result in a partial payment of the cover amount, depending on how severe the impairment is, in which case it is possible to claim more than once against the benefit.

If you were to claim under our disability and impairment benefits, the payment you receive could be used for expenses such as

- Debts, like mortgage and personal loans
- Disability- or impairment-related expenses, like the need to adapt your home and car for improved mobility if you were to end up in a wheelchair
- Basic life expenses, like groceries and clothing
- Provision for your dependants, like children's school fees.

Availability of benefits

Individual insurance

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

Business insurance

Refer to the *Business insurance* chapter for information about availability of benefits. The Express product option is currently not available for business insurance.

Comprehensive Disability (CAR3, CSR3)

The **Comprehensive Disability** benefit is 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

This benefit provides cover for

- permanent occupational disability up to retirement, age 70 or the cover end date of the benefit, whichever is earlier; and
- permanent impairment claim events for as long as the benefit is in force.

If we admit a claim, we will pay the claim amount as a lump sum.

We regard the life insured as retired if he or she is 55 years or older, and does not earn an income over and above a passive income. Passive income refers to income that can continue without the life insured's intervention, for example pension or rental income.

Any reference to age 70 refers to the plan anniversary before or on the life insured's 70th birthday.

If this benefit is a standalone benefit, it also includes the following, which is described in a separate section later in this chapter:

- Built-in Future Cover for Young Lives.

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

An accelerator and standalone version of this benefit can be taken on the same plan for the same life insured.

Benefit	Type of benefit	
	Accelerator	Standalone
Comprehensive Disability (CAR3)	✓	
Comprehensive Disability (CSR3)		✓

When will cover for this benefit end?

Cover will end on the earlier of

- midnight before the cover end date indicated in the plan overview; and
- the plan ending for any reason before the cover end date; and
- 100% of the cover amount being paid or a claim being paid for "Paraplegia due to spinal cord severance or primary neurological disease of the spinal cord" or "Quadriplegia due to spinal cord severance or primary neurological disease of the spinal cord"; and
- the death of the life insured.

Cover limits per life insured	Students in at least their fourth year of study for a professional occupation may qualify for a limited amount of cover under the Classic or Premier product option, as described under "Financial underwriting" in the <i>Underwriting for Classic and Premier</i> chapter. Otherwise the limits below apply.
--------------------------------------	--

- | | |
|----------|--|
| Minimum: | • R50 000 |
| Maximum: | • R5 000 000 under the Express product option* |
| | • R35 000 000 otherwise* |

*Subject to financial underwriting

The sum of the cover amounts of all **accelerator disability and impairment 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				
	<table> <tr> <td>Minimum:</td> <td> <ul style="list-style-type: none"> • Payment patterns other than fixed compulsory growth <ul style="list-style-type: none"> • 19 next birthday under the Express product option • 15 next birthday otherwise • Fixed compulsory growth: 30 next birthday </td> </tr> <tr> <td>Maximum:</td> <td> <ul style="list-style-type: none"> • Benefit with cease age 65: 60 next birthday • Benefit with cease age 70 or with whole life cover: 62 next birthday </td> </tr> </table>	Minimum:	<ul style="list-style-type: none"> • Payment patterns other than fixed compulsory growth <ul style="list-style-type: none"> • 19 next birthday under the Express product option • 15 next birthday otherwise • Fixed compulsory growth: 30 next birthday 	Maximum:	<ul style="list-style-type: none"> • Benefit with cease age 65: 60 next birthday • Benefit with cease age 70 or with whole life cover: 62 next birthday
Minimum:	<ul style="list-style-type: none"> • Payment patterns other than fixed compulsory growth <ul style="list-style-type: none"> • 19 next birthday under the Express product option • 15 next birthday otherwise • Fixed compulsory growth: 30 next birthday 				
Maximum:	<ul style="list-style-type: none"> • Benefit with cease age 65: 60 next birthday • Benefit with cease age 70 or with whole life cover: 62 next birthday 				
	Benefit cease age				
	<ul style="list-style-type: none"> • Topcover products: Choice between 65 or 70 next birthday, or whole life cover. • Term cover products: 65 next birthday. <p>Under Term cover products the term of a benefit is limited to a maximum of the selected term of the plan.</p>				

Qualifying lives	The following lives do not qualify: <ul style="list-style-type: none"> • Housewives/house husbands • Scholars • Certain students • Pensioners • Unemployed persons Other lives may qualify, including students in at least their fourth year of study for a professional occupation, subject to age limits and underwriting.
	Under the Express product option the Comprehensive Disability benefit is available to the planholder and/or his or her spouse only.

Guarantee period	Express product option 5 years
	Classic and Premier product options As selected for the plan. However, if the Comprehensive Disability benefit is selected with whole life cover , the maximum initial guarantee period that may be chosen for a plan with this benefit is 10 years. If the planholder wants to take other benefits in combination with a whole life Comprehensive Disability benefit and he/she requires an initial guarantee period of longer than 10 years for these other benefits, the other benefits must be taken on a separate plan.

What benefit will be paid?

The claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated in the "Claim events: List 1" section later in this chapter (where the below occupational disability claim event is again included). The contractual definitions will apply when we consider a claim. The layman's explanations are provided for a better understanding of the claim events but will not be used in the legal interpretation of the claim events.

If we admit a claim, we will pay the percentage of the cover amount linked to the particular claim event. The cover amount is indicated in the plan overview and may change over time as a result of benefit growth, alterations requested by the planholder, and claims.

Occupational disability cover

Claim event	Percentage of cover amount %
Occupational disability	
Contractual definition: Disability to the extent that the life insured is totally and permanently unable to fulfil the occupational demands of the occupation he or she practised for income immediately before the disability. If the life insured is a qualifying student when he or she becomes disabled: Disability to the extent that the life insured will be totally and permanently unable to fulfil the occupational demands of an occupation we may reasonably expect him or her to have practised, had they not become disabled and had they completed their studies.	100

What is a qualifying student?

A qualifying student is a full-time student

- in their final academic year studying toward an NQF-level 7 qualification; or
- in at least their 3rd academic year studying toward an NQF-level 8 or higher qualification.

A student progresses to the next academic year when they successfully pass a tertiary study year.

Extended occupational disability cover

If the life insured stops working for any reason other than retiring or becoming a qualifying student, for example, taking a sabbatical, becoming a housewife or being retrenched, we will continue to cover the life insured for occupational disability for up to 12 months from the date he or she stopped working.

For this cover, we will assess occupational disability according to the occupation the life insured performed immediately before he or she stopped working.

Extended occupational disability cover will only apply if the occupational disability is not as a result of any of the following conditions:

- depression or dysthymia, whether as an episode or disorder, or as part of the symptom complex of another psychiatric diagnosis;
- post-traumatic stress disorder;
- fibromyalgia;
- chronic fatigue syndrome and its synonyms;
- a back or neck condition, unless it is one of the following: paraplegia; quadriplegia; malignant tumours of the spinal cord and vertebral column; or failed back syndrome after multiple spinal surgery, provided the extent of the functional impairment arising from the failed back syndrome is verified by a specialist that we will nominate;
- any orthopaedic condition based mainly on pain, discomfort, loss of sensation, loss of range of motion, or any combination thereof;
- any decline in cognitive functioning irrespective of the cause thereof;
- an injury or illness that directly or indirectly resulted from, or is traceable to, any of the above causes;
- a complication that directly or indirectly is attributable to any of the above causes, or to such an injury or illness;
- a side-effect of treatment of any of the above causes, or for such an injury or illness or for such a complication.

Qualifying students

If the life insured is a qualifying student and successfully completes his or her studies, but does not yet start working, we will continue to cover him or her for occupational disability as if he or she is still a qualifying student, for up to 12 months from the date he or she stopped studying. This extended occupational disability cover will only apply if the occupational disability is not as a result of any of the above listed conditions.

Conversion options

The payment will not reduce when the cover for occupational disability ends. If the life insured stops working before the cover end date of the benefit, and plans to never work again, the planholder may contact his or her intermediary about conversion options for this benefit. Conversion options may however not necessarily result in a lower payment.

Impairment cover

The claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated in the "Claim events: List 1" section later in this chapter.

Future medical advances

Some claim events 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 claim events, 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.

Admittance of a claim

Besides the conditions for admittance of a claim set out in the *General information* chapter, we will admit a claim only if

- the disability or impairment is caused directly and solely by a bodily injury or by an illness;
- the disability or impairment is permanent, after the life insured has undergone optimal, reasonable treatment;
- the life insured survived more than 10 days from the date the contractual claim event definition has been met. The survival period will only be applied to conditions where the prognosis of survival beyond 10 days is not certain, based on the available medical evidence.

For occupational disability, we will also only admit a claim if the claim event occurs before retirement, age 70 or the cover end date of the benefit, whichever is earlier.

The disability or impairment must be permanent, and evaluated according to the principles and ratings of the latest edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. The disability or impairment, and permanence thereof, will be evaluated only 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.

If we admit a claim, we will pay the percentage of the cover amount linked to the particular claim event indicated in the "Claim events: List 1" section later in this chapter. The amount will be paid as a lump sum, after which the benefit will end.

Multiple claims

If the life insured qualifies for more than one claim event at the same time, we will consider the claim event with the highest percentage of the cover amount. If two claim events have the same percentage, we will consider the claim event that is listed first in the "Claim events: List 1" section later in this chapter.

Exclusions

We will not admit a claim if the disability or impairment of the life insured can be substantially removed or improved by surgery or other medical treatment, which we can reasonably expect him or her to undergo, taking into account the risks involved and the chances of success of such surgery or treatment.

If the life insured at any time practises sport as an occupation, or works as a pilot, and becomes continuously unable to fulfil the occupational demands of that occupation, we will not admit a claim for occupational disability as a result of such inability.

Other general exclusions are set out in the applicable overview chapter in this technical guide. Specific exclusions, if any, are set out in the plan overview, in the special provisions for the life insured concerned.

Comprehensive Disability Plus (CAR4, CSR4)

The **Comprehensive Disability Plus** benefit is 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

This benefit provides cover for

- permanent occupational disability up to retirement, age 70 or the cover end date of the benefit, whichever is earlier; and
- permanent impairment claim events for as long as the benefit is in force; and
- accidental claim events for as long as the benefit is in force.

If we admit a claim, we will pay the claim amount as a lump sum.

We regard the life insured as retired if he or she is 55 years or older, and does not earn an income over and above a passive income. Passive income refers to income that can continue without the life insured's intervention, for example pension or rental income.

Any reference to age 70 refers to the plan anniversary before or on the life insured's 70th birthday.

This benefit also includes the following, which are described in separate sections later in this chapter:

- Temporary Incapacity Cover for Accidental Causes; and
- Temporary Incapacity Cover for non-Accidental Causes; and
- Built-in Future Cover for Young Lives, if the main benefit is a standalone benefit.

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

An accelerator and standalone version of this benefit can be taken on the same plan for the same life insured.

Benefit	Type of benefit	
	Accelerator	Standalone
Comprehensive Disability Plus (CAR4)	✓	
Comprehensive Disability Plus (CSR4)		✓

When will cover for this benefit end?

Cover will end on the earlier of

- midnight before the cover end date indicated in the plan overview; and
- the plan ending for any reason before the cover end date; and
- 100% of the cover amount being paid or a claim being paid for "Paraplegia due to spinal cord severance or primary neurological disease of the spinal cord" or "Quadriplegia due to spinal cord severance or primary neurological disease of the spinal cord"; and
- the death of the life insured.

Cover limits per life insured	Students in at least their fourth year of study for a professional occupation may qualify for a limited amount of cover under the Classic or Premier product option, as described under "Financial underwriting" in the <i>Underwriting for Classic and Premier</i> chapter. Otherwise the limits below apply.
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- Minimum: • R50 000
- Maximum: • R5 000 000 under the Express product option*
- R35 000 000 otherwise*

*Subject to financial underwriting

The sum of the cover amounts of all **accelerator disability and impairment 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 under the Express product option
 • 15 next birthday otherwise
- Fixed compulsory growth: 30 next birthday
- Maximum: • Benefit with cease age 65: 60 next birthday
- Benefit with cease age 70 or with whole life cover: 62 next birthday

Benefit cease age

- Topcover products: Choice between 65 or 70 next birthday, or whole life cover.
- Term cover products: 65 next birthday.
 Under Term cover products the term of a benefit is limited to a maximum of the selected term of the plan.

Qualifying lives

The following lives do not qualify:

- Housewives/house husbands
- Scholars
- Certain students
- Pensioners
- Unemployed persons

Other lives may qualify, including students in at least their fourth year of study for a professional occupation, subject to age limits and underwriting.

Under the **Express product option** the Comprehensive Disability Plus benefit is available to the planholder and/or his or her spouse only.

Guarantee period

Express product option

5 years

Classic and Premier product options

As selected for the plan.

However, if the Comprehensive Disability Plus benefit is selected with **whole life cover**, the maximum initial guarantee period that may be chosen for a plan with this benefit is 10 years.

If the planholder wants to take other benefits in combination with a **whole life** Comprehensive Disability Plus benefit and he/she requires an initial guarantee period of longer than 10 years for these other benefits, the other benefits must be taken on a separate plan.

What benefit will be paid?

The claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated in the "Claim events: List 1" section later in this chapter (where the below occupational disability claim event is again included). The contractual definitions will apply when we consider a claim. The layman's explanations are provided for a better understanding of the claim events but will not be used in the legal interpretation of the claim events.

If we admit a claim, we will pay the percentage of the cover amount linked to the particular claim event. For claim events where a maximum rand amount is indicated, we will not pay more than the indicated rand amount. The cover amount is indicated in the plan overview and may change over time as a result of benefit growth, alterations requested by the planholder, and claims.

Occupational disability cover

Claim event	Percentage of cover amount %
Occupational disability	
Contractual definition: Disability to the extent that the life insured is totally and permanently unable to fulfil the occupational demands of the occupation he or she practised for income immediately before the disability. If the life insured is a qualifying student when he or she becomes disabled: Disability to the extent that the life insured will be totally and permanently unable to fulfil the occupational demands of an occupation we may reasonably expect him or her to have practised, had they not become disabled and had they completed their studies.	100

What is a qualifying student?

A qualifying student is a full-time student

- in their final academic year studying toward an NQF-level 7 qualification; or
- in at least their 3rd academic year studying toward an NQF-level 8 or higher qualification.

A student progresses to the next academic year when they successfully pass a tertiary study year.

Extended occupational disability cover

If the life insured stops working for any reason other than retiring or becoming a qualifying student, for example, taking a sabbatical, becoming a housewife or being retrenched, we will continue to cover the life insured for occupational disability for up to 12 months from the date he or she stopped working.

For this cover, we will assess occupational disability according to the occupation the life insured performed immediately before he or she stopped working.

Extended occupational disability cover will only apply if the occupational disability is not as a result of any of the following conditions:

- depression or dysthymia, whether as an episode or disorder, or as part of the symptom complex of another psychiatric diagnosis;
- post-traumatic stress disorder;
- fibromyalgia;
- chronic fatigue syndrome and its synonyms;
- a back or neck condition, unless it is one of the following: paraplegia; quadriplegia; malignant tumours of the spinal cord and vertebral column; or failed back syndrome after multiple spinal surgery, provided the extent of the functional impairment arising from the failed back syndrome is verified by a specialist that we will nominate;
- any orthopaedic condition based mainly on pain, discomfort, loss of sensation, loss of range of motion, or any combination thereof;
- any decline in cognitive functioning irrespective of the cause thereof;
- an injury or illness that directly or indirectly resulted from, or is traceable to, any of the above causes;
- a complication that directly or indirectly is attributable to any of the above causes, or to such an injury or illness;
- a side-effect of treatment of any of the above causes, or for such an injury or illness or for such a complication.

Qualifying students

If the life insured is a qualifying student and successfully completes his or her studies, but does not yet start working, we will continue to cover him or her for occupational disability as if he or she is still a qualifying student, for up to 12 months from the date he or she stopped studying. This extended occupational disability cover will only apply if the occupational disability is not as a result of any of the above listed conditions.

Conversion options

The payment will not reduce when the cover for occupational disability ends. If the life insured stops working before the cover end date of the benefit, and plans to never work again, the planholder may contact his or her intermediary about conversion options for this benefit. Conversion options may however not necessarily result in a lower payment.

Impairment and accidental cover

The claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated in the "Claim events: List 1" section later in this chapter.

Future medical advances

Some claim events 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 claim events, 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.

Waiting period for joint replacements

A waiting period of 5 years from the cover start date of the benefit is applicable to the following claim events resulting from natural causes:

- Total hip replacement;
- Total knee replacement;
- Total shoulder replacement;
- Total ankle 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.

Replacement of benefits

If a benefit covering the above joint replacement events has been replaced with this benefit without an interruption in cover and for the same amount of cover, the waiting period will not be applicable from the date of the replacement, but will be applicable from the original cover start date of the previous benefit. If the cover amount of the replaced benefit was however increased before the date of the replacement, other than through benefit growth, the waiting period on such an increase will be applicable from the cover start date of the increase.

If, at the time of replacement, the cover amount of this benefit was chosen to be higher than the cover amount of the replaced benefit, the above concession will not apply to the increased portion.

If the cover amount of this benefit is increased after the date of the replacement, other than through benefit growth, a new waiting period of 5 years from the cover start date of the increase will be applicable to the increase in the cover amount.

Admittance of a claim

Besides the conditions for admittance of a claim set out in the *General information* chapter, we will admit a claim only if

- the disability or impairment is caused directly and solely by a bodily injury or by an illness;
- the disability or impairment is permanent, after the life insured has undergone optimal, reasonable treatment;
- we have not previously admitted a claim for the same claim event, except if the claim event is listed under "Musculoskeletal system" in the "Claim events: List 1" section later in this chapter, and the claim is for a different limb;
- the life insured survived more than 10 days from the date the contractual claim event definition has been met. The survival period will only be applied to conditions where the prognosis of survival beyond 10 days is not certain, based on the available medical evidence.

For occupational disability, we will also only admit a claim if the claim event occurs before retirement, age 70 or the cover end date of the benefit, whichever is earlier.

The disability or impairment must be permanent, and evaluated according to the principles and ratings of the latest edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. The disability or impairment, and permanence thereof, will be evaluated only 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.

References to permanence does not apply to the claim events listed under "Trauma" in the "Claim events: List 1" section later in this chapter.

If we admit a claim, we will pay the percentage of the cover amount linked to the particular claim event indicated in the "Claim events: List 1" section later in this chapter. The amount will be paid as a lump sum.

If the amount we pay is equal to or more than the cover amount, the benefit will end when we have paid the claim. If the amount we pay is less than the cover amount, we will reduce the cover amount with the amount that was paid. We will also reduce the payment of the benefit proportionally. Any amount we pay thereafter for a subsequent claim event, will be based on the reduced cover amount. The reduced cover amount will continue to increase on every plan anniversary if benefit growth is applicable to the plan.

Multiple claims

When we apply the rules in this section, claims for occupational disability, impairment as well as Temporary Incapacity will be considered.

If the life insured qualifies for more than one claim event at the same time, we will first consider the claim event with the highest percentage of the cover amount. If two claim events have the same percentage, we will first consider the claim event that is listed first in the "Claim events: List 1" section later in this chapter.

If the life insured however qualifies for more than one claim event at the same time and by qualifying for the one claim event implies qualifying for other claim events, we will only consider the claim event with the highest percentage of the cover amount.

The total lump sum we will pay will be limited to the cover amount of the benefit and once the full cover amount has been paid, the benefit will end. An exception to this is if we make a payment for the claim event "Paraplegia due to spinal cord severance or primary neurological disease of the spinal cord" or "Quadriplegia due to spinal cord severance or primary neurological disease of the spinal cord". For these claim events a lump sum of 125% or 150% of the cover amount will be payable, respectively, after which the benefit will end.

Exclusions

We will not admit a claim if the disability or impairment of the life insured can be substantially removed or improved by surgery or other medical treatment, which we can reasonably expect him or her to undergo, taking into account the risks involved and the chances of success of such surgery or treatment.

If the life insured at any time practises sport as an occupation, or works as a pilot, and becomes continuously unable to fulfil the occupational demands of that occupation, we will not admit a claim for occupational disability as a result of such inability.

Other general exclusions are set out in the applicable overview chapter in this technical guide. Specific exclusions, if any, are set out in the plan overview, in the special provisions for the life insured concerned.

Elite Disability (CAR5, CSR5)

The **Elite Disability** benefit is available under the Premier product option of our Topcover and Term cover products.

Benefit description

This benefit provides cover for

- permanent occupational disability up to retirement, age 70 or the cover end date of the benefit, whichever is earlier; and
- permanent impairment claim events for as long as the benefit is in force; and
- accidental claim events for as long as the benefit is in force.

If we admit a claim, we will pay the claim amount as a lump sum.

We regard the life insured as retired if he or she is 55 years or older, and does not earn an income over and above a passive income. Passive income refers to income that can continue without the life insured's intervention, for example pension or rental income.

Any reference to age 70 refers to the plan anniversary before or on the life insured's 70th birthday.

This benefit also includes the following, which are described in separate sections later in this chapter:

- Temporary Incapacity Cover for Accidental Causes; and
- Temporary Incapacity Cover for non-Accidental Causes; and
- A Prosthesis Booster; and
- Built-in Future Cover for Young Lives, if the main benefit is a standalone benefit; and
- Built-in Child Cover.

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

An accelerator and standalone version of this benefit can be taken on the same plan for the same life insured.

Benefit	Type of benefit	
	Accelerator	Standalone
Elite Disability (CAR5)	✓	
Elite Disability (CSR5)		✓

When will cover for this benefit end?

Cover will end on the earlier of

- midnight before the cover end date indicated in the plan overview; and
- the plan ending for any reason before the cover end date; and
- 100% of the cover amount being paid or a claim being paid for "Paraplegia due to spinal cord severance or primary neurological disease of the spinal cord" or "Quadriplegia due to spinal cord severance or primary neurological disease of the spinal cord"; and
- the death of the life insured.

Cover limits per life insured	Students in at least their fourth year of study for a professional occupation may qualify for a limited amount of cover under the Premier product option, as described under "Financial underwriting" in the <i>Underwriting for Classic and Premier</i> chapter. Otherwise the limits below apply.
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Minimum: R50 000

Maximum: R35 000 000*

*Subject to financial underwriting

The sum of the cover amounts of all **accelerator disability and impairment 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 <ul style="list-style-type: none"> Minimum: • Payment patterns other than fixed compulsory growth: 15 next birthday • Fixed compulsory growth: 30 next birthday Maximum: • Benefit with cease age 65: 60 next birthday • Benefit with cease age 70 or with whole life cover: 62 next birthday Benefit cease age <ul style="list-style-type: none"> • Topcover products: Choice between 65 or 70 next birthday, or whole life cover. • Term cover products: 65 next birthday. Under Term cover products the term of a benefit is limited to a maximum of the selected term of the plan.
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Qualifying lives	The following lives do not qualify: <ul style="list-style-type: none"> • Housewives/house husbands • Scholars • Certain students • Pensioners • Unemployed persons Other lives may qualify, including students in at least their fourth year of study for a professional occupation, subject to age limits and underwriting.
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Guarantee period	As selected for the plan. However, if the Elite Disability benefit is selected with whole life cover , the maximum initial guarantee period that may be chosen for a plan with this benefit is 10 years. If the planholder wants to take other benefits in combination with a whole life Elite Disability benefit and he/she requires an initial guarantee period of longer than 10 years for these other benefits, the other benefits must be taken on a separate plan.
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What benefit will be paid?

The claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated in the "Claim events: List 1" section later in this chapter (where the below occupational disability claim event is again included). The contractual definitions will apply when we consider a claim. The layman's explanations are provided for a better understanding of the claim events but will not be used in the legal interpretation of the claim events.

If we admit a claim, we will pay the percentage of the cover amount linked to the particular claim event. For claim events where a maximum rand amount is indicated, we will not pay more than the indicated rand amount. The cover amount is indicated in the plan overview and may change over time as a result of benefit growth, alterations requested by the planholder, and claims.

Occupational disability cover

Claim event	Percentage of cover amount %
Occupational disability	
Contractual definition: Disability to the extent that the life insured is totally and permanently unable to fulfil the occupational demands of the occupation he or she practised for income immediately before the disability.	100
If the life insured is a qualifying student when he or she becomes disabled: Disability to the extent that the life insured will be totally and permanently unable to fulfil the occupational demands of an occupation we may reasonably expect him or her to have practised, had they not become disabled and had they completed their studies.	

What is a qualifying student?

A qualifying student is a full-time student

- in their final academic year studying toward an NQF-level 7 qualification; or
- in at least their 3rd academic year studying toward an NQF-level 8 or higher qualification.

A student progresses to the next academic year when they successfully pass a tertiary study year.

Extended occupational disability cover

If the life insured stops working for any reason other than retiring or becoming a qualifying student, for example, taking a sabbatical, becoming a housewife or being retrenched, we will continue to cover the life insured for occupational disability for up to 12 months from the date he or she stopped working.

For this cover, we will assess occupational disability according to the occupation the life insured performed immediately before he or she stopped working.

Extended occupational disability cover will only apply if the occupational disability is not as a result of any of the following conditions:

- depression or dysthymia, whether as an episode or disorder, or as part of the symptom complex of another psychiatric diagnosis;
- post-traumatic stress disorder;
- fibromyalgia;
- chronic fatigue syndrome and its synonyms;
- a back or neck condition, unless it is one of the following: paraplegia; quadriplegia; malignant tumours of the spinal cord and vertebral column; or failed back syndrome after multiple spinal surgery, provided the extent of the functional impairment arising from the failed back syndrome is verified by a specialist that we will nominate;
- any orthopaedic condition based mainly on pain, discomfort, loss of sensation, loss of range of motion, or any combination thereof;
- any decline in cognitive functioning irrespective of the cause thereof;
- an injury or illness that directly or indirectly resulted from, or is traceable to, any of the above causes;
- a complication that directly or indirectly is attributable to any of the above causes, or to such an injury or illness;
- a side-effect of treatment of any of the above causes, or for such an injury or illness or for such a complication.

Qualifying students

If the life insured is a qualifying student and successfully completes his or her studies, but does not yet start working, we will continue to cover him or her for occupational disability as if he or she is still a qualifying student, for up

to 12 months from the date he or she stopped studying. This extended occupational disability cover will only apply if the occupational disability is not as a result of any of the above listed conditions.

Conversion options

The payment will not reduce when the cover for occupational disability ends. If the life insured stops working before the cover end date of the benefit, and plans to never work again, the planholder may contact his or her intermediary about conversion options for this benefit. Conversion options may however not necessarily result in a lower payment.

Impairment and accidental cover

The claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated in the "Claim events: List 1" section later in this chapter.

Future medical advances

Some claim events 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 claim events, 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.

Waiting period for joint replacements

A waiting period of 5 years from the cover start date of the benefit is applicable to the following claim events resulting from natural causes:

- Total hip replacement;
- Total knee replacement;
- Total shoulder replacement;
- Total ankle 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.

Replacement of benefits

If a benefit covering the above joint replacement events has been replaced with this benefit without an interruption in cover and for the same amount of cover, the waiting period will not be applicable from the date of the replacement, but will be applicable from the original cover start date of the previous benefit. If the cover amount of the replaced benefit was however increased before the date of the replacement, other than through benefit growth, the waiting period on such an increase will be applicable from the cover start date of the increase.

If, at the time of replacement, the cover amount of this benefit was chosen to be higher than the cover amount of the replaced benefit, the above concession will not apply to the increased portion.

If the cover amount of this benefit is increased after the date of the replacement, other than through benefit growth, a new waiting period of 5 years from the cover start date of the increase will be applicable to the increase in the cover amount.

Admittance of a claim

Besides the conditions for admittance of a claim set out in the *General information* chapter, we will admit a claim only if

- the disability or impairment is caused directly and solely by a bodily injury or by an illness;
- the disability or impairment is permanent, after the life insured has undergone optimal, reasonable treatment;
- we have not previously admitted a claim for the same claim event, except if the claim event is listed under "Musculoskeletal system" in the "Claim events: List 1" section later in this chapter, and the claim is for a different limb;
- the life insured survived more than 10 days from the date the contractual claim event definition has been met. The survival period will only be applied to conditions where the prognosis of survival beyond 10 days is not certain, based on the available medical evidence.

For occupational disability, we will also only admit a claim if the claim event occurs before retirement, age 70 or the cover end date of the benefit, whichever is earlier.

The disability or impairment must be permanent, and evaluated according to the principles and ratings of the latest edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. The disability or

impairment, and permanence thereof, will be evaluated only 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.

References to permanence does not apply to the claim events listed under "Trauma" in the "Claim events: List 1" section later in this chapter.

If we admit a claim, we will pay the percentage of the cover amount linked to the particular claim event indicated in the "Claim events: List 1" section later in this chapter. The amount will be paid as a lump sum.

If the amount we pay is equal to or more than the cover amount, the benefit will end when we have paid the claim. If the amount we pay is less than the cover amount, we will reduce the cover amount with the amount that was paid. We will also reduce the payment of the benefit proportionally. Any amount we pay thereafter for a subsequent claim event, will be based on the reduced cover amount. The reduced cover amount will continue to increase on every plan anniversary if benefit growth is applicable to the plan.

Multiple claims

When we apply the rules in this section, claims for occupational disability, impairment as well as Temporary Incapacity will be considered.

If the life insured qualifies for more than one claim event at the same time, we will first consider the claim event with the highest percentage of the cover amount. If two claim events have the same percentage, we will first consider the claim event that is listed first in the "Claim events: List 1" section later in this chapter.

If the life insured however qualifies for more than one claim event at the same time and by qualifying for the one claim event implies qualifying for other claim events, we will only consider the claim event with the highest percentage of the cover amount.

The total lump sum we will pay will be limited to the cover amount of the benefit and once the full cover amount has been paid, the benefit will end. An exception to this is if we make a payment for the claim event "Paraplegia due to spinal cord severance or primary neurological disease of the spinal cord" or "Quadriplegia due to spinal cord severance or primary neurological disease of the spinal cord". For these claim events a lump sum of 125% or 150% of the cover amount will be payable, respectively, after which the benefit will end.

Exclusions

We will not admit a claim if the disability or impairment of the life insured can be substantially removed or improved by surgery or other medical treatment, which we can reasonably expect him or her to undergo, taking into account the risks involved and the chances of success of such surgery or treatment.

If the life insured at any time practises sport as an occupation, or works as a pilot, and becomes continuously unable to fulfil the occupational demands of that occupation, we will not admit a claim for occupational disability as a result of such inability.

Other general exclusions are set out in the applicable overview chapter in this technical guide. Specific exclusions, if any, are set out in the plan overview, in the special provisions for the life insured concerned.

Comprehensive Impairment (OAI, OSI)

The **Comprehensive Impairment** benefit is 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

This benefit provides cover for

- permanent impairment claim events; and
- accidental claim events.

If we admit a claim, we will pay the claim amount as a lump sum.

This benefit also includes the following, which are described in separate sections later in this chapter:

- Temporary Incapacity Cover for Accidental Causes; and
- Temporary Incapacity Cover for non-Accidental Causes.

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

An accelerator and standalone version of this benefit can be taken on the same plan for the same life insured.

Benefit	Type of benefit	
	Accelerator	Standalone
Comprehensive Impairment (OAI)	✓	
Comprehensive Impairment (OSI)		✓

When will cover for this benefit end?

Cover will end on the earlier of

- midnight before the cover end date indicated in the plan overview; and
- the plan ending for any reason before the cover end date; and
- 100% of the cover amount being paid or a claim being paid for "Paraplegia due to spinal cord severance or primary neurological disease of the spinal cord" or "Quadriplegia due to spinal cord severance or primary neurological disease of the spinal cord"; and
- the death of the life insured.

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:

- R5 000 000 under the Express product option*
- R35 000 000 otherwise*

*Subject to financial underwriting

The sum of the cover amounts of all **accelerator disability and impairment 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	<p>Benefit start age</p> <p>Minimum:</p> <ul style="list-style-type: none"> • Payment patterns other than fixed compulsory growth <ul style="list-style-type: none"> • 19 next birthday under the Express product option • 15 next birthday otherwise • Fixed compulsory growth: 30 next birthday <p>Maximum:</p> <ul style="list-style-type: none"> • Benefit with cease age 65: 60 next birthday • Benefit with cease age 70 or with whole life cover: 65 next birthday <p>Benefit cease age</p> <ul style="list-style-type: none"> • Topcover products: Choice between 65 or 70 next birthday, or whole life cover. • Term cover products: 65 next birthday. <p>Under Term cover products the term of a benefit is limited to a maximum of the selected term of the plan.</p>
Qualifying lives	<p>Express product option</p> <p>Only the planholder and his/her spouse may qualify, subject to age limits and underwriting.</p> <p>Classic and Premier product options</p> <p>Subject to age limits and underwriting.</p>
Guarantee period	<p>Express product option</p> <p>5 years</p> <p>Classic and Premier product options</p> <p>As selected for the plan.</p> <p>However, if the Comprehensive Impairment benefit is selected with whole life cover, the maximum initial guarantee period that may be chosen for a plan with this benefit is 10 years.</p> <p>If the planholder wants to take other benefits in combination with a whole life Comprehensive Impairment benefit and he/she requires an initial guarantee period of longer than 10 years for these other benefits, the other benefits must be taken on a separate plan.</p>

What benefit will be paid?

The claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated in the "Claim events: List 1" section later in this chapter. The contractual definitions will apply when we consider a claim. The layman's explanations are provided for a better understanding of the claim events but will not be used in the legal interpretation of the claim events.

If we admit a claim, we will pay the percentage of the cover amount linked to the particular claim event. For claim events where a maximum rand amount is indicated, we will not pay more than the indicated rand amount. The cover amount is indicated in the plan overview and may change over time as a result of benefit growth, alterations requested by the planholder, and claims.

Impairment and accidental cover

The claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated in the "Claim events: List 1" section later in this chapter.

Future medical advances

Some claim events 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 claim events, 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.

Waiting period for joint replacements

A waiting period of 5 years from the cover start date of the benefit is applicable to the following claim events resulting from natural causes:

- Total hip replacement;
- Total knee replacement;
- Total shoulder replacement;
- Total ankle 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.

Replacement of benefits

If a benefit covering the above joint replacement events has been replaced with this benefit without an interruption in cover and for the same amount of cover, the waiting period will not be applicable from the date of the replacement, but will be applicable from the original cover start date of the previous benefit. If the cover amount of the replaced benefit was however increased before the date of the replacement, other than through benefit growth, the waiting period on such an increase will be applicable from the cover start date of the increase.

If, at the time of replacement, the cover amount of this benefit was chosen to be higher than the cover amount of the replaced benefit, the above concession will not apply to the increased portion.

If the cover amount of this benefit is increased after the date of the replacement, other than through benefit growth, a new waiting period of 5 years from the cover start date of the increase will be applicable to the increase in the cover amount.

Admittance of a claim

Besides the conditions for admittance of a claim set out in the *General information* chapter, we will admit a claim only if

- the impairment is caused directly and solely by a bodily injury or by an illness;
- the impairment is permanent, after the life insured has undergone optimal, reasonable treatment;
- we have not previously admitted a claim for the same claim event, except if the claim event is listed under "Musculoskeletal system" in the "Claim events: List 1" section later in this chapter, and the claim is for a different limb;
- the life insured survived more than 10 days from the date the contractual claim event definition has been met. The survival period will only be applied to conditions where the prognosis of survival beyond 10 days is not certain, based on the available medical evidence.

The impairment must be permanent, and evaluated according to the principles and ratings of the latest edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. The impairment, and permanence thereof, will be evaluated only 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.

References to permanence does not apply to the claim events listed under "Trauma" in the "Claim events: List 1" section later in this chapter.

If we admit a claim, we will pay the percentage of the cover amount linked to the particular claim event indicated in the "Claim events: List 1" section later in this chapter. The amount will be paid as a lump sum.

If the amount we pay is equal to or more than the cover amount, the benefit will end when we have paid the claim. If the amount we pay is less than the cover amount, we will reduce the cover amount with the amount that was paid. We will also reduce the payment of the benefit proportionally. Any amount we pay thereafter for a subsequent claim event, will be based on the reduced cover amount. The reduced cover amount will continue to increase on every plan anniversary if benefit growth is applicable to the plan.

Multiple claims

When we apply the rules in this section, claims for impairment as well as Temporary Incapacity will be considered.

If the life insured qualifies for more than one claim event at the same time, we will first consider the claim event with the highest percentage of the cover amount. If two claim events have the same percentage, we will first consider the claim event that is listed first in the "Claim events: List 1" section later in this chapter.

If the life insured however qualifies for more than one claim event at the same time and by qualifying for the one claim event implies qualifying for other claim events, we will only consider the claim event with the highest percentage of the cover amount.

The total lump sum we will pay will be limited to the cover amount of the benefit and once the full cover amount has been paid, the benefit will end. An exception to this is if we make a payment for the claim event "Paraplegia due to spinal cord severance or primary neurological disease of the spinal cord" or "Quadriplegia due to spinal cord severance or primary neurological disease of the spinal cord". For these claim events a lump sum of 125% or 150% of the cover amount will be payable, respectively, after which the benefit will end.

Exclusions

We will not admit a claim if the impairment of the life insured can be substantially removed or improved by surgery or other medical treatment, which we can reasonably expect him or her to undergo, taking into account the risks involved and the chances of success of such surgery or treatment.

Other general exclusions are set out in the applicable overview chapter in this technical guide. Specific exclusions, if any, are set out in the plan overview, in the special provisions for the life insured concerned.

Accidental Comprehensive Disability (ASO3)

The **Accidental Comprehensive Disability** benefit is 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	<p>This benefit provides cover for</p> <ul style="list-style-type: none"> • permanent occupational disability from accidental causes up to retirement, age 70 or the cover end date of the benefit, whichever is earlier; and • permanent impairment claim events from accidental causes for as long as the benefit is in force. <p>If we admit a claim, we will pay the claim amount as a lump sum.</p> <p>We regard the life insured as retired if he or she is 55 years or older, and does not earn an income over and above a passive income. Passive income refers to income that can continue without the life insured's intervention, for example pension or rental income.</p> <p>Any reference to age 70 refers to the plan anniversary before or on the life insured's 70th birthday.</p>				
Additional features	<p>Additional features are features that are automatically included for a benefit. These features are free of charge. The following additional feature applies:</p> <ul style="list-style-type: none"> • Free cover <p>Refer to the chapter <i>Payments, payment patterns, guarantees and cover</i> for more information about Free cover.</p>				
Type of benefit	Standalone				
When will cover for this benefit end?	<p>Cover will end on the earlier of</p> <ul style="list-style-type: none"> • midnight before the cover end date indicated in the plan overview; and • the plan ending for any reason before the cover end date; and • 100% of the cover amount being paid or a claim being paid for "Paraplegia due to spinal cord severance" or "Quadriplegia due to spinal cord severance"; and • the death of the life insured. 				
Cover limits per life insured	<p>Students in at least their fourth year of study for a professional occupation may qualify for a limited amount of cover under the Classic or Premier product option, as described under "Financial underwriting" in the <i>Underwriting for Classic and Premier</i> chapter. Otherwise the limits below apply.</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">Minimum:</td> <td style="width: 85%;"> <ul style="list-style-type: none"> • R50 000 </td> </tr> <tr> <td>Maximum:</td> <td> <ul style="list-style-type: none"> • R5 000 000 under the Express product option* • R10 000 000 otherwise* </td> </tr> </table> <p>*Subject to financial underwriting</p>	Minimum:	<ul style="list-style-type: none"> • R50 000 	Maximum:	<ul style="list-style-type: none"> • R5 000 000 under the Express product option* • R10 000 000 otherwise*
Minimum:	<ul style="list-style-type: none"> • R50 000 				
Maximum:	<ul style="list-style-type: none"> • R5 000 000 under the Express product option* • R10 000 000 otherwise* 				

Age limits	<p>Benefit start age</p> <p>Minimum:</p> <ul style="list-style-type: none"> • Payment patterns other than fixed compulsory growth <ul style="list-style-type: none"> • 19 next birthday under the Express product option • 15 next birthday otherwise • Fixed compulsory growth: 30 next birthday <p>Maximum:</p> <ul style="list-style-type: none"> • Benefit with cease age 65: 60 next birthday • Benefit with cease age 70 or with whole life cover: 62 next birthday
	<p>Benefit cease age</p> <ul style="list-style-type: none"> • Topcover products: Choice between 65 or 70 next birthday, or whole life cover. • Term cover products: 65 next birthday. <p>Under Term cover products the term of a benefit is limited to a maximum of the selected term of the plan.</p>
Qualifying lives	<p>The following lives do not qualify:</p> <ul style="list-style-type: none"> • Housewives/house husbands • Scholars • Certain students • Pensioners • Unemployed persons <p>Other lives may qualify, including students in at least their fourth year of study for a professional occupation, subject to age limits and underwriting.</p> <p>Under the Express product option the Accidental Comprehensive Disability benefit is available to the planholder and/or his or her spouse only.</p>

Guarantee period	<p>Express product option 5 years</p> <p>Classic and Premier product options As selected for the plan.</p> <p>However, if the Accidental Comprehensive Disability benefit is selected with whole life cover, the maximum initial guarantee period that may be chosen for a plan with this benefit is 10 years.</p> <p>If the planholder wants to take other benefits in combination with a whole life Accidental Comprehensive Disability benefit and he/she requires an initial guarantee period of longer than 10 years for these other benefits, the other benefits must be taken on a separate plan.</p>
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What benefit will be paid?

The claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated in the "Claim events: List 2" section later in this chapter (where the below occupational disability claim event is again included). The contractual definitions will apply when we consider a claim. The layman's explanations are provided for a better understanding of the claim events but will not be used in the legal interpretation of the claim events.

If we admit a claim, we will pay the percentage of the cover amount linked to the particular claim event. The cover amount is indicated in the plan overview and may change over time as a result of benefit growth, alterations requested by the planholder, and claims.

Occupational disability cover

Claim event	Percentage of cover amount %
Occupational disability	
Contractual definition: Disability to the extent that the life insured is totally and permanently unable to fulfil the occupational demands of the occupation he or she practised for income immediately before the disability.	100
If the life insured is a qualifying student when he or she becomes disabled: Disability to the extent that the life insured will be totally and permanently unable to fulfil the occupational demands of an occupation we may reasonably expect him or her to have practised, had they not become disabled and had they completed their studies.	

What is a qualifying student?

A qualifying student is a full-time student

- in their final academic year studying toward an NQF-level 7 qualification; or
- in at least their 3rd academic year studying toward an NQF-level 8 or higher qualification.

A student progresses to the next academic year when they successfully pass a tertiary study year.

Extended occupational disability cover

If the life insured stops working for any reason other than retiring or becoming a qualifying student, for example, taking a sabbatical, becoming a housewife or being retrenched, we will continue to cover the life insured for occupational disability for up to 12 months from the date he or she stopped working.

For this cover, we will assess occupational disability according to the occupation the life insured performed immediately before he or she stopped working.

Extended occupational disability cover will only apply if the occupational disability is not as a result of any of the following conditions:

- a back or neck injury, unless it is one of the following: paraplegia; quadriplegia; or failed back syndrome after multiple spinal surgery, provided the extent of the functional impairment arising from the failed back syndrome is verified by a specialist that we will nominate;
- any orthopaedic injury based mainly on pain, discomfort, loss of sensation, loss of range of motion, or any combination thereof;
- an injury that directly or indirectly resulted from, or is traceable to, any of the above causes;
- a complication that directly or indirectly is attributable to any of the above causes, or to such an injury;
- a side-effect of treatment of any of the above causes, or for such an injury or for such a complication.

Qualifying students

If the life insured is a qualifying student and successfully completes his or her studies, but does not yet start working, we will continue to cover him or her for occupational disability as if he or she is still a qualifying student, for up to 12 months from the date he or she stopped studying. This extended occupational disability cover will only apply if the occupational disability is not as a result of any of the above listed conditions.

Conversion options

The payment will not reduce when the cover for occupational disability ends. If the life insured stops working before the cover end date of the benefit, and plans to never work again, the planholder may contact his or her intermediary about conversion options for this benefit. Conversion options may however not necessarily result in a lower payment.

Impairment cover

The claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated in the "Claim events: List 2" section later in this chapter.

Future medical advances

Some claim events 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 claim events, 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.

Admittance of a claim

Besides the conditions for admittance of a claim set out in the *General information* chapter, we will admit a claim only if

- the disability or impairment is caused directly and solely by a bodily injury as a result of an accident;
- the disability or impairment manifested within 12 months after the bodily injury;
- the disability or impairment is permanent, after the life insured has undergone optimal, reasonable treatment;
- the life insured survived more than 10 days from the date the contractual claim event definition has been met. The survival period will only be applied to conditions where the prognosis of survival beyond 10 days is not certain, based on the available medical evidence.

For occupational disability, we will also only admit a claim if the claim event occurs before retirement, age 70 or the cover end date of the benefit, whichever is earlier.

The disability or impairment must be permanent, and evaluated according to the principles and ratings of the latest edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. The disability or impairment, and permanence thereof, will be evaluated only 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.

For the purpose of this benefit, we will not recognise any intra- or post-operative complication, or any complication following a medical procedure, as an accident, unless the operation or procedure

- is a direct result of a bodily injury that took place after cover for this benefit has started, and
- takes place within 6 months of such a bodily injury.

If we admit a claim, we will pay the percentage of the cover amount linked to the particular claim event indicated in the "Claim events: List 2" section later in this chapter. The amount will be paid as a lump sum, after which the benefit will end.

Multiple claims

If the life insured qualifies for more than one claim event at the same time, we will consider the claim event with the highest percentage of the cover amount. If two claim events have the same percentage, we will consider the claim event that is listed first in the "Claim events: List 2" section later in this chapter.

Exclusions

We will not admit a claim if the disability or impairment of the life insured can be substantially removed or improved by surgery or other medical treatment, which we can reasonably expect him or her to undergo, taking into account the risks involved and the chances of success of such surgery or treatment.

If the life insured at any time practises sport as an occupation, or works as a pilot, and becomes continuously unable to fulfil the occupational demands of that occupation, we will not admit a claim for occupational disability as a result of such inability.

Other general exclusions are set out in the applicable overview chapter in this technical guide. Specific exclusions, if any, are set out in the plan overview, in the special provisions for the life insured concerned.

Accidental Comprehensive Disability Plus (ASO4)

The **Accidental Comprehensive Disability Plus** benefit is 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	<p>This benefit provides cover for</p> <ul style="list-style-type: none"> • permanent occupational disability from accidental causes up to retirement, age 70 or the cover end date of the benefit, whichever is earlier; and • permanent impairment claim events from accidental causes for as long as the benefit is in force; and • other accidental claim events for as long as the benefit is in force. <p>If we admit a claim, we will pay the claim amount as a lump sum.</p> <p>We regard the life insured as retired if he or she is 55 years or older, and does not earn an income over and above a passive income. Passive income refers to income that can continue without the life insured's intervention, for example pension or rental income.</p> <p>Any reference to age 70 refers to the plan anniversary before or on the life insured's 70th birthday.</p> <p>This benefit also includes the following, which are described in a separate section later in this chapter:</p> <ul style="list-style-type: none"> • Temporary Incapacity Cover for Accidental Causes. 				
Additional features	<p>Additional features are features that are automatically included for a benefit. These features are free of charge. The following additional feature applies:</p> <ul style="list-style-type: none"> • Free cover <p>Refer to the chapter <i>Payments, payment patterns, guarantees and cover</i> for more information about Free cover.</p>				
Type of benefit	Standalone				
When will cover for this benefit end?	<p>Cover will end on the earlier of</p> <ul style="list-style-type: none"> • midnight before the cover end date indicated in the plan overview; and • the plan ending for any reason before the cover end date; and • 100% of the cover amount being paid or a claim being paid for "Paraplegia due to spinal cord severance" or "Quadriplegia due to spinal cord severance"; and • the death of the life insured. 				
Cover limits per life insured	<p>Students in at least their fourth year of study for a professional occupation may qualify for a limited amount of cover under the Classic or Premier product option, as described under "Financial underwriting" in the <i>Underwriting for Classic and Premier</i> chapter. Otherwise the limits below apply.</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;">Minimum:</td> <td style="width: 80%;"> <ul style="list-style-type: none"> • R50 000 </td> </tr> <tr> <td>Maximum:</td> <td> <ul style="list-style-type: none"> • R5 000 000 under the Express product option* • R10 000 000 otherwise* </td> </tr> </table> <p>*Subject to financial underwriting</p>	Minimum:	<ul style="list-style-type: none"> • R50 000 	Maximum:	<ul style="list-style-type: none"> • R5 000 000 under the Express product option* • R10 000 000 otherwise*
Minimum:	<ul style="list-style-type: none"> • R50 000 				
Maximum:	<ul style="list-style-type: none"> • R5 000 000 under the Express product option* • R10 000 000 otherwise* 				

Age limits	<p>Benefit start age</p> <p>Minimum:</p> <ul style="list-style-type: none"> • Payment patterns other than fixed compulsory growth <ul style="list-style-type: none"> • 19 next birthday under the Express product option • 15 next birthday otherwise • Fixed compulsory growth: 30 next birthday <p>Maximum:</p> <ul style="list-style-type: none"> • Benefit with cease age 65: 60 next birthday • Benefit with cease age 70 or with whole life cover: 62 next birthday
	<p>Benefit cease age</p> <ul style="list-style-type: none"> • Topcover products: Choice between 65 or 70 next birthday, or whole life cover. • Term cover products: 65 next birthday. <p>Under Term cover products the term of a benefit is limited to a maximum of the selected term of the plan.</p>

Qualifying lives	<p>The following lives do not qualify:</p> <ul style="list-style-type: none"> • Housewives/house husbands • Scholars • Certain students • Pensioners • Unemployed persons <p>Other lives may qualify, including students in at least their fourth year of study for a professional occupation, subject to age limits and underwriting.</p> <p>Under the Express product option the Accidental Comprehensive Disability Plus benefit is available to the planholder and/or his or her spouse only.</p>
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Guarantee period	<p>Express product option 5 years</p> <p>Classic and Premier product options As selected for the plan.</p> <p>However, if the Accidental Comprehensive Disability Plus benefit is selected with whole life cover, the maximum initial guarantee period that may be chosen for a plan with this benefit is 10 years.</p> <p>If the planholder wants to take other benefits in combination with a whole life Accidental Comprehensive Disability Plus benefit and he/she requires an initial guarantee period of longer than 10 years for these other benefits, the other benefits must be taken on a separate plan.</p>
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What benefit will be paid?

The claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated in the "Claim events: List 2" section later in this chapter (where the below occupational disability claim event is again included). The contractual definitions will apply when we consider a claim. The layman's explanations are provided for a better understanding of the claim events but will not be used in the legal interpretation of the claim events.

If we admit a claim, we will pay the percentage of the cover amount linked to the particular claim event. For claim events where a maximum rand amount is indicated, we will not pay more than the indicated rand amount. The cover amount is indicated in the plan overview and may change over time as a result of benefit growth, alterations requested by the planholder, and claims.

Occupational disability cover

Claim event	Percentage of cover amount %
Occupational disability	
Contractual definition: Disability to the extent that the life insured is totally and permanently unable to fulfil the occupational demands of the occupation he or she practised for income immediately before the disability.	100
If the life insured is a qualifying student when he or she becomes disabled: Disability to the extent that the life insured will be totally and permanently unable to fulfil the occupational demands of an occupation we may reasonably expect him or her to have practised, had they not become disabled and had they completed their studies.	

What is a qualifying student?

A qualifying student is a full-time student

- in their final academic year studying toward an NQF-level 7 qualification; or
- in at least their 3rd academic year studying toward an NQF-level 8 or higher qualification.

A student progresses to the next academic year when they successfully pass a tertiary study year.

Extended occupational disability cover

If the life insured stops working for any reason other than retiring or becoming a qualifying student, for example, taking a sabbatical, becoming a housewife or being retrenched, we will continue to cover the life insured for occupational disability for up to 12 months from the date he or she stopped working.

For this cover, we will assess occupational disability according to the occupation the life insured performed immediately before he or she stopped working.

Extended occupational disability cover will only apply if the occupational disability is not as a result of any of the following conditions:

- a back or neck injury, unless it is one of the following: paraplegia; quadriplegia; or failed back syndrome after multiple spinal surgery, provided the extent of the functional impairment arising from the failed back syndrome is verified by a specialist that we will nominate;
- any orthopaedic injury based mainly on pain, discomfort, loss of sensation, loss of range of motion, or any combination thereof;
- an injury that directly or indirectly resulted from, or is traceable to, any of the above causes;
- a complication that directly or indirectly is attributable to any of the above causes, or to such an injury;
- a side-effect of treatment of any of the above causes, or for such an injury or for such a complication.

Qualifying students

If the life insured is a qualifying student and successfully completes his or her studies, but does not yet start working, we will continue to cover him or her for occupational disability as if he or she is still a qualifying student, for up to 12 months from the date he or she stopped studying. This extended occupational disability cover will only apply if the occupational disability is not as a result of any of the above listed conditions.

Conversion options

The payment will not reduce when the cover for occupational disability ends. If the life insured stops working before the cover end date of the benefit, and plans to never work again, the planholder may contact his or her intermediary about conversion options for this benefit. Conversion options may however not necessarily result in a lower payment.

Impairment and other accidental cover

The claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated in the "Claim events: List 2" section later in this chapter.

Future medical advances

Some claim events 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 claim events, 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.

Admittance of a claim

Besides the conditions for admittance of a claim set out in the *General information* chapter, we will admit a claim only if

- the disability or impairment is caused directly and solely by a bodily injury as a result of an accident;
- the disability or impairment manifested within 12 months after the bodily injury;
- the disability or impairment is permanent, after the life insured has undergone optimal, reasonable treatment;
- we have not previously admitted a claim for the same claim event, except if the claim event is listed under "Musculoskeletal system" in the "Claim events: List 2" section later in this chapter, and the claim is for a different limb;
- the life insured survived more than 10 days from the date the contractual claim event definition has been met. The survival period will only be applied to conditions where the prognosis of survival beyond 10 days is not certain, based on the available medical evidence.

For occupational disability, we will also only admit a claim if the claim event occurs before retirement, age 70 or the cover end date of the benefit, whichever is earlier.

The disability or impairment must be permanent, and evaluated according to the principles and ratings of the latest edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. The disability or impairment, and permanence thereof, will be evaluated only 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.

References to permanence does not apply to the claim events listed under "Trauma" in the "Claim events: List 2" section later in this chapter.

For the purpose of this benefit, we will not recognise any intra- or post-operative complication, or any complication following a medical procedure, as an accident, unless the operation or procedure

- is a direct result of a bodily injury that took place after cover for this benefit has started, and
- takes place within 6 months of such a bodily injury.

If we admit a claim, we will pay the percentage of the cover amount linked to the particular claim event indicated in the "Claim events: List 2" section later in this chapter. The amount will be paid as a lump sum.

If the amount we pay is equal to or more than the cover amount, the benefit will end when we have paid the claim. If the amount we pay is less than the cover amount, we will reduce the cover amount with the amount that was paid. We will also reduce the payment of the benefit proportionally. Any amount we pay thereafter for a subsequent claim event, will be based on the reduced cover amount. The reduced cover amount will continue to increase on every plan anniversary if benefit growth is applicable to the plan.

Multiple claims

When we apply the rules in this section, claims for occupational disability, impairment as well as Temporary Incapacity will be considered.

If the life insured qualifies for more than one claim event at the same time, we will first consider the claim event with the highest percentage of the cover amount. If two claim events have the same percentage, we will first consider the claim event that is listed first in the "Claim events: List 2" section later in this chapter.

If the life insured however qualifies for more than one claim event at the same time and by qualifying for the one claim event implies qualifying for other claim events, we will only consider the claim event with the highest percentage of the cover amount.

The total lump sum we will pay will be limited to the cover amount of the benefit and once the full cover amount has been paid, the benefit will end. An exception to this is if we make a payment for the claim event "Paraplegia due to spinal cord severance" or "Quadriplegia due to spinal cord severance". For these claim events a lump sum of 125% or 150% of the cover amount will be payable, respectively, after which the benefit will end.

Exclusions

We will not admit a claim if the disability or impairment of the life insured can be substantially removed or improved by surgery or other medical treatment, which we can reasonably expect him or her to undergo, taking into account the risks involved and the chances of success of such surgery or treatment.

If the life insured at any time practises sport as an occupation, or works as a pilot, and becomes continuously unable to fulfil the occupational demands of that occupation, we will not admit a claim for occupational disability as a result of such inability.

Other general exclusions are set out in the applicable overview chapter in this technical guide. Specific exclusions, if any, are set out in the plan overview, in the special provisions for the life insured concerned.

Accidental Elite Disability (ASO5)

The **Accidental Elite Disability** benefit is available under the Premier product option of our Topcover and Term cover products.

Benefit description	<p>This benefit provides cover for</p> <ul style="list-style-type: none"> • permanent occupational disability from accidental causes up to retirement, age 70 or the cover end date of the benefit, whichever is earlier; and • permanent impairment claim events from accidental causes for as long as the benefit is in force; and • other accidental claim events for as long as the benefit is in force. <p>If we admit a claim, we will pay the claim amount as a lump sum.</p> <p>We regard the life insured as retired if he or she is 55 years or older, and does not earn an income over and above a passive income. Passive income refers to income that can continue without the life insured's intervention, for example pension or rental income.</p> <p>Any reference to age 70 refers to the plan anniversary before or on the life insured's 70th birthday.</p> <p>This benefit also includes the following, which are described in separate sections later in this chapter:</p> <ul style="list-style-type: none"> • Temporary Incapacity Cover for Accidental Causes; and • A Prosthesis Booster.
Additional features	<p>Additional features are features that are automatically included for a benefit. These features are free of charge. The following additional feature applies:</p> <ul style="list-style-type: none"> • Free cover <p>Refer to the chapter <i>Payments, payment patterns, guarantees and cover</i> for more information about Free cover.</p>
Type of benefit	Standalone
When will cover for this benefit end?	<p>Cover will end on the earlier of</p> <ul style="list-style-type: none"> • midnight before the cover end date indicated in the plan overview; and • the plan ending for any reason before the cover end date; and • 100% of the cover amount being paid or a claim being paid for "Paraplegia due to spinal cord severance" or "Quadriplegia due to spinal cord severance"; and • the death of the life insured.
Cover limits per life insured	<p>Students in at least their fourth year of study for a professional occupation may qualify for a limited amount of cover under the Premier product option, as described under "Financial underwriting" in the <i>Underwriting for Classic and Premier</i> chapter. Otherwise the limits below apply.</p> <p>Minimum: R50 000 Maximum: R10 000 000*</p> <p>*Subject to financial underwriting</p>

Age limits	Benefit start age
Minimum:	<ul style="list-style-type: none"> • Payment patterns other than fixed compulsory growth: 15 next birthday • Fixed compulsory growth: 30 next birthday
Maximum:	<ul style="list-style-type: none"> • Benefit with cease age 65: 60 next birthday • Benefit with cease age 70 or with whole life cover: 62 next birthday

Benefit cease age

- Topcover products: Choice between 65 or 70 next birthday, or whole life cover.
- Term cover products: 65 next birthday.
Under Term cover products the term of a benefit is limited to a maximum of the selected term of the plan.

Qualifying lives

The following lives do not qualify:

- Housewives/house husbands
- Scholars
- Certain students
- Pensioners
- Unemployed persons

Other lives may qualify, including students in at least their fourth year of study for a professional occupation, subject to age limits and underwriting.

Guarantee period

As selected for the plan.

However, if the Accidental Elite Disability benefit is selected with **whole life cover**, the maximum initial guarantee period that may be chosen for a plan with this benefit is 10 years.

If the planholder wants to take other benefits in combination with a **whole life** Accidental Elite Disability benefit and he/she requires an initial guarantee period of longer than 10 years for these other benefits, the other benefits must be taken on a separate plan.

What benefit will be paid?

The claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated in the "Claim events: List 2" section later in this chapter (where the below occupational disability claim event is again included). The contractual definitions will apply when we consider a claim. The layman's explanations are provided for a better understanding of the claim events but will not be used in the legal interpretation of the claim events.

If we admit a claim, we will pay the percentage of the cover amount linked to the particular claim event. For claim events where a maximum rand amount is indicated, we will not pay more than the indicated rand amount. The cover amount is indicated in the plan overview and may change over time as a result of benefit growth, alterations requested by the planholder, and claims.

Occupational disability cover

Claim event	Percentage of cover amount %
Occupational disability	
Contractual definition: Disability to the extent that the life insured is totally and permanently unable to fulfil the occupational demands of the occupation he or she practised for income immediately before the disability.	100
If the life insured is a qualifying student when he or she becomes disabled: Disability to the extent that the life insured will be totally and permanently unable to fulfil the occupational demands of an occupation we may reasonably expect him or her to have practised, had they not become disabled and had they completed their studies.	

What is a qualifying student?

A qualifying student is a full-time student

- in their final academic year studying toward an NQF-level 7 qualification; or
- in at least their 3rd academic year studying toward an NQF-level 8 or higher qualification.

A student progresses to the next academic year when they successfully pass a tertiary study year.

Extended occupational disability cover

If the life insured stops working for any reason other than retiring or becoming a qualifying student, for example, taking a sabbatical, becoming a housewife or being retrenched, we will continue to cover the life insured for occupational disability for up to 12 months from the date he or she stopped working.

For this cover, we will assess occupational disability according to the occupation the life insured performed immediately before he or she stopped working.

Extended occupational disability cover will only apply if the occupational disability is not as a result of any of the following conditions:

- a back or neck injury, unless it is one of the following: paraplegia; quadriplegia; or failed back syndrome after multiple spinal surgery, provided the extent of the functional impairment arising from the failed back syndrome is verified by a specialist that we will nominate;
- any orthopaedic injury based mainly on pain, discomfort, loss of sensation, loss of range of motion, or any combination thereof;
- an injury that directly or indirectly resulted from, or is traceable to, any of the above causes;
- a complication that directly or indirectly is attributable to any of the above causes, or to such an injury;
- a side-effect of treatment of any of the above causes, or for such an injury or for such a complication.

Qualifying students

If the life insured is a qualifying student and successfully completes his or her studies, but does not yet start working, we will continue to cover him or her for occupational disability as if he or she is still a qualifying student, for up to 12 months from the date he or she stopped studying. This extended occupational disability cover will only apply if the occupational disability is not as a result of any of the above listed conditions.

Conversion options

The payment will not reduce when the cover for occupational disability ends. If the life insured stops working before the cover end date of the benefit, and plans to never work again, the planholder may contact his or her intermediary about conversion options for this benefit. Conversion options may however not necessarily result in a lower payment.

Impairment and other accidental cover

The claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated in the "Claim events: List 2" section later in this chapter.

Future medical advances

Some claim events 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 claim events, 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.

Admittance of a claim

Besides the conditions for admittance of a claim set out in the *General information* chapter, we will admit a claim only if

- the disability or impairment is caused directly and solely by a bodily injury as a result of an accident;
- the disability or impairment manifested within 12 months after the bodily injury;
- the disability or impairment is permanent, after the life insured has undergone optimal, reasonable treatment;
- we have not previously admitted a claim for the same claim event, except if the claim event is listed under "Musculoskeletal system" in the "Claim events: List 2" section later in this chapter, and the claim is for a different limb;
- the life insured survived more than 10 days from the date the contractual claim event definition has been met. The survival period will only be applied to conditions where the prognosis of survival beyond 10 days is not certain, based on the available medical evidence.

For occupational disability, we will also only admit a claim if the claim event occurs before retirement, age 70 or the cover end date of the benefit, whichever is earlier.

The disability or impairment must be permanent, and evaluated according to the principles and ratings of the latest edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. The disability or impairment, and permanence thereof, will be evaluated only 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.

References to permanence does not apply to the claim events listed under "Trauma" in the "Claim events: List 2" section later in this chapter.

For the purpose of this benefit, we will not recognise any intra- or post-operative complication, or any complication following a medical procedure, as an accident, unless the operation or procedure

- is a direct result of a bodily injury that took place after cover for this benefit has started, and
- takes place within 6 months of such a bodily injury.

If we admit a claim, we will pay the percentage of the cover amount linked to the particular claim event indicated in the "Claim events: List 2" section later in this chapter. The amount will be paid as a lump sum.

If the amount we pay is equal to or more than the cover amount, the benefit will end when we have paid the claim. If the amount we pay is less than the cover amount, we will reduce the cover amount with the amount that was paid. We will also reduce the payment of the benefit proportionally. Any amount we pay thereafter for a subsequent claim event, will be based on the reduced cover amount. The reduced cover amount will continue to increase on every plan anniversary if benefit growth is applicable to the plan.

Multiple claims

When we apply the rules in this section, claims for occupational disability, impairment as well as Temporary Incapacity will be considered.

If the life insured qualifies for more than one claim event at the same time, we will first consider the claim event with the highest percentage of the cover amount. If two claim events have the same percentage, we will first consider the claim event that is listed first in the "Claim events: List 2" section later in this chapter.

If the life insured however qualifies for more than one claim event at the same time and by qualifying for the one claim event implies qualifying for other claim events, we will only consider the claim event with the highest percentage of the cover amount.

The total lump sum we will pay will be limited to the cover amount of the benefit and once the full cover amount has been paid, the benefit will end. An exception to this is if we make a payment for the claim event "Paraplegia due to spinal cord severance" or "Quadriplegia due to spinal cord severance". For these claim events a lump sum of 125% or 150% of the cover amount will be payable, respectively, after which the benefit will end.

Exclusions

We will not admit a claim if the disability or impairment of the life insured can be substantially removed or improved by surgery or other medical treatment, which we can reasonably expect him or her to undergo, taking into account the risks involved and the chances of success of such surgery or treatment.

If the life insured at any time practises sport as an occupation, or works as a pilot, and becomes continuously unable to fulfil the occupational demands of that occupation, we will not admit a claim for occupational disability as a result of such inability.

Other general exclusions are set out in the applicable overview chapter in this technical guide. Specific exclusions, if any, are set out in the plan overview, in the special provisions for the life insured concerned.

Accidental Comprehensive Impairment (ASI)

The **Accidental Comprehensive Impairment** benefit is 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	<p>This benefit provides cover for</p> <ul style="list-style-type: none"> • permanent impairment claim events from accidental causes; and • other accidental claim events. <p>If we admit a claim, we will pay the claim amount as a lump sum.</p> <p>This benefit also includes the following, which is described in a separate section later in this chapter:</p> <ul style="list-style-type: none"> • Temporary Incapacity Cover for Accidental Causes. 				
Additional features	<p>Additional features are features that are automatically included for a benefit. These features are free of charge. The following additional feature applies:</p> <ul style="list-style-type: none"> • Free cover <p>Refer to the chapter <i>Payments, payment patterns, guarantees and cover</i> for more information about Free cover.</p>				
Type of benefit	Standalone				
When will cover for this benefit end?	<p>Cover will end on the earlier of</p> <ul style="list-style-type: none"> • midnight before the cover end date indicated in the plan overview; and • the plan ending for any reason before the cover end date; and • 100% of the cover amount being paid or a claim being paid for "Paraplegia due to spinal cord severance" or "Quadriplegia due to spinal cord severance"; and • the death of the life insured. 				
Cover limits per life insured	<p>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.</p> <table> <tr> <td>Minimum:</td> <td> <ul style="list-style-type: none"> • R50 000 </td> </tr> <tr> <td>Maximum:</td> <td> <ul style="list-style-type: none"> • R5 000 000 under the Express product option* • R10 000 000 otherwise* </td> </tr> </table> <p>*Subject to financial underwriting</p>	Minimum:	<ul style="list-style-type: none"> • R50 000 	Maximum:	<ul style="list-style-type: none"> • R5 000 000 under the Express product option* • R10 000 000 otherwise*
Minimum:	<ul style="list-style-type: none"> • R50 000 				
Maximum:	<ul style="list-style-type: none"> • R5 000 000 under the Express product option* • R10 000 000 otherwise* 				
Age limits	<p>Benefit start age</p> <table> <tr> <td>Minimum:</td> <td> <ul style="list-style-type: none"> • Payment patterns other than fixed compulsory growth <ul style="list-style-type: none"> • 19 next birthday under the Express product option • 15 next birthday otherwise • Fixed compulsory growth: 30 next birthday </td> </tr> <tr> <td>Maximum:</td> <td> <ul style="list-style-type: none"> • Benefit with cease age 65: 60 next birthday • Benefit with cease age 70 or with whole life cover: 65 next birthday </td> </tr> </table> <p>Benefit cease age</p> <ul style="list-style-type: none"> • Topcover products: Choice between 65 or 70 next birthday, or whole life cover. • Term cover products: 65 next birthday. <p>Under Term cover products the term of a benefit is limited to a maximum of the selected term of the plan.</p>	Minimum:	<ul style="list-style-type: none"> • Payment patterns other than fixed compulsory growth <ul style="list-style-type: none"> • 19 next birthday under the Express product option • 15 next birthday otherwise • Fixed compulsory growth: 30 next birthday 	Maximum:	<ul style="list-style-type: none"> • Benefit with cease age 65: 60 next birthday • Benefit with cease age 70 or with whole life cover: 65 next birthday
Minimum:	<ul style="list-style-type: none"> • Payment patterns other than fixed compulsory growth <ul style="list-style-type: none"> • 19 next birthday under the Express product option • 15 next birthday otherwise • Fixed compulsory growth: 30 next birthday 				
Maximum:	<ul style="list-style-type: none"> • Benefit with cease age 65: 60 next birthday • Benefit with cease age 70 or with whole life cover: 65 next birthday 				

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. However, if the Accidental Comprehensive Impairment benefit is selected with whole life cover , the maximum initial guarantee period that may be chosen for a plan with this benefit is 10 years. If the planholder wants to take other benefits in combination with a whole life Accidental Comprehensive Impairment benefit and he/she requires an initial guarantee period of longer than 10 years for these other benefits, the other benefits must be taken on a separate plan.

What benefit will be paid?

The claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated in the "Claim events: List 2" section later in this chapter. The contractual definitions will apply when we consider a claim. The layman's explanations are provided for a better understanding of the claim events but will not be used in the legal interpretation of the claim events.

If we admit a claim, we will pay the percentage of the cover amount linked to the particular claim event. For claim events where a maximum rand amount is indicated, we will not pay more than the indicated rand amount. The cover amount is indicated in the plan overview and may change over time as a result of benefit growth, alterations requested by the planholder, and claims.

Impairment and other accidental cover

The claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated in the "Claim events: List 2" section later in this chapter.

Future medical advances

Some claim events 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 claim events, 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.

Admittance of a claim

Besides the conditions for admittance of a claim set out in the *General information* chapter, we will admit a claim only if

- the impairment is caused directly and solely by a bodily injury as a result of an accident;
- the disability or impairment manifested within 12 months after the bodily injury;
- the impairment is permanent, after the life insured has undergone optimal, reasonable treatment;
- we have not previously admitted a claim for the same claim event, except if the claim event is listed under "Musculoskeletal system" in the "Claim events: List 2" section later in this chapter, and the claim is for a different limb;
- the life insured survived more than 10 days from the date the contractual claim event definition has been met. The survival period will only be applied to conditions where the prognosis of survival beyond 10 days is not certain, based on the available medical evidence.

The impairment must be permanent, and evaluated according to the principles and ratings of the latest edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. The impairment, and permanence thereof, will be evaluated only 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.

References to permanence does not apply to the claim events listed under "Trauma" in the "Claim events: List 2" section later in this chapter.

For the purpose of this benefit, we will not recognise any intra- or post-operative complication, or any complication following a medical procedure, as an accident, unless the operation or procedure

- is a direct result of a bodily injury that took place after cover for this benefit has started, and
- takes place within 6 months of such a bodily injury.

If we admit a claim, we will pay the percentage of the cover amount linked to the particular claim event indicated in the "Claim events: List 2" section later in this chapter. The amount will be paid as a lump sum.

If the amount we pay is equal to or more than the cover amount, the benefit will end when we have paid the claim. If the amount we pay is less than the cover amount, we will reduce the cover amount with the amount that was paid. We will also reduce the payment of the benefit proportionally. Any amount we pay thereafter for a subsequent claim event, will be based on the reduced cover amount. The reduced cover amount will continue to increase on every plan anniversary if benefit growth is applicable to the plan.

Multiple claims

When we apply the rules in this section, claims for impairment as well as Temporary Incapacity will be considered.

If the life insured qualifies for more than one claim event at the same time, we will first consider the claim event with the highest percentage of the cover amount. If two claim events have the same percentage, we will first consider the claim event that is listed first in the "Claim events: List 2" section later in this chapter.

If the life insured however qualifies for more than one claim event at the same time and by qualifying for the one claim event implies qualifying for other claim events, we will only consider the claim event with the highest percentage of the cover amount.

The total lump sum we will pay will be limited to the cover amount of the benefit and once the full cover amount has been paid, the benefit will end. An exception to this is if we make a payment for the claim event "Paraplegia due to spinal cord severance" or "Quadriplegia due to spinal cord severance". For these claim events a lump sum of 125% or 150% of the cover amount will be payable, respectively, after which the benefit will end.

Exclusions

We will not admit a claim if the impairment of the life insured can be substantially removed or improved by surgery or other medical treatment, which we can reasonably expect him or her to undergo, taking into account the risks involved and the chances of success of such surgery or treatment.

Other general exclusions are set out in the applicable overview chapter in this technical guide. Specific exclusions, if any, are set out in the plan overview, in the special provisions for the life insured concerned.

Temporary Incapacity Cover for Accidental Causes

Cover automatically included

This cover is automatically included in the following main benefits, if applicable to the life insured:

- Comprehensive Disability Plus (CAR4/CSR4)
- Elite Disability (CAR5/CSR5)
- Comprehensive Impairment (OAI/OSI)
- Accidental Comprehensive Disability Plus (ASO4)
- Accidental Elite Disability (ASO5)
- Accidental Comprehensive Impairment (ASI).

Cover description

A benefit may be claimed if the life insured suffers any bodily injury as a result of an accident and the recovery period for returning to work will be three months or longer, according to the Official Disability Guidelines (ODG) or scientifically accepted equivalent. The life insured does not have to prove any loss of income to qualify for a claim and the injury does not need to result in permanent impairment.

If we admit a claim, we will pay 10% of the cover amount of the main benefit as a lump sum. The cover amount of the main benefit will be reduced by the claim amount we will pay. We will also reduce the payment of the benefit proportionally. The cover amount of the main benefit is indicated in the plan overview and may change over time as a result of benefit growth, alterations requested by the planholder, and claims.

The Official Disability Guidelines (ODG) uses occupational duties as part of their determination of the recovery period of a claim event. For instances where a life insured is not in formal employment, for example, a student or a pensioner, we will use a life insured's health status before the claim event occurred as the benchmark for return to that level of recovery using the principles of the ODG or scientifically accepted equivalent.

The period of recovery referenced by the ODG will at times involve a range rather than a distinct point. In such instances we will use the midpoint of the range to determine whether the period of recovery will be three months or longer.

Scientifically accepted equivalents will enable a fair assessment of the impact of the injury in instances where the ODG is not sufficiently clear, for example when:

- an occupation is not catered for in the ODG;
- a key duty for the life insured is not standard for the occupational class;
- new scientifically accepted medical evidence supersedes the ODG.

In order for an alternative measure to be viewed as a scientifically accepted equivalent by our Chief Medical Officer it will need to be

- comparable to the ODG, in other words, accurately assess the likely period off work for different occupational duties following an injury event, and
- internationally accepted and used as best practice guidelines by the relevant medical specialists at the time.

Admittance of a claim

Besides the conditions for admittance of a claim set out in the *General information* chapter, we will admit a claim only if

- the claim event is caused directly and solely by a bodily injury due to an accident;
- the life insured survived more than 10 days after the date the claim event occurred. The survival period will only be applied to conditions where the prognosis of survival beyond 10 days is not certain, based on the available medical evidence;
- we have not previously admitted a claim for a claim event caused by the same accident under this cover, the main benefit or any other cover included in the main benefit;
- the claim event occurs before age 70 or the cover end date of the main benefit, whichever is earlier.

Any reference to age 70 refers to the plan anniversary before or on the life insured's 70th birthday.

Multiple claims

If the life insured qualifies for a claim event under this cover and at the same time also qualifies for claim events under the main benefit, the rules in the "Multiple claims" section of the main benefit will apply.

When will the benefit be paid?

The claim event depends on the period of recovery according to the ODG or scientifically accepted equivalent, not the actual period of recovery for the life insured. As such, the benefit can be paid as soon as the claim event definition has been met and the survival period has expired.

When will cover end?

It will end on the earlier of

- age 70 or the cover end date of the main benefit; and
- the plan ending for any reason before the cover end date of the main benefit.

Temporary Incapacity Cover for non-Accidental Causes

Cover automatically included

This cover is automatically included in the following main benefits, if applicable to the life insured:

- Comprehensive Disability Plus (CAR4/CSR4)
- Elite Disability (CAR5/CSR5)
- Comprehensive Impairment (OAI/OSI).

Cover description

If we admit a claim, we will pay 10% of the cover amount of the main benefit as a lump sum. The cover amount of the main benefit will be reduced by the claim amount we will pay. We will also reduce the payment of the benefit proportionally. The cover amount of the main benefit is indicated in the plan overview and may change over time as a result of benefit growth, alterations requested by the planholder, and claims.

The planholder may claim a benefit if the life insured suffers any of the claim events in the table below and, after the indicated waiting period, the recovery period for returning to work will be two months or longer, according to the Official Disability Guidelines (ODG) or scientifically accepted equivalent. The life insured does not have to prove any loss of income to qualify for a claim and the illness does not need to result in permanent impairment.

The Official Disability Guidelines (ODG) uses occupational duties as part of their determination of the recovery period of a claim event. For instances where a life insured is not in formal employment, for example, a student or a pensioner, we will use a life insured's health status before the claim event occurred as the benchmark for return to that level of recovery using the principles of the ODG or scientifically accepted equivalent.

The period of recovery referenced by the ODG will at times involve a range rather than a distinct point. In such instances we will use the midpoint of the range to determine whether the period of recovery will be two months or longer.

Scientifically accepted equivalents will enable a fair assessment of the impact of the illness in instances where the ODG is not sufficiently clear, for example when:

- an occupation is not catered for in the ODG;
- a key duty for the life insured is not standard for the occupational class;
- new scientifically accepted medical evidence supersedes the ODG.

In order for an alternative measure to be viewed as a scientifically accepted equivalent by our Chief Medical Officer it will need to be

- comparable to the ODG, in other words, accurately assess the likely period off work for different occupational duties following the applicable health event, and
- internationally accepted and used as best practice guidelines by the relevant medical specialists at the time.

The claim events with their contractual definitions, layman's explanations, where applicable, and waiting periods are indicated in the table below. The contractual definitions will apply when we consider a claim. The layman's explanations are provided for a better understanding of the claim events but will not be used in the legal interpretation of the claim events. The waiting period indicates the number of months from meeting the claim event definition after which the claim will be assessed according to the ODG or scientifically accepted equivalent.

If any of the claim events indicated in the table below are caused by an injury rather than an illness, it will be assessed under the Temporary Incapacity Cover for Accidental Causes.

Claim event	Waiting period in months
Cardiovascular system	
Valvular heart disease or cardiomyopathy	
<p>Contractual definition: Severe valvular heart disease or cardiomyopathy. This must be confirmed by a specialist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers severe disease of the heart valves or diseases of the heart muscle, where the heart muscle becomes enlarged, thick, or rigid (cardiomyopathy). This results in a weaker heart, with the heart being less able to pump blood through the body and maintain a normal electrical rhythm. This can lead to heart failure, where the symptoms progress to a stage where with light activity there is tiredness, shortness of breath or heart palpitations. This must be confirmed by a specialist.</i></p>	1
Ischaemic heart disease	
<p>Contractual definition: Ischaemic heart disease with cardiac failure. This must be confirmed by a specialist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers blockage of the arteries supplying blood to the heart muscles (ischaemic heart disease), complicated by the heart being less able to pump blood to supply the needs of the body (cardiac failure), where the symptoms progress to a stage where with light activity there is tiredness, shortness of breath or heart palpitations. This must be confirmed by a specialist.</i></p>	1
Pericardial disease	
<p>Contractual definition: Pericardial disease with cardiac failure, confirmed by a specialist.</p> <p><i>Layman's explanation:</i> <i>The pericardium is a sac that holds the heart in place and helps it to work properly. A disease of this sac can result in the heart being less able to pump blood through the body (cardiac failure), with symptoms of tiredness, shortness of breath or heart palpitations.</i></p>	1
Arrhythmia	
<p>Contractual definition: Arrhythmia resulting in cardiac failure or frequent fainting spells, confirmed by a specialist.</p> <p><i>Layman's explanation:</i> <i>Arrhythmia is an abnormal beat of the heart that can be too slow or too fast. This can result in the heart being less able to pump blood through the body (cardiac failure), with symptoms of tiredness, shortness of breath, heart palpitations or frequent fainting.</i></p>	1
Hypertension	
<p>Contractual definition: Hypertension with renal impairment, confirmed by a specialist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers high blood pressure with the kidneys not working as well as they should. This must be confirmed by a specialist.</i></p>	1
Diseases of the aorta	
<p>Contractual definition: Diseases of the aorta with cardiovascular impairment, confirmed by a specialist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers disease of the main artery supplying oxygen rich blood to the body (called the aorta), where the disease of this artery has resulted in heart failure, with the heart being less able to pump blood through the body and with symptoms of tiredness, shortness of breath or heart palpitations. This must be confirmed by a specialist.</i></p>	1
Peripheral arterial disease	
<p>Contractual definition: Peripheral arterial disease with impairment, confirmed by a specialist.</p> <p><i>Layman's explanation:</i> <i>Peripheral arterial disease is a problem with blood flow to the limbs due to narrowing of the arteries in the limbs.</i></p>	1

Claim event	Waiting period in months
Primary pulmonary artery hypertension Contractual definition: Primary pulmonary artery hypertension resulting in cardiovascular or respiratory impairment. This must be confirmed by a specialist.	1
<i>Layman's explanation:</i> <i>This claim event covers severe high blood pressure in the lung arteries which results in heart and lung impairment. This must be confirmed by a specialist.</i>	
Blood system	
Anaemia Contractual definition: Severe anaemia, requiring more than 1 transfusion of 2 or more units of blood or blood products for each transfusion. This must be confirmed by a specialist.	3
<i>Layman's explanation:</i> <i>This claim event covers persistent low oxygen carrying capacity of red blood cell count requiring more than 1 blood transfusion of 2 or more units per transfusion. This must be confirmed by a specialist.</i>	
White blood cell disorder	
Contractual definition: Severe white blood cell disorder, confirmed by a specialist.	1
<i>Layman's explanation:</i> <i>This claim event covers severe disorders of the infection fighting cells in the blood (the white blood cells). This must be confirmed by a specialist.</i>	
Clotting disorder	
Contractual definition: Severe clotting disorder, confirmed by a specialist. <i>Layman's explanation:</i> <i>Clotting disorder occurs when the body is unable to make components that is required by the body for blood to clot. When severe, this disorder can lead to severe bleeding from various sites, which can ultimately lead to multiple organ damage.</i>	3
Respiratory system	
Respiratory failure Contractual definition: Respiratory failure, confirmed by a specialist.	1
<i>Layman's explanation:</i> <i>Respiratory failure is a condition where the lungs are not able to meet the oxygen requirements of the body.</i>	
Central nervous system	
Hemiplegia Contractual definition: The total loss of muscle function of one side of the body due to disease of or injury to the spinal cord or brain, confirmed by a specialist.	1
Diplegia Contractual definition: The total loss of muscle function of both sides of the body due to disease of or injury to the spinal cord or brain, confirmed by a specialist.	1
Paraplegia Contractual definition: The total 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, confirmed by a specialist.	1
Quadriplegia Contractual definition: The total loss of muscle function resulting in the loss of use of both arms and both legs due to disease of or injury to the spinal cord or brain, confirmed by a specialist.	1

Claim event	Waiting period in months
Epilepsy Contractual definition: Uncontrolled epilepsy, with 2 or more epileptic attacks per week, or frequent status epilepticus, confirmed by a specialist.	1
<i>Layman's explanation:</i> <i>This claim event covers poorly controlled epilepsy, with 2 or more convulsions or seizures per week, or frequent status epilepticus. This must be confirmed by a specialist.</i> <i>Status epilepticus is a single seizure lasting for more than 5 minutes, or 2 or more seizures within a 5-minute period without the person returning to normal between them.</i>	
Parkinson's disease Contractual definition: Parkinson's disease with impairment, confirmed by a specialist.	1
<i>Layman's explanation:</i> <i>Parkinson's disease is a degenerative brain condition that leads to various symptoms, like tremor of the hands and head, a slow gait with shuffling feet, inability to show emotions, and a forward-falling posture.</i>	
Cognitive dementia Contractual definition: Cognitive dementia due to an organic brain disease, confirmed by a specialist.	1
<i>Layman's explanation:</i> <i>This claim event covers the onset of a decline in thinking and memory function (cognitive function) not in keeping with what is normal for the age (dementia). This must be as a result of a disease of the brain, and not due to a psychological cause. This must be confirmed by a specialist.</i>	
Cranial nerve VII Contractual definition: Cranial nerve VII paralysis, confirmed by a specialist.	3
<i>Layman's explanation:</i> <i>The facial nerve (the 7th cranial nerve) controls the muscles of facial expression, and functions in taste sensations of two-thirds of the tongue.</i>	
<i>This claim event covers paralysis of this nerve, with upper motor neuron facial paralysis of the facial muscles and inability to close eyelids. This must be confirmed by a specialist.</i>	
Cranial nerve VIII Contractual definition: Cranial nerve VIII paralysis or imbalance with impairment, confirmed by a specialist.	1
<i>Layman's explanation:</i> <i>The 8th cranial nerve transmits sound and balance information from the inner ear to the brain.</i>	
<i>This claim event covers paralysis of this nerve with balance disturbance. This must be confirmed by a specialist.</i>	
Cranial nerves IX, X or XII Contractual definition: Cranial nerves IX, X or XII paralysis or dysarthria or dysphagia, confirmed by a specialist.	1
<i>Layman's explanation:</i> <i>This claim event covers paralysis of cranial nerves 9, 10 or 12, with difficulty with swallowing, hoarseness, difficulty with speech, accidental inhalation of fluids into the lungs or airway, or passage of food through the nasal passages. This must be confirmed by a specialist.</i>	
Neurologic impairment of respiration Contractual definition: Neurologic impairment of respiration, confirmed by a specialist.	1
<i>Layman's explanation:</i> <i>This claim event covers impairment of breathing due to neurological disease or cause. This must be confirmed by a specialist.</i>	

Claim event	Waiting period in months
Gastro-intestinal system	
Gastro-intestinal tract disease	
<p>Contractual definition: Gastro-intestinal tract disease as a result of an organic disease, with stoma or persistent hernia symptoms after surgery. This must be confirmed by a specialist.</p> <p><i>Layman's explanation:</i> <i>The gastro-intestinal tract is an organ system within humans which takes in food, digests it to extract and absorb energy and nutrients, and expels the remaining waste as faeces.</i></p> <p><i>This claim event covers disease of this system, not due to a psychological cause, with</i></p> <ul style="list-style-type: none"> • Stoma (artificial opening in the gut), or • Persistent, irreducible and irreparable part of the bowel that protrudes through a weakness in the abdominal wall (hernia) after surgery, with bowel dysfunction and limitation in activities of daily living. <p><i>This must be confirmed by a specialist.</i></p>	3
Loss of bowel function	
<p>Contractual definition: Complete faecal incontinence as a result of an organic cause, confirmed by a specialist.</p> <p><i>Layman's explanation:</i> <i>Faecal incontinence is the inability to control bowel movements, causing stool (faeces) to leak unexpectedly from the rectum.</i></p> <p><i>This claim event covers faecal incontinence when the condition is with a total loss of control (thus complete). It must not be due to a psychological cause. This must be confirmed by a specialist.</i></p>	3
Liver disease	
<p>Contractual definition: Liver disease, resulting in acute liver failure, confirmed by a specialist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers disease of the liver resulting in acute liver failure (loss of liver function that occurs rapidly - in days or weeks). This must be confirmed by a specialist.</i></p>	1
Biliary tract disease	
<p>Contractual definition: Biliary tract disease resulting in acute liver failure, confirmed by a specialist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers biliary tract disease resulting in acute liver failure (loss of liver function that occurs rapidly - in days or weeks). This must be confirmed by a specialist.</i></p> <p><i>Biliary tract disease refers to diseases affecting the bile ducts, gall bladder and other structures involved in the production and transportation of bile. Bile is a fluid produced by the liver that aids in digestion.</i></p>	1
Endocrine system	
Disorders of the hypothalamic pituitary axis	
<p>Contractual definition: Disorders of the hypothalamic pituitary axis with impairment, confirmed by a specialist.</p> <p><i>Layman's explanation:</i> <i>The hypothalamic pituitary axis plays key roles in controlling hormone secretion that has an effect on other organs in the body.</i></p>	3
Hypoadrenalism	
<p>Contractual definition: Hypoadrenalism with impairment, confirmed by a specialist.</p> <p><i>Layman's explanation:</i> <i>Hypoadrenalism is a condition in which the adrenal glands do not produce adequate amounts of steroid hormones. The adrenal glands are small glands located on the top end of a kidney that produce important hormones in the body.</i></p>	3

Claim event	Waiting period in months
Hyperadrenocorticism	
Contractual definition: Hyperadrenocorticism with impairment, confirmed by a specialist.	3
<i>Layman's explanation:</i> <i>Hyperadrenocorticism, which is often called Cushing's syndrome, is an extremely complex condition that involves many areas of the body. It results from an excess of a hormone called cortisol and its effects on the human body.</i>	
Phaeochromocytoma	
Contractual definition: Phaeochromocytoma with impairment, confirmed by a specialist.	3
<i>Layman's explanation:</i> <i>Pheochromocytoma is a rare tumour of adrenal gland tissue. It results in the release of too many of the hormones that control heart rate, metabolism, and blood pressure. The adrenal glands are small glands located on the top end of a kidney that produce important hormones in the body.</i>	
Diabetes mellitus: type I or II	
Contractual definition: Diabetes mellitus: type I or II with moderate to severe renal or visual or cardiac impairment, confirmed by a specialist.	3
<i>Layman's explanation:</i> <i>Diabetes mellitus is a disorder in which blood sugar (glucose) levels are abnormally high because the body does not produce enough insulin to meet its needs.</i>	
Catch-all for other disorders of the endocrine system	
Contractual definition: Any disorder of the endocrine disorder not specified in the other listed events for the endocrine system that is confirmed by a specialist, resulting in impairment.	3
<i>Layman's explanation:</i> <i>The endocrine system has eight major glands, which make hormones. Hormones affect the functions of the entire body. Any disease of a gland can cause imbalances in the body which can be from mild to serious. This claim event covers any disorder of any of these glands not specified in the listed events that is confirmed by a specialist.</i>	
Renal system	
Kidney failure	
Contractual definition: Moderate to severe kidney failure, confirmed by a specialist, with objective medical evidence.	1
<i>Layman's explanation:</i> <i>Kidney failure refers to failure of the kidneys to function properly.</i>	
Bladder or urethral disease	
Contractual definition: Bladder or urethral disease of organic cause resulting in complete urinary incontinence, confirmed by a specialist.	3
<i>Layman's explanation:</i> <i>This claim event covers bladder or urethral disease, not due to a psychological cause. The disease must result in uncontrolled leakage of urine. This must be confirmed by a specialist.</i>	
Musculoskeletal system	
Loss of use of a hand	
Contractual definition: The total loss of function of an entire hand from the wrist (distal to the wrist), confirmed by a specialist with supporting evidence.	3
Loss of use of an arm	
Contractual definition: The total loss of function of an entire arm from the shoulder (distal to the shoulder), confirmed by a specialist with supporting evidence.	3
Loss of use of a foot	
Contractual definition: The total loss of function of an entire foot from the ankle (distal to the ankle), confirmed by a specialist with supporting evidence.	3

Claim event	Waiting period in months
Loss of use of a lower leg Contractual definition: The total loss of function of an entire leg from below the knee (below and distal to the knee joint), confirmed by a specialist with supporting evidence.	3
Loss of use of a leg Contractual definition: The total loss of function of an entire leg (proximal and distal to the knee joint), confirmed by a specialist with supporting evidence.	3
Loss of use of a combination of two limbs or an eye Contractual definition: The total loss of function of any 2 of the following, as described in this table, resulting from the same cause, provided they are not part of the same limb: <ul style="list-style-type: none">• Loss of use of a hand• Loss of use of an arm• Loss of use of a foot• Loss of use of a lower leg• Loss of use of a leg• Total loss of vision of one eye or hemianopia of one eye. This must be confirmed by a specialist with supporting evidence.	3
Visual system	
Partial loss of vision of both eyes Contractual definition: Bilateral visual impairment of 50% as a result of an organic cause, confirmed by a specialist with supporting evidence and meeting the following criteria: <ul style="list-style-type: none">• A reading of at least 20/125 (or equivalent measure) in each eye, or• Diabetic retinopathy grade III or grade IIII retinopathy as a result of a chronic disease in each eye, or• A visual field loss to a 20° radius in each eye. <i>Layman's explanation:</i> <i>This claim event covers decreased vision of 50%, not due to a psychological cause. It must meet the criteria described in the contractual definition above and must be confirmed by a specialist.</i>	1
Total loss of vision of both eyes or blindness of both eyes Contractual definition: Total loss of vision of both eyes or blindness of both eyes by visual acuity or retinal pathology or visual field measurements, as a result of an organic cause and confirmed by a specialist.	1
<i>Layman's explanation:</i> <i>This claim event covers the total loss of vision of both eyes or blindness of both eyes, not due to a psychological cause. It must meet the criteria described in the contractual definition above, and must be confirmed by a specialist.</i>	
Speech	
Aphasia Contractual definition: Total loss of the ability to speak as a result of an organic brain disease, confirmed by neurosurgeon or neurologist.	1
<i>Layman's explanation:</i> <i>This claim event covers the total loss of the ability to speak, not due to a psychological cause. This must be confirmed by a specialist (neurosurgeon or neurologist).</i>	
Partial loss of speech Contractual definition: Partial loss of the ability to speak as a result of organic ear, nose and throat (ENT) disease, affecting daily activity, confirmed by an ear, nose and throat specialist.	6
<i>Layman's explanation:</i> <i>This claim event covers the partial loss of the ability to speak as a result of a confirmed disease of the ear, nose and throat organ, not due to a psychological cause. This must be confirmed by a specialist (ear, nose and throat specialist).</i>	

Claim event	Waiting period in months
Total loss of speech Contractual definition: Total loss of the ability to speak as a result of organic ear, nose and throat (ENT) disease, confirmed by an ear, nose and throat specialist. <i>Layman's explanation:</i> <i>This claim event covers the total loss of the ability to speak as a result of a confirmed disease of the ear, nose and throat organ, not due to a psychological cause. This must be confirmed by a specialist (ear, nose and throat specialist).</i>	3
Psychiatric conditions	
Psychiatric condition Contractual definition: Psychiatric condition with frequent, extended admissions, meeting the following criteria: <ul style="list-style-type: none"> • Institutionalised in a registered psychiatric facility at least 3 times during the last 12 months, with each admission lasting for longer than 6 weeks, and • Must be confirmed by a specialist. OR Psychiatric condition with one prolonged admission: The diagnosis of a psychiatric disorder, according to the latest Diagnostic and Statistical Manual of Mental Disorders (DSM) classification, meeting the following criteria: <ul style="list-style-type: none"> • Institutionalised in a registered psychiatric facility for more than 3 consecutive months, and • Undergoing of constant supervision with a permanent caregiver, and • Must be confirmed by at least 2 independent psychiatric reports by the relevant specialists. 	12

Future medical advances

Some claim events 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 claim events, 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.

Admittance of a claim

Besides the conditions for admittance of a claim set out in the *General information* chapter, we will admit a claim only if

- the disability is caused directly and solely by an illness;
- the life insured survived more than 10 days after the date the claim event occurred. The survival period will only be applied to conditions where the prognosis of survival beyond 10 days is not certain, based on the available medical evidence;
- the claim event is not related to a claim event previously admitted under this cover, the main benefit or any other cover included in the main benefit;
- the claim event occurs before age 70 or the cover end date of the main benefit, whichever is earlier.

Any reference to age 70 refers to the plan anniversary before or on the life insured's 70th birthday.

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.

Multiple claims

If the life insured qualifies for more than one claim event at the same time, we will first consider one claim event and if we admit the claim, we will only consider the other claim events if they are not related to the first.

If the life insured qualifies for a claim event under this cover and at the same time also qualifies for claim events under the main benefit, the rules in the "Multiple claims" section of the main benefit will apply.

When will the benefit be paid?

The claim event depends on the period of recovery according to the ODG or scientifically accepted equivalent, not the actual period of recovery of the life insured. As such, the benefit can be paid as soon as the waiting period linked to the claim event has expired and it has been confirmed that the recovery period for returning to work will be at least another two months, according to the ODG or scientifically accepted equivalent.

When will cover end?

It will end on the earlier of

- age 70 or the cover end date of the main benefit; and
- the plan ending for any reason before the cover end date of the main benefit.

Prosthesis Booster

Booster automatically included

This Booster is automatically included in the following main benefits, if applicable to the life insured:

- Elite Disability (CAR5/CSR5)
- Accidental Elite Disability (ASO5).

Booster description

If we admit a claim, we will pay a percentage of the cover amount of the main benefit as a lump sum. We will not reduce the cover amount of the main benefit by the claim amount we will pay for this benefit. The cover amount of the main benefit is indicated in the plan overview and may change over time as a result of benefit growth, alterations requested by the planholder, and claims.

If a life insured qualifies for one of the claim events in the table below, he or she will also qualify for the same claim event under the main benefit and may also qualify for the occupational disability claim event under the main benefit. The claim amount for this Prosthesis Booster will however be calculated first, before the cover amount of the main benefit is reduced by the claim under the main benefit. This implies a total payout of up to 250% of the cover amount.

All the claim events in the table below will be limited to a maximum payout of R10 million. This maximum may be adjusted from time to time.

Claim event

The claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount of the main benefit are indicated in the table below. The contractual definitions will apply when we consider a claim. The layman's explanations are provided for a better understanding of the claim events but will not be used in the legal interpretation of the claim events. For multiple claims, we may pay a lower percentage than the claim event percentage, as described under "Multiple claims".

Claim event	Percentage of the cover amount %
Musculoskeletal system	
Amputation of a hand	
Contractual definition: The amputation of a hand at the wrist by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	100
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of a hand at the wrist. This must be confirmed by a specialist with supporting evidence.</i>	
Amputation of an arm below the elbow	
Contractual definition: The amputation of an arm distal to the elbow by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	100
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of an arm below the elbow. This must be confirmed by a specialist with supporting evidence.</i>	
Amputation of an arm above the elbow	
Contractual definition: The amputation of an arm proximal to the elbow by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	100
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of an arm above the elbow. This must be confirmed by a specialist with supporting evidence.</i>	

Claim event	Percentage of the cover amount %
Amputation of a foot	
<p>Contractual definition: The amputation of a foot at the level of the ankle joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.</p> <p><i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of a foot at the ankle joint. This must be confirmed by a specialist with supporting evidence.</i></p>	30
Amputation of a leg below the knee	
<p>Contractual definition: The amputation of a leg distal to the knee joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.</p> <p><i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of a leg below the knee. This must be confirmed by a specialist with supporting evidence.</i></p>	100
Amputation of a leg above the knee	
<p>Contractual definition: The amputation of a leg proximal to the knee joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.</p> <p><i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of a leg above the knee. This must be confirmed by a specialist with supporting evidence.</i></p>	100
Central nervous system	
Paraplegia due to spinal cord severance or primary neurological disease	
<p>Contractual definition: Paraplegia due to spinal cord severance or primary neurological disease of the spinal cord, meeting the following criteria: The total and permanent loss of muscle function resulting in the loss of use of both legs due to complete severance of the spinal cord or primary neurological disease of the spinal cord.</p> <p>The following is required:</p> <ul style="list-style-type: none"> • Radiological evidence such as a computed tomography (CT) scan or magnetic resonance imaging (MRI), and • Must be confirmed by a neurologist or neurosurgeon. 	100
Quadriplegia due to spinal cord severance or primary neurological disease	
<p>Contractual definition: Quadriplegia due to spinal cord severance or primary neurological disease, meeting the following criteria: The total and permanent loss of muscle function resulting in the loss of use of both arms and both legs due to complete severance of the spinal cord or primary neurological disease of the spinal cord.</p> <p>The following is required:</p> <ul style="list-style-type: none"> • Radiological evidence such as a computed tomography (CT) scan or magnetic resonance imaging (MRI), and • Must be confirmed by a neurologist or neurosurgeon. 	100

Admittance of a claim

Besides the conditions for admittance of a claim set out in the *General information* chapter, we will admit a claim only if

- the impairment is caused directly and solely by a bodily injury or by an illness, if the main benefit is Elite Disability;
- the impairment is caused directly and solely by a bodily injury, if the main benefit is Accidental Elite Disability;
- the life insured survived more than 10 days from the date the contractual claim event definition has been met. The survival period will only be applied to conditions where the prognosis of survival beyond 10 days is not certain, based on the available medical evidence;
- the claim event occurs before retirement, age 70 or the cover end date of the main benefit, whichever is earlier.

We regard the life insured as retired if he or she is 55 years or older, and does not earn an income over and above a passive income. Passive income refers to income that can continue without the life insured's intervention, for example pension or rental income.

Any reference to age 70 refers to the plan anniversary before or on the life insured's 70th birthday.

Multiple claims

If the life insured qualifies for more than one claim event at the same time, we will only consider the claim event with the highest percentage of the cover amount. If two claim events have the same percentage, we will only consider one of the claim events.

The planholder can claim under the Prosthesis Booster once only, except if the first claim we have admitted was for the amputation of one foot. In this case a second, future claim will be possible for a different claim event, but will be limited to 70% of the cover amount of the main benefit at the time. The second payout will also be limited to ensure that the total payout for both claims does not exceed R10 million.

When will cover end?

It will end on the earlier of

- 100% of the cover amount or a maximum of R10 million being paid; and
- a second claim being paid, as described under "Multiple claims"; and
- retirement, age 70 or the cover end date of the main benefit; and
- the plan ending for any reason before the cover end date of the main benefit.

Built-in Future Cover for Young Lives

Cover automatically included

This cover is automatically included in the following **standalone** main benefits, if applicable to the life insured:

- Comprehensive Disability (CSR3)
- Comprehensive Disability Plus (CSR4)
- Elite Disability (CSR5)

It may also be included in the following Income Protector benefits, if the main benefit's description in the contract documents refers to it:

- Extended Income (OIO4)
- Extended Income Plus (OIO6).

Cover description

If the criteria under "Qualifying criteria" are met, the planholder has the option to purchase future death cover on the life of the insured. If the planholder exercises the option within five years of the cover start date of the main benefit, it will be without proof of good health. If the planholder exercises the option later than five years after the cover start date of the main benefit, a declaration of good health will be required. The option expires on the plan anniversary before or on the life insured's 35th birthday and can only be exercised at certain life events.

The planholder may purchase cover under one or more of the death benefits available when he or she exercises an option. The list of available benefits will change if we discontinue a benefit, or make other benefits available. The following benefits are currently available:

- Death (DS)
- First death (DS80)
- Credit Life (DSC)
- Immediate Expenses (DSF3)
- Death income (DI3).

Qualifying criteria

This cover is offered subject to the following qualifying criteria:

- The start date of the main benefit must be before the plan anniversary before or on the life insured's 35th birthday; and
- The main benefit must be a standalone benefit; and
- The life insured must not have received any medical loadings or exclusions on the main benefit when the planholder applied for the main benefit.

Life events for exercising an option

The planholder may exercise an option for one or more of the following life events:

- Marriage
- Birth or adoption of a child
- Taking out a home loan
- Taking out a business loan.

Marriage refers to a marriage, civil or customary union as recognised by the laws of the Republic of South Africa, or a union recognised as marriage in accordance with the principles of any religion. The life insured must be a party to the marriage.

Birth or adoption of a child refers to the birth or legal adoption of a child where the life insured is the parent of the child.

What amount may be exercised?

For lump sum benefits the maximum available cover amount for which the planholder may exercise an option is

- the cover amount of the main disability lump sum benefit,
- minus the cover amounts of any death lump sum benefits already purchased under this option.

All of the above cover amounts are at the time when the planholder exercises the new option.

If a medical loading or exclusion did not apply for a life insured when the planholder originally applied for the main benefit, but the life insured received a medical loading or exclusion when the planholder requested a cover increase on the main benefit at a later stage, this increase and all subsequent yearly and requested increases will not be included in the cover amount of the main benefit during the calculation above.

When the planholder exercises an option for a loan, the available option amount will be limited to the value of the loan. The available option amount may be reduced due to financial underwriting when the planholder exercises an option for any of the indicated life events.

The amount exercised must comply with the minimum new business requirements applicable at the time.

If the main benefit or the purchased death benefit is not a lump sum benefit or if the death cover previously purchased was not lump sum cover, the equivalent cover amounts will be determined using conversion factors applicable at the time.

The cover amount of the main benefit will not be reduced when the planholder exercises an option.

Requirements for exercising an option

The option must be exercised within three months of the date of the life event and must be accompanied with the necessary proof of the life event.

When the planholder exercises an option, the planholder must take out a new plan. If the main benefit is on an Express plan, the new death benefit must also be on an Express plan.

We will still require the following for the life insured at the time when the planholder exercises an option:

- financial underwriting;
- occupational underwriting;
- underwriting for risky part-time activities;
- overseas underwriting, where applicable.

The life insured's rating factors at the time of exercising the option will also apply. These include a rating factor for raised body mass (BMI), depending on the life insured's BMI at the time.

When will cover end?

Cover will end on the earlier of

- the plan anniversary before or on the life insured's 35th birthday, and
- midnight before the cover end date of the main benefit set out in the plan overview, and
- the plan ending for any reason before the cover end date of the main benefit.

Built-in Child Cover

Cover automatically included

This cover is automatically included in the Elite Disability (CAR5/CSR5) main benefit, if applicable to a life insured.

Cover description

A benefit may be claimed if a child of the life insured on the main benefit suffers any of the illnesses or injuries indicated under "Claim event".

If we admit a claim, we will pay 10% of the cover amount of the main benefit as a lump sum, or a lower percentage if the claim is within the waiting period. We will not reduce the cover amount of the main benefit with the claim amount we will pay. The cover amount is indicated in the plan overview and may change over time as a result of benefit growth, alterations requested by the planholder, and claims.

We will pay a maximum of R500 000 per child. If one parent has more than one benefit where this cover is included, we will pay a maximum of R500 000 per child. If more than one parent have benefits where this cover is included, we will pay a maximum of R1 million per child.

Claim event

The claim events with their contractual definitions and layman's explanations, where applicable, are indicated in the table below. The contractual definitions will apply when we consider a claim. The layman's explanations are provided for a better understanding of the claim events but will not be used in the legal interpretation of the claim events.

Where "life insured" is used in any of the contractual definitions, it refers to a child of the life insured on the main benefit.

Child refers to a biological, legally adopted or step child of the life insured on the main benefit.

Claim event
Surgery to major blood vessel: aorta, carotid, pulmonary, coronary or femoral artery
Contractual definition: The excision and replacement of a portion of the thoracic or abdominal aorta, pulmonary artery, carotid artery, femoral artery or any coronary artery with a graft, due to an aneurism or damage to the blood vessel. Catheter or keyhole techniques to repair the aneurism or damage are included.
<i>Layman's explanation:</i> <i>Fixing a damaged section of a major blood vessel.</i>
Cardiomyopathy
Contractual definition: Signs and symptoms of cardiomyopathy with functional impairment resulting in symptoms of heart failure at rest despite optimal treatment, as confirmed by a cardiologist.
<i>Layman's explanation:</i> <i>An enlarged heart with very poor function.</i>
Stroke resulting in permanent impairment
Contractual definition: The death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in neurological deficit lasting longer than 24 hours, confirmed by neuro-imaging investigation and appropriate clinical findings by a specialist neurologist.
A full neurological examination by a neurologist three months or longer after the event must confirm that the life insured has a whole person impairment (WPI) of class 1 (1% – 10%) or more.
WPI figures are calculated according to the principles and ratings of the latest edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment.
<i>Layman's explanation:</i> <i>Paralysis of one side of the body due to a blood clot or bleeding on the brain.</i>

Claim event
Open-heart surgery
Contractual definition: Open-heart surgery with sternotomy to replace or repair a diseased heart valve or heart septum defect, or to reposition any of the major heart vessels.
<i>Layman's explanation:</i> <i>Repairing a heart valve or hole in the heart, usually after rheumatic fever or discovering a birth defect. This is done by open-heart surgery, in other words, the chest is cut open.</i>
Heart attack
Contractual definition: The contractual definition for this claim event is given below this table.
Primary pulmonary hypertension (PPH)
Contractual definition: A haemodynamic and pathophysiological condition defined as an increase in mean pulmonary arterial pressure (PAP) of greater than or equal to 25 mmHg at rest as assessed by right heart catheterization.
<i>Layman's explanation:</i> <i>Abnormal blood flow and abnormal pressure in the lungs.</i>
Renal failure
Contractual definition: Chronic irreversible end-stage renal failure, as a result of which regular peritoneal dialysis or haemodialysis is required on a long-term basis.
<i>Layman's explanation:</i> <i>Chronic kidney failure.</i>
Liver failure
Contractual definition: End-stage liver failure due to cirrhosis or chronic progressive liver disease, with objective evidence of jaundice, esophageal varices and ascites.
<i>Layman's explanation:</i> <i>Chronic failure of the liver with yellow jaundice.</i>
End-stage lung disease
Contractual definition: Diagnosis by a pulmonologist of end-stage chronic obstructive lung disease, interstitial lung disease or pneumoconiosis, requiring home oxygen therapy, and one of the following: <ul style="list-style-type: none"> • cor pulmonale, or • diffusion capacity (DCO) of less than 40%, or • forced expiratory volume in one second (FEV1) or forced vital capacity (FVC) of less than one litre. To optimise patient co-operation and ensure reliable and consistent results, all lung function measurements must <ul style="list-style-type: none"> • be done by a registered pulmonologist, • be done on a calibrated apparatus, and • include at least three flow volume curves with less than 5% inter-test variability.
<i>Layman's explanation:</i> <i>End-stage lung disease that requires the use of oxygen at home.</i>
Bone marrow failure (aplastic anaemia)
Contractual definition: An acquired abnormality of blood cell production with total aplasia of the bone marrow as confirmed by a consultant haematologist, requiring one of the following: <ul style="list-style-type: none"> • regular transfusion with whole blood or other blood products for anaemia or thrombocytopenia (transfusion dependant), or • immunosuppressive therapy, or • bone marrow transplantation preceded by total bone marrow ablation.
<i>Layman's explanation:</i> <i>A disease that permanently damages the bone marrow. This will require regular blood transfusions, chemotherapy or a bone marrow transplant.</i>

Claim event
Organ transplant
<p>Contractual definition:</p> <ul style="list-style-type: none"> • Receiving a kidney, heart, lung, liver, pancreas or bone marrow transplant, or • Confirmation of being on a recognized national South African transplant waiting list, awaiting a kidney, heart, lung, liver, pancreas or bone marrow transplant. <p>For a bone marrow transplantation, the transplantation must be preceded by, or will be preceded by, total bone marrow ablation.</p> <p><i>Layman's explanation:</i> <i>Applies if the child receives a transplanted kidney, heart, liver, lung, pancreas or bone marrow.</i></p>
Cancer, except the cancers excluded under "Exclusions"
<p>Contractual definition:</p> <p>A malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukaemia, lymphoma and sarcoma.</p> <p><i>Layman's explanation:</i> <i>Cancer, excluding most skin cancers and very early stages of some cancers that recover completely with minimal treatment.</i></p>
Benign brain tumour that is inoperable or recurrent or results in permanent neurological impairment
<p>Contractual definition:</p> <p>A benign brain tumour that is inoperable or recurrent, or which causes permanent neurological impairment, excluding cognitive impairment.</p> <p><i>Layman's explanation:</i> <i>A brain tumour that is not cancerous, but impossible to operate or keeps coming back after surgery or results in permanent brain damage.</i></p>
Motor neuron disease
<p>Contractual definition:</p> <p>The motor neuron diseases (MND) are a group of progressive neurological disorders that destroy motor neurons, which are the cells that control essential voluntary muscle activity such as speaking, walking, breathing, and swallowing. The diagnosis must be confirmed by a specialist and evidenced by typical findings in electromyography and electroneurography.</p> <p><i>Layman's explanation:</i> <i>A disease that affects the muscles in the body, including the ability to speak, walk and swallow.</i></p>
Multiple sclerosis
<p>Contractual definition:</p> <p>A neurologist must diagnose multiple sclerosis. There must be a reliable history of at least two episodes of neurological deficit, and objective clinical signs of lesions at more than one different anatomical region within the central nervous system. Special investigations, like magnetic resonance imaging, must support the diagnosis.</p> <p><i>Layman's explanation:</i> <i>A disease that damages the nerves in the brain and spinal cord. Also known as MS.</i></p>
Loss of vision in both eyes
<p>Contractual definition:</p> <p>Permanent, irreversible and total loss of vision in both eyes with sharpness of vision of 6/60 or worse in the better eye when measured with the use of visual aids.</p> <p><i>Layman's explanation:</i> <i>Total and permanent blindness in both eyes.</i></p>
Hearing loss
<p>Contractual definition:</p> <p>Permanent, irreversible and total loss of hearing in both ears. This means that the average hearing levels, tested with hearing aids when applicable, at audible frequencies is less than 90 decibels.</p> <p><i>Layman's explanation:</i> <i>Total and permanent deafness in both ears.</i></p>

Claim event
Loss of speech
<p>Contractual definition: Permanent, irreversible and total loss of the ability to speak, due to disease or injury, as established over a continuous period of 3 months. An appropriate medical consultant must confirm the diagnosis.</p>
<p><i>Layman's explanation:</i> <i>Permanently losing the ability to speak; muteness. Not due to psychiatric reasons.</i></p>
Permanent colostomy or ileostomy
<p>Contractual definition: The presence of a permanent colostomy or ileostomy with a stoma bag.</p>
<p><i>Layman's explanation:</i> <i>The need to permanently wear a bag for stools.</i></p>
Head injury
<p>Contractual definition: A head injury requiring surgery in the form of a craniotomy, decompression holes to drain a brain bleeding or open reduction of a depressed skull fracture.</p>
<p><i>Layman's explanation:</i> <i>Serious head injury, requiring surgery.</i></p>
Paraplegia
<p>Contractual definition: Total, permanent and irrecoverable loss of function of both lower extremities, with or without loss of bowel or bladder function.</p>
<p><i>Layman's explanation:</i> <i>Permanently lame in both legs, requiring the use of a wheelchair.</i></p>
Quadriplegia
<p>Contractual definition: Total, permanent and irrecoverable loss of function of all four limbs.</p>
<p><i>Layman's explanation:</i> <i>Permanently lame in both legs and both arms.</i></p>
Accidental HIV infection
<p>Contractual definition: The contractual definition for this claim event is given below this table.</p>
<p><i>Layman's explanation:</i> <i>HIV infection / AIDS that is acquired accidentally through one of the events described in the contractual definition.</i></p>
Bacterial meningitis or encephalitis with permanent impairment
<p>Contractual definition: Bacterial meningitis or encephalitis confirmed by a medical specialist, supported by appropriate cerebrospinal fluid investigations that results in permanent neurological deficit.</p>
<p><i>Layman's explanation:</i> <i>A severe and contagious form of meningitis that results in permanent damage to the brain or nerves.</i></p>
Cerebral malaria
<p>Contractual definition: Cerebral malaria as confirmed by a medical specialist in the presence of Plasmodium falciparum parasites on peripheral blood smears, resulting in permanent neurological deficit.</p>
<p><i>Layman's explanation:</i> <i>Malaria affecting the brain, and resulting in permanent damage to the brain or nerves.</i></p>
Rabies
<p>Contractual definition: Confirmation by a medical specialist that the life insured has presented with the clinical manifestations of rabies contracted from an infected animal.</p>
<p><i>Layman's explanation:</i> <i>A deadly infection after being bitten by a dog or other animal with mad dog disease.</i></p>

Claim event
Juvenile rheumatoid arthritis
<p>Contractual definition: Rheumatoid arthritis in a child of 16 years or younger, causing pain and deformity despite optimal treatment, in at least three major joints bilaterally, in other words, shoulders, elbows, wrists, hips, knees, or ankles. This must be confirmed by a rheumatologist with appropriate radiological evidence of deformity.</p> <p>Layman's explanation: <i>An autoimmune disease that affects the joints in children younger than 16 causing pain and deformity in large joints, not only the hands.</i></p>
Cystic fibrosis
<p>Contractual definition: Clinical features of cystic fibrosis, diagnosed by a medical specialist and confirmed by a sweat test and/or genetic test.</p> <p>Layman's explanation: <i>A genetic disorder affecting multiple organs including the lungs. Also known as Mucoviscidosis.</i></p>

Heart attack

A heart attack 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 acute myocardial infarction. Post procedure myocardial infarction is included, provided it meets the below requirements. Other acute coronary syndromes, including but not limited to angina, are not covered by this description.

- Compatible clinical symptoms.
- Characteristic electrocardiographical (ECG) changes, which can either be myocardial ischaemia that may progress to myocardial infarction or new pathological Q waves, described as:
 - 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.
 - new pathological Q waves:
 - any new Q wave in leads V1 through V3, or
 - 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, or
 - the appearance of a new complete bundle branch block.
- Raised cardiac biomarkers, which include 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

Accidental HIV infection

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

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

- the transfusion of infected blood or blood products from a transfusion service that we recognise, on or after the cover start date;
- an accidental needlestick injury or cut 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 transplanted 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.

Admittance of a claim

Besides the conditions for admittance of a claim set out in the *General information* chapter, we will admit a claim only if

- the claim event occurs after a child's 1st birthday and before his or her 19th birthday;
- the child survived a claim event for an illness or an injury by more than 96 hours, except if the claim event is for bacterial meningitis or encephalitis with permanent impairment, or rabies. For these claim events the child must have survived the claim event by more than 48 hours.

We will admit a maximum of two claims, with a maximum of one claim per child.

Waiting period for natural causes

We will not admit a claim due to natural causes during the first 12 months from the date on which the main benefit has been added to the plan. We will also not admit a claim during the first 12 months from the date on which the life insured on the main benefit becomes the parent of the child.

If the claim event occurred after 12 months but within 24 months from the date on which the main benefit has been added to the plan, or from the date on which the life insured on the main benefit becomes the parent of the child, and we admit the claim, we will only pay 5% of the cover amount of the main benefit.

If the claim event occurred after 24 months from the date on which the main benefit has been added to the plan, or from the date on which the life insured on the main benefit becomes the parent of the child, and we admit the claim, we will pay 10% of the cover amount of the main benefit.

If the cover amount of the main benefit is increased, other than through benefit growth, these waiting periods will apply to the increase in the cover amount from the effective date. They will apply to the full cover amount if the plan is reinstated after an earlier lapse.

No waiting period will apply if the claim event occurs as a result of an accident or an infection.

Exclusions

We will not admit a claim for

- cancer if it is
 - any cancer in situ, or
 - any skin cancer, except malignant melanoma that has been histologically classified as T1N0M0 or worse, or
 - any tumour of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0;
- any premalignant condition, or any condition with low malignant potential, or any condition classified as borderline malignancy;
- a stroke if it is
 - a transient ischaemic attack (TIA), or
 - a vascular disease affecting the eye or optic nerve, or
 - migraine and vestibular disorders;
- liver failure if cirrhosis is due to alcohol or substance abuse;
- a benign brain tumour where the permanent impairment is cognitive impairment only;
- loss of speech if it is due to psychiatric reasons;
- juvenile rheumatoid arthritis if it is only in the hands, fingers and feet;
- congenital conditions.

We will not admit a claim for a claim event resulting from any condition that existed for a child before the date on which the main benefit has been added to the plan. We will also not admit a claim for a claim event resulting from any condition that existed for a child before the date on which the life insured on the main benefit has become the parent of that child. If the cover amount of the main benefit is increased, other than through benefit growth, and we admit a claim for a claim event resulting from any condition that existed for a child before the increase, we will limit the amount of the income payment to what it was before the increase.

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

When will cover end?

It will end on the earlier of

- midnight before the cover end date of the main benefit indicated in the plan overview, and
- the plan ending for any reason before the cover end date of the main benefit, and
- us admitting a second claim.

Claim events: List 1 (for Comprehensive Disability/-Plus, Elite Disability, Comprehensive Impairment)

The claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated in the table below for the following benefits:

- Comprehensive Disability
- Comprehensive Disability Plus
- Elite Disability
- Comprehensive Impairment.

The contractual definitions will apply when we consider a claim. The layman's explanations are provided for a better understanding of the claim events but will not be used in the legal interpretation of the claim events.

If we admit a claim, we will pay the percentage of the cover amount linked to the particular claim event. For claim events where a maximum rand amount is indicated, we will not pay more than the indicated rand amount. The cover amount is indicated in the plan overview and may change over time as a result of benefit growth, alterations requested by the planholder, and claims.

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
Occupational disability				
Contractual definition: Disability to the extent that the life insured	100	100	100	-
<ul style="list-style-type: none"> • is totally, permanently and continuously unable to fulfil the occupational demands of the occupation he or she practised for income immediately before the disability, or • will be, if he or she is a full-time student when he or she becomes disabled, totally, permanently and continuously unable to fulfil the occupational demands of an occupation we may reasonably expect him or her to practise, taking into account his or her education, training and experience. 				
Cardiovascular system				
Valvular heart disease or cardiomyopathy				
Contractual definition: Severe valvular heart disease or cardiomyopathy, meeting the following criteria:	-	50	100	50
<ul style="list-style-type: none"> • New York Heart Association (NYHA) class III on optimal treatment, and • One of the following: <ul style="list-style-type: none"> • Maximal effort test of 4 to 6 metabolic equivalents (METS), or • Ejection fraction (EF) of less than 45%, or • Valve gradient and/or valve area classified as severe. 				
This must be confirmed by a cardiologist.				
Layman's explanation: <i>This claim event covers severe disease of the heart valves or diseases of the heart muscle, where the heart muscle becomes enlarged, thick, or rigid (cardiomyopathy). This results in a weaker heart, with the heart being less able to pump blood through the body and maintain a normal electrical rhythm. This can lead to heart failure, where the symptoms progress to a stage where even with light activity there is tiredness, shortness of breath or heart palpitations (referred to as class III New York Heart Association classification of heart failure).</i>				
<i>This claim event must meet the criteria as described in the contractual definition above, and must be confirmed by a specialist (cardiologist).</i>				

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
<p>Contractual definition: Severe valvular heart disease or cardiomyopathy, meeting the following criteria:</p> <ul style="list-style-type: none"> • New York Heart Association (NYHA) class IV on optimal treatment, and • One of the following: <ul style="list-style-type: none"> • Maximal effort test of less than 4 metabolic equivalents (METS), or • Ejection fraction (EF) of less than 40%, or • Valve gradient and/or valve area classified as severe. <p>This must be confirmed by a cardiologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers severe disease of the heart valves or diseases of the heart muscle, where the heart muscle becomes enlarged, thick, or rigid (cardiomyopathy). This results in a weaker heart, with the heart being less able to pump blood through the body and maintain a normal electrical rhythm. This can lead to heart failure, where the symptoms progress to a stage where at rest there is tiredness, shortness of breath or heart palpitations (referred to as class IV New York Heart Association classification of heart failure).</i></p> <p><i>This claim event must meet the criteria as described in the contractual definition above, and must be confirmed by a specialist (cardiologist).</i></p>	100	100	100	100
<p>Ischaemic heart disease</p> <p>Contractual definition: Ischaemic heart disease with cardiac failure, meeting the following criteria:</p> <ul style="list-style-type: none"> • New York Heart Association (NYHA) class III on optimal treatment, and • Maximal effort test of 4 to 6 metabolic equivalents (METS), and • One of the following: <ul style="list-style-type: none"> • Left ventricular ejection fraction (LVEF) of less than 45%, or • Moderate diastolic dysfunction, as determined by a cardiologist, taking into account the cause of the dysfunction, extent of ventricular hypertrophy, and mitral inflow pattern as determined by echocardiography. <p>This must be confirmed by a cardiologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers blockage of the arteries supplying blood to the heart muscles (ischaemic heart disease), complicated by the heart being less able to pump blood to supply the needs of the body (cardiac failure), where the symptoms progress to a stage where even with light activity there is tiredness, shortness of breath or heart palpitations (referred to as class III New York Heart Association classification of heart failure).</i></p> <p><i>This claim event must meet the criteria as described in the contractual definition above, and must be confirmed by a specialist (cardiologist).</i></p>	-	50	100	50

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
<p>Contractual definition: Ischaemic heart disease with cardiac failure, meeting the following criteria:</p> <ul style="list-style-type: none"> • New York Heart Association (NYHA) class IV on optimal treatment, and • Maximal effort test of less than 4 metabolic equivalents (METS), and • One of the following: <ul style="list-style-type: none"> • Left ventricular ejection fraction (LVEF) of less than 40%, or • Severe diastolic dysfunction, as determined by a cardiologist, taking into account the cause of the dysfunction, extent of ventricular hypertrophy, and mitral inflow pattern as determined by echocardiography. <p>This must be confirmed by a cardiologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers blockage of the arteries supplying blood to the heart muscles (ischaemic heart disease), complicated by the heart being less able to pump blood to supply the needs of the body (cardiac failure), where the symptoms progress to a stage where at rest there is tiredness, shortness of breath or heart palpitations (referred to as class IV New York Heart Association classification of heart failure).</i></p> <p><i>This claim event must meet the criteria as described in the contractual definition above, and must be confirmed by a specialist (cardiologist).</i></p>	100	100	100	100
<p>Heart transplant</p> <p>Contractual definition:</p> <ul style="list-style-type: none"> • The undergoing of a complete heart transplant as a recipient, or • Confirmation of being on a recognised national South African transplant waiting list, awaiting a complete heart transplant. <p>This must be confirmed by a specialist with supporting evidence.</p> <p><i>Layman's explanation:</i> <i>This claim event covers:</i></p> <ul style="list-style-type: none"> • <i>The undergoing of a complete heart transplant as a recipient, to replace a diseased heart, or</i> • <i>Confirmation of being on a recognised national South African transplant waiting list, awaiting a complete heart transplant.</i> <p><i>This must be confirmed by a specialist with supporting evidence.</i></p>	100	100	100	100

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
Pericardial disease				
Contractual definition: Pericardial disease with cardiac failure, meeting the following criteria: <ul style="list-style-type: none"> • Confirmed irreversible pericardial disease by a specialist, and • New York Heart Association (NYHA) class III on optimal treatment, and • One of the following: <ul style="list-style-type: none"> • Maximal effort test of 4 to 6 metabolic equivalents (METS), or • Left ventricular ejection fraction (LVEF) of less than 45%. This must be confirmed by a cardiologist. <i>Layman's explanation:</i> <i>This claim event covers pericardial disease with cardiac failure, meeting the criteria as described in the contractual definition above. This must be confirmed by a specialist (cardiologist).</i> <i>The pericardium is a sac that holds the heart in place and helps it to work properly. The sac is made of two thin layers of tissue that enclose the heart. Various conditions can affect and cause disease of these layers, leading to it becoming scarred and thickened and complicated by the heart being less able to pump blood to supply the needs of the body (cardiac failure), where the symptoms progress to a stage where even with light activity there is tiredness, shortness of breath or heart palpitations (referred to as class III New York Heart Association classification of heart failure).</i>	-	50	100	50
Contractual definition: Pericardial disease with cardiac failure, meeting the following criteria: <ul style="list-style-type: none"> • Confirmed irreversible pericardial disease by a specialist, and • New York Heart Association (NYHA) class IV on optimal treatment, and • One of the following: <ul style="list-style-type: none"> • Maximal effort test of less than 4 metabolic equivalents (METS), or • Left ventricular ejection fraction (LVEF) of less than 40%. This must be confirmed by a cardiologist. <i>Layman's explanation:</i> <i>This claim event covers pericardial disease with cardiac failure, meeting the criteria as described in the contractual definition above. This must be confirmed by a specialist (cardiologist).</i> <i>The pericardium is a sac that holds the heart in place and helps it to work properly. The sac is made of two thin layers of tissue that enclose the heart. Various conditions can affect and cause disease of these layers, leading to it becoming scarred and thickened and complicated by the heart being less able to pump blood to supply the needs of the body (cardiac failure), where the symptoms progress to a stage where at rest there is tiredness, shortness of breath or heart palpitations (referred to as class IV New York Heart Association classification of heart failure).</i>	100	100	100	100

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
Arrhythmia Contractual definition: Arrhythmia with moderate impairment, meeting the following criteria: Arrhythmia on optimal treatment that results in <ul style="list-style-type: none"> • New York Heart Association (NYHA) class III shortness of breath, and • One of the following: <ul style="list-style-type: none"> • 4 or less metabolic equivalents (METS) with maximal effort test, or • Documented arrhythmia that fails to respond to optimal treatment, and leads to frequent fainting. <p>This must be confirmed by a cardiologist, physician or electrophysiologist.</p> <p><i>Layman's explanation:</i> This claim event covers arrhythmia with moderate impairment, meeting the criteria as described in the contractual definition above. This must be confirmed by a specialist (cardiologist, physician or electrophysiologist).</p> <p><i>Arrhythmia is an abnormal beat of the heart that can be too slow or too fast. This can present with moderate impairment, which can result in the following on optimal treatment:</i></p> <ul style="list-style-type: none"> • Heart failure, where the symptoms progress to a stage where even with light activity there is tiredness, shortness of breath or heart palpitations (referred to as class III New York Heart Association classification of heart failure), and • One of the following: <ul style="list-style-type: none"> • Reduced exercise effort test meeting specified criteria, or • Documented arrhythmia that fails to respond to optimal treatment, and leads to frequent fainting. 	-	50	100	50
Contractual definition: Arrhythmia with severe impairment, meeting the following criteria: Arrhythmia on optimal treatment that results in <ul style="list-style-type: none"> • New York Heart Association (NYHA) class IV shortness of breath, and • 2 or less metabolic equivalents (METS) with maximal effort test. <p>This must be confirmed by a cardiologist, physician or electrophysiologist.</p> <p><i>Layman's explanation:</i> This claim event covers arrhythmia with severe impairment, meeting the criteria as described in the contractual definition above. This must be confirmed by a specialist (cardiologist, physician or electrophysiologist).</p> <p><i>Arrhythmia is an abnormal beat of the heart that can be too slow or too fast. This can present with severe impairment, which can result in the following on optimal treatment:</i></p> <ul style="list-style-type: none"> • Heart failure where the symptoms progress to a stage where at rest there is tiredness, shortness of breath or heart palpitations (referred to as class IV New York Heart Association classification of heart failure), and • Reduced exercise effort test meeting specified criteria. 	100	100	100	100

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
Hypertension				
Contractual definition: Hypertension with renal impairment, meeting the following criteria: <ul style="list-style-type: none"> • Stage II hypertension despite optimal treatment, and • Creatinine clearance of less than 50% of normal value for age. This must be confirmed by a physician, nephrologist or cardiologist.	-	50	100	50
<i>Layman's explanation:</i> <i>This claim event covers high blood pressure with impaired kidney function, meeting the following criteria:</i> <ul style="list-style-type: none"> • Persistent blood pressure reading of 140/90 or higher despite optimal medical treatment, and • Specialised laboratory test measuring kidney function (creatinine clearance) of less than 50% of normal value for age. <i>This must be confirmed by a specialist (physician, nephrologist or cardiologist).</i>				
Contractual definition: Hypertension with severe renal impairment, meeting the following criteria: <ul style="list-style-type: none"> • Stage III hypertension despite optimal treatment, and • Creatinine clearance of less than 20% of normal value for age. This must be confirmed by a physician, nephrologist or cardiologist.	100	100	100	100
<i>Layman's explanation:</i> <i>This claim event covers high blood pressure with impaired kidney function, meeting the following criteria:</i> <ul style="list-style-type: none"> • Persistent blood pressure reading of 160/100 up to 179/109 despite optimal medical treatment, and • Specialised laboratory test measuring kidney function (creatinine clearance) of less than 20% of normal value for age. <i>This must be confirmed by a specialist (physician, nephrologist or cardiologist).</i>				
Diseases of the aorta				
Contractual definition: Diseases of the aorta with severe impairment, meeting the following criteria: Confirmed irreversible aortic disease by a cardiologist, cardiothoracic or vascular surgeon, with <ul style="list-style-type: none"> • Persistent symptoms despite compliance with medication, and • New York Heart Association (NYHA) class IV. <i>Layman's explanation:</i> <i>This claim event covers disease of the main artery supplying oxygen rich blood to the body (called the aorta), meeting the following criteria:</i> <ul style="list-style-type: none"> • Confirmed by a specialist (cardiologist, cardiothoracic or vascular surgeon) that the disease is irreversible with persistent symptoms despite compliance with optimal medical treatment, and • Heart failure, where the symptoms progress to a stage where at rest there is tiredness, shortness of breath or heart palpitations (referred to as class IV New York Heart Association classification of heart failure). 	100	100	100	100

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
Peripheral arterial disease				
Contractual definition: Peripheral arterial disease with moderate impairment, with abnormal Doppler readings, cold leg, rubor and pain on exercise. This must be confirmed by a vascular surgeon.	-	50	100	50
<i>Layman's explanation:</i> <i>This claim event covers peripheral arterial disease with moderate impairment, meeting the following criteria:</i>				
<ul style="list-style-type: none"> • Abnormal specialised test measuring blood flow in arteries (Doppler), and • Cold and discoloured and painful leg. <p><i>This must be confirmed by a specialist (vascular surgeon).</i></p> <p><i>Peripheral arterial disease is a problem with blood flow to the limbs due to narrowing of the arteries in the limbs.</i></p>	100	100	100	100
Contractual definition: Peripheral arterial disease with severe impairment despite optimal treatment, meeting the following criteria: <ul style="list-style-type: none"> • No palpable pulses, confirmed by absent Doppler readings, or • Severe vascular ulceration, or • Gangrene. <p>This must be confirmed by a vascular surgeon.</p> <p><i>Layman's explanation:</i> <i>This claim event covers peripheral arterial disease with severe impairment, meeting the following criteria:</i></p> <ul style="list-style-type: none"> • No palpable pulses confirmed by a specialised test measuring blood flow in arteries (Doppler), or • Severe ulcers due to poor blood flow, or • Death of tissue (gangrene). <p><i>This must be confirmed by a specialist (vascular surgeon).</i></p> <p><i>Peripheral arterial disease is a problem with blood flow to the limbs due to narrowing of the arteries in the limbs.</i></p>				
Peripheral venous disease				
Contractual definition: Peripheral venous disease with severe impairment despite optimal treatment, with severe deep and widespread vascular ulceration. This must be confirmed by a vascular surgeon.	-	50	100	50
<i>Layman's explanation:</i> <i>This claim event covers peripheral venous disease with severe impairment despite optimal treatment, with severe deep and widespread ulcers due to poor blood flow. This must be confirmed by a specialist (vascular surgeon).</i>				
<i>Peripheral venous disease is a disease causing blockage of the blood vessels (veins) carrying blood from the arms and legs to the heart.</i>				

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
Primary pulmonary artery hypertension				
Contractual definition: Severe primary pulmonary artery hypertension despite optimal medical treatment, with mean pulmonary artery pressure 40-70 mmHg, and at least New York Heart Association (NYHA) class III classification of cardiac impairment. This must be confirmed by a physician.	-	50	100	50
<i>Layman's explanation:</i> <i>This claim event covers severe high blood pressure in the lung arteries despite optimal treatment, meeting the following criteria:</i>				
<ul style="list-style-type: none"> • Specified artery pressure as in the contractual definition above, and • Symptoms have progressed to a stage where even with light activity there is tiredness, shortness of breath or heart palpitations (referred to as class III New York Heart Association classification of heart failure). 				
<i>This must be confirmed by a specialist (physician).</i>				
Contractual definition: Severe primary pulmonary artery hypertension despite optimal medical treatment, with mean pulmonary artery pressure exceeding 70 mmHg, and at least New York Heart Association (NYHA) class IV classification of cardiac impairment. This must be confirmed by a physician.	100	100	100	100
<i>Layman's explanation:</i> <i>This claim event covers severe high blood pressure in the lung arteries despite optimal treatment, meeting the following criteria:</i>				
<ul style="list-style-type: none"> • Specified artery pressure as in the contractual definition above, and • Symptoms have progressed to a stage where at rest there is tiredness, shortness of breath or heart palpitations (referred to as class IV New York Heart Association classification of heart failure). 				
<i>This must be confirmed by a specialist (physician).</i>				
Blood system				
Anaemia				
Contractual definition: Severe treatment resistant anaemia despite optimal medical treatment, meeting the following criteria:	-	50	100	50
<ul style="list-style-type: none"> • Hb less than 8 g/dL, and • Requiring 2 or more units of blood or blood products every 4 to 6 weeks. 				
This must be confirmed by a physician or haematologist.				
<i>Layman's explanation:</i> <i>This claim event covers persistent low oxygen carrying capacity of red blood cell count despite optimal medical treatment (referred to as treatment resistant anaemia), meeting the following criteria:</i>				
<ul style="list-style-type: none"> • Low blood count meeting specific criteria for oxygen carrying capacity of red blood cells, and • Evidence of blood transfusions of 2 or more units every 4 to 6 weeks. 				
<i>This must be confirmed by a specialist (physician or haematologist).</i>				

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
<p>Contractual definition: Life threatening, treatment resistant anaemia despite optimal medical treatment, meeting the following criteria:</p> <ul style="list-style-type: none"> • Hb less than 8 g/dL, and • Requiring 2 or more units of blood or blood products every 2 weeks. <p>This must be confirmed by a physician or haematologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers persistent low oxygen carrying capacity of red blood cell count despite optimal medical treatment (referred to as treatment-resistant anaemia), meeting the following criteria:</i></p> <ul style="list-style-type: none"> • <i>Low blood count meeting specific criteria for oxygen carrying capacity of red blood cells, and</i> • <i>Evidence of blood transfusions of 2 or more units every 2 weeks.</i> <p><i>This must be confirmed by a specialist (physician or haematologist).</i></p>	100	100	100	100
<p>White blood cell disorder</p> <p>Contractual definition: Severe white blood cell disorder, meeting the following criteria:</p> <ul style="list-style-type: none"> • More than 1 hospitalisation per year for acute bacterial infection and an absolute neutrophil count of between 250 and 500, or • Lymphoma or leukaemia requiring 1 or 2 chemotherapy cycles per year. <p>This must be confirmed by a physician or haematologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers severe white blood cell disorder, meeting the following criteria:</i></p> <ul style="list-style-type: none"> • <i>More than 1 hospitalisation per year for acute infection caused by harmful organisms (bacteria) and infection fighting white blood cells meeting specified criteria (absolute neutrophil count of between 250 and 500), or</i> • <i>Cancer of infection-fighting cells of the immune system (lymphoma) or cancer of white blood cells (leukaemia), requiring 1 or 2 chemotherapy cycles per year.</i> <p><i>This must be confirmed by a specialist (physician or haematologist).</i></p>	-	50	100	50
<p>Contractual definition: Severe white blood cell disorder, meeting the following criteria:</p> <ul style="list-style-type: none"> • Whole person impairment (WPI) of at least 35% despite optimal medical treatment, or • Lymphoma or leukaemia requiring 3 to 6 chemotherapy cycles per year. <p>This must be confirmed by a physician or haematologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers severe white blood cell disorder, meeting the following criteria:</i></p> <ul style="list-style-type: none"> • <i>Whole person impairment (WPI) of at least 35% despite optimal medical treatment, or</i> • <i>Cancer of infection-fighting cells of the immune system (lymphoma) or cancer of white blood cells (leukaemia), requiring 3 to 6 chemotherapy cycles per year.</i> <p><i>This must be confirmed by a specialist (physician or haematologist).</i></p>	100	100	100	100

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
Clotting disorder Contractual definition: Severe clotting disorder, meeting the following criteria: <ul style="list-style-type: none"> • Persistent despite optimal medical and surgical treatment, and • Resulting in end organ failure of one of the following, as described in this table: <ul style="list-style-type: none"> • Respiratory failure • Cardiac failure end-stage • Kidney failure end-stage • Liver failure (which is not described in this document). This must be confirmed by a specialist. <i>Layman's explanation:</i> <i>This claim event covers severe clotting disorder, meeting the criteria in the contractual definition above. This must be confirmed by a specialist.</i> <i>Clotting disorder occurs when the body is unable to make components that are required by the body for blood to clot. When severe, this disorder can lead to severe bleeding from various sites, which can ultimately lead to multiple organ damage.</i>	100	100	100	100
Respiratory system Respiratory failure Contractual definition: Severe respiratory failure, meeting the following criteria: Confirmed chronic respiratory disease despite optimal medical treatment, resulting in impaired airflow, meeting the following criteria: <ul style="list-style-type: none"> • Forced expiratory volume in one second (FEV1) of less than 50%, or • Forced vital capacity (FVC) of less than 50%, or • Impaired diffusion with diffusion capacity (DCO) of less than 50%, or • Impaired exercise tolerance with maximal effort test of 4 to 6 metabolic equivalents (METS). This must be confirmed by a pulmonologist or physician. <i>Layman's explanation:</i> <i>This claim event covers severe chronic disease of the lungs, optimally treated but resulting in respiratory failure (lungs not being able to meet the oxygen requirements of the body) with impaired airflow. This must meet the criteria described in the contractual definition above and must be confirmed by a specialist (pulmonologist or physician).</i>	-	50	100	50

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
<p>Contractual definition: Severe respiratory failure, meeting the following criteria: Confirmed chronic respiratory disease despite optimal medical treatment, resulting in impaired airflow with</p> <ul style="list-style-type: none"> Forced expiratory volume in one second (FEV1) of less than 40%, or Forced vital capacity (FVC) of less than 40%, or Impaired diffusion with diffusion capacity (DCO) of less than 40%, or Impaired exercise tolerance with maximal effort test of less than 4 metabolic equivalents (METS). <p>This must be confirmed by a pulmonologist or physician.</p> <p><i>Layman's explanation:</i> <i>This claim event covers severe chronic disease of the lungs, resulting in respiratory failure (lungs not being able to meet the oxygen requirements of the body) with impaired airflow. This must meet the criteria described in the contractual definition above and must be confirmed by a specialist (pulmonologist or physician).</i></p>	100	100	100	100
<p>Lung transplant</p> <p>Contractual definition:</p> <ul style="list-style-type: none"> The undergoing of a complete lung transplant as a recipient, or Confirmation of being on a recognised national South African transplant waiting list, awaiting a complete lung transplant. <p>This must be confirmed by a specialist with supporting evidence.</p> <p><i>Layman's explanation:</i> <i>This claim event covers:</i></p> <ul style="list-style-type: none"> <i>The undergoing of a complete lung transplant as a recipient, to replace a diseased lung, or</i> <i>Confirmation of being on a recognised national South African transplant waiting list, awaiting a complete lung transplant.</i> <p><i>This must be confirmed by a specialist with supporting evidence.</i></p>	100	100	100	100
<p>Central nervous system</p> <p>Coma</p> <p>Contractual definition: A condition of unconsciousness not induced by sedation where the life insured presents with a Glasgow Coma Scale reading of 8 or less for an uninterrupted period of at least 96 hours. This must be confirmed by a specialist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers coma, where there is a state of unconsciousness not induced by medication causing a state of sleep. Specific criteria must be met, as described in the contractual definition above. This must be confirmed by a specialist.</i></p>	100	100	100	100
<p>Hemiplegia</p> <p>Contractual definition: 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.</p> <p>The following is required:</p> <ul style="list-style-type: none"> Radiological evidence such as a computed tomography (CT) scan or magnetic resonance imaging (MRI), and Must be confirmed by a neurologist or neurosurgeon. 	100	100	100	100

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
Diplegia				
Contractual definition: The total and permanent loss of muscle function of both sides of the body due to disease or injury to the spinal cord or brain.	100	100	100	100
The following is required:				
<ul style="list-style-type: none"> • Radiological evidence, such as a computed tomography (CT) scan or magnetic resonance imaging (MRI), and • Must be confirmed by a neurologist or neurosurgeon. 				
<i>Layman's explanation:</i> <i>This claim event covers diplegia, meeting the criteria in the contractual definition above. This must be confirmed by a specialist (neurologist or neurosurgeon).</i>				
<i>Diplegia is a total and permanent weakness of the same part on both sides of the body, which can be as a result of a disease or injury.</i>				
Paraplegia				
Contractual definition: 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.	100	100	100	100
The following is required:				
<ul style="list-style-type: none"> • Radiological evidence such as a computed tomography (CT) scan or magnetic resonance imaging (MRI), and • Must be confirmed by a neurologist or neurosurgeon. 				
Contractual definition: Paraplegia due to spinal cord severance or primary neurological disease of the spinal cord, meeting the following criteria: The total and permanent loss of muscle function resulting in the loss of use of both legs due to complete severance of the spinal cord or primary neurological disease of the spinal cord.	125	125	125	125
The following is required:				
<ul style="list-style-type: none"> • Radiological evidence such as a computed tomography (CT) scan or magnetic resonance imaging (MRI), and • Must be confirmed by a neurologist or neurosurgeon. 				
Quadriplegia				
Contractual definition: The total and permanent loss of muscle function resulting in the loss of use of both arms and both legs due to disease of or injury to the spinal cord or brain.	100	100	100	100
The following is required:				
<ul style="list-style-type: none"> • Radiological evidence such as a computed tomography (CT) scan or magnetic resonance imaging (MRI), and • Must be confirmed by a neurologist or neurosurgeon. 				

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
<p>Contractual definition: Quadriplegia due to spinal cord severance or primary neurological disease of the spinal cord, meeting the following criteria: The total and permanent loss of muscle function resulting in the loss of use of both arms and both legs due to complete severance of the spinal cord or primary neurological disease of the spinal cord.</p> <p>The following is required:</p> <ul style="list-style-type: none"> • Radiological evidence such as a computed tomography (CT) scan or magnetic resonance imaging (MRI), and • Must be confirmed by a neurologist or neurosurgeon. 	150	150	150	150
<p>Epilepsy</p> <p>Contractual definition: Uncontrolled epilepsy, meeting the following criteria:</p> <ul style="list-style-type: none"> • Documented epileptic attacks confirmed by an abnormal electro-encephalogram (EEG) reading, and • Attacks must be observed to be more than 3 per week, and be resistant to optimal therapy as confirmed by drug serum-level testing. <p>This must be confirmed by a neurologist or physician.</p> <p><i>Layman's explanation:</i> <i>This claim event covers uncontrolled convulsions or seizures, meeting the criteria in the contractual definition above. This must be confirmed by a specialist (neurologist or physician).</i></p>	-	50	100	50
<p>Contractual definition: Frequent status epilepticus, meeting the following criteria: In spite of sustained optimal treatment and documented compliance of treatment, there must be</p> <ul style="list-style-type: none"> • at least 3 documented episodes of status epilepticus within the last 12 months, or • 12 or more grand mal seizures per month, within the last 4 consecutive months. <p>This will be assessed by all of the following evidence:</p> <ul style="list-style-type: none"> • Electro-encephalograms (EEGs), and • Drug serum levels which must show compliance, and • Documented evidence of epileptic attacks on clinical records, and • Evidence of emergency treatment administered. <p>This must be confirmed by a neurologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers frequent status epilepticus, meeting the criteria in the contractual definition above. This must be confirmed by a specialist (neurologist).</i></p> <p><i>Status epilepticus is a single seizure lasting for more than 5 minutes, or 2 or more seizures within a 5-minute period without the person returning to normal between them.</i></p>	100	100	100	100

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
Parkinson's disease Contractual definition: Advanced Parkinson's disease confirmed by a neurologist, meeting the following criteria: <ul style="list-style-type: none">• Appropriate clinical signs and symptoms, and• Permanent inability to perform independently at least 3 basic activities of daily living (ADLs), as indicated in the table "Basic activities of daily living for disability and impairment benefits" later in this chapter. Permanence will be assessed after requirements for reasonable treatment has been met. <i>Layman's explanation:</i> <i>This claim event covers advanced Parkinson's disease, meeting the criteria in the contractual definition above. This must be confirmed by a specialist (neurologist).</i> <i>Parkinson's disease is a degenerative brain condition that leads to various symptoms, like tremor of the hands and head, a slow gait with shuffling feet, inability to show emotions, and a forward-falling posture.</i>	100	100	100	100
Cognitive dementia Contractual definition: Early onset cognitive dementia due to organic brain disease (pre-senile dementia), meeting the following criteria: The diagnosis of cognitive dementia before age 65 (pre-senile dementia), confirmed by a neurologist or psychiatrist. There must be evidence of all of the following: <ul style="list-style-type: none">• Typical findings in cognitive tests according to the latest Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria or 2 consecutive Global Clinical Dementia Rating (CDR) ratings of at least 1.0, and• Supportive findings on neuro-imaging, and• Permanent inability to perform independently at least 3 advanced activities of daily living (ADLs), or the need for assistance by a caregiver. These ADLs are indicated in the table "Advanced activities of daily living for disability and impairment benefits" later in this chapter. Permanence will be established after 3 months. <i>Layman's explanation:</i> <i>This claim event covers the early onset of a decline in thinking and memory function (cognitive function), not in keeping with what is normal for the age and occurring before age 65 (pre-senile dementia). This must be as a result of a disease of the brain, and not due to a psychological cause. This must be confirmed by a specialist (neurologist or psychiatrist).</i> <i>There must be evidence of all of the following:</i> <ul style="list-style-type: none">• Typical findings in specialised testing for memory and thinking called cognitive tests (according to the latest DSM criteria or 2 consecutive CDR ratings of at least 1.0), and• Supportive findings on specialised radiological testing (neuro-imaging), and• Permanent inability to perform independently at least 3 advanced activities of daily living, as indicated later in this chapter, or the need for assistance by a caregiver. Permanence will be established after 3 months.	-	50	100	50

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
<p>Contractual definition: Early onset cognitive dementia due to organic brain disease (pre-senile dementia), meeting the following criteria: The diagnosis of cognitive dementia before age 65 (pre-senile dementia), with profound impairment, confirmed by a neurologist or psychiatrist.</p> <p>There must be evidence of all of the following:</p> <ul style="list-style-type: none"> Typical findings in cognitive tests according to the latest Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria or two consecutive Global Clinical Dementia Rating (CDR) ratings of at least 3.0, and Supportive findings on neuro-imaging, and Permanent inability to perform independently at least 3 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 disability and impairment benefits" later in this chapter. <p>Permanence will be established after 3 months.</p> <p><i>Layman's explanation:</i> <i>This claim event covers the early onset of a decline in thinking and memory function (cognitive function), not in keeping with what is normal for the age and occurring before age 65 (pre-senile dementia). This must be as a result of a disease of the brain, and not due to a psychological cause. This must be confirmed by a specialist (neurologist or psychiatrist).</i></p> <p>There must be evidence of all of the following:</p> <ul style="list-style-type: none"> Typical findings in specialised testing for memory and thinking called cognitive tests (according to the latest DSM criteria or 2 consecutive CDR ratings of at least 3.0), and Supportive findings on specialised radiological testing (neuro-imaging), and Permanent inability to perform independently at least 3 basic activities of daily living, as indicated later in this chapter, or the need for 24-hour supervision by a caregiver. <p>Permanence will be established after 3 months.</p>	100	100	100	100
<p>Cranial nerve V</p> <p>Contractual definition: Cranial nerve V pathology with severe trigeminal neuralgia, meeting the following criteria: The diagnosis of treatment resistant, severe unilateral or bilateral facial neuralgic pain by a neurologist, with evidence of treatment resistance as well as the need for decompression surgery.</p> <p><i>Layman's explanation:</i> <i>The trigeminal nerve (the 5th cranial nerve) is a nerve responsible for sensation in the face and functions such as biting and chewing.</i></p> <p><i>This claim event covers severe chronic pain in this nerve area, meeting the following criteria: Diagnosis by a specialist (neurologist) of treatment resistant, severe one-sided or both-sided facial nerve pain, with evidence of treatment resistance as well as the need for decompression surgery.</i></p>	-	45	45	45

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Plus	Elite Disability	Comprehensive Impairment
Cranial nerve VII				
Contractual definition: Cranial nerve VII paralysis with severe unilateral upper motor neuron facial paralysis, involving more than 75% of the facial muscles, and inability to control eyelid closure. This must be confirmed by a neurologist.	-	50	100	50
<i>Layman's explanation:</i> <i>The facial nerve (the 7th cranial nerve) controls the muscles of facial expression, and functions in taste sensations of two-thirds of the tongue.</i>				
<i>This claim event covers paralysis of this nerve with upper motor neuron facial paralysis of more than 75% of the facial muscles and inability to close eyelids. This must be confirmed by a specialist (neurologist).</i>				
Cranial nerve VIII				
Contractual definition: Cranial nerve VIII paralysis or imbalance with moderately severe equilibrium impairment, with limitations of all activities of daily living (ADLs), and requiring permanent assistance with self-care. These ADLs are indicated in the tables "Basic activities of daily living for disability and impairment benefits" and "Advanced activities of daily living for disability and impairment benefits" later in this chapter. This must be confirmed by a neurologist or ear, nose and throat surgeon.	-	50	100	50
<i>Layman's explanation:</i> <i>The 8th cranial nerve transmits sound and balance information from the inner ear to the brain.</i>				
<i>This claim event covers paralysis of this nerve with moderate balance disturbance, with limitations in all activities of daily living (ADLs) and requiring permanent assistance with self-care. This must be confirmed by a specialist (neurologist or ear, nose and throat surgeon).</i>				
Contractual definition: Cranial nerve VIII paralysis or imbalance with severe equilibrium impairment, with limitations of all activities of daily living (ADLs), requiring permanent assistance with self-care and permanent confinement to a bed or wheelchair. These ADLs are indicated in the tables "Basic activities of daily living for disability and impairment benefits" and "Advanced activities of daily living for disability and impairment benefits" later in this chapter. This must be confirmed by a neurologist.	-	75	100	75
<i>Layman's explanation:</i> <i>The 8th cranial nerve transmits sound and balance information from the inner ear to the brain.</i>				
<i>This claim event covers paralysis of this nerve with severe balance disturbance, with limitations in all activities of daily living (ADLs) and requiring permanent assistance with self-care and permanent confinement to a bed or wheelchair. This must be confirmed by a specialist (neurologist).</i>				

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
Cranial nerves IX, X or XII				
Contractual definition: Cranial nerves IX, X or XII paralysis or dysarthria or dysphagia, with moderately severe dysarthria or dysphagia with hoarseness, nasal regurgitation and aspiration of fluids. This must be confirmed by a neurologist.	-	25	25	25
<i>Layman's explanation:</i> <i>This claim event covers paralysis of cranial nerves 9, 10 or 12, with moderate difficulty with swallowing, hoarseness, difficulty with speech, accidental inhalation of fluids into the lungs or airway or passage of food through the nasal passages. This must be confirmed by a specialist (neurologist).</i>				
Contractual definition: Cranial nerves IX, X or XII paralysis or dysarthria or dysphagia, with severe functional inability to swallow without choking and with the need for assistance and suctioning. This must be confirmed by a neurologist.	-	75	100	75
<i>Layman's explanation:</i> <i>This claim event covers paralysis of cranial nerves 9, 10 or 12, with severe inability to swallow without choking with the need for assistance and suctioning. This must be confirmed by a specialist (neurologist).</i>				
Neurologic impairment of respiration				
Contractual definition: Neurologic impairment of respiration, where the life insured is capable of spontaneous respiration, but is restricted to sitting, standing or limited ambulation. This must be confirmed by a neurologist.	-	50	100	50
<i>Layman's explanation:</i> <i>This claim event covers impairment of breathing due to neurological cause or reason, where the life insured is capable of spontaneous breathing, but is restricted to sitting or standing with limited ambulation. This must be confirmed by a specialist (neurologist).</i>				
Contractual definition: Neurologic impairment of respiration with severe functional impairment where the life insured is capable of spontaneous respiration, but to such a limited degree that he or she is permanently confined to a bed. This must be confirmed by a neurologist.	-	75	100	75
<i>Layman's explanation:</i> <i>This claim event covers impairment of breathing due to neurological cause or reason, where the life insured is capable of spontaneous breathing, but is limited to such a degree that he or she is permanently confined to a bed. This must be confirmed by a specialist (neurologist).</i>				
Contractual definition: Neurologic impairment of respiration to such an extent that there is no spontaneous respiration. This must be confirmed by a neurologist.	100	100	100	100
<i>Layman's explanation:</i> <i>This claim event covers impairment of breathing due to neurological cause or reason, where the life insured is incapable of spontaneous breathing. This must be confirmed by a specialist (neurologist).</i>				

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
Gastro-intestinal system				
Gastro-intestinal tract disease				
<p>Contractual definition: Gastro-intestinal tract disease, meeting the following criteria: Anatomic loss or alteration in gastro-intestinal tract, as a result of an organic cause, with any of the following:</p> <ul style="list-style-type: none"> • Symptoms uncontrolled by adequate treatment and 15% weight loss below accepted desirable weight for a period exceeding a year, or • Permanent stoma, or • Anatomic loss or alteration in gastro-intestinal tract, with persistent, irreducible and irreparable protrusion of a hernia after surgery, with bowel dysfunction and limitation in activities of daily living. <p>This must be confirmed by a surgeon, physician or gastroenterologist.</p> <p><i>Layman's explanation:</i> <i>The gastro-intestinal tract is an organ system within humans which takes in food, digests it to extract and absorb energy and nutrients, and expels the remaining waste as faeces. This claim event covers loss of a part of this system, or disease of this system, not due to a psychological cause.</i></p> <p><i>The following criteria must be met:</i></p> <ul style="list-style-type: none"> • Loss due to trauma or surgery of a part of this system with evidence of disease and symptoms uncontrolled by adequate treatment with weight loss, as specified in the contractual definition above, despite optimal medical treatment, or • Permanent stoma (artificial opening in the gut), or • Persistent, irreducible and irreparable part of the bowel that protrudes through a weakness in the abdominal wall (hernia) after surgery, with bowel dysfunction and limitation in activities of daily living. <p><i>This must be confirmed by a specialist (surgeon, physician or gastroenterologist).</i></p>	-	50	100	50
<p>Contractual definition: Gastro-intestinal tract disease, meeting the following criteria: Anatomic loss or alteration in gastro-intestinal tract, as a result of an organic cause, with symptoms uncontrolled by adequate treatment, and 25% weight loss below accepted desirable weight. This must be confirmed by a surgeon, physician or gastroenterologist.</p> <p><i>Layman's explanation:</i> <i>The gastro-intestinal tract is an organ system within humans which takes in food, digests it to extract and absorb energy and nutrients, and expels the remaining waste as faeces. This claim event covers loss of a part of this system, or disease of this system, not due to a psychological cause.</i></p> <p><i>The following criteria must be met:</i></p> <p><i>Loss due to trauma or surgery of a part of this system with evidence of disease and symptoms uncontrolled by adequate treatment with weight loss, as specified in the contractual definition above, despite optimal medical treatment. This must be confirmed by a specialist (surgeon, physician or gastroenterologist).</i></p>	100	100	100	100

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
Loss of bowel function				
Contractual definition: Permanent colostomy as a result of loss of bowel function, as a result of traumatic or medical conditions and confirmed by a specialist.	-	50	100	50
<i>Layman's explanation:</i> <i>A surgical operation in which the colon is shortened to remove a damaged or diseased part and the cut end diverted to create a permanent opening in the abdominal wall. This must be confirmed by a specialist.</i>				
Contractual definition: Complete and permanent faecal incontinence not amenable to medical treatment, as a result of an organic cause, confirmed by a specialist.	100	100	100	100
<i>Layman's explanation:</i> <i>Faecal incontinence is the inability to control bowel movements, causing stool (faeces) to leak unexpectedly from the rectum.</i>				
<i>This claim event covers faecal incontinence when the condition is permanent with a total loss of control (thus complete). It must not be amenable to medical treatment and not due to a psychological cause. This must be confirmed by a specialist.</i>				
Chronic liver disease				
Contractual definition: Severe chronic liver disease despite optimal medical treatment and confirmed by a gastroenterologist, with abnormal liver function tests, as evidenced by at least two of the following: <ul style="list-style-type: none">• Albumin 28-35 mg/L• INR 1.71-2.20• Bilirubin 34-50 umol/l• Ascites.	-	50	100	50
<i>Layman's explanation:</i> <i>This claim event covers severe chronic liver disease despite optimal medical treatment, meeting the criteria as described in the contractual definition above. This must be confirmed by a specialist (gastroenterologist).</i>				
<i>Ascites is the abnormal accumulation of fluid in the abdominal cavity.</i>				

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
<p>Contractual definition: Severe progressive chronic liver disease despite optimal medical treatment, confirmed by a gastroenterologist and meeting the following criteria:</p> <ul style="list-style-type: none"> • Objective evidence of jaundice, and • Ascites or bleeding oesophageal varices within the last year, and • 25% weight loss below accepted desirable weight. <p>Layman's explanation: <i>This claim event covers severe worsening chronic liver disease despite optimal medical treatment, meeting the following criteria:</i></p> <ul style="list-style-type: none"> • <i>Objective evidence of a medical condition with yellowing of the skin or whites of the eyes, arising from excess of the pigment bilirubin (jaundice), and</i> • <i>Abnormal accumulation of fluid in the abdominal cavity (ascites) or bleeding enlarged veins in the food pipe (oesophagus) within the last year, and</i> • <i>25% weight loss below accepted desirable weight.</i> <p><i>This must be confirmed by a specialist (gastroenterologist).</i></p> <p><i>The oesophagus (food pipe) is a muscular tube that moves food and liquids from the throat to the stomach.</i></p>	100	100	100	100
<p>Liver transplant</p> <p>Contractual definition:</p> <ul style="list-style-type: none"> • The undergoing of a complete liver transplant as a recipient, or • Confirmation of being on a recognised national South African transplant waiting list, awaiting a complete liver transplant. <p>This must be confirmed by a specialist with supporting evidence.</p> <p>Layman's explanation: <i>This claim event covers:</i></p> <ul style="list-style-type: none"> • <i>The undergoing of a complete liver transplant as a recipient, to replace a diseased liver, or</i> • <i>Confirmation of being on a recognised national South African transplant waiting list, awaiting a complete liver transplant.</i> <p><i>This must be confirmed by a specialist with supporting evidence.</i></p>	100	100	100	100
<p>Biliary tract disease</p> <p>Contractual definition: Irreparable biliary tract obstruction with persistent jaundice despite optimal medical treatment, confirmed by a gastroenterologist.</p> <p>Layman's explanation: <i>This claim event covers irreparable biliary tract obstruction with persistent jaundice. This must be confirmed by a specialist (gastroenterologist).</i></p> <p><i>Biliary obstruction is when one of the ducts that carry bile from the liver to the intestine via the gallbladder becomes blocked. Irreparable biliary tract obstruction with persistent jaundice is when the obstruction is irreparable and jaundice persists despite optimal medical treatment.</i></p>	100	100	100	100

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
Pancreas transplant				
Contractual definition: <ul style="list-style-type: none"> The undergoing of a complete pancreas transplant as a recipient, or Confirmation of being on a recognised national South African transplant waiting list, awaiting a complete pancreas transplant. <p>This must be confirmed by a specialist with supporting evidence.</p> <p><i>Layman's explanation:</i> <i>This claim event covers:</i> <ul style="list-style-type: none"> <i>The undergoing of a complete pancreas transplant as a recipient, to replace a diseased pancreas, or</i> <i>Confirmation of being on a recognised national South African transplant waiting list, awaiting a complete pancreas transplant.</i> </p> <p><i>This must be confirmed by a specialist with supporting evidence.</i></p>	100	100	100	100
Endocrine system				
Disorders of the hypothalamic pituitary axis				
Contractual definition: Disorders of the hypothalamic pituitary axis, with permanent whole person impairment (WPI) exceeding 26% despite optimal medical treatment. This must be confirmed by an endocrinologist.	-	50	100	50
<i>Layman's explanation:</i> <i>This claim event covers disorders of the hypothalamic pituitary axis, with permanent whole person impairment exceeding 26% despite optimal medical treatment. This must be confirmed by a specialist (endocrinologist).</i>				
<i>The hypothalamic pituitary axis plays key roles in controlling hormone secretion that has an effect on other organs in the body.</i>				
Hypoadrenalinism				
Contractual definition: Hypoadrenalinism, with permanent whole person impairment (WPI) exceeding 30% despite optimal medical treatment. This must be confirmed by an endocrinologist.	-	50	100	50
<i>Layman's explanation:</i> <i>This claim event covers hypoadrenalinism, with permanent whole person impairment exceeding 30% despite optimal medical treatment. This must be confirmed by a specialist (endocrinologist).</i>				
<i>Hypoadrenalinism is a condition in which the adrenal glands do not produce adequate amounts of steroid hormones. The adrenal glands are small glands located on the top end of the kidney that produce important hormones in the body.</i>				

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
Hyperadrenocorticism				
Contractual definition: Hyperadrenocorticism, with permanent whole person impairment (WPI) exceeding 30% despite optimal medical treatment. This must be confirmed by an endocrinologist.	-	50	100	50
<i>Layman's explanation:</i> <i>This claim event covers hyperadrenocorticism, with permanent whole person impairment exceeding 30% despite optimal medical treatment. This must be confirmed by a specialist (endocrinologist).</i>				
<i>Hyperadrenocorticism, which is often called Cushing's syndrome, is an extremely complex condition that involves many areas of the body. It results from an excess of a hormone called cortisol and its effects on the human body.</i>				
Phaeochromocytoma				
Contractual definition: Phaeochromocytoma, with permanent whole person impairment (WPI) exceeding 30% despite optimal medical treatment. This must be confirmed by an endocrinologist.	-	50	100	50
<i>Layman's explanation:</i> <i>This claim event covers phaeochromocytoma, with permanent whole person impairment exceeding 30% despite optimal medical treatment. This must be confirmed by a specialist (endocrinologist).</i>				
<i>Pheochromocytoma is a rare tumour of adrenal gland tissue. It results in the release of too many of the hormones that control heart rate, metabolism, and blood pressure.</i>				
<i>The adrenal glands are small glands located on the top end of the kidney that produce important hormones in the body.</i>				
Diabetes mellitus: type I or II				
Contractual definition: Diabetes mellitus: type I or II with moderate to severe organ impairment, confirmed by a specialist and meeting the following criteria:	-	50	100	50
<ul style="list-style-type: none"> • Kidney functions impaired, which will be assessed under kidney failure events • Retinopathy with visual impairment, which will be assessed under visual impairment events • Ischaemic heart disease, which will be assessed under ischaemic heart disease with cardiac failure. 				
<i>Layman's explanation:</i> <i>Diabetes mellitus is a disorder in which blood sugar (glucose) levels are abnormally high because the body does not produce enough insulin to meet its needs.</i>				
<i>This claim event covers type I or II with moderate to severe organ impairment, meeting the criteria described in the contractual definition above. This must be confirmed by a specialist.</i>				
<i>Diabetic retinopathy is caused by damage to the blood vessels in the tissue at the back of the eye (retina). Poorly controlled blood sugar is a risk factor.</i>				

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
<p>Contractual definition: Diabetes mellitus: type I or II with severe organ impairment, confirmed by a specialist and meeting the following criteria:</p> <ul style="list-style-type: none"> • Kidney functions impaired, which will be assessed under kidney failure events • Retinopathy with visual impairment, which will be assessed under visual impairment events • Ischaemic heart disease, which will be assessed under ischaemic heart disease with cardiac failure. <p><i>Layman's explanation:</i> <i>Diabetes mellitus is a disorder in which blood sugar (glucose) levels are abnormally high because the body does not produce enough insulin to meet its needs.</i></p> <p><i>This claim event covers type I or II with severe organ impairment, meeting the criteria in the contractual definition above. This must be confirmed by a specialist.</i></p> <p><i>Diabetic retinopathy is caused by damage to the blood vessels in the tissue at the back of the eye (retina). Poorly controlled blood sugar is a risk factor.</i></p>	100	100	100	100
<p>Catch-all for other disorders of the endocrine system</p> <p>Contractual definition: Any disorder of the endocrine system not specified in the other listed events for the endocrine system, that is confirmed by an endocrinologist, with permanent whole person impairment (WPI) exceeding 30% despite optimal medical treatment.</p> <p><i>Layman's explanation:</i> <i>The endocrine system has eight major glands, which make hormones. Hormones affect the functions of the entire body. Any disease of a gland can cause imbalances in the body which can be from mild to serious.</i></p> <p><i>This claim event covers any disorder of any of these glands not specified in the listed events that is confirmed by a specialist (endocrinologist), with permanent whole person impairment exceeding 30% despite optimal medical treatment.</i></p> <p>Contractual definition: Any disorder of the endocrine system not specified in the listed events for the endocrine system, that is confirmed by an endocrinologist, with permanent whole person impairment (WPI) exceeding 40% despite optimal medical treatment.</p> <p><i>Layman's explanation:</i> <i>The endocrine system has eight major glands, which make hormones. Hormones affect the functions of the entire body. Any disease of a gland can cause imbalances in the body which can be from mild to serious.</i></p> <p><i>This claim event covers any disorder of any of these glands not specified in the listed events that is confirmed by a specialist (endocrinologist), with permanent whole person impairment exceeding 40% despite optimal medical treatment.</i></p>	-	50	100	50

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
Renal system				
Kidney failure				
Contractual definition: Kidney failure with moderate impairment, meeting the following criteria: The diagnosis of permanent kidney failure by a nephrologist or urologist, with evidence of a creatinine clearance of 28 to 42 ml per minute despite adequate medical treatment.	-	50	100	50
<i>Layman's explanation:</i> <i>Kidney failure refers to failure of the kidneys to function properly.</i>				
<i>This claim event covers kidney failure with moderate impairment, meeting the criteria in the contractual definition above. This must be confirmed by a specialist (nephrologist or urologist).</i>				
Contractual definition: Kidney failure with severe impairment, meeting the following criteria: The diagnosis of permanent kidney failure by a nephrologist or urologist, with evidence of a creatinine clearance of less than 28 ml per minute, or the need for more than 8 hours of dialysis per week.	100	100	100	100
<i>Layman's explanation:</i> <i>Kidney failure refers to failure of the kidneys to function properly.</i>				
<i>This claim event covers kidney failure with severe impairment, meeting the criteria in the contractual definition above. This must be confirmed by a specialist (nephrologist or urologist).</i>				
Kidney transplant				
Contractual definition: <ul style="list-style-type: none">• 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.	100	100	100	100
This must be confirmed by a specialist with supporting evidence.				
<i>Layman's explanation:</i> <i>This claim event covers:</i>				
<ul style="list-style-type: none">• <i>The undergoing of a complete kidney transplant as a recipient, to replace a diseased kidney, or</i>• <i>Confirmation of being on a recognised national South African transplant waiting list, awaiting a complete kidney transplant.</i>				
<i>This must be confirmed by a specialist with supporting evidence.</i>				
Loss of bladder function				
Contractual definition: Loss of bladder function due to organic cause, which despite optimal medical treatment requires frequent catheterisation (at least weekly). This must be confirmed by an urologist.	-	45	45	45
<i>Layman's explanation:</i> <i>This claim event covers loss of bladder function, not due to a psychological cause. The life insured must require frequent catheterisation (at least weekly) despite optimal medical treatment. This must be confirmed by a specialist (urologist).</i>				
<i>Catheterisation is when a plastic tube (a catheter) is inserted into the bladder to provide urinary drainage.</i>				

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
Bladder or urethral disease				
Contractual definition: Bladder or urethral disease of organic cause resulting in complete urinary incontinence, which despite optimal medical treatment requires indwelling catheterisation. This must be confirmed by an urologist.	100	100	100	100
<i>Layman's explanation:</i> <i>This claim event covers bladder or urethral disease, not due to a psychological cause. The following criteria must be met:</i>				
<ul style="list-style-type: none"> <i>The disease must result in uncontrolled leakage of urine despite optimal medical treatment, and</i> <i>It must require permanent catheterisation to provide continuous urinary drainage.</i> <p><i>This must be confirmed by a specialist (urologist).</i></p> <p><i>Catheterisation is when a plastic tube (a catheter) is inserted into the bladder to provide urinary drainage.</i></p>				
Surgical removal of the bladder				
Contractual definition: The surgical excision of the bladder by a surgeon, confirmed with a surgical report by an urologist or surgeon.	100	100	100	100
<i>Layman's explanation:</i> <i>This claim event covers the removal of the entire bladder by surgery. A surgical report from a specialist (urologist or surgeon) needs to confirm this.</i>				
Musculoskeletal system				
Amputation of a thumb				
Contractual definition: The amputation of a thumb, at the interphalangeal level and proximal to the joint, by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	-	30**	30**	30**
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of a thumb at the first joint. This must be confirmed by a specialist with supporting evidence.</i>				
Amputation of three fingers other than thumb				
Contractual definition: The amputation of 3 fingers other than the thumb on the same hand, at the proximal interphalangeal joint or more proximal than this joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	-	15*	15*	15*
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of 3 fingers, excluding the thumb on the same hand, at the level of the middle knuckles. This must be confirmed by a specialist with supporting evidence.</i>				
Amputation of three fingers, including the thumb				
Contractual definition: The amputation of 3 fingers, including the thumb, on the same hand, at the proximal interphalangeal joint or more proximal than this joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	-	45**	45**	45**
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of 3 fingers including the thumb on the same hand – the thumb at the first joint and the other fingers at the level of the middle knuckles. This must be confirmed by a specialist with supporting evidence.</i>				

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
Amputation of four fingers other than thumb				
Contractual definition: The amputation of 4 fingers other than the thumb on the same hand, at the proximal interphalangeal joint or more proximal than this joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	-	45**	45**	45**
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of 4 fingers excluding the thumb on the same hand, at the level of the middle knuckles. This must be confirmed by a specialist with supporting evidence.</i>				
Amputation of a hand				
Contractual definition: The amputation of a hand at the wrist by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	-	70	100	70
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of a hand at the wrist. This must be confirmed by a specialist with supporting evidence.</i>				
Loss of use of a hand				
Contractual definition: <ul style="list-style-type: none">• The permanent loss of function of an entire hand from the wrist (distal to the wrist), or• The permanent loss of function of an upper limb, with at least 60% impairment of the limb according to the latest American Medical Association (AMA) guidelines. This must be confirmed by a specialist with supporting evidence.	-	70	100	70
<i>Layman's explanation:</i> <i>This claim event covers:</i> <ul style="list-style-type: none">• <i>The permanent loss of function of an entire hand from the wrist, or</i>• <i>The permanent loss of use of an arm (upper limb), meeting the criteria in the contractual definition above.</i> <i>This must be confirmed by a specialist with supporting evidence.</i>				
Amputation of an arm below the elbow				
Contractual definition: The amputation of an arm distal to the elbow by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	-	75	100	75
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of an arm below the elbow. This must be confirmed by a specialist with supporting evidence.</i>				

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
Loss of use of an arm				
Contractual definition: <ul style="list-style-type: none">• The permanent loss of function of an entire arm from the shoulder (distal to the shoulder), or• The permanent loss of function of an upper limb, with at least 90% impairment of the limb according to the latest American Medical Association (AMA) guidelines. This must be confirmed by a specialist with supporting evidence. <i>Layman's explanation:</i> <i>This claim event covers:</i> <ul style="list-style-type: none">• <i>The permanent loss of use of an entire arm from the shoulder, or</i>• <i>The permanent loss of use of an arm (upper limb), meeting the criteria in the contractual definition above.</i> <i>This must be confirmed by a specialist with supporting evidence.</i>	-	75	100	75
Amputation of an arm above the elbow				
Contractual definition: The amputation of an arm proximal to the elbow by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence. <i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of an arm above the elbow. This must be confirmed by a specialist with supporting evidence.</i>	-	80	100	80
Amputation of a foot				
Contractual definition: The amputation of a foot at the level of the ankle joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence. <i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of a foot at the ankle joint. This must be confirmed by a specialist with supporting evidence.</i>	-	30	30	30
Loss of use of a foot				
Contractual definition: The permanent loss of function of an entire foot from the ankle (distal to the ankle). This must be confirmed by a specialist with supporting evidence. <i>Layman's explanation:</i> <i>The permanent loss of use of an entire foot from the ankle. This must be confirmed by a specialist with supporting evidence.</i>	-	30	30	30
Amputation of a leg below the knee				
Contractual definition: The amputation of a leg distal to the knee joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence. <i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of a leg below the knee. This must be confirmed by a specialist with supporting evidence.</i>	-	50	100	50

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
Loss of use of a lower leg				
Contractual definition:	-	50	100	50
<ul style="list-style-type: none"> The permanent loss of function of an entire leg from below the knee (below and distal to the knee joint), or The permanent loss of function of a lower limb, with at least 60% impairment of the limb according to the latest American Medical Association (AMA) guidelines. 				
This must be confirmed by a specialist with supporting evidence.				
<i>Layman's explanation:</i>				
<i>This claim event covers:</i>				
<ul style="list-style-type: none"> <i>The permanent loss of use of an entire leg from below the knee, or</i> <i>The permanent loss of use of a leg (lower limb), meeting the criteria in the contractual definition above.</i> 				
<i>This must be confirmed by a specialist with supporting evidence.</i>				
Loss of use of a leg				
Contractual definition:	-	75	100	75
<ul style="list-style-type: none"> The permanent loss of function of an entire leg (proximal and distal to the knee joint), or The permanent loss of function of a lower limb, with at least 90% impairment of the limb according to the latest American Medical Association (AMA) guidelines. 				
This must be confirmed by a specialist with supporting evidence.				
<i>Layman's explanation:</i>				
<i>This claim event covers:</i>				
<ul style="list-style-type: none"> <i>The permanent loss of use of an entire leg, or</i> <i>The permanent loss of use of a leg (lower limb), meeting the criteria in the contractual definition above.</i> 				
<i>This must be confirmed by a specialist with supporting evidence.</i>				
Amputation of a leg above the knee				
Contractual definition:	-	75	100	75
The amputation of a leg proximal to the knee joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.				
<i>Layman's explanation:</i>				
<i>The surgical or traumatic removal or severance of a leg above the knee. This must be confirmed by a specialist with supporting evidence.</i>				

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
Amputation or loss of a combination of two limbs or an eye				
Contractual definition: The amputation or loss of any 2 of the following, as described in this table, resulting from the same cause, provided they are not part of the same limb:	100	100	100	100
<ul style="list-style-type: none"> • Amputation of a hand • Amputation of an arm below the elbow • Amputation of an arm above the elbow • Amputation of a foot • Amputation of a leg below the knee • Amputation of a leg above the knee • Loss of an eye. 				
This must be confirmed by a specialist with supporting evidence.				
Loss of use of a combination of two limbs or an eye				
Contractual definition: The permanent loss of function of any 2 of the following, as described in this table, resulting from the same cause, provided they are not part of the same limb:	100	100	100	100
<ul style="list-style-type: none"> • Loss of use of a hand • Loss of use of an arm • Loss of use of a foot • Loss of use of a lower leg • Loss of use of a leg • Total loss of vision of one eye or hemianopia of one eye. 				
This must be confirmed by a specialist with supporting evidence.				
Total hip replacement***				
Contractual definition: Total surgical replacement of the hip joint with a prosthesis, confirmed by an orthopaedic surgeon. This must be supported by surgical reports.	-	20**	20**	20**
<i>Layman's explanation:</i> <i>Surgical total hip joint replacement with an artificial joint, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.</i>				
Hip fracture surgery				
Contractual definition: Open surgical repair with internal fixation or prosthesis of a fracture of the femur neck, femur head or acetabulum. This must be confirmed by a specialist with supporting evidence.	-	10*	10*	10*
<i>Layman's explanation:</i> <i>Hip repair involving the stabilising of broken bones with surgical screws, nails, rods or plates, or alternatively with artificial joints of the broken part – femur neck, femur head or acetabulum (all parts forming the hip). This must be confirmed by a specialist with supporting evidence.</i>				
Total knee replacement***				
Contractual definition: Total surgical replacement of the knee joint with a prosthesis, confirmed by an orthopaedic surgeon. This must be supported by surgical reports.	-	10*	10*	10*
<i>Layman's explanation:</i> <i>Surgical total knee joint replacement with an artificial joint, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.</i>				

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
Total shoulder replacement***				
Contractual definition: Total surgical replacement of the shoulder joint with a prosthesis, confirmed by an orthopaedic surgeon. This must be supported by surgical reports.	-	10*	10*	10*
<i>Layman's explanation:</i> <i>Surgical total shoulder joint replacement with an artificial joint, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.</i>				
Total ankle replacement***				
Contractual definition: Total surgical replacement of the ankle joint with a prosthesis, confirmed by an orthopaedic surgeon. This must be supported by surgical reports.	-	10*	10*	10*
<i>Layman's explanation:</i> <i>Surgical total ankle joint replacement with artificial parts, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.</i>				

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
Chronic back and neck pain				
Contractual definition: Chronic back or neck pain, where the neck and back are both part of the spine. Only one claim for spinal pain will be allowed per spinal region.	-	25	25	25
The spinal regions are the following: <ul style="list-style-type: none"> • The cervical region (C1 to C7), and • The thoracic region (T1 to T12), and • The lumbosacral region (L1 to S1). The C7 to T1 joint will be classified in the cervical region, and the T12 to L1 joint in the lumbosacral region.				
One of the following four diagnoses must be made as the cause of chronic pain: <ul style="list-style-type: none"> • 50% compression of a vertebral body, or • Clinically significant radiculopathy, verified by an imaging study that confirms a herniated disc at the level and side as found clinically, and verified by electrodiagnostic testing, or • Alteration of motion segment integrity (instability), using flexion and extension radiographs, or • A back or cervical operation comprising laminectomy, discectomy or fusion, or a combination thereof. In all four of the above diagnoses the clinical findings, pain distribution and findings on special examinations must make pathophysiological sense. The chronic pain will be evaluated by the following criteria: <ul style="list-style-type: none"> • pain questionnaires, and • pain diagrams, and • analgesic medication usage. This must be confirmed by an orthopaedic specialist or neurosurgeon with supporting evidence.				
<i>Layman's explanation:</i> <i>Long-standing back and neck pain (where the neck and the back are both part of the spine). Only one claim for spinal pain will be allowed per spinal section.</i>				
<i>The spinal sections are:</i> <ul style="list-style-type: none"> • <i>Cervical – holds up the head</i> • <i>Thoracic – ribs are attached</i> • <i>Lumbar – lower back.</i> <i>The pain must be due to one of the following causes:</i> <ul style="list-style-type: none"> • <i>A back bone (vertebra) having lost half of its height due to compression.</i> <i>Compression of a vertebral body is when one or more back bones (vertebrae) collapse into itself and become squashed (compressed), or</i> • <i>Significant signs of a pinched nerve, which is confirmed by specialised testing (MRI and electrodiagnostic testing), or</i> • <i>Proven instability of vertebrae on x-rays, or</i> • <i>A back or neck operation as stipulated in the contractual definition above.</i> <i>This must be confirmed by a specialist (orthopaedic specialist or neurosurgeon), with the evidence provided as stipulated in the contractual definition above.</i>				

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
Cancer				
Malignant tumours of the spinal cord and vertebral column				
Contractual definition: The incontrovertible presence of uncontrolled growth and spread of malignant cells, the invasion of normal tissue, and the definite histological evidence of a malignant growth in the spinal cord and vertebral column. This must be confirmed by an oncologist with supporting objective evidence.	-	50	100	50
<i>Layman's explanation:</i> <i>Cancer of the spinal cord or vertebral column, confirmed by taking a sample of tissue of the area and confirming the presence of cancerous cells in these areas. A clinical report is required from a specialist (oncologist).</i>				
Stage III cancer				
Contractual definition: Any stage III cancer, where the expected time off work due to active treatment exceeds more than 3 months in total, irrespective of whether this period is interrupted or uninterrupted. The expected time off work must be confirmed by the relevant specialist.	-	-	10	-
Contractual definition: Any stage III cancer, confirmed by an oncologist with supporting objective evidence, with the permanent inability to do 2 or more basic activities of daily living (ADLs) and 2 or more advanced activities of daily living (ADLs), as indicated in the tables "Basic activities of daily living for disability and impairment benefits" and "Advanced activities of daily living for disability and impairment benefits" later in this chapter.	100	100	100	100
<i>Layman's explanation:</i> <i>This claim event covers stage III cancer, meeting the criteria in the contractual definition above. A clinical report is required from a specialist (oncologist).</i>				
<i>Cancer prevents cells from dying when they should and causes new cells to form when the body does not need them. These cells are able to invade other tissues and spread to other parts of the body through the blood and lymph systems.</i>				
<i>Stage III cancer is cancer with regional spread – the cancer has spread within the general region in which it first began, and into the lymph nodes but not to other parts of the body.</i>				
Stage IV cancer				
Contractual definition: Any stage IV cancer, confirmed by an oncologist with supporting objective evidence.	100	100	100	100
<i>Layman's explanation:</i> <i>Cancer prevents cells from dying when they should and causes new cells to form when the body does not need them. These cells are able to invade other tissues and spread to other parts of the body through the blood and lymph systems.</i>				
<i>This claim event covers stage IV cancer, which is cancer with distant spread (cancer that has spread to other parts of the body). A clinical report is required from a specialist (oncologist).</i>				
Visual system				
Total loss of vision of one eye or hemianopia of one eye				
Contractual definition: Total and permanent loss of vision of one eye or permanent hemianopia of one eye as a result of an organic cause, confirmed by an ophthalmologist with supporting evidence.	-	25	25	25
<i>Layman's explanation:</i> <i>This claim event covers the total and permanent loss of vision of one eye or permanent loss of either the left or right half of the visual field of one eye, not due to a psychological cause. This must be confirmed by a specialist (ophthalmologist) with supporting documents.</i>				

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
Loss of an eye				
Contractual definition: Complete enucleation of one eye due to injury or disease, confirmed by an ophthalmologist with supporting evidence.	-	50	100	50
<i>Layman's explanation:</i> <i>The complete removal of one eye from its socket as a result of trauma or surgery, confirmed by a specialist (ophthalmologist) with supporting documents.</i>				
Partial loss of vision of both eyes				
Contractual definition: Permanent bilateral visual impairment of 50% as a result of an organic cause, confirmed by an ophthalmologist with supporting evidence and meeting the following criteria: <ul style="list-style-type: none"> • A reading of at least 20/125 (or equivalent measure) in each eye, or • Diabetic retinopathy grade III or grade III retinopathy as a result of a chronic disease in each eye, or • A visual field loss to a 20° radius of each eye. 	-	50	100	50
<i>Layman's explanation:</i> <i>This claim event covers permanent decreased vision of 50%, not due to a psychological cause. It must meet the criteria described in the contractual definition above and must be confirmed by a specialist (ophthalmologist).</i>				
Total loss of vision of both eyes or blindness of both eyes				
Contractual definition: Total and permanent loss of vision of both eyes or blindness of both eyes by visual acuity or retinal pathology or visual field measurements, as a result of an organic cause, confirmed by an ophthalmologist with supporting evidence and meeting the following criteria: Bilateral visual impairment of 70%, with evidence of 1 of the following: <ul style="list-style-type: none"> • A reading of at least 20/200 (or equivalent measure) in each eye, or • Diabetic retinopathy grade IV or grade IV retinopathy as a result of a chronic disease in each eye, or • Permanent hemianopia of both eyes, or • A visual field loss to a 10° radius of each eye. 	100	100	100	100
<i>Layman's explanation:</i> <i>This claim event covers the total and permanent loss of vision of both eyes or blindness of both eyes, not due to a psychological cause. It must meet the criteria described in the contractual definition above, and must be confirmed by a specialist (ophthalmologist).</i>				
Hearing				
Total loss of hearing in one ear				
Contractual definition: The total and permanent loss of hearing in one ear as confirmed by an ear, nose and throat surgeon, with objective audiology evidence, recording an average loss of at least 70dB across all measured frequencies.	-	25	25	25
Partial loss of hearing in both ears				
Contractual definition: The permanent loss of hearing of 60% or more in both ears as confirmed by an ear, nose and throat surgeon, with objective audiology evidence, recording an average loss of 70-87dB across all measured frequencies.	-	50	100	50
Total loss of hearing in both ears				
Contractual definition: The total and permanent loss of hearing in both ears as confirmed by an ear, nose and throat surgeon, with objective audiology evidence, recording an average loss of greater than 87dB across all measured frequencies.	100	100	100	100

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
Speech				
Aphasia				
Contractual definition: Total and permanent loss of the ability to speak as a result of an organic brain disease, confirmed by a neurosurgeon or neurologist.	100	100	100	100
<i>Layman's explanation:</i> <i>This claim event covers the total and permanent loss of the ability to speak, not due to a psychological cause. This must be confirmed by a specialist (neurosurgeon or neurologist).</i>				
Partial loss of speech				
Contractual definition: Partial and permanent loss of the ability to speak as a result of organic ear, nose and throat (ENT) disease, affecting daily activity, confirmed by an ear, nose and throat specialist.	-	50	100	50
<i>Layman's explanation:</i> <i>This claim event covers the partial and permanent loss of the ability to speak as a result of confirmed disease of the ear, nose and throat organ, not due to a psychological cause. This must be confirmed by a specialist (ear, nose and throat specialist).</i>				
Total loss of speech				
Contractual definition: Total and permanent loss of the ability to speak as a result of organic ear, nose and throat (ENT) disease, confirmed by an ear, nose and throat specialist.	100	100	100	100
<i>Layman's explanation:</i> <i>This claim event covers the total and permanent loss of the ability to speak as a result of confirmed disease of the ear, nose and throat organ, not due to a psychological cause. This must be confirmed by a specialist (ear, nose and throat specialist).</i>				
Psychiatric conditions				
Psychiatric condition				
Contractual definition: Psychiatric condition with frequent, extended admissions, meeting the following criteria:	-	50	100	50
<ul style="list-style-type: none"> • Institutionalised in a registered psychiatric facility at least 3 times during the last 12 months, with each admission lasting for longer than 6 weeks, and • Global Assessment Function (GAF) score of less than 40, and • Must be confirmed by a specialist. 				
OR				
Psychiatric condition with one prolonged admission: The diagnosis of a psychiatric disorder, according to the latest Diagnostic and Statistical Manual of Mental Disorders (DSM) classification, meeting the following criteria:				
<ul style="list-style-type: none"> • Institutionalised in a registered psychiatric facility for more than 6 consecutive months, and • Undergoing of constant supervision with a permanent caregiver, and • Global Assessment Function (GAF) score of 30 or less, and • Must be confirmed by at least 2 independent psychiatric reports by the relevant specialists. 				

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
<p>Contractual definition: Psychiatric condition with permanent institutionalisation: The diagnosis of a psychiatric disorder, according to the latest Diagnostic and Statistical Manual of Mental Disorders (DSM) classification, meeting the following criteria:</p> <ul style="list-style-type: none"> • Permanent institutionalisation in a registered psychiatric facility, and • Undergoing of constant supervision with a permanent caregiver, and • Global Assessment Function (GAF) score of 30 or less, and • Must be confirmed by at least 2 independent psychiatric reports by the relevant specialists. 	100	100	100	100
Face and skin				
Facial disfigurement				
<p>Contractual definition: Severe facial disfigurement despite more than two corrective facial surgical procedures by a registered plastic or maxillo facial surgeon, resulting in social withdrawal. The severity of the disfigurement and the social withdrawal must be confirmed by the relevant specialists.</p>	-	50	100	50
Combination burns				
<p>Contractual definition: A combination of 2nd and 3rd degree burns that covers more than 80% of the face or hands or feet, confirmed by a surgeon.</p> <p><i>Layman's explanation:</i> <i>A combination of less severe (2nd degree) and severe (3rd degree) burns that covers more than 80% of the face or hands or feet. This must be confirmed by a specialist (surgeon).</i></p> <p><i>2nd degree burns are burn wounds to the outer skin layer and the layer directly under this.</i></p> <p><i>3rd degree burns are burn wounds to all three layers of the skin.</i></p>	-	10	10	10
Third degree burns				
<p>Contractual definition: Third degree burns, full thickness of the skin, covering at least 20% of the total body surface, confirmed by a surgeon.</p> <p><i>Layman's explanation:</i> <i>Burn wounds to all three layers of the skin which affect at least 20% of the body's surface, as measured with a Lund and Browder chart, or a similar chart. This must be confirmed by a specialist (surgeon).</i></p>	-	50	100	50
<p>Contractual definition: Third degree burns, full thickness of the skin, covering at least 30% of the total body surface, confirmed by a surgeon.</p> <p><i>Layman's explanation:</i> <i>Burn wounds to all three layers of the skin which affect at least 30% of the body's surface, as measured with a Lund and Browder chart, or a similar chart. This must be confirmed by a specialist (surgeon).</i></p>	100	100	100	100

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
Trauma				
Gunshot wounds or penetrating stab wounds				
Contractual definition: Gunshot or penetrating stab wound resulting in theatre debridement, with an operation report provided by a surgeon or trauma surgeon.	-	5*	5*	5*
<i>Layman's explanation:</i> <i>Gunshot or penetrating stab wound, with removal of dead, damaged or infected tissue in theatre to improve the healing potential of the remaining healthy tissue. An operation report must be provided by a specialist (surgeon or trauma surgeon).</i>	-	10**	10**	10**
Contractual definition: Penetration by a bullet or a sharp object through the skull, resulting in surgical exploration of the skull under general anaesthetic, with an operation report provided by a surgeon or trauma surgeon.	-	10**	10**	10**
<i>Layman's explanation:</i> <i>Penetration by a bullet or a sharp object through the skull, resulting in an operation opening up the skull to determine and repair damage caused by the penetrating injury of the skull (surgical exploration of the skull) under general anaesthetic. An operation report must be provided by a specialist (surgeon or trauma surgeon).</i>	-	10**	10**	10**
Contractual definition: Penetration by a bullet or a sharp object through the chest, resulting in an underwater drain, with an operation report provided by a surgeon or trauma surgeon.	-	20**	20**	20**
<i>Layman's explanation:</i> <i>Penetration by a bullet or a sharp object through the chest, resulting in the placement of a tube into the chest (underwater drain) to drain air, fluid or blood from the space around the lung and thus allowing the lung to expand. An operation report must be provided by a specialist (surgeon or trauma surgeon).</i>	-	20**	20**	20**
Contractual definition: Penetration by a bullet or a sharp object through the chest, resulting in a thoracotomy, with an operation report provided by a surgeon or trauma surgeon.	-	10**	10**	10**
<i>Layman's explanation:</i> <i>Penetration by a bullet or a sharp object through the chest, resulting in an operation with an incision into the chest wall (a thoracotomy). An operation report must be provided by a specialist (surgeon or trauma surgeon).</i>	-	10**	10**	10**
Contractual definition: Penetration by a bullet or a sharp object through the abdomen, resulting in surgical exploration of the cavity under general anaesthetic, with an operation report provided by a surgeon or trauma surgeon.	-	10**	10**	10**
<i>Layman's explanation:</i> <i>Penetration by a bullet or a sharp object through the abdomen, resulting in an operation of the belly to assess damage caused by the injury to internal organs or blood vessels (surgical exploration of the cavity) under general anaesthetic. An operation report must be provided by a specialist (surgeon or trauma surgeon).</i>	-	10**	10**	10**

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
<p>Contractual definition: Penetration by a bullet or a sharp object through the neck, with damage to one or more of the following: subclavian or carotid artery, oesophagus or trachea, with an operation report provided by a surgeon or trauma surgeon.</p> <p><i>Layman's explanation:</i> <i>Penetration by a bullet or a sharp object through the neck, with damage to one or more of the following blood vessels or organs:</i></p> <ul style="list-style-type: none"> • <i>The subclavian arteries, which are a pair of large arteries in the chest that supply blood to the chest, head, neck, shoulder and arms, or</i> • <i>The carotid arteries, which are major blood vessels in the neck that supply blood to the brain, neck, and face, or</i> • <i>The food pipe (oesophagus), which is a muscular tube that moves food and liquids from the throat to the stomach, or</i> • <i>The windpipe (trachea).</i> <p><i>An operation report must be provided by a specialist (surgeon or trauma surgeon).</i></p>	-	10**	10**	10**
Multiple rib fractures				
<p>Contractual definition: Multiple rib fractures with ICU admission: Numerous rib fractures, requiring admission to an intensive care unit (ICU), confirmed by a specialist.</p> <p><i>Contractual definition:</i> <i>Multiple rib fractures with ICU admission:</i> <i>Numerous rib fractures, requiring ventilation in an intensive care unit in order to sustain a stable blood-gas profile, confirmed by a specialist.</i></p>	-	5	5	5
Pelvis fracture				
<p>Contractual definition: More than one fracture of different bones of the pelvic framework, resulting in instability, confirmed by an orthopaedic specialist or surgeon.</p> <p><i>Layman's explanation:</i> <i>A pelvic fracture is a break of the bony structure of the pelvis. For this claim event there must be more than one fracture of different bones of the pelvic framework, resulting in instability of the pelvic ring. This must be confirmed by a specialist (orthopaedic specialist or surgeon).</i></p>	-	5	5	5
Unstable pelvis fracture				
<p>Contractual definition: More than one fracture of the pelvic framework, resulting in instability, and requiring surgical intervention, confirmed by an orthopaedic specialist or surgeon.</p> <p><i>Layman's explanation:</i> <i>A pelvic fracture is a break of the bony structure of the pelvis. For this claim event there must be more than one fracture of the pelvic framework, resulting in instability of the pelvic ring, and requiring surgical intervention. This must be confirmed by a specialist (orthopaedic specialist or surgeon).</i></p>	-	20	20	20

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
Compression fracture				
Contractual definition: A compression fracture of more than 50% of a spinal vertebra with documented spinal cord injury or myelopathy, confirmed by a neurosurgeon or orthopaedic specialist.	-	10	10	10
<i>Layman's explanation:</i> <i>When the bone of a vertebral body collapses it is called a compression fracture. For this claim event there must be a compression fracture of more than 50% of a spinal vertebra leading to collapse of the vertebra with documented spinal cord injury or compression of the nerves of the spinal cord. This must be confirmed by a specialist (neurosurgeon or orthopaedic specialist).</i>				
Fracture dislocation of the spine				
Contractual definition: A fracture dislocation of the spine, without neurological deficit, confirmed with supporting evidence by a neurosurgeon or orthopaedic specialist.	-	5	5	5
<i>Layman's explanation:</i> <i>A fracture is a break or crack in the bone. A dislocation occurs when 2 bones are out of place at the joint that connects them. A fracture dislocation of the spine, without neurological deficit, is when this occurs in the vertebral column, but the life insured has no signs of altered function due to the weaker function of the spinal cord. There must be objective evidence of the dislocation on the imaging of the spine. This must be confirmed with supporting evidence by a specialist (neurosurgeon or orthopaedic specialist).</i>				
Contractual definition: A fracture dislocation of the spine, with neurological deficit, confirmed with supporting evidence by a neurosurgeon or orthopaedic specialist.	-	10	10	10
<i>Layman's explanation:</i> <i>A fracture is a break or crack in the bone. A dislocation occurs when 2 bones are out of place at the joint that connects them. A fracture dislocation of the spine, with neurological deficit, is when this occurs in the vertebral column and the life insured has signs of altered function due to the weaker function of the spinal cord. There must be objective evidence of the dislocation on the imaging of the spine. This must be confirmed with supporting evidence by a specialist (neurosurgeon or orthopaedic specialist).</i>				
Compression or avulsion fractures				
Contractual definition: Compression or avulsion fractures without joint dislocation on two or more vertebrae, confirmed with supporting evidence by a neurosurgeon or orthopaedic specialist.	-	5	5	5
<i>Layman's explanation:</i> <i>When the bone of a back bone (vertebra) collapses it is called a compression fracture. An avulsion fracture is an injury to the bone in a location where a ligament attaches to the bone. When an avulsion fracture occurs, the tendon or ligament pulls off a piece of the bone. This claim event covers compression or avulsion fractures without dislocation (the movement of the joints on two or more of the bones of the spine (vertebrae)) of two or more vertebrae. This must be confirmed with supporting evidence by a specialist (neurosurgeon or orthopaedic specialist).</i>				
Liver rupture				
Contractual definition: Rupture of the liver, necessitating emergency laparotomy and surgical repair, with an operation report provided by a surgeon.	-	10	10	10
<i>Layman's explanation:</i> <i>Bursting of the liver due to an accident or injury to the belly by a blunt object or surface, which leads to an emergency operation to repair the liver. An operation report must be provided by a specialist (surgeon).</i>				

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Plus	Elite Disability	Comprehensive Impairment
Spleen rupture				
Contractual definition: Rupture of the spleen, necessitating emergency laparotomy and surgical repair or splenectomy, with an operation report provided by a surgeon.	-	10	10	10
<i>Layman's explanation:</i> <i>Bursting of the spleen due to an accident or injury to the belly by a blunt object or surface, which leads to an emergency operation to repair or remove the spleen. An operation report must be provided by a specialist (surgeon).</i>				
Post-traumatic fat-embolism of the lungs				
Contractual definition: Fat-embolism of the lungs, confirmed by a ventilation-perfusion (VQ) scan. This must be confirmed by a pulmonologist, physician or anaesthetist.	-	10	10	10
<i>Layman's explanation:</i> <i>This claim event covers fat-embolism of the lungs.</i>				
<i>An embolism is when a lump of material, in this case fat material, is dislodged and travels into the bloodstream, which then blocks blood vessels and leads to catastrophic events in the body. This must be confirmed by a specialist (pulmonologist, physician or anaesthetist).</i>				
Compartment syndrome				
Contractual definition: Definitive history of compartment syndrome as a result of an acute injury, with permanent motor nerve damage, confirmed by a specialist. This must be confirmed with all of the following supporting evidence: <ul style="list-style-type: none">• History and clinical signs of compartment syndrome, and• Nerve conduction studies.	-	5	5	5
<i>Layman's explanation:</i> <i>Compartment syndrome is a condition of severe tissue compression, which has resulted from an acute injury. This compression in a closed muscle compartment results in permanent damage to the nerves of the affected muscles.</i>				
<i>This claim event covers a definitive history of compartment syndrome as a result of an acute injury, with permanent motor nerve damage, confirmed by a specialist. The evidence required for this claim event is specified in the contractual definition above.</i>				

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
HIV				
Advanced HIV				
Contractual definition:	100	100	100	100
<ul style="list-style-type: none"> • Advanced HIV despite optimal treatment by a relevant HIV medical practitioner and full adherence to prescribed antiretroviral therapy for more than 3 years, a permanent CD4 cell count of less than 50 measured 6 months apart and a positive PCR, or • Advanced HIV despite optimal treatment by a relevant HIV medical practitioner and full adherence to prescribed antiretroviral therapy for more than 3 years, a persistent CD4 cell count of less than 200 measured 6 months or more apart and a positive PCR; 				
AND				
At least one of the following diseases must be diagnosed:				
<ul style="list-style-type: none"> • Kaposi's sarcoma, or • Pneumocystis jirovecii pneumonia (PJP), or • Confirmed progressive multifocal leukoencephalopathy, or • Active extra-pulmonary tuberculosis, or • Cryptococcosis, or • Disseminated non-tuberculous mycobacteria infection, or • Confirmed diagnosis of any other condition as defined as stage 4 on the World Health Organisation (WHO) clinical criteria list. 				
<i>Layman's explanation:</i>				
<ul style="list-style-type: none"> • <i>Human immune virus (HIV) infection optimally treated by a doctor who manages patients with HIV. Despite the life insured's compliance to treatment for more than 3 years, the CD4 test (blood test for immune cells) remains below 50 continuously when measured every 6 months, and the PCR test (a specialised HIV detection blood test) remains positive, or</i> • <i>HIV infection optimally treated by a doctor who manages patients with HIV. Despite the life insured's compliance to treatment for more than 3 years, the CD4 test (blood test for immune cells) remains below 200 continuously when measured every 6 months, and the PCR test (a specialised HIV detection blood test) remains positive;</i> 				
AND				
One of the following diseases must be diagnosed:				
<ul style="list-style-type: none"> • <i>Kaposi sarcoma (KS), which is a cancer that causes patches of abnormal tissue to grow under the skin, in the lining of the mouth, nose and throat, in lymph nodes, or in other organs, or</i> • <i>Pneumocystis jirovecii pneumonia (PJP), which is a type of pneumonia caused by a fungal infection, or</i> • <i>Progressive multiple leukoencephalopathy, which is a serious disease of the brain that causes progressive damage or inflammation of the white matter of the brain in many areas, or</i> • <i>Active extra-pulmonary tuberculosis, which is active tuberculosis in organs of the body other than the lungs, or</i> • <i>Cryptococcosis, which is a disease caused by fungus which is inhaled and spreads to the brain, or</i> • <i>Disseminated non-tuberculous mycobacteria infection, which is a widespread infection in the body by organisms which are related to the tuberculosis family, but which does not cause tuberculosis, or</i> • <i>Confirmed diagnosis of any other condition, with a World Health Organisation classification of severe stage of HIV infection (stage IV).</i> 				

Claim event	Percentage of cover amount %			
	Comprehensive Disability	Comprehensive Disability Plus	Elite Disability	Comprehensive Impairment
Activities of daily living / Catch-all / Frail care				
Activities of daily living				
Contractual definition: The permanent inability to perform independently 2 or more basic activities of daily living (ADLs) and 2 or more advanced activities of daily living (ADLs), as indicated in the tables "Basic activities of daily living for disability and impairment benefits" and "Advanced activities of daily living for disability and impairment benefits" later in this chapter. This must be confirmed by the treating health professional.	-	50	100	50
Contractual definition: The permanent inability to perform independently 3 or more basic activities of daily living (ADLs), as indicated in the table "Basic activities of daily living for disability and impairment benefits" later in this chapter. This must be confirmed by the treating health professional.	100	100	100	100

*This claim event is limited to a maximum amount of R500 000. This maximum amount may change from time to time.

**This claim event is limited to a maximum amount of R1 million. This maximum amount may change from time to time.

***A waiting period applies to this claim event.

Claim events: List 2 (for accidental disability and impairment benefits)

The claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated in the table below for the following benefits:

- Accidental Comprehensive Disability
- Accidental Comprehensive Disability Plus
- Accidental Elite Disability
- Accidental Comprehensive Impairment.

The contractual definitions will apply when we consider a claim. The layman's explanations are provided for a better understanding of the claim events but will not be used in the legal interpretation of the claim events.

If we admit a claim, we will pay the percentage of the cover amount linked to the particular claim event. For claim events where a maximum rand amount is indicated, we will not pay more than the indicated rand amount. The cover amount is indicated in the plan overview and may change over time as a result of benefit growth, alterations requested by the planholder, and claims.

Claim event	Percentage of cover amount %			
	Accidental Comprehensive Disability	Accidental Comprehensive Plus	Accidental Elite Disability	Accidental Comprehensive Impairment
Occupational disability				
Contractual definition: Disability to the extent that the life insured	100	100	100	-
<ul style="list-style-type: none"> • is totally, permanently and continuously unable to fulfil the occupational demands of the occupation he or she practised for income immediately before the disability, or • will be, if he or she is a full-time student when he or she becomes disabled, totally, permanently and continuously unable to fulfil the occupational demands of an occupation we may reasonably expect him or her to practise, taking into account his or her education, training and experience. 				
Central nervous system				
Coma				
Contractual definition: A condition of unconsciousness not induced by sedation where the life insured presents with a Glasgow Coma Scale reading of 8 or less for an uninterrupted period of at least 96 hours. This must be confirmed by a specialist.	100	100	100	100
<i>Layman's explanation:</i> <i>This claim event covers coma, where there is a state of unconsciousness not induced by medication causing a state of sleep. Specific criteria must be met, as described in the contractual definition above. This must be confirmed by a specialist.</i>				
Hemiplegia				
Contractual definition: The total and permanent loss of muscle function of one side of the body due to injury to the spinal cord or brain.	100	100	100	100
The following is required:				
<ul style="list-style-type: none"> • Radiological evidence such as a computed tomography (CT) scan or magnetic resonance imaging (MRI), and • Must be confirmed by a neurologist or neurosurgeon. 				

Claim event	Percentage of cover amount %			
	Accidental Comprehensive Disability	Accidental Comprehensive Disability Plus	Accidental Elite Disability	Accidental Comprehensive Impairment
Diplegia				
Contractual definition: The total and permanent loss of muscle function of both sides of the body due to injury to the spinal cord or brain. The following is required: <ul style="list-style-type: none">• Radiological evidence, such as a computed tomography (CT) scan or magnetic resonance imaging (MRI), and• Must be confirmed by a neurologist or neurosurgeon.	100	100	100	100
<i>Layman's explanation:</i> <i>This claim event covers diplegia, meeting the criteria in the contractual definition above. This must be confirmed by a specialist (neurologist or neurosurgeon).</i>				
<i>Diplegia is a total and permanent weakness of the same part on both sides of the body, which can be as a result of an injury.</i>				
Paraplegia				
Contractual definition: The total and permanent loss of muscle function resulting in the loss of use of both legs due to injury to the spinal cord or brain. The following is required: <ul style="list-style-type: none">• Radiological evidence such as a computed tomography (CT) scan or magnetic resonance imaging (MRI), and• Must be confirmed by a neurologist or neurosurgeon.	100	100	100	100
Contractual definition: Paraplegia due to spinal cord severance , meeting the following criteria: The total and permanent loss of muscle function resulting in the loss of use of both legs due to complete severance of the spinal cord. The following is required: <ul style="list-style-type: none">• Radiological evidence such as a computed tomography (CT) scan or magnetic resonance imaging (MRI), and• Must be confirmed by a neurologist or neurosurgeon.	125	125	125	125
Quadriplegia				
Contractual definition: The total and permanent loss of muscle function resulting in the loss of use of both arms and both legs due injury to the spinal cord or brain. The following is required: <ul style="list-style-type: none">• Radiological evidence such as a computed tomography (CT) scan or magnetic resonance imaging (MRI), and• Must be confirmed by a neurologist or neurosurgeon.	100	100	100	100

Claim event	Percentage of cover amount %			
	Accidental Comprehensive Disability	Accidental Comprehensive Disability Plus	Accidental Elite Disability	Accidental Comprehensive Impairment
<p>Contractual definition: Quadriplegia due to spinal cord severance, meeting the following criteria: The total and permanent loss of muscle function resulting in the loss of use of both arms and both legs due to complete severance of the spinal cord.</p> <p>The following is required:</p> <ul style="list-style-type: none"> • Radiological evidence such as a computed tomography (CT) scan or magnetic resonance imaging (MRI), and • Must be confirmed by a neurologist or neurosurgeon. 	150	150	150	150
Cranial nerve V				
<p>Contractual definition: Cranial nerve V pathology with severe trigeminal neuralgia, meeting the following criteria: The diagnosis of treatment resistant, severe unilateral or bilateral facial neuralgic pain by a neurologist, with evidence of treatment resistance as well as the need for decompression surgery.</p> <p><i>Layman's explanation:</i> <i>The trigeminal nerve (the 5th cranial nerve) is a nerve responsible for sensation in the face and functions such as biting and chewing.</i></p> <p><i>This claim event covers severe chronic pain in this nerve area, meeting the following criteria: Diagnosis by a specialist (neurologist) of treatment resistant, severe one-sided or both-sided facial nerve pain, with evidence of treatment resistance as well as the need for decompression surgery.</i></p>	-	45	45	45
Cranial nerve VII				
<p>Contractual definition: Cranial nerve VII paralysis with severe unilateral upper motor neuron facial paralysis, involving more than 75% of the facial muscles, and inability to control eyelid closure. This must be confirmed by a neurologist.</p> <p><i>Layman's explanation:</i> <i>The facial nerve (the 7th cranial nerve) controls the muscles of facial expression, and functions in taste sensations of two-thirds of the tongue.</i></p> <p><i>This claim event covers paralysis of this nerve with upper motor neuron facial paralysis of more than 75% of the facial muscles and inability to close eyelids. This must be confirmed by a specialist (neurologist).</i></p>	-	50	100	50
Cranial nerve VIII				
<p>Contractual definition: Cranial nerve VIII paralysis or imbalance with moderately severe equilibrium impairment, with limitations of all activities of daily living (ADLs), and requiring permanent assistance with self-care. These ADLs are indicated in the tables "Basic activities of daily living for disability and impairment benefits" and "Advanced activities of daily living for disability and impairment benefits" later in this chapter. This must be confirmed by a neurologist or ear, nose and throat surgeon.</p> <p><i>Layman's explanation:</i> <i>The 8th cranial nerve transmits sound and balance information from the inner ear to the brain.</i></p> <p><i>This claim event covers paralysis of this nerve with moderate balance disturbance, with limitations in all activities of daily living (ADLs) and requiring permanent assistance with self-care. This must be confirmed by a specialist (neurologist or ear, nose and throat surgeon).</i></p>	-	50	100	50

Claim event	Percentage of cover amount %			
	Accidental Comprehensive Disability	Accidental Comprehensive Disability Plus	Accidental Elite Disability	Accidental Comprehensive Impairment
<p>Contractual definition: Cranial nerve VIII paralysis or imbalance with severe equilibrium impairment, with limitations of all activities of daily living (ADLs), requiring permanent assistance with self-care and permanent confinement to a bed or wheelchair. These ADLs are indicated in the tables "Basic activities of daily living for disability and impairment benefits" and "Advanced activities of daily living for disability and impairment benefits" later in this chapter,. This must be confirmed by a neurologist.</p> <p>Layman's explanation: <i>The 8th cranial nerve transmits sound and balance information from the inner ear to the brain.</i></p> <p><i>This claim event covers paralysis of this nerve with severe balance disturbance, with limitations in all activities of daily living (ADLs) and requiring permanent assistance with self-care and permanent confinement to a bed or wheelchair. This must be confirmed by a specialist (neurologist).</i></p>	-	75	100	75
<p>Cranial nerves IX, X or XII</p> <p>Contractual definition: Cranial nerves IX, X or XII paralysis or dysarthria or dysphagia, with moderately severe dysarthria or dysphagia with hoarseness, nasal regurgitation and aspiration of fluids. This must be confirmed by a neurologist.</p> <p>Layman's explanation: <i>This claim event covers paralysis of cranial nerves 9, 10 or 12, with moderate difficulty with swallowing, hoarseness, difficulty with speech, accidental inhalation of fluids into the lungs or airway or passage of food through the nasal passages. This must be confirmed by a specialist (neurologist).</i></p> <p>Contractual definition: Cranial nerves IX, X or XII paralysis or dysarthria or dysphagia, with severe functional inability to swallow without choking and with the need for assistance and suctioning. This must be confirmed by a neurologist.</p> <p>Layman's explanation: <i>This claim event covers paralysis of cranial nerves 9, 10 or 12, with severe inability to swallow without choking with the need for assistance and suctioning. This must be confirmed by a specialist (neurologist).</i></p>	-	25	25	25
<p>Neurologic impairment of respiration</p> <p>Contractual definition: Neurologic impairment of respiration, where the life insured is capable of spontaneous respiration, but is restricted to sitting, standing or limited ambulation. This must be confirmed by a neurologist.</p> <p>Layman's explanation: <i>This claim event covers impairment of breathing due to neurological cause or reason, where the life insured is capable of spontaneous breathing, but is restricted to sitting or standing with limited ambulation. This must be confirmed by a specialist (neurologist).</i></p>	-	50	100	50

Claim event	Percentage of cover amount %			
	Accidental Comprehensive Disability	Accidental Comprehensive Disability Plus	Accidental Elite Disability	Accidental Comprehensive Impairment
Contractual definition: Neurologic impairment of respiration with severe functional impairment where the life insured is capable of spontaneous respiration, but to such a limited degree that he or she is permanently confined to a bed. This must be confirmed by a neurologist.	-	75	100	75
<i>Layman's explanation:</i> <i>This claim event covers impairment of breathing due to neurological cause or reason, where the life insured is capable of spontaneous breathing, but is limited to such a degree that he or she is permanently confined to a bed. This must be confirmed by a specialist (neurologist).</i>				
Contractual definition: Neurologic impairment of respiration to such an extent that there is no spontaneous respiration. This must be confirmed by a neurologist.	100	100	100	100
<i>Layman's explanation:</i> <i>This claim event covers impairment of breathing due to neurological cause or reason, where the life insured is incapable of spontaneous breathing. This must be confirmed by a specialist (neurologist).</i>				
Renal system				
Surgical removal of the bladder				
Contractual definition: The surgical excision of the bladder by a surgeon, confirmed with a surgical report by an urologist or surgeon.	100	100	100	100
<i>Layman's explanation:</i> <i>This claim event covers the removal of the entire bladder by surgery. A surgical report from a specialist (urologist or surgeon) needs to confirm this.</i>				
Musculoskeletal system				
Amputation of a thumb				
Contractual definition: The amputation of a thumb, at the interphalangeal level and proximal to the joint, by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	-	30**	30**	30**
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of a thumb at the first joint. This must be confirmed by a specialist with supporting evidence.</i>				
Amputation of three fingers other than thumb				
Contractual definition: The amputation of 3 fingers other than the thumb on the same hand, at the proximal interphalangeal joint or more proximal than this joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	-	15*	15*	15*
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of 3 fingers, excluding the thumb on the same hand, at the level of the middle knuckles. This must be confirmed by a specialist with supporting evidence.</i>				

Claim event	Percentage of cover amount %			
	Accidental Comprehensive Disability	Accidental Comprehensive Disability Plus	Accidental Elite Disability	Accidental Comprehensive Impairment
Amputation of three fingers, including the thumb				
Contractual definition: The amputation of 3 fingers, including the thumb, on the same hand, at the proximal interphalangeal joint or more proximal than this joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	-	45**	45**	45**
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of 3 fingers including the thumb on the same hand – the thumb at the first joint and the other fingers at the level of the middle knuckles. This must be confirmed by a specialist with supporting evidence.</i>				
Amputation of four fingers other than thumb				
Contractual definition: The amputation of 4 fingers other than the thumb on the same hand, at the proximal interphalangeal joint or more proximal than this joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	-	45**	45**	45**
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of 4 fingers excluding the thumb on the same hand, at the level of the middle knuckles. This must be confirmed by a specialist with supporting evidence.</i>				
Amputation of a hand				
Contractual definition: The amputation of a hand at the wrist by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	-	70	100	70
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of a hand at the wrist. This must be confirmed by a specialist with supporting evidence.</i>				
Loss of use of a hand				
Contractual definition: <ul style="list-style-type: none">• The permanent loss of function of an entire hand from the wrist (distal to the wrist), or• The permanent loss of function of an upper limb, with at least 60% impairment of the limb according to the latest American Medical Association (AMA) guidelines. This must be confirmed by a specialist with supporting evidence.	-	70	100	70
<i>Layman's explanation:</i> <i>This claim event covers:</i> <ul style="list-style-type: none">• <i>The permanent loss of function of an entire hand from the wrist, or</i>• <i>The permanent loss of use of an arm (upper limb), meeting the criteria in the contractual definition above.</i> <i>This must be confirmed by a specialist with supporting evidence.</i>				
Amputation of an arm below the elbow				
Contractual definition: The amputation of an arm distal to the elbow by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	-	75	100	75
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of an arm below the elbow. This must be confirmed by a specialist with supporting evidence.</i>				

Claim event	Percentage of cover amount %			
	Accidental Comprehensive Disability	Accidental Comprehensive Disability Plus	Accidental Elite Disability	Accidental Comprehensive Impairment
Loss of use of an arm				
Contractual definition: <ul style="list-style-type: none">• The permanent loss of function of an entire arm from the shoulder (distal to the shoulder), or• The permanent loss of function of an upper limb, with at least 90% impairment of the limb according to the latest American Medical Association (AMA) guidelines. This must be confirmed by a specialist with supporting evidence. <i>Layman's explanation:</i> <i>This claim event covers:</i> <ul style="list-style-type: none">• <i>The permanent loss of use of an entire arm from the shoulder, or</i>• <i>The permanent loss of use of an arm (upper limb), meeting the criteria in the contractual definition above.</i> <i>This must be confirmed by a specialist with supporting evidence.</i>	-	75	100	75
Amputation of an arm above the elbow				
Contractual definition: The amputation of an arm proximal to the elbow by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence. <i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of an arm above the elbow. This must be confirmed by a specialist with supporting evidence.</i>	-	80	100	80
Amputation of a foot				
Contractual definition: The amputation of a foot at the level of the ankle joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence. <i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of a foot at the ankle joint. This must be confirmed by a specialist with supporting evidence.</i>	-	30	30	30
Loss of use of a foot				
Contractual definition: The permanent loss of function of an entire foot from the ankle (distal to the ankle). This must be confirmed by a specialist with supporting evidence. <i>Layman's explanation:</i> <i>The permanent loss of use of an entire foot from the ankle. This must be confirmed by a specialist with supporting evidence.</i>	-	30	30	30
Amputation of a leg below the knee				
Contractual definition: The amputation of a leg distal to the knee joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence. <i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of a leg below the knee. This must be confirmed by a specialist with supporting evidence.</i>	-	50	100	50

Claim event	Percentage of cover amount %			
	Accidental Comprehensive Disability	Accidental Comprehensive Disability Plus	Accidental Elite Disability	Accidental Comprehensive Impairment
Loss of use of a lower leg				
Contractual definition:	-	50	100	50
<ul style="list-style-type: none"> The permanent loss of function of an entire leg from below the knee (below and distal to the knee joint), or The permanent loss of function of a lower limb, with at least 60% impairment of the limb according to the latest American Medical Association (AMA) guidelines. 				
This must be confirmed by a specialist with supporting evidence.				
<i>Layman's explanation:</i>				
<i>This claim event covers:</i>				
<ul style="list-style-type: none"> <i>The permanent loss of use of an entire leg from below the knee, or</i> <i>The permanent loss of use of a leg (lower limb), meeting the criteria in the contractual definition above.</i> 				
<i>This must be confirmed by a specialist with supporting evidence.</i>				
Loss of use of a leg				
Contractual definition:	-	75	100	75
<ul style="list-style-type: none"> The permanent loss of function of an entire leg (proximal and distal to the knee joint), or The permanent loss of function of a lower limb, with at least 90% impairment of the limb according to the latest American Medical Association (AMA) guidelines. 				
This must be confirmed by a specialist with supporting evidence.				
<i>Layman's explanation:</i>				
<i>This claim event covers:</i>				
<ul style="list-style-type: none"> <i>The permanent loss of use of an entire leg, or</i> <i>The permanent loss of use of a leg (lower limb), meeting the criteria in the contractual definition above.</i> 				
<i>This must be confirmed by a specialist with supporting evidence.</i>				
Amputation of a leg above the knee				
Contractual definition:	-	75	100	75
The amputation of a leg proximal to the knee joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.				
<i>Layman's explanation:</i>				
<i>The surgical or traumatic removal or severance of a leg above the knee. This must be confirmed by a specialist with supporting evidence.</i>				

Claim event	Percentage of cover amount %			
	Accidental Comprehensive Disability	Accidental Comprehensive Disability Plus	Accidental Elite Disability	Accidental Comprehensive Impairment
Amputation or loss of a combination of two limbs or an eye				
Contractual definition: The amputation or loss of any 2 of the following, as described in this table, resulting from the same cause, provided they are not part of the same limb:	100	100	100	100
<ul style="list-style-type: none"> • Amputation of a hand • Amputation of an arm below the elbow • Amputation of an arm above the elbow • Amputation of a foot • Amputation of a leg below the knee • Amputation of a leg above the knee • Loss of an eye. 				
This must be confirmed by a specialist with supporting evidence.				
Loss of use of a combination of two limbs or an eye				
Contractual definition: The permanent loss of function of any 2 of the following, as described in this table, resulting from the same cause, provided they are not part of the same limb:	100	100	100	100
<ul style="list-style-type: none"> • Loss of use of a hand • Loss of use of an arm • Loss of use of a foot • Loss of use of a lower leg • Loss of use of a leg • Total loss of vision of one eye or hemianopia of one eye. 				
This must be confirmed by a specialist with supporting evidence.				
Total hip replacement				
Contractual definition: Total surgical replacement of the hip joint with a prosthesis, confirmed by an orthopaedic surgeon. This must be supported by surgical reports.	-	20**	20**	20**
<i>Layman's explanation:</i> <i>Surgical total hip joint replacement with an artificial joint, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.</i>				
Hip fracture surgery				
Contractual definition: Open surgical repair with internal fixation or prosthesis of a fracture of the femur neck, femur head or acetabulum. This must be confirmed by a specialist with supporting evidence.	-	10*	10*	10*
<i>Layman's explanation:</i> <i>Hip repair involving the stabilising of broken bones with surgical screws, nails, rods or plates, or alternatively with artificial joints of the broken part – femur neck, femur head or acetabulum (all parts forming the hip). This must be confirmed by a specialist with supporting evidence.</i>				
Total knee replacement				
Contractual definition: Total surgical replacement of the knee joint with a prosthesis, confirmed by an orthopaedic surgeon. This must be supported by surgical reports.	-	10*	10*	10*
<i>Layman's explanation:</i> <i>Surgical total knee joint replacement with an artificial joint, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.</i>				

Claim event	Percentage of cover amount %			
	Accidental Comprehensive Disability	Accidental Comprehensive Disability Plus	Accidental Elite Disability	Accidental Comprehensive Impairment
Total shoulder replacement				
Contractual definition: Total surgical replacement of the shoulder joint with a prosthesis, confirmed by an orthopaedic surgeon. This must be supported by surgical reports.	-	10*	10*	10*
<i>Layman's explanation:</i> <i>Surgical total shoulder joint replacement with an artificial joint, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.</i>				
Total ankle replacement				
Contractual definition: Total surgical replacement of the ankle joint with a prosthesis, confirmed by an orthopaedic surgeon. This must be supported by surgical reports.	-	10*	10*	10*
<i>Layman's explanation:</i> <i>Surgical total ankle joint replacement with artificial parts, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.</i>				
Visual system				
Total loss of vision of one eye or hemianopia of one eye				
Contractual definition: Total and permanent loss of vision of one eye or permanent hemianopia of one eye, confirmed by an ophthalmologist with supporting evidence.	-	25	25	25
<i>Layman's explanation:</i> <i>This claim event covers the total and permanent loss of vision of one eye or permanent loss of either the left or right half of the visual field of one eye. This must be confirmed by a specialist (ophthalmologist) with supporting documents.</i>				
Loss of an eye				
Contractual definition: Complete enucleation of one eye due to injury, confirmed by an ophthalmologist with supporting evidence.	-	50	100	50
<i>Layman's explanation:</i> <i>The complete removal of one eye from its socket as a result of trauma or surgery, confirmed by a specialist (ophthalmologist) with supporting documents.</i>				
Partial loss of vision of both eyes				
Contractual definition: Permanent bilateral visual impairment of 50%, confirmed by an ophthalmologist with supporting evidence and meeting the following criteria:	-	50	100	50
<ul style="list-style-type: none"> • A reading of at least 20/125 (or equivalent measure) in each eye, or • A visual field loss to a 20° radius of each eye. 				
<i>Layman's explanation:</i> <i>This claim event covers permanent decreased vision of 50% in each eye. It must meet the criteria described in the contractual definition above and must be confirmed by a specialist (ophthalmologist).</i>				

Claim event	Percentage of cover amount %			
	Accidental Comprehensive Disability	Accidental Comprehensive Disability Plus	Accidental Elite Disability	Accidental Comprehensive Impairment
Total loss of vision of both eyes or blindness of both eyes				
Contractual definition: Total and permanent loss of vision of both eyes or blindness of both eyes by visual acuity or retinal pathology or visual field measurements, confirmed by an ophthalmologist with supporting evidence and meeting the following criteria: Bilateral visual impairment of 70%, with evidence of 1 of the following: <ul style="list-style-type: none"> • A reading of at least 20/200 (or equivalent measure) in each eye, or • Permanent hemianopia of both eyes, or • A visual field loss to a 10° radius of each eye. <i>Layman's explanation:</i> <i>This claim event covers the total and permanent loss of vision of both eyes or blindness of both eyes. It must meet the criteria described in the contractual definition above, and must be confirmed by a specialist (ophthalmologist).</i>	100	100	100	100
Hearing				
Total loss of hearing in one ear				
Contractual definition: The total and permanent loss of hearing in one ear as confirmed by an ear, nose and throat surgeon with objective audiology evidence, recording an average loss of at least 70dB across all measured frequencies.	-	25	25	25
Partial loss of hearing in both ears				
Contractual definition: The permanent loss of hearing of 60% or more in both ears as confirmed by an ear, nose and throat surgeon with objective audiology evidence, recording an average loss of 70-87dB across all measured frequencies.	-	50	100	50
Total loss of hearing in both ears				
Contractual definition: The total and permanent loss of hearing in both ears as confirmed by an ear, nose and throat surgeon, with objective audiology evidence, recording an average loss of greater than 87dB across all measured frequencies.	100	100	100	100
Face and skin				
Facial disfigurement				
Contractual definition: Severe facial disfigurement despite more than two corrective facial surgical procedures by a registered plastic or maxillo facial surgeon, resulting in social withdrawal. The severity of the disfigurement and the social withdrawal must be confirmed by the relevant specialists.	-	50	100	50
Combination burns				
Contractual definition: A combination of 2nd and 3rd degree burns that covers more than 80% of the face or hands or feet, confirmed by a surgeon. <i>Layman's explanation:</i> <i>A combination of less severe (2nd degree) and severe (3rd degree) burns that covers more than 80% of the face or hands or feet. This must be confirmed by a specialist (surgeon).</i>	-	10	10	10
<i>2nd degree burns are burn wounds to the outer skin layer and the layer directly under this.</i>				
<i>3rd degree burns are burn wounds to all three layers of the skin.</i>				

Claim event	Percentage of cover amount %			
	Accidental Comprehensive Disability	Accidental Comprehensive Disability Plus	Accidental Elite Disability	Accidental Comprehensive Impairment
Third degree burns				
Contractual definition: Third degree burns, full thickness of the skin, covering at least 20% of the total body surface, confirmed by a surgeon.	-	50	100	50
<i>Layman's explanation:</i> <i>Burn wounds to all three layers of the skin which affect at least 20% of the body's surface, as measured with a Lund and Browder chart, or a similar chart. This must be confirmed by a specialist (surgeon).</i>				
Contractual definition: Third degree burns, full thickness of the skin, covering at least 30% of the total body surface, confirmed by a surgeon.	100	100	100	100
<i>Layman's explanation:</i> <i>Burn wounds to all three layers of the skin which affect at least 30% of the body's surface, as measured with a Lund and Browder chart, or a similar chart. This must be confirmed by a specialist (surgeon).</i>				
Trauma				
Gunshot wounds or penetrating stab wounds				
Contractual definition: Gunshot or penetrating stab wound resulting in theatre debridement, with an operation report provided by a surgeon or trauma surgeon.	-	5*	5*	5*
<i>Layman's explanation:</i> <i>Gunshot or penetrating stab wound, with removal of dead, damaged or infected tissue in theatre to improve the healing potential of the remaining healthy tissue. An operation report must be provided by a specialist (surgeon or trauma surgeon).</i>				
Contractual definition: Penetration by a bullet or a sharp object through the skull, resulting in surgical exploration of the skull under general anaesthetic, with an operation report provided by a surgeon or trauma surgeon.	-	10**	10**	10**
<i>Layman's explanation:</i> <i>Penetration by a bullet or a sharp object through the skull, resulting in an operation opening up the skull to determine and repair damage caused by the penetrating injury of the skull (surgical exploration of the skull) under general anaesthetic. An operation report must be provided by a specialist (surgeon or trauma surgeon).</i>				
Contractual definition: Penetration by a bullet or a sharp object through the chest, resulting in an underwater drain, with an operation report provided by a surgeon or trauma surgeon.	-	10**	10**	10**
<i>Layman's explanation:</i> <i>Penetration by a bullet or a sharp object through the chest, resulting in the placement of a tube into the chest (underwater drain) to drain air, fluid or blood from the space around the lung and thus allowing the lung to expand. An operation report must be provided by a specialist (surgeon or trauma surgeon).</i>				
Contractual definition: Penetration by a bullet or a sharp object through the chest, resulting in a thoracotomy, with an operation report provided by a surgeon or trauma surgeon.	-	20**	20**	20**
<i>Layman's explanation:</i> <i>Penetration by a bullet or a sharp object through the chest, resulting in an operation with an incision into the chest wall (a thoracotomy). An operation report must be provided by a specialist (surgeon or trauma surgeon).</i>				

Claim event	Percentage of cover amount %			
	Accidental Comprehensive Disability	Accidental Comprehensive Disability Plus	Accidental Elite Disability	Accidental Comprehensive Impairment
<p>Contractual definition: Penetration by a bullet or a sharp object through the abdomen, resulting in surgical exploration of the cavity under general anaesthetic, with an operation report provided by a surgeon or trauma surgeon.</p> <p>Layman's explanation: <i>Penetration by a bullet or a sharp object through the abdomen, resulting in an operation of the belly to assess damage caused by the injury to internal organs or blood vessels (surgical exploration of the cavity) under general anaesthetic. An operation report must be provided by a specialist (surgeon or trauma surgeon).</i></p>	-	10**	10**	10**
<p>Contractual definition: Penetration by a bullet or a sharp object through the neck, with damage to one or more of the following: subclavian or carotid artery, oesophagus or trachea, with an operation report provided by a surgeon or trauma surgeon.</p> <p>Layman's explanation: <i>Penetration by a bullet or a sharp object through the neck, with damage to one or more of the following blood vessels or organs:</i></p> <ul style="list-style-type: none"> • <i>The subclavian arteries, which are a pair of large arteries in the chest that supply blood to the chest, head, neck, shoulder and arms, or</i> • <i>The carotid arteries, which are major blood vessels in the neck that supply blood to the brain, neck, and face, or</i> • <i>The food pipe (oesophagus), which is a muscular tube that moves food and liquids from the throat to the stomach, or</i> • <i>The windpipe (trachea).</i> <p><i>An operation report must be provided by a specialist (surgeon or trauma surgeon).</i></p>	-	10**	10**	10**
Multiple rib fractures				
<p>Contractual definition: Multiple rib fractures with ICU admission: Numerous rib fractures, requiring admission to an intensive care unit (ICU), confirmed by a specialist.</p> <p>Contractual definition: Multiple rib fractures with ICU admission: Numerous rib fractures, requiring ventilation in an intensive care unit in order to sustain a stable blood-gas profile, confirmed by a specialist.</p>	-	5	5	5
<p>Pelvis fracture</p> <p>Contractual definition: More than one fracture of different bones of the pelvic framework, resulting in instability, confirmed by an orthopaedic specialist or surgeon.</p> <p>Layman's explanation: <i>A pelvic fracture is a break of the bony structure of the pelvis. For this claim event there must be more than one fracture of different bones of the pelvic framework, resulting in instability of the pelvic ring. This must be confirmed by a specialist (orthopaedic specialist or surgeon).</i></p>	-	5	5	5

Claim event	Percentage of cover amount %			
	Accidental Comprehensive Disability	Accidental Comprehensive Disability Plus	Accidental Elite Disability	Accidental Comprehensive Impairment
Unstable pelvis fracture				
Contractual definition: More than one fracture of the pelvic framework, resulting in instability, and requiring surgical intervention, confirmed by an orthopaedic specialist or surgeon.	-	20	20	20
<i>Layman's explanation:</i> <i>A pelvic fracture is a break of the bony structure of the pelvis. For this claim event there must be more than one fracture of the pelvic framework, resulting in instability of the pelvic ring, and requiring surgical intervention. This must be confirmed by a specialist (orthopaedic specialist or surgeon).</i>				
Compression fracture				
Contractual definition: A compression fracture of more than 50% of a spinal vertebra with documented spinal cord injury or myelopathy, confirmed by a neurosurgeon or orthopaedic specialist.	-	10	10	10
<i>Layman's explanation:</i> <i>When the bone of a vertebral body collapses it is called a compression fracture. For this claim event there must be a compression fracture of more than 50% of a spinal vertebra leading to collapse of the vertebra with documented spinal cord injury or compression of the nerves of the spinal cord. This must be confirmed by a specialist (neurosurgeon or orthopaedic specialist).</i>				
Fracture dislocation of the spine				
Contractual definition: A fracture dislocation of the spine, without neurological deficit, confirmed with supporting evidence by a neurosurgeon or orthopaedic specialist.	-	5	5	5
<i>Layman's explanation:</i> <i>A fracture is a break or crack in the bone. A dislocation occurs when 2 bones are out of place at the joint that connects them. A fracture dislocation of the spine, without neurological deficit, is when this occurs in the vertebral column, but the life insured has no signs of altered function due to the weaker function of the spinal cord. There must be objective evidence of the dislocation on the imaging of the spine. This must be confirmed with supporting evidence by a specialist (neurosurgeon or orthopaedic specialist).</i>				
Contractual definition: A fracture dislocation of the spine, with neurological deficit, confirmed with supporting evidence by a neurosurgeon or orthopaedic specialist.	-	10	10	10
<i>Layman's explanation:</i> <i>A fracture is a break or crack in the bone. A dislocation occurs when 2 bones are out of place at the joint that connects them. A fracture dislocation of the spine, with neurological deficit, is when this occurs in the vertebral column and the life insured has signs of altered function due to the weaker function of the spinal cord. There must be objective evidence of the dislocation on the imaging of the spine. This must be confirmed with supporting evidence by a specialist (neurosurgeon or orthopaedic specialist).</i>				

Claim event	Percentage of cover amount %			
	Accidental Comprehensive Disability	Accidental Comprehensive Disability Plus	Accidental Elite Disability	Accidental Comprehensive Impairment
Compression or avulsion fractures				
Contractual definition: Compression or avulsion fractures without joint dislocation on two or more vertebrae, confirmed with supporting evidence by a neurosurgeon or orthopaedic specialist.	-	5	5	5
<i>Layman's explanation:</i> <i>When the bone of a back bone (vertebra) collapses it is called a compression fracture. An avulsion fracture is an injury to the bone in a location where a ligament attaches to the bone. When an avulsion fracture occurs, the tendon or ligament pulls off a piece of the bone. This claim event covers compression or avulsion fractures without dislocation (the movement of the joints on two or more of the bones of the spine (vertebrae)) of two or more vertebrae. This must be confirmed with supporting evidence by a specialist (neurosurgeon or orthopaedic specialist).</i>				
Liver rupture				
Contractual definition: Rupture of the liver, necessitating emergency laparotomy and surgical repair, with an operation report provided by a surgeon.	-	10	10	10
<i>Layman's explanation:</i> <i>Bursting of the liver due to an accident or injury to the belly by a blunt object or surface, which leads to an emergency operation to repair the liver. An operation report must be provided by a specialist (surgeon).</i>				
Spleen rupture				
Contractual definition: Rupture of the spleen, necessitating emergency laparotomy and surgical repair or splenectomy, with an operation report provided by a surgeon.	-	10	10	10
<i>Layman's explanation:</i> <i>Bursting of the spleen due to an accident or injury to the belly by a blunt object or surface, which leads to an emergency operation to repair or remove the spleen. An operation report must be provided by a specialist (surgeon).</i>				
Post-traumatic fat-embolism of the lungs				
Contractual definition: Fat-embolism of the lungs, confirmed by a ventilation-perfusion (VQ) scan. This must be confirmed by a pulmonologist, physician or anaesthetist.	-	10	10	10
<i>Layman's explanation:</i> <i>This claim event covers fat-embolism of the lungs.</i>				
<i>An embolism is when a lump of material, in this case fat material, is dislodged and travels into the bloodstream, which then blocks blood vessels and leads to catastrophic events in the body. This must be confirmed by a specialist (pulmonologist, physician or anaesthetist).</i>				

Claim event	Percentage of cover amount %			
	Accidental Comprehensive Disability	Accidental Comprehensive Disability Plus	Accidental Elite Disability	Accidental Comprehensive Impairment
Compartment syndrome				
<p>Contractual definition: Definitive history of compartment syndrome as a result of an acute injury, with permanent motor nerve damage, confirmed by a specialist. This must be confirmed with all of the following supporting evidence:</p> <ul style="list-style-type: none"> History and clinical signs of compartment syndrome, and Nerve conduction studies. <p><i>Layman's explanation:</i> <i>Compartment syndrome is a condition of severe tissue compression, which has resulted from an acute injury. This compression in a closed muscle compartment results in permanent damage to the nerves of the affected muscles.</i></p> <p><i>This claim event covers a definitive history of compartment syndrome as a result of an acute injury, with permanent motor nerve damage, confirmed by a specialist. The evidence required for this claim event is specified in the contractual definition above.</i></p>	-	5	5	5

*This claim event is limited to a maximum amount of R500 000. This maximum amount may change from time to time.

**This claim event is limited to a maximum amount of R1 million. This maximum amount may change from time to time.

Basic activities of daily living for disability and impairment 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

Advanced activities of daily living for disability and impairment 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

Severe illness benefits

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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	<p>The Cancer and Cancer Plus benefits cover the same claim events and provide cover against cancers (including early cancers), tumours, leukaemias and lymphomas.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>
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Additional features	<p>Additional features are features that are automatically included for a benefit. These features are free of charge. The following additional feature applies:</p> <ul style="list-style-type: none"> • Free cover <p>Refer to the chapter <i>Payments, payment patterns, guarantees and cover</i> for more information about Free cover.</p>
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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?	<p>Benefits selected with a fixed term</p> <p>Cover will end</p> <ul style="list-style-type: none"> • 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. <p>Benefits selected with whole life cover</p> <p>Cover is provided for whole of life. However, the cover will end earlier:</p> <ul style="list-style-type: none"> • 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.
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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.

Cover limits per life insured	Minimum: R50 000 Maximum: • Express product option: R5 000 000* • Classic and Premier product options: R6 000 000*
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*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 <ul style="list-style-type: none">• 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 (<i>Whole life option only available under Topcover products</i>).	

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.
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Guarantee period	Express product option 5 years Classic and Premier product options As selected for the plan.
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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			
	Level A Most severe	Level B	Level C	Level D Least severe
Claim event				
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			
	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.
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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	<p>Benefit start age</p> <p>Minimum:</p> <ul style="list-style-type: none"> • Payment patterns other than fixed compulsory growth <ul style="list-style-type: none"> • 19 next birthday for the Express product option • 15 next birthday otherwise • Fixed compulsory growth: 30 next birthday <p>Maximum:</p> <ul style="list-style-type: none"> • 5 years before the benefit cease age for benefits selected with a fixed term • 65 next birthday for benefits selected with whole life cover <p>Benefit cease age</p> <ul style="list-style-type: none"> • 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 (<i>Whole life option only available under Topcover products</i>).
Qualifying lives	<p>Express product option</p> <p>Only the planholder and his/her spouse may qualify, subject to age limits and underwriting.</p> <p>Classic and Premier product options</p> <p>Subject to age limits and underwriting.</p>
Guarantee period	<p>Express product option</p> <p>5 years</p> <p>Classic and Premier product options</p> <p>As selected for the plan.</p>

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			
	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			
	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
Pericardectomy 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
Pericardectomy 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
Hemicolecction	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 thrombocythaemia	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.

Pericardectomy 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 $10 \times 10^9/L$; 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 thrombocythosis

Essential thrombocythosis, 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.

Temporomandibular 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 mechanical 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 total and permanent loss of sight in both eyes, with all of the following: 1) Visual acuity of 6/30 or worse for both eyes when measured with the use of visual aids; 2) Reports by an ophthalmologist. 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

Layman's terms for claim events for severe illness benefits

Layman's terms	9
Cancers, tumours, leukaemias and lymphomas	9
Pancreatic cancer stage I to IV	9
Oesophageal cancer stage I to IV	9
Stomach cancer stage I to IV	9
Lung cancer stage I to IV	9
Liver cancer stage I to IV	9
Bile duct cancer stage I to IV	10
Mesothelioma stage I to IV	10
Tongue cancer stage I to IV	10
Hypopharyngeal cancer stage I to IV	10
Retroperitoneal cancer stage I to IV	10
Omental cancer stage I to IV	10
Mesenteric cancer stage I to IV	10
Acute lymphoblastic leukaemia	10
Acute myeloblastic leukaemia	10
Basal cell skin carcinoma or squamous cell skin carcinoma (stage I or II) having undergone a skin graft or skin flap	10
Bone marrow transplant	11
Brain tumour (Grade II on WHO classification)	11
Brain tumour (Grade III or IV on WHO classification)	11
Carcinoid syndrome	11
Carcinoid syndrome with evidence of liver metastasis of atypical carcinoid tumour	11
Chronic lymphocytic leukaemia (stage 0 or I on the Rai classification system)	11
Chronic lymphocytic leukaemia (stage II on the Rai classification system)	11
Chronic lymphocytic leukaemia (stage III on the Rai classification system)	11
Chronic lymphocytic leukaemia (stage IV on the Rai classification system)	11
Chronic myeloid leukaemia (no bone marrow transplant)	11
Chronic myeloid leukaemia (with bone marrow transplant)	11
Hairy cell leukaemia	12
Hodgkin's or non-Hodgkin's lymphoma (stage I on Ann Arbor classification system)	12
Hodgkin's or non-Hodgkin's lymphoma (stage II on Ann Arbor classification system)	12
Hodgkin's or non-Hodgkin's lymphoma (stage III or IV on Ann Arbor classification system)	12
Malignant melanoma with invasion beyond the epidermis or T1N0M0	12
Malignant melanoma stage II	12
Malignant melanoma stage III or IV	12
Multiple myeloma (stage I or II on the Durie-Salmon scale)	12
Multiple myeloma (stage III on the Durie-Salmon scale)	12
Myelodysplastic syndrome	13
Partial mastectomy for ductal or lobular carcinoma in situ	13
Total mastectomy for breast pathology	13
Prostate cancer – T1a-c N0M0, Gleason score 2-6	13
Prostate cancer – T1a-c N0M0, Gleason score ≥7	13
Prostate cancer – T2N0M0, Gleason score 2-6	13
Prostate cancer – T2N0M0, Gleason score ≥7	13
Prostate cancer – T3N0M0, Gleason score 2-6	13
Prostate cancer – T3N0M0, Gleason score ≥7	13
Prostate cancer stage IV	14

Any non-melanoma skin cancer stage III	14
Any non-melanoma skin cancer stage IV	14
Benign brain tumour treated surgically	14
Brain tumour treated with chemotherapy	14
Brain tumour treated with radiotherapy	14
Recurrent benign brain tumour showing symptoms	14
Inoperable benign brain tumour	14
Inoperable benign brain tumour with progression	14
Brain tumour having undergone open brain surgery	15
Brain tumour with permanent neurological deficit	15
Acoustic neuroma resulting in neurological deficit	15
Pituitary tumour with surgical resection	15
Benign endocrine tumours having undergone surgical excision	15
Brain abscess having undergone surgical drainage	15
Amyloidosis	15
Catch-all stage I cancer	16
Catch-all stage II cancer	16
Catch-all stage III or IV cancer	16
Early cancer	16
A neuro-endocrine tumour of low malignant potential	16
Carcinoma in situ of one or both ovaries	17
Carcinoma in situ of one or both ovaries for which an oophorectomy has been performed	17
Cervical intraepithelial neoplasia grade III (CIN 3), or carcinoma in situ of the cervix	17
Cervical intraepithelial neoplasia grade III (CIN 3), or carcinoma in situ of the cervix for which a hysterectomy has been performed	17
Carcinoma in situ of the larynx	17
Carcinoma in situ of the larynx for which a total laryngectomy has been performed	17
Carcinoma in situ of the oesophagus for which surgery to remove the tumour has been performed	17
Carcinoma in situ of the stomach	18
Carcinoma in situ of the stomach for which a partial or total gastrectomy has been performed	18
Carcinoma in situ of the urinary bladder	18
Carcinoma in situ of the vagina or vulva	18
Carcinoma in situ of the vagina or vulva for which surgery defined as a skin flap or skin graft has been performed	18
Lobular carcinoma in situ or ductal carcinoma in situ of the breast resulting in chemotherapy, lumpectomy or breast conserving surgery	18
Catch-all carcinoma in situ of any other internal organ or body structure	19
Cardiovascular conditions: heart, blood vessels and stroke	19
Heart transplant	19
Heart valve replacement irrespective of technique	19
Any heart valve surgery such as valvuloplasty or valvotomy irrespective of technique	19
Cardiomyopathy at class III NYHA and EF less than 40%	19
Cardiomyopathy at class IV NYHA and EF less than 30%	19
Takotsubo cardiomyopathy	20
Transcoronary ablation of septal hypertrophy	20
Pericardectomy irrespective of technique	20
Arrhythmia having undergone pathway ablation	20
Arrhythmia having undergone a permanent pacemaker insertion	20
Arrhythmia having undergone a permanent defibrillator insertion	20
Peripheral arterial disease requiring angioplasty, stent or bypass graft of one peripheral artery	21
Peripheral arterial disease requiring angioplasty, stent or bypass graft of more than one peripheral artery	21

Loss of use of or loss of one foot due to peripheral arterial disease	21
Loss of use of or loss of one hand due to peripheral arterial disease	21
Angioplasty with or without stenting of one carotid artery	21
Angioplasty with or without stenting of bilateral carotid arteries	22
Carotid arterial disease: narrowing of at least one carotid artery requiring either bypass graft or endarterectomy	22
Endovascular surgery or stent to repair any thoracic or abdominal aortic aneurysm	22
Surgical repair of an iliofemoral aneurysm or stenosis	22
Surgical repair of any aneurysm or stenosis of major arterial branches of the aorta	22
Major surgery to dissect and surgically graft an aortic aneurysm	23
Primary pulmonary hypertension	23
Surgery for atrial septal defects or ventricular septal defects	23
Surgical repair of coarctation of the aorta	23
Left ventricular aneurysm repaired surgically	23
Surgery for atrial myxoma	23
Subarachnoid haemorrhage without neurological impairment	23
Arteriovenous malformation treated with radiological intervention	23
Arteriovenous malformation treated with open surgery craniotomy	24
Angioplasty with or without stenting of one or more coronary arteries	24
Coronary artery disease with coronary artery bypass graft for up to two arteries	24
Coronary artery disease with coronary artery bypass graft for three or more arteries	24
Mild heart attack	24
Mild heart attack of specified severity	24
Moderate heart attack of specified severity	24
Heart attack with permanent mild impairment in function	25
Heart attack with permanent severe impairment in function	25
Takayasu's disease	25
Superior sagittal sinus thrombosis	25
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Layman's terms

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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.

Sanlam's severe illness benefits to which these layman's terms apply are the following:

- Benefits that cover only the "Cancers, tumours, leukaemias and lymphomas" and the "Early cancer" claim categories:
 - Cancer (*lump sum benefit*)
 - Cancer Plus (*lump sum benefit*).
- Benefits that cover only the "Cardiovascular conditions: heart, blood vessels and stroke" claim category:
 - Cardiovascular (*lump sum benefit*)
 - Cardiovascular Plus (*lump sum benefit*).
- Benefits that cover all claim categories:
 - Comprehensive Severe Illness (*lump sum benefit*)
 - Comprehensive Severe Illness Plus (*lump sum benefit*)
 - Severe Illness Income (*income benefit*).

Cancers, tumours, leukaemias and lymphomas

Pancreatic cancer stage I to IV

Confirmed diagnosis of cancer of any stage (stage I, II, III or IV), as confirmed by a specialist, that starts in the pancreas.

The pancreas is a gland located behind the stomach and in front of the spine. It secretes hormones, including insulin and digestive enzymes.

Oesophageal cancer stage I to IV

Confirmed diagnosis of cancer of any stage (stage I, II, III or IV), as confirmed by a specialist, that starts in the oesophagus.

The oesophagus is a muscular tube that moves food and liquids from the throat to the stomach.

Stomach cancer stage I to IV

Confirmed diagnosis of cancer of any stage (stage I, II, III or IV), as confirmed by a specialist, that starts in the stomach.

Lung cancer stage I to IV

Confirmed diagnosis of cancer of any stage (stage I, II, III or IV), as confirmed by a specialist, that starts primarily in the lungs.

Liver cancer stage I to IV

Confirmed diagnosis of cancer of any stage (stage I, II, III or IV), as confirmed by a specialist, that starts in the liver.

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Bile duct cancer stage I to IV

Confirmed diagnosis of cancer of any stage (stage I, II, III or IV), as confirmed by a specialist, that starts in the bile duct. The bile duct system is made up of a series of tubes that begins in the liver and ends in the small intestine.

Mesothelioma stage I to IV

Confirmed diagnosis of cancer of any stage (stage I, II, III or IV), as confirmed by a specialist, that originates from mesothelial cells.

Mesothelial cells are a thin layer of cells that forms a protective lining or cover around many of the internal organs, e.g. around the lungs, abdomen or heart.

Tongue cancer stage I to IV

Confirmed diagnosis of cancer of any stage (stage I, II, III or IV), as confirmed by a specialist, that starts in the tongue.

Hypopharyngeal cancer stage I to IV

Confirmed diagnosis of cancer of any stage (stage I, II, III or IV), as confirmed by a specialist, that starts in the hypopharynx.

The hypopharynx is the bottom part of the pharynx (throat).

Retroperitoneal cancer stage I to IV

Confirmed diagnosis of cancer of any stage (stage I, II, III or IV), as confirmed by a specialist, that starts in the retroperitoneal space.

The retroperitoneal space is found deep inside the abdominal cavity and contains the kidneys, pancreas, bladder and big blood vessels.

Omental cancer stage I to IV

Confirmed diagnosis of cancer of any stage (stage I, II, III or IV), as confirmed by a specialist, that starts in the omentum.

The omentum is a double layer of fatty membranes in the lower abdomen that covers and keeps the organs and intestines in place.

Mesenteric cancer stage I to IV

Confirmed diagnosis of cancer of any stage (stage I, II, III or IV), as confirmed by a specialist, that starts in the mesentery.

The mesentery is a double layer of membranes that covers the organs of the abdominal cavity.

Acute lymphoblastic leukaemia

Confirmed diagnosis of adult acute lymphocytic leukaemia (ALL) (a cancer of immature lymphoid cells).

Acute myeloblastic leukaemia

Confirmed diagnosis of acute myeloid leukaemia (AML) (a type of cancer in which the bone marrow makes abnormal myeloblasts (a type of white blood cell), red blood cells, or platelets).

Basal cell skin carcinoma or squamous cell skin carcinoma (stage I or II) having undergone a skin graft or skin flap

Confirmed diagnosis of stage 1 or II cancer of the basal cells (found in the deeper layers of the skin) or squamous cells (found at the surface of the skin) having undergone an operation where healthy skin is transplanted to the area (skin graft or skin flap).

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Bone marrow transplant

The undergoing of a bone marrow transplant after complete bone marrow ablation (destruction with radio- or chemotherapy) as confirmed by a specialist. The required medical evidence must be provided.

Brain tumour (Grade II on WHO classification)

Confirmed diagnosis of brain cancer at World Health Organisation (WHO) Grade II, with or without permanent brain damage.

Brain tumour (Grade III or IV on WHO classification)

Confirmed diagnosis of brain cancer at World Health Organisation (WHO) Grade III or IV.

Carcinoid syndrome

Confirmed diagnosis of carcinoid syndrome.

Carcinoid syndrome occurs when a carcinoid tumour secretes certain chemicals into the bloodstream. This causes a variety of signs and symptoms. A carcinoid tumour is a type of neuroendocrine tumour that begins in the gastrointestinal tract (stomach, intestines) or lungs.

Carcinoid syndrome with evidence of liver metastasis of atypical carcinoid tumour

Confirmed diagnosis of carcinoid syndrome with evidence of spread of carcinoid tumour to liver.

Carcinoid syndrome occurs when a carcinoid tumour secretes certain chemicals into the bloodstream. This causes a variety of signs and symptoms. A carcinoid tumour is a type of neuroendocrine tumour that begins in the gastrointestinal tract (stomach, intestines) or lungs.

Chronic lymphocytic leukaemia (stage 0 or I on the Rai classification system)

Confirmed diagnosis of chronic lymphocytic leukaemia (a cancer of a certain type of white blood cells called lymphocytes) that is in the early stages and diagnosed at Rai stage 0 or I.

Chronic lymphocytic leukaemia (stage II on the Rai classification system)

Confirmed diagnosis of chronic lymphocytic leukaemia (a cancer of a certain type of white blood cells called lymphocytes), where the cancer is more advanced and diagnosed at Rai stage II.

Chronic lymphocytic leukaemia (stage III on the Rai classification system)

Confirmed diagnosis of chronic lymphocytic leukaemia (a cancer of a certain type of white blood cells called lymphocytes) where the cancer is moderately advanced and diagnosed at Rai stage III.

Chronic lymphocytic leukaemia (stage IV on the Rai classification system)

Confirmed diagnosis of chronic lymphocytic leukaemia (a cancer of a certain type of white blood cells called lymphocytes) where the cancer is severely advanced and diagnosed at Rai stage IV.

Chronic myeloid leukaemia (no bone marrow transplant)

Confirmed diagnosis of chronic myeloid leukaemia (CML) (a cancer involving an overproduction of mature white blood cells) which does not require a bone marrow transplant.

Chronic myeloid leukaemia (with bone marrow transplant)

Confirmed diagnosis by a specialist of chronic myeloid leukaemia (CML) (a cancer involving an overproduction of mature white blood cells) which requires a bone marrow transplant.

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Hairy cell leukaemia

Confirmed diagnosis of hairy cell leukaemia (a slow-growing cancer of the blood in which the bone marrow makes too many B cells (lymphocytes), a type of white blood cell that fights infection).

Hodgkin's or non-Hodgkin's lymphoma (stage I on Ann Arbor classification system)

Confirmed diagnosis of Hodgkin's or non-Hodgkin's lymphoma (cancer of the lymphatic system, which is a network of organs, ducts and nodes that helps the body to get rid of toxins and waste products) where the cancer has not spread and is diagnosed at Ann Arbor stage I.

Hodgkin's or non-Hodgkin's lymphoma (stage II on Ann Arbor classification system)

Confirmed diagnosis of Hodgkin's or non-Hodgkin's lymphoma (cancer of the lymphatic system, which is a network of organs, ducts and nodes that helps the body to get rid of toxins and waste products) where the cancer has started to spread and is diagnosed at Ann Arbor stage II.

Hodgkin's or non-Hodgkin's lymphoma (stage III or IV on Ann Arbor classification system)

Confirmed diagnosis of Hodgkin's or non-Hodgkin's lymphoma (cancer of the lymphatic system, which is a network of organs, ducts and nodes that helps the body to get rid of toxins and waste products) where the cancer has spread extensively and is diagnosed at Ann Arbor stage III or IV.

Malignant melanoma with invasion beyond the epidermis or T1N0M0

Confirmed diagnosis of a malignant melanoma where the cancer has invaded the skin and the size of the tumour is less than a certain size and has not spread and is classified as T1N0M0.

Malignant melanoma is a type of skin cancer that develops from the pigmented cell types in the skin.

Malignant melanoma stage II

Confirmed diagnosis by an oncologist of a malignant melanoma where the cancer has invaded the skin and is classified as per the size of tumour (T2b-T4N0M0) with or without ulceration, but has not spread beyond the skin.

Malignant melanoma is a type of skin cancer that develops from the pigmented cell types in the skin.

Malignant melanoma stage III or IV

Confirmed diagnosis by an oncologist of a malignant melanoma where the cancer has invaded the skin and has spread to lymph glands in the area and distant of the tumour.

Malignant melanoma is a type of skin cancer that develops from the pigmented cell types in the skin.

Multiple myeloma (stage I or II on the Durie-Salmon scale)

Confirmed diagnosis of multiple myeloma at stage I or II on the Durie-Salmon (DS) scale.

Multiple myeloma is a cancer of abnormal plasma cells. These plasma cells are found in bone marrow and are a part of the body's immune system, making antibodies which fight and kill germs. When they grow out of control, they form a lump or growth in the bone marrow.

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

Confirmed diagnosis of multiple myeloma at stage III on the Durie-Salmon (DS) scale.

Multiple myeloma is a cancer of abnormal plasma cells. These plasma cells are found in bone marrow and are a part of the body's immune system, making antibodies which fight and kill germs. When they grow out of control, they form a lump or growth in the bone marrow.

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Myelodysplastic syndrome

Confirmed diagnosis of myelodysplastic syndrome (a collection of conditions in which immature blood cells in the bone marrow do not mature or become healthy blood cells).

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

Confirmed diagnosis of prostate cancer where the cancer is very early and diagnosed at stage I or II, T1a-c N0M0, Gleason score 2-6.

The prostate, a gland found in men, sits below the bladder and in front of the rectum and provides 30% of the fluid that is part of semen.

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

Confirmed diagnosis of prostate cancer where the cancer is early and diagnosed at stage II, T1a-c N0M0, Gleason score ≥7.

The prostate, a gland found in men, sits below the bladder and in front of the rectum and provides 30% of the fluid that is part of semen.

Prostate cancer – T2N0M0, Gleason score 2-6

Confirmed diagnosis of prostate cancer at stage II, T2N0M0, Gleason score 2-6.

The prostate, a gland found in men, sits below the bladder and in front of the rectum and provides 30% of the fluid that is part of semen.

Prostate cancer – T2N0M0, Gleason score ≥7

Confirmed diagnosis of prostate cancer where the cancer is advanced and diagnosed at stage II, T2N0M0, Gleason score ≥7.

The prostate, a gland found in men, sits below the bladder and in front of the rectum and provides 30% of the fluid that is part of semen.

Prostate cancer – T3N0M0, Gleason score 2-6

Confirmed diagnosis of prostate cancer at stage III, T3N0M0, Gleason score 2-6.

The prostate, a gland found in men, sits below the bladder and in front of the rectum and provides 30% of the fluid that is part of semen.

Prostate cancer – T3N0M0, Gleason score ≥7

Confirmed diagnosis of prostate cancer where the cancer is advanced and diagnosed at stage III, T3N0M0, Gleason score ≥7.

The prostate, a gland found in men, sits below the bladder and in front of the rectum and provides 30% of the fluid that is part of semen.

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Prostate cancer stage IV

Confirmed diagnosis of stage IV prostate cancer, with or without regional extension into lymph nodes or spread to other organs.

The prostate, a gland found in men, sits below the bladder and in front of the rectum and provides 30% of the fluid that is part of semen.

Any non-melanoma skin cancer stage III

Confirmed diagnosis of non-melanoma skin cancer diagnosed at stage III. Non-melanoma refers to all other types of skin cancer other than cancers that develop from the pigmented cells.

Stage III cancer (regional spread) is when the cancer has spread within the general region in which it first began and into the lymph nodes, but not to other parts of the body.

Any non-melanoma skin cancer stage IV

Confirmed diagnosis of non-melanoma skin cancer that has advanced to stage IV. Non-melanoma refers to all other types of skin cancer other than cancers that develop from the pigmented cells.

Stage IV cancer (distant spread) is when cancer cells have spread to other (distant) parts of the body and formed new colonies there.

Benign brain tumour treated surgically

Confirmed diagnosis of a benign or non-cancerous brain tumour that is treated by a brain surgeon using stereotactic brain ablation (SRS) (a non-surgical radiation therapy used to treat small brain tumours), stimulation, implantation or radiosurgery.

Brain tumour treated with chemotherapy

A growth of the brain treated with anti-cancer drugs/medication. Reports by a specialist is required to provide supporting information for the specific treatment provided.

Brain tumour treated with radiotherapy

A growth of the brain that is treated with radiation, similar to x-rays. Reports should be provided by a specialist to provide supporting information for the specific treatment provided.

Recurrent benign brain tumour showing symptoms

A growth of the brain which recurs after it has been fully treated with medication and/or surgically removed. Reports and specialised imaging indicating recurrence of growth should be provided as supporting information by the treating specialist (neurosurgeon).

Inoperable benign brain tumour

A growth of the brain that is deemed not to be suitable for surgical removal with associated signs and symptoms due to this tumor. Reports should be provided by the specialist (neurosurgeon).

Inoperable benign brain tumour with progression

A growth in the brain that is deemed not suitable for surgical removal with evidence of:

1) Signs of raised pressure inside the scull and brain as manifested by certain symptoms and signs; 2) Continued growth of the tumour over a time period. This should be confirmed by a specialist (neurosurgeon), with objective clinical signs and symptoms and appropriate special investigations.

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Brain tumour having undergone open brain surgery

The removal of a growth in the brain through an operation where part of the scull is removed to access the growth. This should be confirmed by a specialist (neurosurgeon) report.

Brain tumour with permanent neurological deficit

A cancer of the brain that results in permanent signs that central nervous system has been affected, but excluding cognitive function (memory, judgement, etc.). This should be confirmed by a specialist (neurosurgeon), with objective clinical signs and symptoms .

Acoustic neuroma resulting in neurological deficit

The confirmed diagnosis by an Ear, Nose and Throat (ENT) specialist of acoustic neuroma, with hearing loss. The required medical evidence must be provided.

Acoustic neuroma is a benign (non-cancerous) tumour arising from the nerve supply to the ear that results in hearing loss.

Pituitary tumour with surgical resection

The confirmed diagnosis of any growth or lump in the pituitary gland that has been removed during an operation by a brain surgeon 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.

The pituitary gland is small and sits on the underside of the brain. It produces and controls the release of hormones into the body. Most times a growth or lump in the pituitary gland (a pituitary tumor) is not a cancer, and is sometimes called an adenoma.

Benign endocrine tumours having undergone surgical excision

Surgical removal by an appropriate specialist surgeon of a benign (non-cancerous) endocrine tumour (a tumour that secretes a hormone). Medical evidence must be provided.

The following benign endocrine tumours are covered: adrenal adenoma (tumour of the adrenal gland, an organ secreting hormones located above the kidney), phaeochromocytoma (tumour of the adrenal gland, a small organ above the kidney), pancreatic tumour (pancreas is an organ in abdomen secreting hormones and digestive enzymes), insulinoma (a tumour secreting a hormone called insulin), parathyroid tumour (parathyroid is a small gland secreting hormones in the neck) and thyroid adenoma (tumour of thyroid, an organ secreting hormones in the neck).

Brain abscess having undergone surgical drainage

Confirmed diagnosis by a specialist brain surgeon of a brain abscess (a localised collection of pus in the brain caused by an infection) caused by bacteria or fungi and where treatment includes surgical drainage (draining of pus) or intravenous (medication) antimicrobial therapy.

Brain abscesses are fairly uncommon. They can result from an infection that spreads from somewhere else in the head (such as a tooth, the nose, or an ear) or that spreads from another part of the body through the bloodstream to the brain.

Amyloidosis

The confirmed diagnosis of amyloidosis in any tissue or organ.

Amyloidosis is a rare disease that occurs when a substance 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.

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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.

Cancer prevents cells from dying when they should, and causes new cells to form when the body does not need them. These cells are able to invade other tissues and spread to other parts of the body through the blood and lymph systems.

Stage 1 cancer (localised cancer) is when the cancer remains a single lump in the tissue where it began and spreads only partly to a neighbouring 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.

Cancer prevents cells from dying when they should and causes new cells to form when the body does not need them. These cells are able to invade other tissues and spread to other parts of the body through the blood and lymph systems.

Stage II cancer (local spread) is when the cancer has spread to neighbouring structures or organs.

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.

Cancer prevents cells from dying when they should and causes new cells to form when the body does not need them. These cells are able to invade other tissues and spread to other parts of the body through the blood and lymph systems.

Stage III cancer (regional spread) is when the cancer has spread within the general region in which it first began and into the lymph nodes, but not to other parts of the body.

Stage IV cancer (distant spread) is when cancer cells have spread to other (distant) parts of the body and formed new colonies there.

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

A neuro-endocrine tumour of low malignant potential

The confirmed diagnosis of a neuro-endocrine tumour of low malignant potential.

Neuro-endocrine tumours (NETs) are growths (neoplasms) that arise from cells of the endocrine (hormonal) and nervous systems. Can be non-cancerous growths.

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Carcinoma in situ of one or both ovaries

The confirmed diagnosis of carcinoma in situ of one or both ovaries.

Carcinoma in situ is a group of abnormal cells that remain in place where they originated and have not spread. These abnormal cells can become cancer.

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

The confirmed diagnosis of carcinoma in situ of one or both ovaries for which an oophorectomy has been performed.

Carcinoma in situ is a group of abnormal cells that remain in place where they originated and have not spread. These abnormal cells can become cancer.

An oophorectomy is surgery to remove one or both ovaries.

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

The confirmed diagnosis of cervical intraepithelial neoplasia grade III (CIN 3), or carcinoma in situ of the cervix.

Cervical intraepithelial neoplasia grade III (CIN 3) is a pre-cancerous lesion that has not invaded into the deeper layers of the bottom part of the womb called the cervix.

Carcinoma in situ is a group of abnormal cells that remain in place where they originated and have not spread. These abnormal cells can become cancer.

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

The confirmed diagnosis of cervical intraepithelial neoplasia grade III (CIN 3), or carcinoma in situ of the cervix for which a hysterectomy (removal of all or part of the uterus) has been performed. This claim event excludes all other forms of treatment except partial or complete removal of the uterus (womb).

Cervical intraepithelial neoplasia grade III (CIN 3) is a pre-cancerous lesion that has not invaded into the deeper layers of the bottom part of the womb called the cervix.

Carcinoma in situ is a group of abnormal cells that remain in place where they originated and have not spread. These abnormal cells can become cancer.

Carcinoma in situ of the larynx

The confirmed diagnosis of carcinoma in situ of the larynx (voicebox).

Carcinoma in situ is a group of abnormal cells that remain in place where they originated and have not spread. These abnormal cells can become cancer.

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

The confirmed diagnosis of carcinoma in situ of the larynx (voicebox) for which surgery to remove the entire larynx has been performed.

Carcinoma in situ is a group of abnormal cells that remain in place where they originated and have not spread. These abnormal cells can become cancer.

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

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

Carcinoma in situ is a group of abnormal cells that remain in place where they originated and have not spread. These abnormal cells can become cancer.

The oesophagus is a muscular tube that moves food and liquids from the throat to the stomach.

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Carcinoma in situ of the stomach

The confirmed diagnosis of carcinoma in situ of the stomach, confirmed to be a tumour that has not spread to the deeper layers of the stomach.

Carcinoma in situ is a group of abnormal cells that remain in place where they originated and have not spread. These abnormal cells can become cancer.

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

The confirmed diagnosis of carcinoma in situ of the stomach, confirmed to be a tumour that has not spread to the deeper layers of the stomach, for which a partial or total removal of the stomach has been performed.

Carcinoma in situ is a group of abnormal cells that remain in place where they originated and have not spread. These abnormal cells can become cancer.

Carcinoma in situ of the urinary bladder

The confirmed diagnosis of carcinoma in situ of the urinary bladder, confirmed histologically as Tis, thus early cancer not spreading to deeper layers. This claim event excludes non-invasive papillary carcinoma or stage Ta bladder cancer.

Carcinoma in situ is a group of abnormal cells that remain in place where they originated and have not spread. These abnormal cells can become cancer.

Carcinoma in situ of the vagina or vulva

The confirmed diagnosis of carcinoma in situ of the vagina or vulva.

Carcinoma in situ is a group of abnormal cells that remain in place where they originated and have not spread. These abnormal cells can become cancer.

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

The confirmed diagnosis of 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 is a group of abnormal cells that remain in place where they originated and have not spread. These abnormal cells can become cancer. Skin graft or flap is an operation where healthy skin from an adjacent or other area from the body is used to close a skin deficit.

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

The confirmed diagnosis of lobular or ductal carcinoma in situ of the breast, resulting in chemotherapy, lumpectomy (only tumour and some of normal tissue is removed from breast) or breast conserving surgery (only part of breast is removed to attempt to leave as much as possible normal tissue).

Lobular carcinoma in situ of the breast (LCIS) is a condition in which abnormal cells form in the lobules (milk producing glands at the end of the breast ducts or milk glands) in the breast where the cancer has not spread out of the lobules of the breast to invade other parts of the breast. LCIS indicates that a person has an increased risk of developing breast cancer.

Ductal carcinoma in situ (DCIS) is the presence of abnormal cells inside a milk duct in the breast where the cancer has not spread out of the milk duct to invade other parts of the breast. DCIS is considered the earliest form of breast cancer.

Carcinoma in situ is a group of abnormal cells that remain in place where they originated and have not spread. These abnormal cells can become cancer.

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

The confirmed diagnosis of 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. This claim event excludes carcinoma in situ of the skin which is not an internal organ.

Carcinoma in situ is a group of abnormal cells that remain in place where they originated and have not spread. These abnormal cells can become cancer

Cardiovascular conditions: heart, blood vessels and stroke

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 repairing the valve, 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%

The confirmed 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 refers to diseases of the heart muscle, where the heart muscle becomes enlarged, thick, or rigid. This results in a weaker heart, with the heart being less able to pump blood through the body and maintain a normal electrical rhythm, and can lead to heart failure. Class III New York Heart Association classification of heart failure is where the symptoms progress to a stage where with light activity there is tiredness, shortness of breath or heart palpitations.

Cardiomyopathy at class IV NYHA and EF less than 30%

The confirmed 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.

Cardiomyopathy refers to diseases of the heart muscle, where the heart muscle becomes enlarged, thick, or rigid. This results in a weaker heart, with the heart being less able to pump blood through the body and maintain a normal electrical rhythm, and can lead to heart failure. Class IV New York Heart Association classification of heart failure is where the symptoms progress to a stage where at rest there is tiredness, shortness of breath or heart palpitations.

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Takotsubo cardiomyopathy

The confirmed diagnosis of Takotsubo cardiomyopathy (TCM) by a cardiologist. This must be supported by contractually stipulated medical evidence.

Takotsubo cardiomyopathy is a type of cardiomyopathy in which there is a sudden temporary weakening of the muscular portion of the heart.

Cardiomyopathy refers to diseases of the heart muscle, where the heart muscle becomes enlarged, thick, or rigid. This results in a weaker heart, with the heart being less able to pump blood through the body and maintain a normal electrical rhythm, and can lead to heart failure.

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.

Transcoronary ablation of septal hypertrophy (TASH) is a procedure where a transcatheter septal branch injection using alcohol is performed to reduce outflow obstruction in the hearts of selected people with enlarged hearts.

Pericardectomy 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.

The pericardium is a sac that holds the heart in place and helps it to work properly. The sac is made up of two thin layers of tissue that enclose the heart. In chronic pericarditis this sac becomes inflamed regularly and eventually becomes scarred and thickened. Pericardectomy is the surgical procedure where the scarring is surgically removed.

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 is an abnormality of the heartbeat. The heart could beat too fast (tachycardia), too slowly (bradycardia) or irregularly. Most arrhythmias are harmless, but some can be serious or even life threatening.

Pathway ablation may be used to treat some arrhythmias. In this procedure a cardiologist guides a catheter with an electrode at its tip to the area of heart muscle where the damaged site is located. Then a mild, painless radiofrequency energy (similar to microwave heat) is transmitted to the site of the pathway. Heart muscle cells in a very small area (about 1/5 of an inch) die and stop conducting the extra impulses that caused the rapid heartbeats.

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 is an abnormality of the heartbeat. The heart could beat too fast (tachycardia), too slowly (bradycardia) or irregularly. Most arrhythmias are harmless, but some can be serious or even life threatening.

A pacemaker is a small device used to treat arrhythmia. It is placed in the chest or abdomen to help control abnormal heart rhythms. This device uses electrical pulses to prompt the heart to beat at a normal rate.

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.

Arrhythmia is an abnormality of the heartbeat. The heart could beat too fast (tachycardia), too slowly (bradycardia) or irregularly. Most arrhythmias are harmless, but some can be serious or even life threatening.

A permanent implantable cardioverter-defibrillator (ICD) can be placed in the chest or abdomen. It continually monitors the rate and rhythm of the heart, automatically detects fast arrhythmias, and delivers a shock to convert the arrhythmia back to a normal rhythm. Most commonly, these devices are used in people who might otherwise die of the arrhythmia.

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Peripheral arterial disease requiring angioplasty, stent or bypass graft of one peripheral artery

The confirmed diagnosis of peripheral arterial disease resulting in an angioplasty, stent or bypass graft by a vascular surgeon of one peripheral artery.

Peripheral arterial disease (PAD) is a disease that results in reduced blood flow in the peripheral arteries (arteries of the trunk, arms and legs) due to atherosclerosis (plaques in blood vessels).

Angioplasty is a surgical procedure used to widen narrowed or obstructed arteries. A stent is a small metal mesh tube that is inserted in a narrowed or obstructed artery to keep the artery open. Bypass graft is a surgical procedure where a graft is made from another artery which is then inserted to bypass a problem in another artery.

Peripheral arterial disease requiring angioplasty, stent or bypass graft of more than one peripheral artery

The confirmed diagnosis of peripheral arterial disease resulting in an angioplasty, stent or bypass graft by a vascular surgeon of more than one peripheral artery.

Peripheral arterial disease (PAD) is a disease that results in reduced blood flow in the peripheral arteries (arteries of the trunk, arms and legs) due to atherosclerosis (plaques in blood vessels).

Angioplasty is a surgical procedure used to widen narrowed or obstructed arteries. A stent is a small metal mesh tube that is inserted in a narrowed or obstructed artery to keep the artery open. Bypass graft is a surgical procedure where a graft is made from another artery which is then inserted to bypass a problem in another artery.

Loss of use of or loss of one foot due to peripheral arterial disease

The confirmed diagnosis of peripheral arterial disease which results in the loss of use of or loss of one foot at the ankle or below.

Peripheral arterial disease (PAD) results in reduced blood flow in the peripheral arteries (arteries of the trunk, arms and legs) due to atherosclerosis (plaques in blood vessels). In advanced cases, there may be chronic ulcers on the foot or gangrene resulting in the loss of use of or loss of a foot.

Loss of use of or loss of one hand due to peripheral arterial disease

The confirmed diagnosis of peripheral arterial disease which results in the loss of use of or loss of one hand at the wrist or below.

Peripheral arterial disease (PAD) results in reduced blood flow in the peripheral arteries (arteries of the trunk, arms and legs) due to atherosclerosis (plaques in blood vessels). In advanced cases, there may be chronic ulcers on the hand or gangrene resulting in the loss of use of or loss of a hand.

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. The required medical evidence must be provided.

Angioplasty is a surgical procedure used to widen narrowed or obstructed arteries. A stent is a small metal mesh tube that is inserted in a narrowed or obstructed artery to keep the artery open.

Carotid arteries are located on each side of the neck, that divide into internal and external carotid arteries. The internal carotid arteries supply blood to the brain. If there is blockage in any one of the internal carotid arteries due to fatty material called plaque, there will be reduced blood flow to the brain. This increases the risk of a stroke.

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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. The required medical evidence must be provided.

Angioplasty is a surgical procedure used to widen narrowed or obstructed arteries. A stent is a small metal mesh tube that is inserted in a narrowed or obstructed artery to keep the artery open.

Carotid arteries are located on each side of the neck, that divide into internal and external carotid arteries. The internal carotid arteries supply blood to the brain. If there is blockage in any one of the internal carotid arteries due to fatty material called plaque, there will be reduced blood flow to the brain. This increases the risk of a stroke.

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

The confirmed diagnosis of carotid arterial disease with narrowing of at least one carotid artery requiring either bypass graft or endarterectomy. The required medical evidence must be provided.

Carotid arteries are located on each side of the neck. Carotid arteries divide into internal and external carotid arteries, where the internal carotid arteries supply blood to the brain. If there is narrowing or blockage in any of the internal carotid arteries due to fatty material called plaque, there will be reduced blood flow to the brain. This increases the risk of a stroke.

Bypass graft is a surgical procedure where a graft is made from another blood vessel, which is inserted to bypass a problem in one or both neck arteries. Endarterectomy is a surgical procedure where blockage or fatty build up in an artery is removed.

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.

A thoracic or abdominal aortic aneurysm is an abnormal ballooning or widening of the wall of the thoracic or abdominal aortic artery (thoracic aortic artery located in the chest and abdominal aortic artery located in the abdomen) that is caused by a weakness in the artery wall. If the aneurysm grows too big, there is a danger that it will rupture (split) which can cause potentially fatal internal bleeding and organ damage. Large thoracic or abdominal aortic aneurysms can often be repaired with endovascular surgery or stenting. With stenting the weak or damaged portion of the aorta is reinforced with a stent (a small metal mesh tube that is inserted in the aorta). Endovascular surgery is a minimally invasive procedure where blood vessel procedures are done through a small incision in groin area and access the affected vessel from here.

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.

An ileofemoral aneurysm is an abnormal ballooning or widening of the wall of the ileofemoral artery, which is located in the hip area. Ileofemoral stenosis is caused by a reduction in blood flow in the ileofemoral artery due to fatty plaque build up. Bypass graft is a surgical procedure where a synthetic graft is inserted to bypass an aneurysm or stenosis in the ileofemoral artery. Keyhole surgery is a modern surgical technique in which operations are performed far from their location through small incisions (usually 0.5 - 1.5 cm) elsewhere in the body.

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.

An aneurysm is an abnormal ballooning or widening of the wall of an artery. A stenosis is a blockage of a blood vessel. Bypass graft is a surgical procedure where a graft is made from another artery which is then inserted to bypass a problem in another artery. Keyhole surgery is surgery which is performed through small incisions (usually 0.5 - 1.5 cm) to locations elsewhere in the body.

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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 aorta (located in the chest) or abdominal aorta (located in the abdomen) with a synthetic graft. This must be supported with a detailed report by a surgeon, including copies of the operation reports.

An aneurysm is an abnormal ballooning or widening of the wall of an artery. Surgery to repair involves opening the chest (thoracic aorta) or the abdomen (abdominal aorta) for the repair and replacement with a synthetic graft.

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.

Primary pulmonary hypertension is a condition in which blood pressure in the arteries of the lungs is abnormally high. The cause is not known. The high pressure makes it hard for the heart to push blood through the arteries and into the lungs. Thus the pressure in the arteries rises. The excess pressure can weaken the heart and damage the lungs.

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.

Atrial septal defects and ventricular septal defects are holes in the walls (septa) that separate the heart into the left and right sides. A hole in the septum between the heart's two upper chambers is called an atrial septal defect (ASD). A hole in the septum between the heart's two lower chambers is called a ventricular septal defect (VSD). Many defects are small, cause no symptoms, and close without treatment. Some large septal defects must be closed surgically.

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.

A ventricular aneurysm can be a serious complication of a heart attack. It occurs when a weakened section of the wall of one of the ventricles (the lower heart chambers) expands and bulges like a balloon at the spot where the heart attack occurred. This is treated with surgery to the affected ventricle.

Surgery for atrial myxoma

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

An atrial myxoma is a cardiac tumour. They can cause serious complications, therefore they are removed through surgery.

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.

Subarachnoid haemorrhage is bleeding in the area between the brain and the thin tissues that cover the brain.

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 in the brain is a tangle of abnormal blood vessels connecting arteries and veins in the brain. The arteries are responsible for taking oxygen-rich blood from the heart to the brain. Veins carry the oxygen-depleted blood back to the lungs and heart. A brain AVM disrupts this vital process. Radiosurgery or stereotactic radiosurgery (SRS) is a non-surgical radiation therapy used to treat the AVM.

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Arteriovenous malformation treated with open surgery craniotomy

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

Arteriovenous malformation (AVM) in the brain, is a tangle of abnormal blood vessels connecting arteries and veins in the brain. The arteries are responsible for taking oxygen-rich blood from the heart to the brain. Veins carry the oxygen-depleted blood back to the lungs and heart. A brain AVM disrupts this vital process. Open brain surgery via a craniotomy is the surgical removal of part of the bone from the skull to expose the brain in order to remove or repair the AVM.

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.

A coronary angioplasty is a surgical procedure that is used to widen blocked or narrowed coronary arteries. A stent is a short, hollow metal tube. A small balloon is inflated to open the stent, which pushes against the artery walls. This widens the artery, squashing fatty plaques against the artery wall so that blood can flow through it more freely.

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.

A coronary artery bypass graft (CABG) is a surgical procedure widely used to treat coronary heart disease. CABG involves taking a blood vessel from another part of the body, usually the chest or leg, and attaching it to the coronary artery above and below the narrowed area or blockage. This new blood vessel is known as a graft.

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.

A coronary artery bypass graft (CABG) is a surgical procedure widely used to treat coronary heart disease. CABG involves taking a blood vessel from another part of the body, usually the chest or leg, and attaching it to the coronary artery above and below the narrowed area or blockage. This new blood vessel is known as a graft.

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

A mild heart attack of specified severity. The required medical evidence must be provided.

A mild heart attack occurs when blood flow to a section of heart muscle becomes blocked. If the flow of blood isn't restored quickly, a small section of heart muscle becomes damaged from lack of oxygen, begins to die and be replaced by scar tissue.

Moderate heart attack of specified severity

A moderate heart attack of specified severity. The required medical evidence must be provided.

A moderate heart attack occurs when blood flow to a section of heart muscle becomes blocked. If the flow of blood isn't restored quickly a larger section of heart muscle becomes damaged from lack of oxygen, begins to die and be replaced by scar tissue.

Heart attack with permanent mild impairment in function

A moderate heart attack with moderate, but permanent damage to the heart, which is measured using various medical investigations.

A moderate heart attack occurs when blood flow to a section of heart muscle becomes blocked. If the flow of blood isn't restored quickly a larger section of heart muscle becomes damaged from lack of oxygen, begins to die and be replaced by scar tissue.

Heart attack with permanent severe impairment in function

A heart attack with severe and permanent damage to the heart, which is measured using various medical investigations.

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.

Takayasu's disease (also known as Takayasu's arteritis) is a rare systemic disease where there is inflammation of the large blood vessels in the body. The cause is unknown.

Superior sagittal sinus thrombosis

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

Superior sagittal sinus thrombosis is an uncommon stroke that is frequently associated with diseases that may contribute to the development of blood clots through hypercoagulability (increased clotting) or stasis (stagnation) of the local blood stream and abnormalities of the vessel wall.

Cavernous sinus thrombosis

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

Cavernous sinus thrombosis (CST) is the formation of a blood clot within the cavernous sinus (a cavity at the base of the brain which drains deoxygenated blood). The usual cause is an infection.

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.

Venous ulcers are chronic wounds that occur due to improper functioning of venous valves, usually of the legs.

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.

Postthrombotic syndrome (PTS) or postphlebitic syndrome occurs when chronic symptoms of leg or arm swelling occur after a deep vein thrombosis. Other symptoms can include pain and cramping.

Giant cell arteritis

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

Giant cell arteritis disease is characterised by inflammation in the walls of medium- and large-sized arteries. The cause is unknown.

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.

Giant cell arteritis disease is characterised by inflammation in the walls of medium- and large-sized arteries. The cause is unknown.

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. A stroke occurs when a blood vessel that carries oxygen and nutrients to the brain is either blocked by a clot or if the blood vessel bursts. When that happens, part of the brain cannot get the blood (and oxygen) it needs, so it starts to die. If the blood flow cannot reach the region that controls a particular body function, that part of the body will not work as it should.

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), as indicated in the tables "Basic activities of daily living" and "Advanced activities of daily living" 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.

A stroke occurs when a blood vessel that carries oxygen and nutrients to the brain is either blocked by a clot or bursts. When that happens, part of the brain cannot get the blood (and oxygen) it needs, so it starts to die. If the blood flow cannot reach the region that controls a particular body function, that part of the body will not work as it should.

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.

A stroke occurs when a blood vessel that carries oxygen and nutrients to the brain is either blocked by a clot or bursts. When that happens, part of the brain cannot get the blood (and oxygen) it needs, so it starts to die. If the blood flow cannot reach the region that controls a particular body function, that part of the body will not work as it should.

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.

A stroke occurs when a blood vessel that carries oxygen and nutrients to the brain is either blocked by a clot or bursts. When that happens, part of the brain cannot get the blood (and oxygen) it needs, so it starts to die. If the blood flow cannot reach the region that controls a particular body function, that part of the body will not work as it should.

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.

A stroke occurs when a blood vessel that carries oxygen and nutrients to the brain is either blocked by a clot or bursts. When that happens, part of the brain cannot get the blood (and oxygen) it needs, so it starts to die. If the blood flow cannot reach the region that controls a particular body function, that part of the body will not work as it should.

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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.

A stroke occurs when a blood vessel that carries oxygen and nutrients to the brain is either blocked by a clot or bursts. When that happens, part of the brain cannot get the blood (and oxygen) it needs, so it starts to die. If the blood flow cannot reach the region that controls a particular body function, that part of the body will not work as it should.

Connective tissue

Progressive systemic sclerosis (scleroderma)

The confirmed diagnosis by an appropriate specialist of systemic sclerosis (a disease that involves the hardening and tightening of body tissue) with fibrosis (scarring) of the skin, joints, and at least two internal organs. The disease must be unresponsive to treatment with disease modifying drugs for a continuous period of at least 3 months. The required medical evidence must be provided.

Seropositive rheumatoid arthritis

The confirmed diagnosis by a rheumatologist of sero-positive rheumatoid arthritis (inflammation of the joints as a result of an autoimmune disorder). The required medical evidence must be provided.

Advanced or progressive rheumatoid arthritis despite optimal treatment

The confirmed diagnosis by a rheumatologist of sero-positive rheumatoid arthritis (inflammation of the joints as a result of an autoimmune disorder) with joint destruction and deformity in at least three large joints (excluding joints in hands or feet) and no or poor response to corticosteroids and disease-modifying medication for a continuous period of at least 3 months. The required medical evidence must be provided.

Systemic lupus erythematosis (SLE)

The confirmed diagnosis by a rheumatologist of systemic lupus erythematosus (a chronic inflammatory condition caused by an autoimmune disease* involving the skin, heart, lungs, kidneys, joints and nervous system). The required medical evidence must be provided.

*An autoimmune disease occurs when the body's tissues are attacked by its own immune system.

Systemic lupus erythematosis with multiple organ impairment

The confirmed diagnosis by a rheumatologist of systemic lupus erythematosus (SLE) (a chronic inflammatory condition caused by an autoimmune disease* involving the skin, heart, lungs, kidneys, joints and nervous system) with impairment of at least two other organs besides the kidney. The required medical evidence must be provided.

*An autoimmune disease occurs when the body's tissues are attacked by its own immune system.

Sarcoidosis

The confirmed diagnosis by a specialist of sarcoidosis (a condition of abnormal inflammatory masses forming in some organs). The required medical evidence must be provided.

Sarcoidosis with multiple organ involvement

The confirmed diagnosis by a specialist of sarcoidosis (a condition of abnormal inflammatory masses forming in some organs) with involvement of at least three of the following: 1) Lung system; 2) Eye system; 3) Skin system; 4) Nervous system; 5) Liver involvement; 6) Kidney involvement. The required medical evidence must be provided.

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Polyarteritis nodosa

The confirmed diagnosis by a specialist of polyarteritis nodosa, which is a systemic vasculitis (inflammation of vessels) of small- or medium-sized muscular arteries, typically involving blood vessels of the kidneys and internal organs. The required medical evidence must be provided.

Wegener's granulomatosis

The confirmed diagnosis by a specialist of Wegener's granulomatosis with respiratory system, kidneys and skin involvement. The required medical evidence must be provided.

Wegener's granulomatosis is a rare disease that affects many different organs and systems (in particular the lung and kidney systems), characterised by inflammation of the blood vessels (vasculitis).

Ear, nose and throat

Mastoiditis requiring mastoidectomy

The diagnosis of chronic mastoiditis (a persistent bacterial infection of the mastoid bone, which is situated behind the ear) requiring surgery to remove the infected bone. Confirmation by a specialist is required with supporting documents.

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%

The permanent loss of hearing of more than 60% in both ears, 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%

The permanent loss of hearing of more than 75% in both ears, 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

A cochlear or middle ear implant (a surgically implanted electronic device that provides sound by the transmission of signals to a range of electrodes placed in the cochlea, which stimulates the cochlear nerve). This must be confirmed by an Ear, Nose and Throat (ENT) specialist with supporting documents.

The cochlea is the snail-like part of the inner ear that is vital in hearing as it produces nerve impulses in response to sound.

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Otosclerosis resulting in hearing loss after failed surgery

The diagnosis of otosclerosis (a hereditary disorder causing progressive deafness due to overgrowth of bone in the inner ear) with hearing loss that persists despite surgery. This must be confirmed by an Ear, Nose and Throat (ENT) specialist with supporting documents.

Chronic osteomyelitis of the sinuses

The confirmed diagnosis by a specialist of chronic osteomyelitis of the sinuses (persistent inflammation of the bones of the sinuses). The required medical evidence must be provided.

Endocrine system

The endocrine system has eight major glands, which manufacture hormones. Hormones affect the functions of the entire body. Any disease of these glands can cause imbalances in the body which can be mild to serious.

Diagnosis of thyrotoxic crisis

The confirmed diagnosis of thyrotoxic crisis by an endocrinologist. This must be supported by appropriate investigations. Thyrotoxic crisis is a disease that results in a sudden and dangerous increase in hormones from the thyroid gland causing high fever, irregular heartbeat, diarrhoea, vomiting and mood swings. The thyroid gland is an important gland in the neck that secretes hormones.

Diagnosis of acromegaly

The confirmed diagnosis of acromegaly by an endocrinologist. This must be supported by appropriate investigations. Acromegaly is a disorder caused by excessive production of growth hormone by the pituitary gland (a gland in the brain) and marked especially by progressive enlargement of the hands, feet and face.

Diagnosis of Addisonian crisis

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

Addisonian crisis is a disease that causes extreme weight loss, vomiting, abdominal pain, confusion, extreme weakness and low blood pressure as a result of the inadequate release of two chemical messengers (hormones) from the adrenal glands. The adrenal glands are organs sitting on the kidneys that produce important hormones.

Diagnosis of parathyroid tetany

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

Parathyroid tetany is a disease that causes periodic painful muscular spasms and tremors as a result of abnormal calcium metabolism and inadequate functioning of the parathyroid glands. Parathyroid glands are small glands in the neck producing hormones.

Diagnosis of Simmonds' disease

The confirmed diagnosis of Simmond's disease by an endocrinologist. This must be supported by appropriate investigations.

Simmond's disease is a disorder as a result of the destruction of one part of the pituitary gland (a gland in the brain), resulting in failure to release important chemical messengers. The signs include the wasting or inadequate functioning of many other glands and the reproductive organs.

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Diagnosis of Conn's syndrome

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

Conn's syndrome is a disorder characterised by high blood pressure, headaches and visual impairment as a result of excessive release of aldosterone (a hormone) by the adrenal glands. The adrenal glands are organs sitting on the kidneys that produce important hormones.

Diagnosis of primary Cushing's disease

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

Cushing's disease is a disorder resulting from excessive exposure to the hormone cortisol. This leads to many signs and symptoms, including but not limited to weight gain, high blood pressure, muscular weakness and sexual dysfunction.

Diagnosis of diabetes insipidus

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

Diabetes insipidus is a disease that causes excessive thirst and urination as a result of inadequate output of a hormone (chemical messenger) which is released by the pituitary gland (a gland in the brain).

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.

Type 1 diabetes is a condition of high blood glucose levels caused by a total lack of insulin production by the pancreas. Type 1 diabetes develops most often in children and young people.

Diabetes mellitus type II with permanent renal impairment

The diagnosis of diabetes mellitus type II (adult onset diabetes) with permanent kidney damage (renal impairment). 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 is an eye disease caused by diabetes mellitus where damage occurs to the retina, which can eventually lead to blindness. Diabetic retinopathy may progress through four stages, where this claim event covers stage III:

Stage I (mild nonproliferative retinopathy): This is the earliest stage of the disease where small areas of balloon-like swelling occur in the retina's tiny arteries. These swellings may leak fluid into the retina.

Stage II (moderate nonproliferative retinopathy): This is the moderate stage of the disease where arteries that nourish the retina may swell and distort and thereby lose their ability to transport blood.

Stage III (severe nonproliferative retinopathy): This is the severe stage of the disease where more arteries are blocked, reducing blood supply to the areas of the retina that secrete growth factors that cause the retina to grow new blood vessels.

Stage IV (also known as proliferative diabetic retinopathy (PDR)): This is the advanced stage of the disease where growth factors secreted by the retina cause the proliferation (growth) of new arteries which grow along the inside surface of the retina and inside the fluid that fills the eye. This can cause retinal detachment and blindness.

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Diabetic retinopathy stage IV

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

Diabetic retinopathy is an eye disease caused by diabetes mellitus where damage occurs to the retina, which can eventually lead to blindness. Diabetic retinopathy may progress through four stages, where this claim event covers stage IV:

Stage I (mild nonproliferative retinopathy): This is the earliest stage of the disease where small areas of balloon-like swelling occur in the retina's tiny arteries. This swelling may leak fluid into the retina.

Stage II (moderate nonproliferative retinopathy): This is the moderate stage of the disease where arteries that nourish the retina may swell and distort and thereby lose their ability to transport blood.

Stage III (severe nonproliferative retinopathy): This is the severe stage of the disease where more arteries are blocked, reducing blood supply to the areas of the retina that secrete growth factors that cause the retina to grow new blood vessels.

Stage IV (also known as proliferative diabetic retinopathy (PDR)): This is the advanced stage of the disease where growth factors secreted by the retina cause the proliferation (growth) of new arteries which grow along the inside surface of the retina and inside the fluid that fills the eye. This can cause retinal detachment and blindness.

Gastrointestinal system

Tracheoesophageal fistula having undergone surgery

An operation to repair an abnormal connection between the trachea (the windpipe) and the oesophagus (tracheal oesophageal fistula). This must be performed by a specialist surgeon, with surgical reports.

The oesophagus is a muscular tube that moves food and liquids from the throat to the stomach.

Crohn's disease or ulcerative colitis with prolonged advanced therapy

The unequivocal diagnosis by a gastroenterologist of Crohn's disease or ulcerative colitis (both inflammatory diseases of the digestive tract resulting in abnormal bowel function, discomfort and erosion of the lining of the digestive tract) having undergone treatment for 4 continuous months with specialised medication called immunomodulators to control symptoms. The required medical evidence must be provided.

Crohn's disease or ulcerative colitis with recurrent surgery

The unequivocal diagnosis by a gastroenterologist of Crohn's disease or ulcerative colitis (both inflammatory diseases of the digestive tract resulting in abnormal bowel function, discomfort and erosion of the lining of the digestive tract) having undergone 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 by a gastroenterologist of Crohn's disease or ulcerative colitis (both inflammatory diseases of the digestive tract resulting in abnormal bowel function, discomfort and erosion of the lining of the digestive tract) resulting in a total colectomy (removal of the ascending, descending and transverse colon) with a permanent external bag (colostomy) or artificial external intestinal opening (ileostomy). This must be confirmed by surgical reports.

Hemicolectomy

A hemicolectomy (surgical removal of half of the colon) that is as a result of any disease or disorder. The required medical evidence must be provided.

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.

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Any disease or disorder requiring partial hepatectomy

Any disease or disorder of the liver requiring surgical removal 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

The confirmed diagnosis by a specialist of chronic hepatitis (inflammation of the liver) present for at least 6 months, with liver failure classified at Child-Pugh class A or higher. The required medical evidence must be provided.

Sclerosing cholangitis classified as Child-Pugh class A or worse

The confirmed diagnosis by a specialist of sclerosing cholangitis (a disorder of the liver in which the bile ducts within and outside of the liver become inflamed and scarred (sclerotic)) present for at least 6 months, with liver failure classified at Child-Pugh class A or higher. The required medical evidence must be provided

End-stage liver failure

The confirmed diagnosis by a specialist of any disease or disorder that results in end-stage liver failure classified at Child-Pugh class A or higher.. The required medical evidence must be provided

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. The required medical evidence must be provided.

Amyloidosis is a rare disease that occurs when a substance 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.

Complete pancreatectomy

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

Primary biliary cirrhosis

The confirmed diagnosis by a gastroenterologist of primary biliary cirrhosis (a disease in which the bile ducts in the liver are slowly destroyed).

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 (an abnormal connection between the surface of the skin and the lower part of the intestine (rectum)). This must be confirmed with surgical reports by a surgeon.

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Proven acute peritonitis requiring surgical intervention (excluding appendectomy)

Proven acute peritonitis (inflammation of the thin layer of tissue that covers the abdominal organs) requiring emergency surgical intervention. The required medical evidence must be provided. This claim event does not cover surgery for an inflamed/infected appendix (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

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 the required medical evidence.

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 (destruction with radio- or chemotherapy) as confirmed by a specialist. The required medical evidence must be provided.

Diffuse intravascular clotting

Diffuse intravascular clotting (DIC) (a disease characterised by the systemic activation of the blood clotting system resulting in multiple small clots). This must be confirmed by a specialist with laboratory evidence and must meet the international scoring criteria.

Idiopathic thrombocytopenic purpura with splenectomy

The confirmed diagnosis by a specialist of idiopathic thrombocytopenic purpura (a bleeding disorder in which the immune system destroys platelets) with splenectomy (surgical removal of the spleen). Surgical records and blood tests must support the diagnosis.

Chronic anaemia despite optimal treatment needing blood transfusion every second week

Chronic anaemia (persistent low red blood cell count) despite optimal oral treatment needing blood transfusions every second week, occurring for at least 3 consecutive months. This must be confirmed by a specialist with supporting evidence.

Autoimmune haemolytic anaemia with splenectomy

Autoimmune haemolytic anaemia (a disorder marked by the destruction of red blood cells in excess of new red blood cell production) with splenectomy (removal of spleen), confirmed by a specialist.. Surgical reports and blood tests must support the diagnosis.

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Essential thrombocytosis

Essential thrombocytosis (a rare chronic blood disorder characterised by the overproduction of platelets). This must be confirmed by a specialist with supporting laboratory and bone marrow evidence.

Musculoskeletal system

Any long-bone chronic osteomyelitis

The confirmed diagnosis by an orthopaedic surgeon of any long-bone chronic osteomyelitis (inflammation of bone or bone marrow, usually due to infection) that is present for at least 6 months. The required medical evidence must be provided.

Septic arthritis of a major joint

The confirmed diagnosis by an orthopaedic surgeon of septic arthritis of a major joint (an inflammation of a major joint: shoulders, elbows, wrists, hips, knees, ankles and spine as a result of infection). The required medical evidence must be provided.

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

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.

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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 use of or loss 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 use of or loss 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 use of or loss 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 use of or loss 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

Irreversible loss of use of or loss 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 use of or loss 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 use of or loss 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 use of or loss 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 use of or loss 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 (nerve supplying muscles) after complete severance of the nerve. This must be confirmed with surgical reports by a surgeon.

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Confirmed diagnosis of Paget's disease of the bone

Confirmed diagnosis by a specialist of Paget's disease of the bone (a disease marked by abnormal bone remodelling over time that leads to a structurally disorganized bone (woven bone) which is weaker, larger, less compact, more blood vessel-rich and more likely to fracture). The required medical information must be provided.

Persistent neurological impairment despite recurrent spinal surgery

Persistent documented neurological impairment despite two or more spinal operations (see contract for type of procedures) on separate occasions within a 5-year period. 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.

Temporomandibular joint replacement

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

Nervous system and psychiatric disorders

Conditions having undergone open brain surgery via a craniotomy

Open brain surgery via a craniotomy (a surgical operation in which a bone flap is temporarily removed from the skull to access the brain). 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.

Status epilepticus (SE) is an epileptic seizure or fit of greater than five minutes or more than one seizure within a five-minute period without the person returning to normal between them.

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 syndrome (GBS) is a rapid-onset muscle weakness caused by the immune system damaging the peripheral nervous system. The disorder can be life-threatening as weakness of the breathing muscles requires mechanical ventilation.

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.

Guillain-Barre syndrome (GBS) is a rapid-onset muscle weakness caused by the immune system damaging the peripheral nervous system. The disorder can be life-threatening as weakness of the breathing muscles requires mechanical ventilation.

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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 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, as confirmed by neuro-imaging and 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.

Hemiparesis is unilateral paresis, that is, weakness of the entire left or right side of the body ("hemi" means "half").

Permanent moderate to severe impairment of intellectual capacity as a result of brain injury or systemic hypoxia

Brain injury or systemic hypoxia (inadequate oxygen supply) that results in permanent moderate to severe impairment of intellectual capacity. This must be evidenced by all three of the following: 1) The permanent inability to do six or more advanced activities of daily living (ADLs) as indicated in the table "Advanced activities of daily living" at the end of this chapter; 2) Neuro-imaging (any form of brain scanning that can diagnose abnormalities related to hypoxia); 3) Confirmation by a neurologist. Permanence will be established after 3 months.

Motor neuron disease

The diagnosis of motor neurone disease, confirmed by a neurologist, with all of the following: 1) Evidence on electromyography and electroneurography (studies of nerve supply to the muscles and nerve conduction); 2) Permanent inability to perform independently at least three basic activities of daily living as indicated in the table "Advanced activities of daily living" at the end of this chapter. Permanence will be established after 3 months.

Motor neuron disease (MND) is any of several neurological disorders that selectively affect motor neurons, the cells that control voluntary muscles of the body.

Diagnosis of muscular dystrophy

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

Muscular dystrophy (MD) is a disease that causes muscles to waste away, leaving patients weak and eventually unable to help themselves.

Progressive muscular dystrophy

The diagnosis of muscular dystrophy, confirmed by a neurologist with all of the following: 1) Characteristic clinical presentation; 2) Characteristic electromyogram; 3) Clinical suspicion confirmed by muscle biopsy; 4) The disease must result in a permanent inability to perform independently at least three basic activities of daily living (ADLs) as indicated in the table "Basic activities of daily living" at the end of this document. Permanence will be established after 3 months.

Muscular dystrophy (MD) is a disease that causes muscles to waste away, leaving patients weak and eventually unable to help themselves

Induced coma

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

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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. Evidence of two episodes of nerve supply problems as well as confirmation of the diagnosis by two neurologists are needed.

Multiple sclerosis is a disorder that results in abnormalities with the sheath cover around nerves. This causes different types of nerve supply disorders depending on which group of nerves are affected.

Advanced multiple sclerosis

The diagnosis of advanced multiple sclerosis, with all of the following: 1) Two separate neurological events resulting in permanent nerve supply fallout; 2) This permanent nerve supply fallout 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 (brain and nerve supply scanning) and neurological reports.

Multiple sclerosis is a disorder that results in abnormalities with the sheath cover around nerves. This causes different types of nerve supply disorders depending on which group of nerves are affected.

Optic neuritis with demyelinating on MRI

Inflammation of the nerve supplying the eye (optic neuritis) where 2 or more plaques are confirmed as demyelinating (absence of the protective nerve sheath (myelin)) 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.

Parkinson's disease is a degenerative brain condition that leads to various symptoms, like tremor of the hands and head, a slow gait with shuffling feet, inability to show emotions, and a forward-falling posture.

Advanced Parkinson's disease

The diagnosis of Parkinson's disease, confirmed by a neurologist, with all of the following: 1) Appropriate clinical signs and symptoms; 2) Permanent inability to perform independently at least three basic activities of daily living (ADLs) as indicated in the table "Basic activities of daily living" at the end of this chapter. Permanence will be assessed after 3 months.

Parkinson's disease is a degenerative brain condition that leads to various symptoms, like tremor of the hands and head, a slow gait with shuffling feet, inability to show emotions, and a forward-falling posture.

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 (MG) is a long term neuromuscular disease that leads to varying degrees of muscle weakness. The most commonly affected muscles are those of the eyes, face, and swallowing. It can result in double vision, drooping eyelids, trouble talking, and trouble walking.

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

Myasthenia gravis (MG) is a long term neuromuscular disease that leads to varying degrees of muscle weakness. The most commonly affected muscles are those of the eyes, face, and swallowing. It can result in double vision, drooping eyelids, trouble talking, and trouble walking.

Hydrocephalus with the insertion of a VP shunt

The diagnosis of a hydrocephalus (accumulation of fluid in the brain), 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.

Stereotactic brain ablation is a surgical procedure where lesions or diseases are removed or treated with assistance of image guidance, to be as minimally invasive as possible, without affecting surrounding normal brain tissue.

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 (chewing); 3) Loss of corneal eye reflex. This must be confirmed by a neurologist, as well as 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 (difficulties with speech or swallowing); 2) Nasal regurgitation (backward movement of food through nasal area); 3) An inability to swallow, or process oral secretions without choking, or aspiration (inhalation) 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 (irreversible inadequate function of the posterior part of the brain called the cerebellum), 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) as indicated in the table "Basic activities of daily living" at the end of this chapter, or the need for 24 hour supervision by a caregiver. Permanence will be established after 3 months.

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Schizophrenia

The confirmed diagnosis of schizophrenia (a mental disorder that affects how people think, feel and behave) 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 (a psychiatric eating disorder that results in extreme loss of weight), 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

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 is caused by different disorders that damage the clusters of small blood vessels in the kidneys that filter waste and excess water from the blood. This damage leads to the release of too much protein in the urine, low blood protein levels, high cholesterol and triglyceride levels, and generalised body swelling.

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 laboratory tests and ultrasound of kidneys.

Nephrotic syndrome is caused by different disorders that damage the kidneys. This damage leads to the release of too much protein in the urine, decrease in blood protein levels, high cholesterol and triglyceride levels, and generalised body swelling.

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.

Amyloidosis is a rare disease that occurs when a substance 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.

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Nephrectomy as kidney donor, meeting ethical and legal requirements

The donation of a kidney within South Africa, provided that this 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.

Renal cortical necrosis is a rare cause of acute renal failure as a result of lack of blood supply to the kidney.

Moderate progressive chronic kidney disease with decline in function

Progressive chronic kidney disease (progressive deterioration of kidneys) 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 50ml/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 (progressive deterioration of kidneys) 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.

Polycystic kidney disease is an inherited disorder where multiple cysts (fluid-filled sacs) develop primarily in kidneys.

Documented renal vein thrombosis

Formation of a clot in the blood vessel that drains blood from the kidney, 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.

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Reproductive system

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.

Eclampsia is a complication of pregnancy, during pregnancy or in the 6 weeks after pregnancy. The condition may result in convulsions/seizures or unexplained coma due to severe high blood pressure and poses a threat to the health of mother and baby whilst the mother is still pregnant.

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.

Amniotic fluid embolism is when amniotic fluid (the fluid that surrounds a baby in the uterus, or fetal material such as fetal cells) enters the mother's bloodstream. This is most likely to occur during delivery or the period immediately afterward. This is a severe life threatening condition.

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 specialist.

Diffuse intravascular clotting during pregnancy and the 6 week period after delivery of the baby occurs when there is abnormal formation of blood clots in the small blood vessels throughout the body. This leads to compromise of tissue blood flow and can ultimately lead to multiple organ damage. Eventually normal clotting is disrupted and severe bleeding can occur from various sites.

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.

Renal cortical necrosis is a rare cause of acute renal failure in pregnancy. It occurs where there is lack of blood supply to the kidneys.

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.

An ectopic pregnancy is an abnormal pregnancy in which the fetus develops outside the womb, typically in a fallopian tube.

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

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

Intrauterine death after 24 weeks gestation

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

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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.

Uterine rupture is a serious complication during normal childbirth. The muscles of the womb tear during childbirth and an emergency hysterectomy is required.

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.

Sheehan's syndrome is a condition that affects women who lose a life-threatening amount of blood during or after childbirth resulting in oxygen deprivation and damage to the pituitary gland (a gland at the base of the brain secreting various hormones) at the base of the brain. This causes the permanent underproduction of essential hormones produced by this gland.

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.

Molar pregnancy is an abnormal form of pregnancy where a non-viable fertilised egg is implanted in the womb and grows but does not produce a normal fetus.

Respiratory disorders

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.

Interstitial lung disease is a large group of diseases that inflame or scar the lungs. These lung diseases can include pneumoniosis and fibrosing alveolitis. The inflammation and scarring make it hard to get enough oxygen.

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.

Status asthmaticus is a severe condition in which asthma attacks follow one another without pause resulting in the insertion of a plastic tube into the windpipe (intubation) and mechanical ventilation in an intensive care unit (ICU).

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.

Pulmonary embolism is a sudden blockage in a lung artery. The blockage is usually caused by a blood clot that travels to the lung from a vein in the leg.

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.

Recurrent pulmonary embolism that does not respond to treatment are blood clots that repeatedly occur in the arteries of the lung. This can cause significant and chronic damage to the lung. If this occurs then this is called pulmonary hypertension.

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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 is when there is a reduced volume of air from the lungs that can be blown out in the first second (FEV1) or a reduced volume of air that can be blown out after inhaling fully (FVC) or a reduced ability to transfer oxygen or diffusion capacity (DCO), all of which indicate poor functioning of the lungs.

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.

Chronic irreversible lung disease is when there is a reduced volume of air from the lungs that can be blown out in the first second (FEV1) or a reduced volume of air that can be blown out after inhaling fully (FVC) or a reduced ability to transfer oxygen or diffusion capacity (DCO), all of which indicate poor functioning of the lungs.

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.

Pleurectomy is a type of surgery in which part of the pleura is removed. The pleura is a membrane that surrounds the lungs. This procedure helps to prevent fluid from collecting in the affected area. Decortication is a surgical procedure that removes a restrictive layer of fibrous tissue overlying the lung, chest wall and diaphragm. This improves the elasticity of the lung.

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.

Sarcoidosis is the growth of tiny collections of inflammatory cells called granulomas. This can occur in different parts of the body, but most commonly in the lungs. This can cause progressive loss of lung function.

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 fibrosis is a disease whereby scarring in the lungs occur. Tissue deep in the lungs becomes thick, stiff and scarred. The scarring is called fibrosis. As the lung tissue becomes scarred, it interferes with a person's ability to breathe.

Pulmonary alveolar proteinosis

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

Pulmonary alveolar proteinosis is a rare lung condition where protein build up occurs in air sacs of the lungs, reducing lung function.

Repair of bronchopleural fistula

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

A bronchopleural fistula is a communication of the area between lung and chestwall and the branching system of bronchi and bronchioles which are responsible for air transport in the lung.

Skin and soft tissue

Pemphigus vulgaris

Pemphigus vulgaris, confirmed with histopathological (tissue examination) evidence by a specialist.

Pemphigus vulgaris is a chronic autoimmune disorder marked by blistering and sores (erosions) of the skin and mucus membranes.

Stevens-Johnson syndrome

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

Stevens-Johnson syndrome is a disorder of the skin and mucous membranes as a result of an immune reaction to infection, medication or external triggers causing flu-like symptoms, with a painful blistering rash with peeling of less than 10% body skin.

Toxic epidermal necrolysis

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

Toxic epidermal necrolysis is a severe, life threatening disorder of the skin and mucous membranes as a result of an immune reaction to infection, medication or external triggers causing flu-like symptoms, with a painful blistering rash with peeling of less than 30% body skin.

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.

Psoriasis is a condition marked by skin cells that multiply abnormally fast, causing scaling and plaque formation with surrounding inflammation. The condition can also affect nailbeds and nails, causing discolouration, distortion and inflammation, as well as cause an arthritic process in major joints.

Discoid lupus

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

Discoid lupus is a chronic skin condition of sores with inflammation and scarring favouring the face, ears and scalp, and at times other body areas.

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.

Compartment syndrome is a condition of severe tissue compression, usually as a result of trauma, in a closed muscle compartment with permanent motor nerve damage.

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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.

Scleroderma is a condition of chronic hardening and contraction of the skin and connective tissue.

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

CREST syndrome (the acronym for the disease processes) is a multisystem connective tissue disorder marked by calcinosis (deposition of calcific nodules), Raynaud's phenomenon (constriction of blood vessels in the digits in reaction to change in temperature), esophageal dysmotility (poor movement of the oesophagus), sclerodactyly (thickening of the skin) and telangiectasia (dilated vessels just below surface of the skin). Confirmed by a specialist with supporting documents.

The oesophagus is a muscular tube that moves food and liquids from the throat to the stomach.

Urogenital disorders

Vesicovaginal or rectovaginal fistula having undergone surgery

An operation done by a specialist to repair an abnormal connection between the bladder and vagina (vesico vaginal fistula) or to repair an abnormal connection between the lower part of the large intestine (rectum) and the vagina (recto-vaginal fistula). This must be 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

Surgery to remove one testicle for a medical reason. This must be performed by a specialist and confirmed with surgical reports. This claim event does not cover any part of sex change surgery.

Bilateral orchidectomy

Surgery to remove both testicles for a medical reason. This must be performed by a specialist and confirmed with surgical reports. This claim event does not cover any part of sex change surgery.

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Vision

Macular degeneration

Diagnosis of macular degeneration (an eye disease that progressively destroys the macula, the central portion of the retina). 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. This must be confirmed by an ophthalmologist with supporting documents.

Retinal detachment is an emergency situation in which a thin layer of tissue (the retina) at the back of the eye pulls away from the layer of blood vessels that provides it with oxygen and nutrients.

Corneal transplant

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

The cornea is the clear outer lens on the front of the eye. A corneal transplant is surgery to replace the cornea with tissue from a donor.

Optic neuritis

The confirmed diagnosis of optic neuritis (inflammation of the nerve supplying the eye) by an ophthalmologist. Only one payment for this claim event.

Enucleation of one eye

The complete removal of one eye from its socket as a result of trauma or surgery, confirmed with supporting documents by an ophthalmologist.

Retinitis pigmentosa

Retinitis pigmentosa, confirmed with supporting reports by an ophthalmologist.

Retinitis pigmentosa is an inherited disease of the retina (the thin layer at the back of the eye) that progresses over time, resulting in blindness.

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 total and permanent loss of sight in both eyes, with all of the following: 1) Visual acuity of 6/30 or worse for both eyes when measured with the use of visual aids; 2) Reports by an ophthalmologist. 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.

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Irreversible hemianopia in both eyes

Irreversible loss of either the left or right half 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

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 in the execution of the life insured's duties as a full time medical student, or normal professional duties as a medical or dental practitioner or nurse, registered with the Health Professions Council of South Africa (HPCSA), or the South African Nursing Council. The incident must have been recorded in writing in the workplace, for example with the Superintendent if in a hospital. An HIV test must have been performed within 24 hours to confirm the HIV negative status of the life insured at the time of the incident, as well as the HIV status of the patient with whom the incident took place. There must be proof that the life insured has been started on a course of anti-retroviral drugs. A subsequent HIV test must have been performed within 6 months after the incident to confirm the change in the life insured's HIV status from negative to positive;
- receiving a transplanted organ where the organ has previously been infected with the HI virus;
- any other medical or dental procedure, recognised by the HPCSA, performed on the life insured by a medical or dental practitioner, registered with the HPCSA. An HIV test must have been performed, but not longer than 12 months before the medical or dental procedure, to confirm the HIV negative status of the life insured at the time of the incident. A subsequent HIV test must have been performed within at least 12 months after the incident to confirm the change in the life insured's HIV status from negative to positive;
- rape or indecent assault. The offence must have been reported to the South African Police Services (SAPS) and a case number and/or a criminal case must have been opened. An HIV test must have been performed within 24 hours to confirm the HIV negative status of the life insured at the time of the assault. A medical examination must have been performed within 24 hours after the incident, confirming the rape or indecent assault. There must be proof that the life insured has been started on a course of anti-retroviral drugs. A subsequent HIV test must have been performed within 6 months after the incident to confirm the change in the life insured's HIV status from negative to positive;
- a violent crime. The offence must have been reported to the SAPS and a case number and/or criminal case must have been opened. A medical examination must have been performed within 24 hours after the incident, confirming the crime. Medically documented proof of acute trauma and suspicion of HIV infection must have been submitted, as well as an HIV test that proves that the life insured was HIV negative at the time of the crime. There must be proof that the life insured has been started on a course of anti-retroviral drugs. A subsequent HIV test must have been performed within 6 months after the incident to confirm the change in the life insured's HIV status from negative to positive;
- a road traffic accident. The accident must have been reported to the SAPS and a case number and/or criminal case must have been opened. A medical examination must have been performed within 24 hours after the incident, confirming the accident. Medically documented proof of acute trauma and suspicion of HIV infection must have been submitted, as well as an HIV test that proves that the life insured was HIV negative at the time of the accident. There must be proof that the life insured has been started on a course of anti-retroviral drugs. A subsequent HIV test must have been performed within 6 months after the incident to confirm the change in the life insured's HIV status from negative to positive. If the accidental HIV infection is a result of emergency assistance at the scene of the accident, an affidavit by the SAPS or an eyewitness to prove the assistance of the life insured must have been submitted.

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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

Full thickness burns involving more than 30% of one hand or more than 30% of the head

Full thickness burns (burns through all the layers of the skin) 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.

The Lund and Browder chart is a special chart which is used to measure burns by percentages allocated to body parts.

Grade II partial thickness burns involving more than 20% of the body surface area

Partial thickness or second degree burns (burns which affect the outer layer of skin, the epidermis) 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.

The Lund and Browder chart is a special chart which is used to measure burns by percentages allocated to body parts.

Full thickness burns involving more than 10% but less than or equal to 20% of the body surface area

Full thickness burns (burns through all the layers of the skin) 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.

The Lund and Browder chart is a special chart which is used to measure burns by percentages allocated to body parts.

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Full thickness burns involving more than 20% but less than or equal to 30% of the body surface area

Full thickness burns (burns through all the layers of the skin) 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.

The Lund and Browder chart is a special chart which is used to measure burns by percentages allocated to body parts.

Full thickness burns involving more than 30% of the body surface area

Full thickness burns (burns through all the layers of the skin) 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.

The Lund and Browder chart is a special chart which is used to measure burns by percentages allocated to body parts.

Spinal fusion

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

Spinal fusion surgery is designed to prevent movement at a painful vertebral segment in order to decrease pain from a joint damaged by injury or an accident.

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.

Laminectomy and laminotomy are used to relieve pressure and pain on the spine. In these operations all (decompression laminectomy) or part (decompression laminotomy) of the boney roof covering the spinal cord and nerves is removed.

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.

A burr hole for subdural hematoma is performed to remove a haemorrhage (blood clot) from around the surface of the brain. A sudden injury to the brain may cause blood to collect between the brain and the outermost membrane, the dura mater. The blood must be removed by drilling small holes in the skull bone (burr hole).

Emergency tracheostomy or cricothyrotomy

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

In an emergency, where an airway needs to be established, a tracheotomy can be performed. This is a surgical procedure that opens up the windpipe. A cricothyrotomy can also be done, where an incision is made through the skin and cricothyroid membrane to establish an airway.

ICU admission with mechanical ventilation for at least 96 hours

Traumatic event resulting in intensive care unit (ICU) admission, with assisted breathing on a ventilator 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 assisted breathing on a ventilator 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.

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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.

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.

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.

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).

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.

Cauda equina syndrome is where there is damage to the cauda equina nerves. These nerves are found at the bottom end of the spinal cord. This can cause a permanent loss of bowel or bladder function or loss of use of the legs.

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.

A dislocation is where a bone moves from its original place.

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 spinal injury resulting in permanent bladder incontinence (loss of control of the bladder) requiring a permanent indwelling catheter or bowel incontinence (loss of control of the bowel) requiring a permanent colostomy. This must be confirmed by a specialist with copies of all scans.

A colostomy is where the end of the large intestine is surgically brought out through an opening in the abdominal wall.

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.

Fat embolism occurs when there is the presence of fat globules inside the lung. This occurs when fat from the bone marrow escapes after a fracture of a long bone and travels to the lungs.

Skull fracture requiring reconstruction

Any injury which causes a depressed fracture of the bones of the skull and requires 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, where the initial repair to the face is done under general anaesthetic. This must be performed by a plastic surgeon, supported with an operation report.

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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, where the initial repair to the face is followed by at least one surgery by a plastic or reconstructive surgeon to improve the appearance of the scar, 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

A blunt injury to the abdomen (where there is no penetration of the abdomen), with rupture of the liver or spleen, or injury to the kidney, which requires emergency surgery into the abdomen, 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.

The brachial plexus is a collection of nerves from the neck that branches off and forms nerves that control movement and sensation of the upper limbs. If these nerves are severely damaged, it can cause total and permanent paralysis of the arm.

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.

Damage to the radial nerve can cause weakness in the wrist and fingers, which reduces the ability to open the hand to grasp objects. In severe cases, the hand droops from the wrist and the fingers are curved.

When the median nerve is damaged, the thumb and first two fingers may lose sensation or have a burning sensation or tingling. Median nerve damage can also affect the ability to use the thumb to pinch or grip items.

Ulnar nerve damage results in a pins-and-needles (tingling) sensation and hand weakness. Severe ulnar nerve damage can result in muscles becoming smaller in the hand and a deformity called "claw hand".

Plateau fracture of the tibia

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

A tibial plateau fracture is a break in the bone on the top part of the shinbone where it makes contact with the thigh bone (the tibial plateau). A tibial plateau fracture can affect the knee joint, thus stability and motion of the knee.

Open fracture of the tibia

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

An open fracture of the tibia is a break in the shinbone with bone protruding through the skin.

Open fracture of the femur

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

An open fracture of the femur is a break in the thigh bone with bone protruding through the skin.

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.

Acute lead poisoning symptoms may include stomach pain and cramping. Acute mercury poisoning signs and symptoms may include numbness, tingling, hearing loss, sight difficulties, loss of balance, as well as emotional and mental difficulties.

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Venomous snake bite necessitating anti-venom administration and ICU admission requiring mechanical ventilation

A snake bite, which results in the administration of anti-venom and admission to an intensive care unit (ICU) for assistance with breathing by a machine. 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

Any accident or injury that results in the admission to an intensive care unit (ICU) for 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 (broken bones in the face) 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 a poison in the workplace, which results in the admission to an intensive care unit (ICU) 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 to poison.

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

Near drowning, which results in the admission to an intensive care unit (ICU) with assisted breathing by a machine 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.

Decompression sickness occurs in divers where nitrogen bubbles form in the tissues of the body, especially if the diver surfaces too quickly. This can cause pain in the muscles and joints, cramps, numbness, nausea and paralysis. In order to treat this condition, the person is treated in a special hyperbaric chamber with pure oxygen, which removes the nitrogen bubbles that form.

Orbital fracture requiring surgical correction

A break in the bones of the eye socket, which is surgically repaired. 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.

Le Fort is a classification system for facial fractures severity. Le Fort II fractures of the face typically affect the middle third of the face including the nose and the bones behind it. A higher severity fracture such as Le Fort III involves a larger area of the face, and can include bones of the lower third of the face as well.

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Catch-all

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

Basic activities of daily living

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

Advanced activities of daily living

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

Dread disease and injury benefits

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Why dread disease and injury benefits?

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

Core dread disease and Whole life core dread disease benefits

Serious diseases, like falling victim to cancer or suffering a heart attack, 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.
- 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.

Accidental injury benefit

The alarming number of injuries and deaths on South African roads as well as the risk of injury due to violent crime make accident cover something to consider. Accidents can also happen at home or at work, possibly resulting in the loss of an arm or a leg, or the ability to see or hear. Apart from the personal loss and trauma associated with an accident, the financial consequences can be crippling.

Which expenses could be incurred if you were to suffer an accidental injury?

- The cost of therapy to learn new physical skills to compensate for loss.
- The cost of structural changes to your home or car.
- The cost of a prosthesis, like an artificial limb.
- Etc.

If an injury is suffered as a result of an accident, a lump sum will be paid out. Even if the loss is not completely devastating, for example, if you lose your hearing in one ear, you will still receive a percentage of the sum insured.

Child: Illness and injury benefit

If your child were to suffer a severe illness, injury, impairment or infection, it could place significant financial strain on you as parent.

In such an instance a cash payout could be essential, in order to cover the following kind of expenses:

- Additional expenses may have to be covered when your child is hospitalised, such as making arrangements for the care of your other children, and your homecare duties, while you are at the hospital with your child.
- Travel expenses may have to be incurred to take your child for treatment in major centres, or for your relatives to visit you in your hour of need.
- Taking time off work to care for your child might mean a reduction in income, for which you might not have sufficient savings set aside.
- The cost of therapy to teach your child new physical skills to compensate for loss.
- The cost of structural changes to your home or car.
- The cost of a prosthesis, like an artificial limb.
- Etc.

Availability of benefits

Individual insurance

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

Business insurance

Refer to the *Business insurance* chapter for information about availability of benefits. The Express product option is currently not available for business insurance.

Core dread disease (TAC, TSC) & Whole life core dread disease (TAC2, TSC2)

- The **Core dread disease** benefit is available under the Express, Classic and Premier product options of our Topcover products and under the Premier product option of our Term cover products.
- The **Whole life core dread disease** benefit is available under the Express, Classic and Premier product options of our Topcover products.

Benefit description	These benefits provide cover for dread disease 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 under "Claim events" for these benefits. The amount will be paid as a lump sum.
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SCIDEP	The table below indicates 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).
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Claim event	% of the cover amount for a severity level			
	Level A Most severe	Level B	Level C	Level D Least severe
Cancer, except the cancers excluded by SCIDEP	100	100	100	100
Myocardial infarction (Heart attack)	100	100	100	100
Stroke resulting in permanent impairment	100	100	100	100
Coronary artery bypass graft (CABG)	100	100	100	100

Additional features	Additional features are features that are automatically included for a benefit. These features are free of charge. The following additional feature applies:
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- 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
	Core dread disease (TAC)	✓	
	Core dread disease (TSC)		✓
	Whole life core dread disease (TAC2)	✓	
	Whole life core dread disease (TSC2)		✓

When will cover for this benefit end?**Core dread disease**

- Accelerator benefit: 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
 - when the full cover amount has been paid.
- Standalone benefit: 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
 - when the full cover amount has been paid for claims involving each organ, system or body part, or related group of organs, systems or body parts.

Whole life core dread disease

- Accelerator benefit: 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
 - when the full cover amount has been paid.
- Standalone benefit: 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
 - when the full cover amount has been paid for claims involving each organ, system or body part, or related group of organs, systems or body parts.

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.

Cover limits per life insured

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

Age limits**Benefit start age**

- | | |
|----------|---|
| Minimum: | <ul style="list-style-type: none"> • Payment patterns other than fixed compulsory growth <ul style="list-style-type: none"> • 19 next birthday for the Express product option • 15 next birthday otherwise • Fixed compulsory growth: 30 next birthday |
| Maximum: | <ul style="list-style-type: none"> • 5 years before the benefit cease age for Core dread disease • 65 next birthday for Whole life core dread disease |

Benefit cease age

- 65 next birthday for Core dread disease
 Under Term cover products the term of a benefit is limited to a maximum of the selected term of the plan.
- At death for Whole life core dread disease

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.

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 below. The cover amount is set out in the plan overview.

Claim event	% of the cover amount
Cancer	
• Cancer in situ of the breast, that according to best medical practice at the time requires a total unilateral or bilateral mastectomy	30
• All other cancers, except the cancers excluded under "Exclusions"	100
Premalignant condition	
Fibrocystic disease of the breasts in the presence of a strong family history, that according to best medical practice at the time requires a total unilateral or bilateral mastectomy	30
Myocardial infarction (Heart attack)	
Stroke	
• Stroke resulting in permanent impairment	100
• Stroke with full recovery	25
Coronary artery bypass graft (CABG)	100

Admittance of a claim for an accelerator benefit

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 the diagnosis of the claim event, or the incident causing the claim event, by more than 14 days;
- we have not previously admitted a claim for the same claim event, except if the claim event is one of the following:
 - stroke with full recovery, which is limited to two claims per life insured;
 - mastectomy* for cancer in situ of the breast;
 - mastectomy* for fibrocystic disease of the breasts in the presence of a strong family history.

*Claims for mastectomy will be limited to two claims per life insured.

If we have admitted a claim, we will reduce the cover amount of this benefit for the life insured by the claim amount. We will reduce the payment to reflect any reduction in the cover amount. Cover for this benefit will end once the full cover amount has been paid.

Admittance of a claim for a standalone benefit

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 the diagnosis of the claim event, or the incident causing the claim event, by more than 14 days.

If we have admitted a claim, we will not reduce the cover amount of this benefit for the life insured by the claim amount. However, we will not allow claims involving any one organ, system or body part, or related group of organs, systems or body parts, to exceed 100% of the cover amount, except if the causes for the claims are totally unrelated according to the opinion of our Chief Medical Officer. The table below indicates which organ, system or body part, or related group of organs, systems or body parts, are involved for each specific claim event.

Claim event	Organ, system or body part involved
Cancer	Organ, system or body part where it originated, and organs, systems or body parts to which it subsequently spreads
Premalignant condition	Any organ, system or body part where the premalignant condition originated
Myocardial infarction	Cardiovascular system
Stroke	Cardiovascular system
Coronary artery bypass graft (CABG)	Cardiovascular system

Exclusions

We will not admit a claim for

- cancer if it is
 - any cancer in situ, except cancer in situ of the breast, that according to best medical practice at the time requires a total unilateral or bilateral mastectomy, or
 - any skin cancer, except malignant melanoma that has been histologically classified as T1N0M0 or worse, or
 - any tumour of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0;
- any premalignant condition, or any condition with low malignant potential, or classified as borderline malignancy, except fibrocystic disease of the breasts in the presence of a strong family history, that according to best medical practice at the time requires a total unilateral or bilateral mastectomy;
- acute coronary syndromes, including but not limited to angina;
- a stroke if it is
 - a transient ischaemic attack (TIA), or
 - a vascular disease affecting the eye or optic nerve, or
 - migraine and vestibular disorders;
- coronary artery bypass graft if it is only an insertion of a stent.

Other general exclusions are set out in the applicable overview chapter in this technical guide. Specific exclusions, if any, are set out in the plan overview, in the special provisions for the life insured concerned.

Explanations

Cancer

A malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukaemia, lymphoma and sarcoma.

Cardiovascular system

Only applicable to standalone benefits.

The cardiovascular system includes the heart and its structural components, and the arterial and venous blood system, including the blood supply system of the brain, where a stroke is usually caused.

Myocardial infarction (Heart attack)

A heart attack 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. Post procedure myocardial infarction is included, provided it meets the below requirements. Other acute coronary syndromes, including but not limited to angina, are not covered by the description.

- Compatible clinical symptoms.
- Characteristic electrocardiographical (ECG) changes, which can either be myocardial ischaemia that may progress to myocardial infarction or new pathological Q waves, described as:
 - 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.
 - new pathological Q waves:

- any new Q wave in leads V1 through V3, or
- 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, or
- the appearance of a new complete bundle branch block.
- 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	Tnl	> 1500	> 1.5
Beckman AccuTnI	Tnl	> 2500	> 2.5
Siemens Centaur Ultra	Tnl	> 3000	> 3.0
Siemens Dimension RxL	Tnl	> 3000	> 3.0
Siemens Stratus CS	Tnl	> 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	Tnl	> 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

Stroke resulting in permanent impairment

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 three months or longer after the event must confirm that the life insured has a whole person impairment (WPI) of class 1 (1% – 10%) or more.

WPI figures are calculated according to the principles and ratings of 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.

Coronary artery bypass graft (CABG)

The undergoing of surgery, regardless of the surgical method, to correct the narrowing of, or blockage to, any one coronary artery by means of a bypass graft.

Child: Illness and injury (TSK)

This benefit is available under the Premier product option of our Topcover and Term cover products.

Benefit description	This benefit provides cover for a child life insured for dread disease, injury, impairment and infection-type 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 under "Claim events" for this benefit. The amount will be paid as a lump sum.																													
SCIDEP	The table below indicates 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).																													
	<table border="1"> <thead> <tr> <th rowspan="2">Claim event</th><th colspan="4">% of the cover amount for a severity level</th></tr> <tr> <th>Level A Most severe</th><th>Level B</th><th>Level C</th><th>Level D Least severe</th></tr> </thead> <tbody> <tr> <td>Cancer, except the cancers excluded by SCIDEP</td><td>100</td><td>100</td><td>100</td><td>100</td></tr> <tr> <td>Myocardial infarction (Heart attack)</td><td>100</td><td>100</td><td>100</td><td>100</td></tr> <tr> <td>Stroke resulting in permanent impairment</td><td>100</td><td>100</td><td>100</td><td>100</td></tr> <tr> <td>Coronary artery bypass graft (CABG)</td><td>100</td><td>100</td><td>100</td><td>100</td></tr> </tbody> </table>	Claim event	% of the cover amount for a severity level				Level A Most severe	Level B	Level C	Level D Least severe	Cancer, except the cancers excluded by SCIDEP	100	100	100	100	Myocardial infarction (Heart attack)	100	100	100	100	Stroke resulting in permanent impairment	100	100	100	100	Coronary artery bypass graft (CABG)	100	100	100	100
Claim event	% of the cover amount for a severity level																													
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Myocardial infarction (Heart attack)	100	100	100	100																										
Stroke resulting in permanent impairment	100	100	100	100																										
Coronary artery bypass graft (CABG)	100	100	100	100																										
	The claim event "Coronary artery bypass graft (CABG)" in the table above is covered under the claim event "Surgery to major blood vessel: aorta, carotid, pulmonary, coronary or femoral artery" as described under "Explanations".																													
Additional features	Additional features are features that are automatically included for a benefit. These features are free of charge. The following additional feature applies: <ul style="list-style-type: none"> Free cover Refer to the chapter <i>Payments, payment patterns, guarantees and cover</i> for more information about Free cover.																													
Type of benefit	Standalone																													
When will cover for this benefit end?	It will end <ul style="list-style-type: none"> 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 when the full cover amount has been paid. 																													
Cover limits per life insured	<p>Minimum: R50 000</p> <p>Maximum: The maximum cover amount will depend on the rate group of the planholder, subject to the maximum rate group for this benefit*: <ul style="list-style-type: none"> R500 000** for rate groups 1 and 2 R1 000 000** for rate groups 3 and 4 </p>																													

*The maximum rate group for this benefit is 4.

**Subject to financial underwriting

Age limits	<p>Benefit start age</p> <ul style="list-style-type: none"> • Minimum: 2 next birthday • Maximum: 18 next birthday <p>Benefit cease age</p> <p>20 next birthday</p> <p>Under Term cover products the term of a benefit is limited to a maximum of the selected term of the plan.</p>
Qualifying lives	<p>Subject to age limits and underwriting, and the following applies:</p> <ul style="list-style-type: none"> • The planholder must be the parent or legal guardian of the life insured (child). • The life insured must be financially dependent on the planholder, including where the obligation for support was determined in accordance with a custom, indigenous law, or court of law. • Biological children, legally adopted children and step children may be insured.
Guarantee period	<p>The maximum initial guarantee period that is may be chosen for a plan with a Child: Illness and injury benefit is 10 years.</p> <p>If the planholder wants to take other benefits in combination with the Child: Illness and injury benefit and he/she requires an initial guarantee period of longer than 10 years for these other benefits, the other benefits must be taken on a separate plan.</p>
Payment pattern	<p>All payment patterns as allowed for a specific product are available, with the following exception:</p> <p>If the benefit start age is greater than 15 next birthday and this benefit is the only benefit on a Whole life plan, only yearly-rated growth is allowed.</p>

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 below. The cover amount is set out in the plan overview.

Claim Event	Claim event explained in layman's terms*	% of the cover amount
Vascular system		
Surgery to major blood vessel: aorta, carotid, pulmonary, coronary or femoral artery	Fixing a damaged section of a major blood vessel.	100
Cardiomyopathy	An enlarged heart with very poor function.	100
Stroke resulting in permanent impairment	Paralysis of one side of the body due to a blood clot or bleeding on the brain.	100
Open-heart surgery	Repairing a heart valve or hole in the heart, usually after rheumatic fever or discovering a birth defect. This is done by open-heart surgery, in other words, the chest is cut open.	100
Heart attack	Heart attack.	100
Primary pulmonary hypertension (PPH)	Abnormal blood flow and abnormal pressure in the lungs.	100
Heart valve surgery by endoscopic procedures (keyhole surgery)	Replacing a heart valve through a small hole in the chest, in other words, the chest is not cut open.	75
Arrhythmia requiring pacemaker or ablation	An irregular heartbeat requiring a pacemaker or the destruction of an abnormal electric pathway by a cardiologist.	25
Pulmonary embolism	Blood clot in the lungs.	30

Claim Event	Claim event explained in layman's terms*	% of the cover amount
Organ failure		
Renal failure	Chronic kidney failure.	100
Liver failure	Chronic failure of the liver with yellow jaundice.	100
End-stage lung disease	End-stage lung disease that requires the use of oxygen at home.	100
Bone marrow failure (aplastic anaemia)	A disease that permanently damages the bone marrow. This will require regular blood transfusions, chemotherapy or a bone marrow transplant.	100
Organ transplant	Applies if the life insured receives a transplanted kidney, heart, liver, lung, pancreas or bone marrow, or is on a waiting list for a kidney, heart, liver, lung or pancreas transplant.	100
Cancer		
Cancer in situ of the breast requiring a mastectomy	A very early stage of breast cancer without any spreading, for which the breast is removed as a precautionary measure.	30
Any other cancer, except the cancers excluded under "Exclusions"	Any other type of cancer, excluding most skin cancers and very early stages of some cancers that recover completely with minimal treatment.	100
Premalignant conditions		
Fibrocystic disease of the breasts requiring a mastectomy	Lumps in the breasts diagnosed as fibroadenosis. This is not a cancer, but in the presence of a family history of breast cancer, one or both breasts are sometimes removed as precaution. This benefit only pays if the latter has been performed.	30
Tumours		
Benign brain tumour that is inoperable or recurrent or results in permanent neurological impairment	A brain tumour that is not cancerous, but impossible to operate or keeps coming back after surgery or results in permanent brain damage.	100
Benign brain tumour that is only partially removable or treated with chemotherapy or radiotherapy	A brain tumour that is not cancerous, but only partially removable or treated with chemotherapy or radiotherapy.	50
Nervous system		
Motor neuron disease	A disease that affects the muscles in the body, including the ability to speak, walk and swallow.	100
Multiple sclerosis	A disease that damages the nerves in the brain and spinal cord. Also known as MS.	100
Guillain-Barre with permanent impairment	A disease that affects the nervous system and causes paralysis. Some patients recover fully. Those that do not recover, may qualify for this benefit.	75
Hydrocephalus	Accumulation of water on the brain, requiring an operation to drain the fluid.	50
Coma	Being in a coma in the intensive care unit (ICU), for example, as a result of a head injury, near drowning, accidental poisoning, bleeding on the brain, blood clot in the brain.	50
Uncontrolled epilepsy	Epilepsy that is uncontrolled with frequent attacks, even with the best treatment.	25
Psychiatric conditions		
Anorexia	Anorexia with severe weight loss for more than 6 months, requiring hospitalisation.	25
Schizophrenia	A split personality mental disorder.	25

Claim Event	Claim event explained in layman's terms*	% of the cover amount
Senses		
Loss of vision in both eyes	Total and permanent blindness in both eyes.	100
Loss of vision in one eye	Total and permanent blindness in one eye.	50
Hearing loss	Total and permanent deafness in both ears.	100
Loss of speech	Permanently losing the ability to speak; muteness. Not due to psychiatric reasons.	100
Locomotor system		
Total loss of function of one arm	Losing the total use of an arm permanently, usually caused by an injury.	40
Total loss of function of one leg	Losing the total use of a leg permanently, usually caused by an injury.	25
Muscular dystrophy	A disease that causes the muscles to waste away. Also known as MD.	50
Perthe's disease	A disease of the hips.	30
Septic arthritis	An abscess or infection in a major joint.	25
Osteomyelitis	An abscess or infection of the bone or bone marrow.	25
Gastro-intestinal system		
Permanent colostomy or ileostomy	The need to permanently wear a bag for stools.	100
Loss of control of bladder or rectum	Incontinence of urine or stool due to an anal or rectal injury, tumour or spine injury.	50
Crohn's disease	A disease affecting the digestive tract that is serious enough to cause weight loss and growth failure.	25
Ulcerative colitis	A disease of the colon that is serious enough to cause weight loss and growth failure.	25
Injuries		
Head injury	Serious head injury, requiring surgery.	100
Paraplegia	Permanently lame in both legs, requiring the use of a wheelchair.	100
Quadriplegia	Permanently lame in both legs and both arms.	100
Fracture dislocation of the spine	Fracture and dislocation of the bodies of two spinal vertebrae.	75
Near drowning	Near drowning, requiring care in ICU for at least 48 hours. The near drowning event must be confirmed by the attending doctor or paramedical personnel.	50
Choking or suffocation	Choking or suffocation, requiring care in ICU.	50
Amputation of one hand	Amputation of a hand at the wrist.	40
Amputation of one arm	Amputation of an arm above the elbow.	50
Amputation of one foot	Amputation of a foot at the ankle joint.	25
Amputation of one leg	Amputation of a leg above the knee.	30
Amputation of one thumb	Amputation of a thumb as a whole.	20
Skull fracture requiring reconstruction	A skull fracture that needs to be operated.	50
Gunshot wound	A wound to the skull, chest or abdomen, caused by a bullet, that needs emergency surgery.	50
Penetrating stab wound	A wound to the skull, chest or abdomen, caused by a knife, that needs emergency surgery.	50
Major burns	Serious burn wounds requiring skin grafts over at least 20% of the body.	50

Claim Event	Claim event explained in layman's terms*	% of the cover amount
Fracture of the facial bones requiring reconstructive surgery	Severe fractures of the face that needs to be operated.	25
Unstable pelvis fracture	A pelvis fracture that needs to be operated.	25
Multiple rib fractures with unstable ribcage	Breaking several ribs, requiring care in ICU.	25
Abdominal injury with liver rupture, spleen rupture or kidney damage requiring emergency surgical repair	Liver, spleen or kidney injury that needs emergency surgery.	25
Bilateral orchidectomy	An operation to remove both testes, mostly due to cancer or injury.	25
Dog bite to the face requiring plastic surgery	Dog bite to the face requiring a single session of plastic surgery under general anaesthesia.	10
	Dog bite to the face requiring multiple sessions of plastic surgery under general anaesthesia.	25
Infections		
Accidental HIV infection	HIV infection / AIDS that is acquired accidentally through one of the events described in the explanation.	100
Bacterial meningitis or encephalitis with permanent impairment	A severe and contagious form of meningitis that results in permanent damage to the brain or nerves.	100
Cerebral malaria	Malaria affecting the brain, and resulting in permanent damage to the brain or nerves.	100
Rabies	A deadly infection after being bitten by a dog or other animal with mad dog disease.	100
Polio with permanent impairment	Polio with permanent lameness or weakness of a limb.	75
Rheumatic fever with heart valve-involvement	Rheumatic fever resulting in damage to a heart valve.	75
Tetanus	A disease that results in muscle spasms, usually obtained from a wound, for example, stepping into a rusty nail. Also known as lock-jaw.	75
Haemorrhagic fever	An infectious disease that causes bleeding disorders, like Congo fever, or other infections caused by the Ebola, Marburg, Lassa, Nairo or yellow fever viruses.	50
Rheumatology		
Juvenile rheumatoid arthritis	An autoimmune disease that affects the joints in children younger than 16 causing pain and deformity in large joints, not only the hands.	100
Polymyositis	A disease that affects the muscles, to the extent that it is difficult to do normal daily activities.	50
Systemic illnesses		
Cystic fibrosis	A genetic disorder affecting multiple organs including the lungs. Also known as Mucoviscidosis.	100
Polycystic kidneys	A familial disease of the kidneys that ultimately leads to kidney failure.	50
Addison's disease	A disease of the glands causing abnormal hormone production.	30

Claim Event	Claim event explained in layman's terms*	% of the cover amount
Hirschsprung's disease	A genetic deficiency of the nerve supply of the oesophagus, stomach or large bowel, leading to severe constipation or obstruction of the bowels. It is treated by removing the affected part by surgery.	30
Amino acid disorders	A genetic disorder of protein building blocks called amino acids, which may lead to a wide spectrum of symptoms including delay in development of the child, epileptic seizures, rash, hyperactivity, aggressive behaviour, abnormalities of the bones, poor vision.	30
Diabetes	Sugar disease in children that requires the use of insulin injections.	10
Other		
Admission into an intensive care unit (ICU) with ventilation for at least 48 hours	Any serious condition that needs care in ICU for at least 48 hours, for example as a result of a snake bite, scorpion bite, electric shock, smoke inhalation, accidental poisoning.	50
Catch all	Any other disease or injury not specifically listed, but severe enough to warrant a payment. Specific criteria are used as published in a Guideline to determine the severity.	100

*The explanations provided in this column are intended only to give a better understanding of the claim events in the first column. They are not to be used in the legal interpretation of the claim events. The definitions of the claim events as described under "Explanations" are the only contractual definitions applicable.

Waiting period for anorexia

A waiting period of 12 months will apply for the above-mentioned claim event from the cover start date of the benefit or the date the plan has been reinstated after an earlier lapse. If the cover amount is increased, other than through benefit growth, this period will also apply to the increase in the cover amount from the effective date.

Admittance of a claim

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 meets the definition of a child, as described under "Explanations";
- the life insured survived the diagnosis of the claim event, or the incident causing the claim event, by more than 96 hours, except if the claim event is for bacterial meningitis or encephalitis with permanent impairment, rabies or tetanus. For these claim events the life insured must have survived the diagnosis or the incident by more than 48 hours;
- we have not previously admitted a claim for the same claim event, except if the claim event is one of the following, which is limited to two claims per life insured:
 - heart valve surgery by endoscopic procedures (keyhole surgery);
 - arrhythmia requiring pacemaker or ablation;
 - pulmonary embolism;
 - cancer in situ of the breast;
 - fibrocystic disease of the breasts in the presence of a strong family history;
 - coma;
 - loss of vision in one eye;
 - total loss of function of one arm;
 - total loss of function of one leg;
 - fracture dislocation of the spine;
 - near drowning;
 - choking or suffocation;
 - amputation of one hand;
 - amputation of one arm;
 - amputation of one foot;
 - amputation of one leg;
 - amputation of one thumb;

- skull fracture requiring reconstruction;
- gunshot wound;
- penetrating stab wound;
- major burns;
- fracture of the facial bones requiring reconstructive surgery;
- unstable pelvis fracture;
- multiple rib fractures with unstable ribcage;
- abdominal injury with liver rupture, spleen rupture or kidney damage requiring emergency surgical repair;
- dog bite to the face requiring plastic surgery;
- rheumatic fever with heart valve involvement;
- haemorrhagic fever;
- admission into an intensive care unit (ICU) with ventilation for at least 48 hours. This claim event will not be limited to two claims per life insured.

If we admit a claim, we will reduce the cover amount of this benefit for the life insured by the claim amount paid. If the claim amount paid is less than 100% of the cover amount, the benefit will continue until the full cover amount has been paid. Any subsequent claim will be based on the reduced cover amount. The total claim amount for the life insured may not exceed 100% of the cover amount.

If the same cause results in more than one claim simultaneously, and we admit a claim, we will, despite anything to the contrary in the plan, only pay for the claim event with the highest percentage of the cover amount in the table above.

Exclusions

We will not admit a claim for

- any condition that existed before the cover start date of the benefit;
- cancer if it is
 - any cancer in situ, except cancer in situ of the breast that, according to best medical practice at the time, requires a total unilateral or bilateral mastectomy, or
 - any skin cancer, except malignant melanoma that has been histologically classified as T1N0M0 or worse, or
 - any tumour of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0;
- any premalignant condition, or any condition with low malignant potential, or any condition classified as borderline malignancy, except fibrocystic disease of the breasts in the presence of a strong family history that, according to best medical practice at the time, requires a total unilateral or bilateral mastectomy;
- a stroke if it is
 - a transient ischaemic attack (TIA), or
 - a vascular disease affecting the eye or optic nerve, or
 - migraine and vestibular disorders;
- liver failure if cirrhosis is due to alcohol or substance abuse;
- a benign brain tumour where the permanent impairment is cognitive impairment only;
- loss of speech if it is due to psychiatric reasons;
- surgery for sex changes;
- surgery for cosmetic reasons;
- septic arthritis if it is only in the hands, fingers and feet;
- juvenile rheumatoid arthritis if it is only in the hands, fingers and feet.

Other general exclusions are set out in the applicable overview chapter in this technical guide. Specific exclusions, if any, are set out in the plan overview, in the special provisions for the life insured concerned.

Explanations

Child

A biological, legally adopted or step child.

Surgery to major blood vessel: aorta, carotid, pulmonary, coronary or femoral artery

The excision and replacement of a portion of the thoracic or abdominal aorta, pulmonary artery, carotid artery, femoral artery or any coronary artery with a graft, due to an aneurism or damage to the blood vessel. Catheter or keyhole techniques to repair the aneurism or damage are included.

Coronary artery bypass graft (CABG)

The undergoing of surgery, regardless of the surgical method, to correct the narrowing of, or blockage to, any one coronary artery by means of a bypass graft.

Cardiomyopathy

Signs and symptoms of cardiomyopathy with functional impairment resulting in symptoms of heart failure at rest despite optimal treatment, as confirmed by a cardiologist.

Stroke resulting in permanent impairment

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 three months or longer after the event must confirm that the life insured has a whole person impairment (WPI) of class 1 (1% – 10%) or more.

WPI figures are calculated according to the principles and ratings of the latest edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment.

Open-heart surgery

Open-heart surgery with sternotomy to replace or repair a diseased heart valve or heart septum defect, or to reposition any of the major heart vessels.

Heart attack

A heart attack 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 acute myocardial infarction. Post procedure myocardial infarction is included, provided it meets the below requirements. Other acute coronary syndromes, including but not limited to angina, are not covered by this description.

- Compatible clinical symptoms.
- Characteristic electrocardiographical (ECG) changes, which can either be myocardial ischaemia that may progress to myocardial infarction or new pathological Q waves, described as:
 - 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.
 - new pathological Q waves:
 - any new Q wave in leads V1 through V3, or
 - 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, or
 - the appearance of a new complete bundle branch block.
- Raised cardiac biomarkers, which include 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

Primary pulmonary hypertension (PPH)

A haemodynamic and pathophysiological condition defined as an increase in mean pulmonary arterial pressure (PAP) of greater than or equal to 25 mmHg at rest as assessed by right heart catheterization.

Heart valve surgery by endoscopic procedures (keyhole surgery)

Surgery to replace or repair a diseased heart valve by endoscopic procedures or minimally invasive procedures.

Arrhythmia requiring pacemaker or ablation

Documented arrhythmia with the undergoing of

- the insertion of a permanent pacemaker or defibrillator, or
- ablation surgery by a cardiothoracic surgeon or cardiologist.

Pulmonary embolism

A blood clot in the lung, confirmed by a ventilation-perfusion (VQ) scan.

Renal failure

Chronic irreversible end-stage renal failure, as a result of which regular peritoneal dialysis or haemodialysis is required on a long-term basis.

Liver failure

End-stage liver failure due to cirrhosis or chronic progressive liver disease, with objective evidence of jaundice, esophageal varices and ascites.

End-stage lung disease

Diagnosis by a pulmonologist of end-stage chronic obstructive lung disease, interstitial lung disease or pneumoconiosis, requiring home oxygen therapy, and one of the following:

- cor pulmonale, or
- diffusion capacity (DCO) of less than 40%, or
- forced expiratory volume in one second (FEV1) or forced vital capacity (FVC) of less than one litre.

To optimise patient co-operation and ensure reliable and consistent results, all lung function measurements must

- be done by a registered pulmonologist,
- be done on a calibrated apparatus, and
- include at least three flow volume curves with less than 5% inter-test variability.

Bone marrow failure (aplastic anaemia)

An acquired abnormality of blood cell production with total aplasia of the bone marrow as confirmed by a consultant haematologist, requiring one of the following:

- regular transfusion with whole blood or other blood products for anaemia or thrombocytopenia (transfusion dependant), or
- immunosuppressive therapy, or
- bone marrow transplantation preceded by total bone marrow ablation.

Organ transplant

Any of the following:

- receiving a heart transplant, human or mechanical, or confirmation of being on a recognised national South African transplant waiting list, awaiting a heart transplantation;
- receiving a kidney, lung, liver or pancreas transplantation, or confirmation of being on a recognised national South African transplant waiting list, awaiting a kidney, lung, liver or pancreas transplantation;
- receiving a bone marrow transplantation where the bone marrow transplantation is preceded by total bone marrow ablation.

The above must be confirmed by a specialist with supporting evidence.

Cancer in situ of the breast requiring a mastectomy

Cancer in situ of the breast that, according to best medical practice at the time, requires a total unilateral or bilateral mastectomy.

Cancer

A malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukaemia, lymphoma and sarcoma.

Fibrocystic disease of the breasts requiring a mastectomy

Fibrocystic disease in the presence of a strong family history that, according to best medical practice at the time, requires a total unilateral or bilateral mastectomy.

Benign brain tumour that is inoperable or recurrent or results in permanent neurological impairment

A benign brain tumour that is inoperable or recurrent, or which causes permanent neurological impairment, excluding cognitive impairment.

Benign brain tumour that is only partially removable or treated with chemotherapy or radiotherapy

A benign brain tumour that is only partially removable or that is treated with chemotherapy or radiotherapy.

Motor neurone disease

The motor neuron diseases (MND) are a group of progressive neurological disorders that destroy motor neurons, which are the cells that control essential voluntary muscle activity such as speaking, walking, breathing, and swallowing. The diagnosis must be confirmed by a specialist and evidenced by typical findings in electromyography and electroneurography.

Multiple sclerosis

A neurologist must diagnose multiple sclerosis. There must be a reliable history of at least two episodes of neurological deficit, and objective clinical signs of lesions at more than one different anatomical region within the central nervous system. Special investigations, like magnetic resonance imaging, must support the diagnosis.

Guillain-Barre with permanent impairment

An acute autoimmune polyradiculopathy manifesting with motor, sensory and/or autonomic demyelinating or axonal neuropathy. The diagnosis must be confirmed by a neurologist and permanent neurological impairment must be documented.

Hydrocephalus

Raised intracranial pressure requiring a surgical shunt procedure.

Coma

A condition of unconsciousness not induced by sedation where the life insured

- presents with a Glasgow Coma Scale of 8 or less, and
- is dependent on life-sustaining aids, such as a ventilator and intravenous infusion, for an uninterrupted period of at least 96 hours.

Uncontrolled epilepsy

Documented epileptic attacks confirmed by an abnormal electro-encephalogram (EEG) reading. Attacks must be observed to be more than three per week, and be resistant to optimal therapy as confirmed by serum drug-level testing and specialist confirmation.

Anorexia

Anorexia nervosa as defined by the DSM 5 criteria and diagnosed and treated by a psychiatrist, with a body mass index (BMI) of less than 16 kg/m² for longer than 6 months. There must be at least one in-patient admission during this period.

Schizophrenia

Any form of schizophrenia as diagnosed by a psychiatrist according to DSM 5 criteria, and that warrants admission as an inpatient into hospital for at least 1 week, followed by long term treatment with antipsychotic drugs by a psychiatrist.

Loss of vision in both eyes

Permanent, irreversible and total loss of vision in both eyes with sharpness of vision of 6/60 or worse in the better eye when measured with the use of visual aids.

Loss of vision in one eye

Permanent, irreversible and total loss of vision in one eye with sharpness of vision of 3/60 or worse when measured with the use of visual aids.

Hearing loss

Permanent, irreversible and total loss of hearing in both ears. This means that the average hearing levels, tested with hearing aids when applicable, at audible frequencies is less than 90 decibels.

Loss of speech

Permanent, irreversible and total loss of the ability to speak, due to disease or injury, as established over a continuous period of 3 months. An appropriate medical consultant must confirm the diagnosis.

Total loss of function of one arm

Total, permanent and irrecoverable loss of function of an upper limb. Maximum medical improvement must have been reached with little or no chance of significant further improvement. The loss of function will be estimated after all medical, surgical and rehabilitation measures have been applied. All percentages of loss of function are calculated per limb according to principles and ratings of the latest edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment.

Total loss of function of one leg

Total, permanent and irrecoverable loss of function of a lower limb. Maximum medical improvement must have been reached with little or no chance of significant further improvement. The loss of function will be estimated after all medical, surgical and rehabilitation measures have been applied. All percentages of loss of function are calculated per limb according to principles and ratings of the latest edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment.

Muscular dystrophy

Diagnosis of a recognised muscular dystrophy, which is progressive in nature, by a consultant neurologist. This must cause the irreversible inability to perform, without assistance, three or more of the following activities of daily living:

- The permanent inability to get into and out of a bath or shower and to wash oneself independently;
- The permanent inability to put on or take off clothes or shoes independently, including doing buttons, fastenings and shoelaces independently;
- The permanent inability to use the toilet independently, including cleaning and washing of hands after using the toilet;
- The permanent inability to eat food independently after it has been served;
- The permanent inability to independently move in and out of bed or a chair, even with the use of walking aids.

The inability to perform activities of daily living (ADL's) will be assessed with supervision from an adult for children from 6 to 9 years old and without supervision by an adult for older children.

Perthe's disease

Perthe's disease of the hips requiring traction, splinting or surgery to correct the defect.

Septic arthritis

Septic arthritis of a synovial joint, requiring surgical drainage and immobilisation.

Osteomyelitis

Osteomyelitis of the bone or bone marrow, requiring surgical drainage and immobilisation.

Permanent colostomy or ileostomy

The presence of a permanent colostomy or ileostomy with a stoma bag.

Loss of control of bladder or rectum

Total, permanent and irrecoverable loss of function of the bowel or bladder, resulting in a permanent stoma or indwelling catheter.

Crohn's disease

Crohn's disease of the small or large bowel confirmed by a medical specialist through an endoscopy and biopsy, resulting in a history of weight loss and confirmed growth failure that is inappropriate for age.

Ulcerative colitis

Ulcerative colitis of the large bowel treated by a medical specialist and confirmed by an endoscopy and biopsy, resulting in a history of weight loss and confirmed growth failure that is inappropriate for age.

Head injury

A head injury requiring surgery in the form of a craniotomy, decompression holes to drain a brain bleeding or open reduction of a depressed skull fracture.

Paraplegia

Total, permanent and irrecoverable loss of function of both lower extremities, with or without loss of bowel or bladder function.

Quadriplegia

Total, permanent and irrecoverable loss of function of all four limbs.

Fracture dislocation of the spine

Objective radiological evidence of a fracture dislocation of the spine, involving dislocation of the facet joints, with or without neurological deficit.

Near drowning

Near drowning is the survival from a drowning event which involves

- emergency resuscitation, and
- impaired consciousness due to water inhalation as assessed by a medical practitioner or paramedical personnel, and
- care in ICU required for at least 48 hours.

Choking or suffocation

A choking or suffocation incident necessitating emergency resuscitation and care in an intensive care unit for at least 48 hours.

Amputation of one hand

Complete physical severance of one hand at the level of the wrist. Surgical reconstruction after amputation will not affect this benefit.

Amputation of one arm

Complete physical severance of one arm above the level of the elbow. Surgical reconstruction after amputation will not affect this benefit.

Amputation of one foot

Complete physical severance of one foot at the level of the ankle joint. Surgical reconstruction after amputation will not affect this benefit.

Amputation of one leg

Complete physical severance of one leg above the level of the knee. Surgical reconstruction after amputation will not affect this benefit.

Amputation of one thumb

Complete physical severance of a thumb at the level of the metacarpo-phalangeal (MP) joint.

Skull fracture requiring reconstruction

Depressed or displaced skull fracture of the frontal, parietal, temporal, sphenoid or occipital bones requiring surgical correction.

Gunshot wound

Penetration by a bullet through the skull or into the chest or abdominal cavities, resulting in surgical exploration of the skull or cavity concerned under general anaesthetic.

Penetrating stab wound

Penetration by a 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.

Major burns

Third-degree burn wounds, full thickness of the skin, that cover at least 20% of the body surface area, as determined by the Lund and Browder chart or equivalent.

Fracture of the facial bones requiring reconstructive surgery

Fractures of the frontal bones, orbital bones, zygoma, and/or maxilla resulting in maxillofacial reconstructive surgery.

Unstable pelvis fractures

More than one fracture of the pelvic framework, resulting in instability, and requiring surgical intervention.

Multiple rib fractures with unstable ribcage

Multiple rib fractures, resulting in artificial ventilation in an intensive care unit to sustain a stable blood-gas profile.

Abdominal injury with liver rupture, spleen rupture or kidney damage requiring emergency surgical repair

Blunt injury to the abdomen resulting in rupture of the liver or spleen, or injury to the kidney, necessitating emergency laparotomy and surgical repair, splenectomy or nephrectomy.

Bilateral orchidectomy

The surgical removal of both testes for medically necessary reasons.

Dog bite to the face requiring plastic surgery

A dog bite to the face requiring primary suturing under general anaesthetic by a plastic surgeon.

Dog bite to the face requiring multiple sessions of plastic surgery

A dog bite to the face requiring primary suturing, followed by multiple sessions of repair by a plastic and reconstructive surgeon under general anaesthetic.

Accidental HIV infection

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 transplanted 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.

Bacterial meningitis or encephalitis with permanent impairment

Bacterial meningitis or encephalitis confirmed by a medical specialist, supported by appropriate cerebrospinal fluid investigations that results in permanent neurological deficit.

Cerebral malaria

Cerebral malaria as confirmed by a medical specialist in the presence of Plasmodium falciparum parasites on peripheral blood smears, resulting in permanent neurological deficit.

Rabies

Confirmation by a medical specialist that the insured has presented with the clinical manifestations of rabies contracted from an infected animal.

Polio with permanent impairment

The confirmation of the diagnosis of polio by a medical specialist, with permanent paralysis or paresis of a limb.

Rheumatic fever with heart valve involvement

Acute rheumatic fever with structural damage to a heart valve, severe enough to have haemodynamic consequences as confirmed by a cardiologist.

Tetanus

The confirmation of tetanus by a medical specialist, resulting in either parenteral feeding due to significant difficulty in swallowing or mechanical ventilation by ventilator to assist with breathing difficulty.

Haemorrhagic fever

Acute haemorrhagic fever as a result of the Ebola, Marburg, Lassa or yellow fever virus, necessitating hospitalisation and treatment in isolation.

Juvenile rheumatoid arthritis

Rheumatoid arthritis in a child of 16 years or younger, causing pain and deformity despite optimal treatment, in at least three major joints bilaterally, in other words, shoulders, elbows, wrists, hips, knees, or ankles. This must be confirmed by a rheumatologist with appropriate radiological evidence of deformity.

Polymyositis

Polymyositis as diagnosed by a medical specialist, confirmed by muscle biopsy. This must cause the irreversible inability to perform, without assistance, three or more of the following activities of daily living (ADL's):

- The permanent inability to get into and out of a bath or shower and to wash oneself independently;
- The permanent inability to put on or take off clothes or shoes independently, including doing buttons, fastenings and shoelaces independently;
- The permanent inability to use the toilet independently, including cleaning and washing of hands after using the toilet;
- The permanent inability to eat food independently after it has been served;
- The permanent inability to independently move in and out of bed or a chair, even with the use of walking aids.

The inability to perform activities of daily living (ADL's) will be assessed with supervision from an adult for children from 6 to 9 years old and without supervision by an adult for older children.

Cystic fibrosis

Clinical features of cystic fibrosis, diagnosed by a medical specialist and confirmed by a sweat test and/or genetic test.

Polycystic kidneys

Polycystic kidneys presenting with multiple cysts in both kidneys as demonstrated by CT or MRI scan, with a positive genetic test confirming Autosomal Recessive Polycystic Disease.

Addison's disease

Confirmation by a medical specialist of the diagnosis of Addison's disease, necessitating replacement corticosteroid therapy for life.

Hirschsprung's disease

The histological confirmation of a congenital aganglionic segment of the gastro-intestinal tract that needed surgery resection of the affected segment and re-anastomosis.

Amino acid disorders

The diagnosis of a recognised congenital amino acid disorder by a specialist paediatrician.

Diabetes

The diagnosis of juvenile insulin dependent diabetes in a child by a medical specialist.

Admission into an intensive care unit (ICU) with ventilation for at least 48 hours

Admission into a registered intensive care unit with mechanical ventilation continuously for at least 48 hours.

Catch-all

Any physical disease or injury that results in a permanent whole person impairment (WPI) of at least 45% and also meets the criteria of at least a class 4 impairment according to the latest edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. 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.

Accidental injury (ASW)

This benefit is 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	This benefit provides cover for accidental injury claim events. If we admit a claim, we will pay the claim amount as a lump sum.
Additional features	<p>Additional features are features that are automatically included for a benefit. These features are free of charge. The following additional feature applies:</p> <ul style="list-style-type: none"> • Free cover <p>Refer to the chapter <i>Payments, payment patterns, guarantees and cover</i> for more information about Free cover.</p>
Type of benefit	Standalone
When will cover for this benefit end?	<p>Cover will end</p> <ul style="list-style-type: none"> • 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 • when the full cover amount has been paid.
Cover limits per life insured	<p>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.</p> <p>Minimum: R50 000</p> <p>Maximum: • Express product option: R5 000 000* • Classic and Premier product options: R10 000 000*</p> <p>*Subject to financial underwriting</p>
Age limits	<p>Benefit start age</p> <p>Minimum: • Payment patterns other than fixed compulsory growth <ul style="list-style-type: none"> • 19 next birthday for the Express product option • 15 next birthday otherwise • Fixed compulsory growth: 30 next birthday</p> <p>Maximum: 5 years before the benefit cease age</p> <p>Benefit cease age</p> <p>65 next birthday</p> <p>Under Term cover products the term of a benefit is limited to a maximum of the selected term of the plan.</p>
Qualifying lives	<p>Express product option</p> <p>Only the planholder and his/her spouse may qualify, subject to age limits and underwriting.</p> <p>Classic and Premier product options</p> <p>Subject to age limits and underwriting.</p>

Guarantee period	Express product option 5 years
	Classic and Premier product options As selected for the plan.

What benefit will be paid?

The claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated in the table below. The contractual definitions will apply when we consider a claim. The layman's explanations are provided for a better understanding of the claim events but will not be used in the legal interpretation of the claim events.

If we admit a claim, we will pay the percentage of the cover amount linked to the particular claim event. For claim events where a maximum rand amount is indicated, we will not pay more than the indicated rand amount. The cover amount is indicated in the plan overview and may change over time as a result of benefit growth, alterations requested by the planholder, and claims.

Claim event	% of the cover amount
Central nervous system	
Coma	
Contractual definition: A condition of unconsciousness not induced by sedation where the life insured presents with a Glasgow Coma Scale reading of 8 or less, for an uninterrupted period of at least 96 hours. This must be confirmed by a specialist.	100
<i>Layman's explanation:</i> <i>This claim event covers coma, where there is a state of unconsciousness not induced by medication causing a state of sleep. Specific criteria must be met, as described in the contractual definition above. This must be confirmed by a specialist.</i>	
Paraplegia	
Contractual definition: The total and permanent loss of muscle function resulting in the loss of use of both legs due to injury to the spinal cord or brain.	100
The following is required: <ul style="list-style-type: none"> • Radiological evidence such as a computed tomography (CT) scan or magnetic resonance imaging (MRI), and • Must be confirmed by a neurologist or neurosurgeon. 	
Quadriplegia	
Contractual definition: The total and permanent loss of muscle function resulting in the loss of use of both arms and both legs due to injury to the spinal cord or brain.	100
The following is required: <ul style="list-style-type: none"> • Radiological evidence such as a computed tomography (CT) scan or magnetic resonance imaging (MRI), and • Must be confirmed by a neurologist or neurosurgeon. 	
Gastro-intestinal system/Renal system	
Loss of bowel or bladder function, with permanent stoma or indwelling catheter	
Contractual definition: Total and permanent loss of function of the bowel or bladder, resulting in a permanent stoma or indwelling catheter.	50
<i>Layman's explanation:</i> <i>Total and permanent loss of the function of the bladder (organ responsible for excretion of urine) requiring plastic tube (a catheter) inserted into the bladder that remains there to provide continuous urinary drainage, or loss of bowel function to an extent where a permanent artificial opening (stoma) is made into the bowel.</i>	

Claim event	% of the cover amount
Musculoskeletal system	
Amputation of a thumb	
Contractual definition: The amputation of a thumb, at the interphalangeal level and proximal to the joint, by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	30*
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of a thumb at the first joint. This must be confirmed by a specialist with supporting evidence.</i>	
Amputation of one finger other than thumb	
Contractual definition: The amputation of one finger other than the thumb, at the proximal interphalangeal joint or more proximal than this joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	5****
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of one finger, excluding the thumb, at the level of the middle knuckles. This must be confirmed by a specialist with supporting evidence.</i>	
Amputation of two fingers other than thumb	
Contractual definition: The amputation of two fingers other than the thumb on the same hand, at the proximal interphalangeal joint or more proximal than this joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	10***
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of two fingers, excluding the thumb on the same hand, at the level of the middle knuckles. This must be confirmed by a specialist with supporting evidence.</i>	
Amputation of three fingers other than thumb	
Contractual definition: The amputation of three fingers other than the thumb on the same hand, at the proximal interphalangeal joint or more proximal than this joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	20**
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of three fingers, excluding the thumb on the same hand, at the level of the middle knuckles. This must be confirmed by a specialist with supporting evidence.</i>	
Amputation of four fingers other than thumb	
Contractual definition: The amputation of four fingers other than the thumb on the same hand, at the proximal interphalangeal joint or more proximal than this joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	40*
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of four fingers, excluding the thumb on the same hand, at the level of the middle knuckles. This must be confirmed by a specialist with supporting evidence.</i>	
Amputation of a hand	
Contractual definition: The amputation of a hand at the wrist by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	70
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of a hand at the wrist. This must be confirmed by a specialist with supporting evidence.</i>	
Amputation of an arm	
Contractual definition: The amputation of an arm below or above the elbow by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	80
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of an arm below or above the elbow. This must be confirmed by a specialist with supporting evidence.</i>	

Claim event	% of the cover amount
Amputation of a foot Contractual definition: The amputation of a foot at the level of the ankle joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence. <i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of a foot at the ankle joint. This must be confirmed by a specialist with supporting evidence.</i>	50
Amputation of a leg below the knee Contractual definition: The amputation of a leg distal to the knee joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence. <i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of a leg below the knee. This must be confirmed by a specialist with supporting evidence.</i>	60
Amputation of a leg above the knee Contractual definition: The amputation of a leg proximal to the knee joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence. <i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of a leg above the knee. This must be confirmed by a specialist with supporting evidence.</i>	70
Loss of function of an arm, excluding amputation Contractual definition: Total and permanent loss of 50% of function of an arm according to the latest American Medical Association (AMA) guidelines. Maximum medical improvement must have been reached with little or no chance of significant further improvement. The loss of function will be estimated after all medical, surgical and rehabilitation measures have been applied. This must be confirmed by a specialist with supporting evidence. <i>Layman's explanation:</i> <i>Total and permanent loss of 50% of function of arm from the level of the shoulder and lower as determined by the American Medical Association (AMA) guidelines. This must be confirmed by a specialist with supporting documentation after completion of all appropriate medical and surgical measures as well as optimum rehabilitation. The treatment must be deemed maximal with little chance for significant improvement.</i>	50
 Contractual definition: Total and permanent loss of 80% of function of an arm according to the latest American Medical Association (AMA) guidelines. Maximum medical improvement must have been reached with little or no chance of significant further improvement. The loss of function will be estimated after all medical, surgical and rehabilitation measures have been applied. This must be confirmed by a specialist with supporting evidence. <i>Layman's explanation:</i> <i>Total and permanent loss of 80% of function of arm from the level of the shoulder and lower as determined by the American Medical Association (AMA) guidelines. This must be confirmed by a specialist with supporting documentation after completion of all appropriate medical and surgical measures as well as optimum rehabilitation. The treatment must be deemed maximal with little chance for significant improvement.</i>	80
Loss of function of a leg, excluding amputation Contractual definition: Total and permanent loss of 50% of function of a leg according to the latest American Medical Association (AMA) guidelines. Maximum medical improvement must have been reached with little or no chance of significant further improvement. The loss of function will be estimated after all medical, surgical and rehabilitation measures have been applied. This must be confirmed by a specialist with supporting evidence. <i>Layman's explanation:</i> <i>Total and permanent loss of 50% of function of a leg as determined by the American Medical Association (AMA) guidelines. This must be confirmed by a specialist with supporting documentation after completion of all appropriate medical and surgical measures as well as optimum rehabilitation. The treatment must be deemed maximal with little chance for significant improvement.</i>	40

Claim event	% of the cover amount
<p>Contractual definition: Total and permanent loss of 75% of function of a leg according to the latest American Medical Association (AMA) guidelines. Maximum medical improvement must have been reached with little or no chance of significant further improvement. The loss of function will be estimated after all medical, surgical and rehabilitation measures have been applied. This must be confirmed by a specialist with supporting evidence.</p> <p>Layman's explanation: <i>Total and permanent loss of 75% of function of a leg as determined by the American Medical Association (AMA) guidelines. This must be confirmed by a specialist with supporting documentation after completion of all appropriate medical and surgical measures as well as optimum rehabilitation. The treatment must be deemed maximal with little chance for significant improvement.</i></p>	70
Visual system	
Total loss of vision of one eye or hemianopia of one eye	
<p>Contractual definition: Total and permanent loss of vision of one eye or permanent hemianopia of one eye, confirmed by an ophthalmologist with supporting evidence.</p> <p>Layman's explanation: <i>This claim event covers the total and permanent loss of vision of one eye or permanent loss of either the left or right half of the visual field of one eye. This must be confirmed by a specialist (ophthalmologist) with supporting documents.</i></p>	60
Total loss of vision of both eyes or blindness of both eyes	
<p>Contractual definition: Total and permanent loss of vision of both eyes or blindness of both eyes by visual acuity or retinal pathology or visual field measurements, confirmed by an ophthalmologist with supporting evidence and meeting the following criteria: Bilateral visual impairment of 70%, with evidence of one of the following:</p> <ul style="list-style-type: none"> • A reading of at least 20/200 (or equivalent measure) in each eye, or • Permanent hemianopia of both eyes, or • A visual field loss to a 10° radius of each eye. <p>Layman's explanation: <i>This claim event covers the total and permanent loss of vision of both eyes or blindness of both eyes. It must meet the criteria described in the contractual definition above, and must be confirmed by a specialist (ophthalmologist).</i></p>	100
Hearing	
Total loss of hearing in one ear	
<p>Contractual definition: The total and permanent loss of hearing in one ear as confirmed by an ear, nose and throat surgeon, with objective audiology evidence, recording an average loss of at least 70dB across all measured frequencies.</p>	20
Total loss of hearing in both ears	
<p>Contractual definition: The total and permanent loss of hearing in both ears as confirmed by an ear, nose and throat surgeon, with objective audiology evidence, recording an average loss of greater than 87dB across all measured frequencies.</p>	75
Face and skin	
Combination burns	
<p>Contractual definition: A combination of 2nd and 3rd degree burns that covers more than 80% of the face or hands or feet, confirmed by a surgeon.</p> <p>Layman's explanation: <i>A combination of less severe (2nd degree) and severe (3rd degree) burns that covers more than 80% of the face or hands or feet. This must be confirmed by a specialist (surgeon).</i></p> <p><i>2nd degree burns are burn wounds to the outer skin layer and the layer directly under this.</i></p> <p><i>3rd degree burns are burn wounds to all three layers of the skin.</i></p>	30

Claim event	% of the cover amount
Third degree burns	
<p>Contractual definition: Third degree burns, full thickness of the skin, covering at least 20% of the total body surface, confirmed by a surgeon.</p> <p><i>Layman's explanation:</i> <i>Burn wounds to all three layers of the skin which affect at least 20% of the body's surface, as measured with a Lund and Browder chart, or a similar chart. This must be confirmed by a specialist (surgeon).</i></p>	100
Trauma	
Gunshot-wounds or penetrating stab-wounds	
<p>Contractual definition: Gunshot or penetrating stab wound, resulting in theatre debridement, with an operation report provided by a surgeon or trauma surgeon.</p> <p><i>Layman's explanation:</i> <i>Gunshot or penetrating stab wound, with removal of dead, damaged or infected tissue in theatre to improve the healing potential of the remaining healthy tissue. An operation report must be provided by a specialist (surgeon or trauma surgeon).</i></p>	5**
<p>Contractual definition: Penetration by a bullet or a sharp object through the chest, resulting in an underwater drain, with an operation report provided by a surgeon or trauma surgeon.</p> <p><i>Layman's explanation:</i> <i>Penetration by a bullet or a sharp object through the chest, resulting in the placement of a tube into the chest (underwater drain) to drain air, fluid or blood from the space around the lung and thus allowing the lung to expand. An operation report must be provided by a specialist (surgeon or trauma surgeon).</i></p>	25*
<p>Contractual definition: Penetration by a bullet or a sharp object through the chest, resulting in a thoracotomy, with an operation report provided by a surgeon or trauma surgeon.</p> <p><i>Layman's explanation:</i> <i>Penetration by a bullet or a sharp object through the chest, resulting in an operation with an incision into the chest wall (a thoracotomy). An operation report must be provided by a specialist (surgeon or trauma surgeon).</i></p>	50*
<p>Contractual definition: Penetration by a bullet or a sharp object through the abdomen, resulting in surgical exploration of the cavity under general anaesthetic, with an operation report provided by a surgeon or trauma surgeon.</p> <p><i>Layman's explanation:</i> <i>Penetration by a bullet or a sharp object through the abdomen, resulting in an operation of the belly to assess damage caused by the injury to internal organs or blood vessels (surgical exploration of the cavity) under general anaesthetic. An operation report must be provided by a specialist (surgeon or trauma surgeon).</i></p>	40*
<p>Contractual definition: Penetration by a bullet or a sharp object through the neck, with damage to one or more of the following: subclavian or carotid artery, oesophagus or trachea, with an operation report provided by a surgeon or trauma surgeon.</p> <p><i>Layman's explanation:</i> <i>Penetration by a bullet or a sharp object through the neck, with damage to one or more of the following blood vessels or organs:</i></p> <ul style="list-style-type: none"> • The subclavian arteries, which are a pair of large arteries in the chest that supply blood to the chest, head, neck, shoulder and arms, or • The carotid arteries, which are major blood vessels in the neck that supply blood to the brain, neck, and face, or • The food pipe (oesophagus), which is a muscular tube that moves food and liquids from the throat to the stomach, or • The windpipe (trachea). <p><i>An operation report must be provided by a specialist (surgeon or trauma surgeon).</i></p>	40*

Claim event	% of the cover amount
<p>Contractual definition: Penetration by a bullet or a sharp object through the skull, resulting in surgical exploration of the skull under general anaesthetic, with an operation report provided by a surgeon or trauma surgeon.</p> <p>Layman's explanation: <i>Penetration by a bullet or a sharp object through the skull, resulting in an operation opening up the skull to determine and repair damage caused by the penetrating injury of the skull (surgical exploration of the skull) under general anaesthetic. An operation report must be provided by a specialist (surgeon or trauma surgeon).</i></p>	60*
<p>Multiple rib fractures</p> <p>Contractual definition: Multiple rib fractures with ICU admission: Numerous rib fractures, requiring admission to an intensive care unit (ICU), confirmed by a specialist.</p> <p>Contractual definition: Multiple rib fractures with ICU admission: Numerous rib fractures, requiring ventilation in an intensive care unit in order to sustain a stable blood-gas profile, confirmed by a specialist.</p>	15 80
<p>Pelvis fracture</p> <p>Contractual definition: More than one fracture of different bones of the pelvic framework, resulting in instability, confirmed by an orthopaedic specialist or surgeon.</p> <p>Layman's explanation: <i>A pelvic fracture is a break of the bony structure of the pelvis. For this claim event there must be more than one fracture of different bones of the pelvic framework, resulting in instability of the pelvic ring. This must be confirmed by a specialist (neurosurgeon or orthopaedic specialist).</i></p>	15
<p>Unstable pelvis fractures</p> <p>Contractual definition: More than one fracture of the pelvic framework, resulting in instability, and requiring surgical intervention, confirmed by an orthopaedic specialist or surgeon.</p> <p>Layman's explanation: <i>A pelvic fracture is a break of the bony structure of the pelvis. For this claim event there must be more than one fracture of the pelvic framework, resulting in instability of the pelvic ring, and requiring surgical intervention. This must be confirmed by a specialist (neurosurgeon or orthopaedic specialist).</i></p>	60
<p>Compression fracture</p> <p>Contractual definition: A compression fracture of more than 50% of a spinal vertebra with documented spinal cord injury or myelopathy, confirmed by a neurosurgeon or an orthopaedic specialist.</p> <p>Layman's explanation: <i>When the bone of a vertebral body collapses it is called a compression fracture. For this claim event there must be a compression fracture of more than 50% of a spinal vertebra leading to collapse of the vertebra with documented spinal cord injury or compression of the nerves of the spinal cord.</i> <i>This must be confirmed by a specialist (neurosurgeon or orthopaedic specialist).</i></p>	30
<p>Fracture dislocation of the spine</p> <p>Contractual definition: A fracture dislocation of the spine, without neurological deficit, confirmed with supporting evidence by a neurosurgeon or orthopaedic specialist.</p> <p>Layman's explanation: <i>A fracture is a break or crack in the bone. A dislocation occurs when 2 bones are out of place at the joint that connects them. A fracture dislocation of the spine, without neurological deficit, is when this occurs in the vertebral column, but the life insured has no signs of altered function due to the weaker function of the spinal cord. There must be objective evidence of the dislocation on the imaging of the spine. This must be confirmed with supporting evidence by a specialist (neurosurgeon or orthopaedic surgeon).</i></p>	50

Claim event	% of the cover amount
<p>Contractual definition: A fracture dislocation of the spine, with neurological deficit, confirmed with supporting evidence by a neurosurgeon or orthopaedic specialist.</p> <p>Layman's explanation: <i>A fracture is a break or crack in the bone. A dislocation occurs when 2 bones are out of place at the joint that connects them. A fracture dislocation of the spine, with neurological deficit, is when this occurs in the vertebral column and the life insured has signs of altered function due to the weaker function of the spinal cord. There must be objective evidence of the dislocation on the imaging of the spine. This must be confirmed with supporting evidence by a specialist (neurosurgeon or orthopaedic surgeon).</i></p>	75
<p>Compression or avulsion fractures</p> <p>Contractual definition: Compression or avulsion fractures without joint dislocation on two or more vertebrae, confirmed with supporting evidence by an orthopaedic or neurosurgeon.</p> <p>Layman's explanation: <i>When the bone of a back bone (vertebrae) collapses it is called a compression fracture. An avulsion fracture is an injury to the bone in a location where a ligament attaches to the bone. When an avulsion fracture occurs, the tendon or ligament pulls off a piece of the bone. This claim event covers compression or avulsion or fractures without dislocation (the movement of the joints on two or more of the bones of the spine (vertebrae)) of two or more vertebrae. This must be confirmed with supporting evidence by a specialist (neurosurgeon or orthopaedic specialist).</i></p>	15
<p>Liver or spleen rupture</p> <p>Contractual definition: Rupture of the liver or spleen, necessitating emergency laparotomy and surgical repair, with an operation report provided by a surgeon.</p> <p>Layman's explanation: <i>Bursting of the liver or spleen due to an accident or injury to the belly by a blunt object or surface, which leads to an emergency operation to repair the liver or spleen. An operation report must be provided by a specialist (surgeon).</i></p>	40
<p>Post-traumatic fat-embolism of the lungs</p> <p>Contractual definition: Fat-embolism of the lungs, confirmed by a ventilation-perfusion (VQ) scan. This must be confirmed by a pulmonologist, physician or anaesthetist.</p> <p>Layman's explanation: <i>This claim event covers fat-embolism of the lungs. An embolism is when a lump of material, in this case fat material, is dislodged and travels into the bloodstream, which then blocks blood vessels and leads to catastrophic events in the body. This must be confirmed by a specialist (pulmonologist, physician or anaesthetist).</i></p>	30
<p>Compartment syndrome</p> <p>Contractual definition: Definitive history of compartment syndrome as a result of an acute injury, with permanent motor nerve damage, confirmed by a specialist. This must be confirmed with all of the following supporting evidence:</p> <ul style="list-style-type: none"> • History and clinical signs of compartment syndrome, and • Nerve conduction studies. <p>Layman's explanation: <i>Compartment syndrome is a condition of severe tissue compression, which has resulted from an acute injury. This compression in a closed muscle compartment results in permanent damage to the nerves of the affected muscles.</i></p> <p><i>This claim event covers a definitive history of compartment syndrome as a result of an acute injury, with permanent motor nerve damage, confirmed by a specialist. The evidence required for this claim event is specified in the contractual definition above.</i></p>	15

Claim event	% of the cover amount
HIV	
Accidental HIV infection	

Contractual definition:

The contractual definition for this claim event is given below this table.

100

Layman's explanation:

HIV infection / AIDS that is acquired accidentally through one of the events described in the contractual definition.

*This claim event is limited to a maximum amount of R1 000 000.

**This claim event is limited to a maximum amount of R500 000.

***This claim event is limited to a maximum amount of R250 000.

****This claim event is limited to a maximum amount of R125 000.

The above maximum amounts may change from time to time.

Future medical advances

Some claim events 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 claim events, 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.

Accidental HIV infection

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

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

- the transfusion of infected blood or blood products from a transfusion service that we recognise, on or after the cover start date;
- an accidental needlestick injury or cut 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 transplanted 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.

Admittance of a claim

Besides the conditions for admittance of a claim set out in the *General information* chapter, we will admit a claim only if

- the claim event
 - is caused directly and solely by a bodily injury due to an accident;
 - manifested within 12 months after the bodily injury;
- we have not previously admitted a claim for the same claim event, except if the claim event is listed under "Musculoskeletal system" in the claim event table above, and the claim is for a different limb;
- the life insured survived more than 10 days from the date the contractual claim event definition has been met. The survival period will only be applied to conditions where the prognosis of survival beyond 10 days is not certain, based on the available medical evidence.

For the purpose of this benefit, we will not recognise any intra- or post-operative complication, or any complication following a medical procedure, as an accident, unless the operation or procedure

- is a direct result of a bodily injury that took place after cover for this benefit has started, and
- takes place within six months of such a bodily injury.

The impairment must be permanent, and evaluated according to the principles and ratings of the latest edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. The impairment, and permanence thereof, will be evaluated only 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.

If we admit a claim, we will pay the percentage of the cover amount linked to the particular claim event indicated in the claim event table above. The amount will be paid as a lump sum.

If the amount we pay is equal to the cover amount, the benefit will end when we have paid the claim. If the amount we pay is less than the cover amount, we will reduce the cover amount with the amount that was paid. We will also reduce the payment of the benefit proportionally. Any amount we pay thereafter for a subsequent claim event, will be based on the reduced cover amount. The reduced cover amount will continue to increase on every plan anniversary if benefit growth is applicable to the plan.

Multiple claims

If the life insured qualifies for more than one claim event at the same time, we will first consider the claim event with the highest percentage of the cover amount. If two claim events have the same percentage, we will first consider the claim event that is listed first in the claim event table above.

If the life insured however qualifies for more than one claim event at the same time and by qualifying for the one claim event implies qualifying for other claim events, we will only consider the claim event with the highest percentage of the cover amount.

The total lump sum we will pay will be limited to the cover amount of the benefit and once the full cover amount has been paid, the benefit will end.

Exclusions

We will not admit a claim if the impairment of the life insured can be substantially removed or improved by surgery or other medical treatment, which we can reasonably expect him or her to undergo, taking into account the risks involved and the chances of success of such surgery or treatment.

Other general exclusions are set out in the applicable overview chapter in this technical guide. Specific exclusions, if any, are set out in the plan overview, in the special provisions for the life insured concerned.

Credit Life cover

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Why Credit Life cover?

Credit life cover is normally required by credit providers as security when a loan is taken out. Current legislation requires that any credit life product must include at least the following cover:

- Death cover, for the outstanding balance of the loan
- Permanent disability cover, for the outstanding balance of the loan
- Temporary disability cover, for the loan instalments for a period of 12 months, or alternatively to the end of the loan term, or until recovery of the life insured
- Retrenchment cover, for the loan instalments for a period of 12 months, or alternatively to the end of the loan term, or until new employment has been found.

Our Credit life benefit combined with the mandatory Permanent Disability, Temporary Disability and Retrenchment rider benefits provide cover for death, permanent and temporary disability, and retrenchment.

The Credit Life benefit will not be integrated with the loan itself in terms of outstanding loan amounts and instalments, but will instead provide cover for certain defined cover amounts and claim percentages that should be sufficient to comply with legal obligations.

Availability for individual and business insurance

The Credit life benefit is available for individual insurance under all product options, and for business insurance under the Classic and Premier product options. Refer to the *Business insurance* chapter for more information.

Credit Life (DSC)

This benefit is 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	A benefit may be claimed at the death of the life insured. If we admit a claim, we will pay the cover amount as a lump sum. This benefit and all rider benefits linked to this benefit as well as all other benefits on the life of the insured will then end. The conditions for admittance of a claim are set out in the <i>General information</i> chapter.
Rider benefits	<p>Compulsory rider benefits</p> <ul style="list-style-type: none"> • Permanent Disability • Temporary Disability • Retrenchment (not available to lives insured who are self-employed). <p>An additional payment will be charged for a rider benefit.</p>
Additional features	<p>Additional features are features that are automatically included for a benefit. These features are free of charge. The following additional features apply:</p> <ul style="list-style-type: none"> • Terminal illness • Free cover <p>Terminal illness is discussed below for this benefit. Refer to the chapter <i>Payments, payment patterns, guarantees and cover</i> for more information about Free cover.</p>
Type of benefit	<p>Standalone</p> <p>If a Credit Life benefit with whole life cover is taken in combination with a Credit Life benefit with term cover, the two benefits must be taken on separate Topcover and Term cover plans.</p>
When will cover for this benefit end?	<p>Topcover products Cover is provided for whole of life. However, the cover will end earlier:</p> <ul style="list-style-type: none"> • if the plan ends for any reason before the cover end date, or • if we admit a claim. <p>Term cover products Cover will end</p> <ul style="list-style-type: none"> • 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 • if we admit a claim.
Cover limits per life insured	<p>The cover amount should match the total loan amount, subject to the cover limits below and financial underwriting.</p> <p>Minimum: R150 000</p> <p>Maximum:</p> <ul style="list-style-type: none"> • Express product option: R5 000 000 • Classic and Premier product options: R16 000 000
Tapering	There will be no automatic decreasing of the cover amount.

Age limits	<p>Benefit start age</p> <p>Minimum: 19 next birthday</p> <p>Maximum: Earliest of the following:</p> <ul style="list-style-type: none"> • 50 next birthday • 70 next birthday minus the term of the loan. (Note that the term of the loan must be at least 6 months for the benefit to be available.) <p>Benefit cease age</p> <p>At death.</p> <p>Under Term cover products the term of a benefit is limited to a maximum of the selected term of the plan.</p>
Conditions for availability of benefit	<p>The benefit is only available if a new loan is taken out with the application, where</p> <ul style="list-style-type: none"> • the loan must be taken from a registered credit provider, and • the term of the loan must be at least 6 months, and • the annual loan instalments must be less than 15% of the outstanding balance, and • the life insured must have been in permanent employment for at least 2 years before the quotation date, and • the life insured must not have been aware of, or have received notice of possible retrenchments in his/her company, during the last 3 months before the quotation date. <p>The following lives are not eligible for the Credit Life benefit:</p> <ul style="list-style-type: none"> • Lives in rate groups 1 or 2 • Housewives/house husbands, scholars, students, pensioners or unemployed persons. • Lives who practise sport as an occupation, or work as a pilot. <p>Other lives may be eligible, subject to age limits and underwriting. Under the Express product option only the planholder and his/her spouse are eligible.</p>
Combination with other benefits/rider benefits	In addition to the rider benefits in this chapter, only Cashback benefits are allowed in combination with Credit Life benefits on the same plan.
Cessions and beneficiaries	<ul style="list-style-type: none"> • Collateral cessions: It is required that a plan with the Credit Life benefit be ceded as security to the financial institution that provides the loan. • Outright cessions: Not allowed. • Beneficiaries: Up to 10 beneficiaries are allowed for a Credit Life benefit on the planholder's life, but the appointment of beneficiaries are not compulsory. In the event of a death claim, the rights of the collateral cessionary will take precedence over that of a beneficiary, i.e. only after the loan has been settled will any remaining amount be paid to the beneficiaries. <p>Refer to the <i>General information</i> chapter for more information.</p>
Payment pattern and cover growth	Only a Level payment pattern with no cover growth is allowed.

Guarantee period	Express product option 5 years
	Classic and Premier product options As selected for the plan.

Exclusions

We will not admit a claim if death is caused by suicide, also during insanity, committed before or within 24 months from the cover start date of the benefit or the date the plan has been reinstated after an earlier lapse. If the cover amount is increased, this waiting period will also apply to the increase in the cover amount from the effective date of the increase. The claimant must prove that the life insured did not commit suicide.

Other general exclusions, if applicable, are set out in the applicable overview chapter in this technical guide. Specific exclusions, if any, are set out in the plan overview, in the special provisions for the life insured concerned.

What if the life insured is diagnosed with a terminal illness?

If the life insured is diagnosed with a medical condition that, according to our Chief Medical Officer, will result in death within 12 months, the planholder may apply for an early payment of this benefit. We may then pay an early death benefit. The amount of the early payment will be equal to the cover amount of this benefit set out in the plan overview.

We will also consider a claim for a terminal illness payment if the plan has lapsed and the life insured qualified for a claim at the time of the lapse.

After we have made this payment, this benefit and all rider benefits linked to this benefit as well as all other benefits on the life of the insured will end.

Permanent Disability

Rider benefit

This is a compulsory rider benefit which must be chosen with the Credit Life benefit, and cannot be purchased on its own. An additional payment will be charged for this rider benefit that will fall away if this rider benefit ends for any reason.

Rider benefit description

This rider benefit provides cover for permanent occupational disability. In addition to occupational disability, it also provides cover for certain defined recognised and personal disability events. If we admit a claim, we will pay the cover amount of the benefit for which this rider benefit has been chosen. That benefit and all rider benefits linked to that benefit will then end. The amount will be paid as a lump sum.

A benefit may be claimed if the life insured becomes disabled, and the disability amounts to one of the following:

- total, permanent and irrecoverable loss of
 - the vision in two eyes, or
 - the use of two hands, or
 - the use of two feet, or
 - the use of one hand and one foot
- disability to the extent that the life insured
 - is totally, permanently and continuously unable to take care of his or her body, or take care of his or her personal interests, or
 - is totally, permanently and continuously unable to fulfil the occupational demands of the occupation he or she practised for income immediately before the disability, or
 - will be, if he or she is a full-time student when he or she becomes disabled, totally, permanently and continuously unable to fulfil the occupational demands of an occupation we may reasonably expect him or her to practise, taking into account his or her education, training, and experience.

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.

When will cover for this rider benefit end?

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
- if we admit a claim, or
- if the life insured dies.

Conditions for availability of rider benefit

The same conditions apply as for the Credit Life benefit for which this rider benefit is chosen.

Note that it is compulsory to choose the Permanent Disability rider benefit with the Credit Life benefit.

Guarantee period
Express product option

5 years

Classic and Premier product options

As selected for the plan.

Admittance of a claim

Besides the conditions for admittance of a claim set out in the *General information* chapter, we will admit a claim only if

- the disability is caused directly and solely by a bodily injury or by an illness;
- the claim event occurs before the earlier of retirement and the plan anniversary before or on the life insured's 70th birthday;
- the life insured survived, without life support, more than 14 days from or after the date the contractual claim event definition has been met.

If the life insured retires before the plan anniversary before or on his or her 70th birthday, it is the planholder's responsibility to request us in writing to cancel this rider benefit.

The planholder will be responsible for the cost of medical proof when a claim is submitted.

If the life insured travels or lives outside South Africa when the claim event occurs, we will require the medical proof issued in a foreign country to be in English to consider a claim.

Exclusions

We will not admit a claim if the disability of the life insured can be substantially removed or improved by surgery or other medical treatment, which we can reasonably expect him or her to undergo, taking into account the risks involved and the chances of success of such surgery or treatment.

If the life insured at any time practises sport as an occupation, or works as a pilot, and becomes continuously unable to fulfil the occupational demands of that occupation, we will not admit a claim as a result of such inability.

Other general exclusions are set out in the applicable overview chapter in this technical guide. Specific exclusions, if any, are set out in the plan overview, in the special provisions for the life insured concerned under the benefit for which this rider benefit has been chosen.

Explanations

Retirement

We regard the life insured as retired if he or she is 55 years or older, and does not earn an income over and above a passive income. Passive income refers to income that can continue without the life insured's intervention, for example pension or rental income.

Temporary Disability

Rider benefit	This is a compulsory rider benefit which must be chosen with the Credit Life benefit, and cannot be purchased on its own. An additional payment will be charged for this rider benefit that will fall away if this rider benefit ends for any reason.
Rider benefit description	<p>This rider benefit provides cover for temporary occupational disability. If we admit a claim, we will pay 3.75% of the cover amount of the benefit for which this rider benefit has been chosen. The amount will be paid as a lump sum.</p> <p>A benefit may be claimed if the life insured becomes disabled to the extent that he or she is continuously unable to fulfil the occupational demands of the regular occupation he or she practised for income immediately before the disability.</p> <p>A benefit may be claimed after every three months of continuous disability as described above, with a maximum of four benefit payments for a particular cause of the claim event. The three-month periods may not overlap and the disability must be continuous within each period of three months. Further claims are possible if the cause of the claim event is not related to the cause of a previously admitted claim event.</p> <p>(Note that a claim under this rider benefit will not reduce the cover amount of the benefit for which this rider benefit has been chosen, and also not the cover amounts of any other rider benefits chosen for that benefit.)</p>
Additional features	<p>Additional features are features that are automatically included for a benefit. These features are free of charge. The following additional feature applies:</p> <ul style="list-style-type: none"> • Free cover <p>Refer to the chapter <i>Payments, payment patterns, guarantees and cover</i> for more information about Free cover.</p>
When will cover for this rider benefit end?	<p>Cover will end</p> <ul style="list-style-type: none"> • 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 • if the life insured dies.
Conditions for availability of rider benefit	<p>The same conditions apply as for the Credit Life benefit for which this rider benefit is chosen.</p> <p>Note that it is compulsory to choose the Temporary Disability rider benefit with the Credit Life benefit.</p>
Guarantee period	<p>Express product option 5 years</p> <p>Classic and Premier product options As selected for the plan.</p>

Admittance of a claim

Besides the conditions for admittance of a claim set out in the *General information* chapter, we will admit a claim only if

- the disability is caused directly and solely by a bodily injury or by an illness;
- the cause of the claim event is not related to the cause of a previously admitted claim event;
- the disability has lasted continuously for three months, starting on the date the life insured becomes disabled, as described under "Rider benefit description", or the day after the previous three-month period has expired;
- the claim event occurs before the earlier of retirement and the plan anniversary before or on the life insured's 70th birthday.

If the life insured retires before the plan anniversary before or on his or her 70th birthday, it is the planholder's responsibility to request us in writing to cancel this rider benefit.

The planholder will be responsible for the cost of medical proof when a claim is submitted.

If the life insured travels or lives outside South Africa when the claim event occurs, we will require the medical proof issued in a foreign country to be in English to consider a claim.

Exclusions

If the life insured at any time practises sport as an occupation, or works as a pilot, and becomes continuously unable to fulfil the occupational demands of that occupation, we will not admit a claim for disability as a result of such inability.

We will also not admit a claim if it directly or indirectly resulted from

- normal pregnancy, or
- normal childbirth.

Other general exclusions are set out in the applicable overview chapter in this technical guide. Specific exclusions, if any, are set out in the plan overview, in the special provisions for the life insured concerned under the benefit for which this rider benefit has been chosen.

Explanations

Cause

A health event such as an accident, injury, illness or operation, resulting in the claim event as described for this rider benefit.

Retirement

We regard the life insured as retired if he or she is 55 years or older, and does not earn an income over and above a passive income. Passive income refers to income that can continue without the life insured's intervention, for example pension or rental income.

Retrenchment

Rider benefit	This is a compulsory rider benefit which must be chosen with the Credit Life benefit, and cannot be purchased on its own. An additional payment will be charged for this rider benefit that will fall away if this rider benefit ends for any reason.
Rider benefit description	<p>This rider benefit provides cover for up to two retrenchments. If we admit a claim, we will pay 3.75% of the cover amount of the benefit for which this rider benefit has been chosen. The amount will be paid as a lump sum.</p> <p>A benefit may be claimed if the life insured's employment is terminated by the employer as a result of or in anticipation of business conditions, or as a result of any other business decision of the employer resulting in a staff reduction. The date of retrenchment is the date from which the life insured is no longer employed by the employer.</p> <p>A benefit may be claimed on the date of retrenchment and after every three months of continuous unemployment thereafter, with a maximum of four benefit payments for one occurrence of retrenchment. After the life insured has been employed again for at least two years one further benefit with a maximum of four benefit payments as described may be claimed. If the life insured becomes employed again before we have made the maximum of four benefit payments for this second occurrence of retrenchment, it is the planholder's responsibility to request us in writing to cancel this rider benefit.</p> <p>(Note that a claim under this rider benefit will not reduce the cover amount of the benefit for which this rider benefit has been chosen, and also not the cover amounts of any other rider benefits chosen for that benefit.)</p>
Additional features	<p>Additional features are features that are automatically included for a benefit. These features are free of charge. The following additional feature applies:</p> <ul style="list-style-type: none"> • Free cover <p>Refer to the chapter <i>Payments, payment patterns, guarantees and cover</i> for more information about Free cover.</p>
When will cover for this rider benefit end?	<p>Cover will end</p> <ul style="list-style-type: none"> • 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 • if we admit a second claim, or • if the life insured dies.
Conditions for availability of rider benefit	<p>The same conditions apply as for the main benefit for which this rider benefit is chosen. In addition to this, this rider benefit is not available to lives insured who are self-employed. (Note that this rider benefit can also not be added later for lives insured who were self-employed when applying for the Credit Life benefit but are no longer self-employed.)</p>
Guarantee period	<p>Express product option 5 years</p> <p>Classic and Premier product options As selected for the plan.</p>

Admittance of a claim

Besides the conditions for admittance of a claim set out in the *General information* chapter, we will admit a claim only if

- we have not already admitted claims for two occurrences of retrenchment;
- the life insured was not self-employed when the claim event occurred;
- the life insured can provide proof of his or her retrenchment;
- the life insured received notification of his or her retrenchment after the waiting period to claim for retrenchment has expired;
- the claim event occurs before the earlier of retirement and the plan anniversary before or on the life insured's 70th birthday.

If the life insured retires or becomes self-employed before the plan anniversary before or on his or her 70th birthday, it is the planholder's responsibility to request us in writing to cancel this rider benefit.

Waiting period to claim for retrenchment

The waiting period to claim for retrenchment will apply for 3 months from the original cover start date of the rider benefit. This waiting period will also apply from the date the plan has been reinstated after an earlier lapse. If the cover amount is increased, the waiting period will also apply to the increase in the cover amount from the effective date.

Exclusions

We will not admit a claim if

- the life insured was aware of retrenchment or received notice of retrenchment during the three months before the date on which the cover for this rider benefit started;
- the retrenchment is voluntary;
- the life insured volunteered to forfeit his or her salary, wages or other employment income;
- the life insured resigned or retired;
- the life insured was lawfully dismissed, including dismissal as a result of wilful misconduct that is a violation of any established, definite rule of conduct, a forbidden act, or wilful dereliction of duty;
- the life insured participated in an unprotected strike.

Explanations

Self-employment

Self-employment is the state of working for oneself rather than an employer. Self-employed means the life insured's primary income is earned from being a sole proprietor, or partner in a firm or association, or a member of a close corporation, or a director of a company, or a trustee of a trust, or an employee in a family-owned business.

Retirement

We regard the life insured as retired if he or she is 55 years or older, and does not earn an income over and above a passive income. Passive income refers to income that can continue without the life insured's intervention, for example pension or rental income.

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Why Waiver of payments and FutureCover?

Waiver of payment benefits

Cover becomes more expensive as you grow older, and you may also become uninsurable if your health deteriorates, or your personal circumstances change in other ways. The same applies to your dependants. That is why it is so important to protect the cover that you or your dependants already have. You can do this by taking out our waiver of payment benefits. Our waiver of payment benefits help to protect existing cover by ensuring that payments for your plan continue uninterruptedly after your death or disability.

FutureCover benefits

Some of the advantages of future cover benefits are:

- In respect of individual insurance, to allow cover on the insured's life to be increased after events that typically trigger an increased need for cover, like getting married, having a child, or buying a home.
- In respect of business insurance, to allow cover on the life of a key person or partner to grow with the business.
- Protection against not being able to obtain new cover in future due to having become uninsurable.

When the planholder exercises an option, no HIV test or other proof of good health will be required, and we will require only the following for the life insured:

- a cotinine test for non-smokers;
- financial underwriting;
- occupational underwriting;
- underwriting for risky part-time activities;
- overseas underwriting, where applicable.

Individual insurance

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

Business insurance

Refer to the *Business insurance* chapter for information about availability of benefits.

Waiver of payment with future growth at death (DG) & Waiver of payment without future growth at death (DP)

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	A benefit may be claimed if the life insured dies. If we admit a claim, we will waive the payments of the plan. This means we will treat the future payments as having been made when they become due. The conditions for admittance of a claim are set out in the <i>General information</i> chapter.
Additional features	Additional features are features that are automatically included for a benefit. These features are free of charge. The following additional feature applies: <ul style="list-style-type: none">• Free cover Refer to the chapter <i>Payments, payment patterns, guarantees and cover</i> for more information about Free cover.
Claim for terminal illness	If we admit claim for Terminal illness for the Death (DS) or First death (DS80) benefit for a life insured and that life insured with a terminal illness has a waiver of payment at death benefit, we will consider a claim for that benefit as well. Refer to the terminal illness section for the Death and First death benefits in the <i>Life cover</i> chapter for more information.
Type of benefit	Additional benefit
When will cover for this benefit end?	Cover will end <ul style="list-style-type: none">• 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. Cover will also end if, due to a claim or reaching their cover end date, all non-waiver of payment benefits are removed from the plan, and waiver of payment benefits are the only remaining benefits on the plan.
Cover limits per life insured	None* <small>*Subject to financial underwriting</small>
Age limits	Benefit start age Minimum: <ul style="list-style-type: none">• Payment patterns other than fixed compulsory growth: 15 next birthday• Fixed compulsory growth: 30 next birthday Maximum: 65 next birthday Benefit cease age 80 next birthday Under Term cover products the term of a benefit is limited to a maximum of the selected term of the plan.

Qualifying lives	Subject to age limits and underwriting.
	Only one waiver of payment at death benefit is allowed on a plan. A waiver of payment at death benefit is only allowed if there is more than one life insured on the plan. At least one of the lives without the waiver of payment at death benefit must have a lump sum benefit other than the Cashback benefit.
Benefit and payment growth	<p>Waiver of payment with future growth at death</p> <ul style="list-style-type: none">• This benefit may be selected with any of the available payment patterns, with or without cover growth. However, on the Level or Stepped payment pattern, it is only available if cover growth is also selected.• If we admit a claim, payment growth and cover growth, if applicable, will still take place each year as set out in the plan overview.• If payment and cover growth are ceased before a claim has been admitted, the benefit will be changed to a similar benefit without future growth. This means that, if a claim is admitted, the benefits and payments will not be increased anymore. <p>Waiver of payment without future growth at death</p> <ul style="list-style-type: none">• This benefit is only available with the Level or Stepped payment pattern, with or without cover growth.• If we admit a claim, the benefits and payments will not be increased anymore.
Guarantee period	As selected for the plan.

Exclusions

We will not admit a claim if death is caused by suicide, also during insanity, committed before or within 24 months from the cover start date of the benefit or the date the plan has been reinstated after an earlier lapse. If the cover amount is increased, other than through benefit growth, this waiting period will also apply to the increase in the cover amount from the effective date of the increase. The claimant must prove that the life insured did not commit suicide.

Other general exclusions are set out in the applicable overview chapter in this technical guide. Specific exclusions, if any, are set out in the plan overview, in the special provisions for the life insured concerned.

Waiving of payments

When will it start?

We will start waiving the payments from the first payment date on or after the date we admit the claim.

How long will the waiving continue?

We will waive the payments up to midnight before the cover end date set out in the plan overview. From the cover end date, the payments must be resumed.

Waiver of payment with future growth at disability (OGG1) & Waiver of payment without future growth at disability (OPG1)

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	<p>These benefits provide cover for occupational disability. In addition to occupational disability, these benefits also provide cover for certain defined recognised and personal disability events.</p> <p>If we admit a claim, we will waive the payments of the plan. This means we will treat the future payments as having been made when they become due.</p> <p>A benefit may be claimed if the life insured becomes disabled, and the disability amounts to one of the following:</p> <ul style="list-style-type: none">• total, permanent and irrecoverable loss of<ul style="list-style-type: none">• the vision in two eyes, or• the use of two hands, or• the use of two feet, or• the use of one hand and one foot• functional impairment to the extent that the life insured is<ul style="list-style-type: none">• totally, permanently and continuously unable to take care of his or her body, or take care of his or her personal interests, or• totally and continuously unable to fulfil the occupational demands of the occupation he or she practised for income immediately before the functional impairment, resulting in a loss of such income.
Additional features	<p>Additional features are features that are automatically included for a benefit. These features are free of charge. The following additional feature applies:</p> <ul style="list-style-type: none">• Free cover <p>Refer to the chapter <i>Payments, payment patterns, guarantees and cover</i> for more information about Free cover.</p>
Type of benefit	Additional benefit
When will cover for this benefit end?	<p>Cover will end</p> <ul style="list-style-type: none">• 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 <p>Cover will also end if, due to a claim or reaching their cover end date, all non-waiver of payment benefits are removed from the plan, and waiver of payment benefits are the only remaining benefits on the plan.</p>
Cover limits per life insured	<p>None*</p> <p>*Subject to financial underwriting</p>

Age limits	Benefit start age Minimum: <ul style="list-style-type: none"> • Payment patterns other than fixed compulsory growth: 15 next birthday • Fixed compulsory growth: 30 next birthday Maximum: 60 next birthday
	Benefit cease age 65 next birthday Under Term cover products the term of a benefit is limited to a maximum of the selected term of the plan.
Qualifying lives	The following lives do not qualify: <ul style="list-style-type: none"> • Housewives/house husbands • Scholars • Certain students • Pensioners • Unemployed persons Other lives may qualify, including students in at least their fourth year of study for a professional occupation, subject to age limits and underwriting.
	A waiver of payment at disability benefit is only allowed for one life insured on a plan.
Benefit and payment growth	<p>Waiver of payment with future growth at disability</p> <ul style="list-style-type: none"> • This benefit may be selected with any of the available payment patterns, with or without cover growth. However, on the Level or Stepped payment pattern, it is only available if cover growth is also selected. • If we admit a claim, payment growth and cover growth, if applicable, will still take place each year as set out in the plan overview. • If payment and cover growth are ceased before a claim has been admitted, the benefit will be changed to a similar benefit without future growth. This means that, if a claim is admitted, the benefits and payments will not be increased anymore. <p>Waiver of payment without future growth at disability</p> <ul style="list-style-type: none"> • This benefit is only available with the Level or Stepped payment pattern, with or without cover growth. • If we admit a claim, the benefits and payments will not be increased anymore.
Guarantee period	As selected for the plan.

Admittance of a claim

Besides the conditions for admittance of a claim set out in the *General information* chapter, we will admit a claim only if the disability

- is caused directly and solely by a bodily injury or by an illness;
- has lasted continuously for the entire waiting period.

Waiting period

The waiting period is 6 months from the date we receive the claim.

Exclusions

We will not admit a claim if the disability of the life insured can be substantially removed or improved by surgery or other medical treatment, which we can reasonably expect him or her to undergo, taking into account the risks involved and the chances of success of such surgery or treatment.

If the life insured at any time practises sport as an occupation, or works as a pilot, and becomes continuously unable to fulfil the occupational demands of that occupation, we will not admit a claim as a result of such inability.

During the first 3 years after cover for this benefit has started, we will not admit a claim if the disability directly or indirectly resulted from any of the following:

- depression or dysthymia, whether as an episode or disorder, or as part of the symptom complex of another psychiatric diagnosis;
- post-traumatic stress disorder;
- fibromyalgia;
- chronic fatigue syndrome and its synonyms;
- a neck or back condition, unless it is one of the following: paraplegia; quadriplegia; malignant tumours of the spinal cord and vertebral column; or failed back syndrome after multiple spinal surgery, provided the extent of the functional impairment arising from the failed back syndrome is verified by a specialist that we will nominate;
- an injury or illness that directly or indirectly resulted from, or is traceable to, any of the above causes;
- a complication that directly or indirectly is attributable to any of the above causes, or to such an injury or illness;
- a side-effect of treatment for any of the above causes, or for such an injury or illness, or for such a complication.

Other general exclusions are set out in the applicable overview chapter in this technical guide. Specific exclusions, if any, are set out in the plan overview, in the special provisions for the life insured concerned.

Waiving of payments

When will it start?

We will start waiving the payments from the first payment date on or after the date we admit the claim.

How long will the waiving continue?

We will waive the payments for as long as the disability continues, but only up to midnight before the cover end date set out in the plan overview. From the cover end date, the payments must be resumed.

If we admit the claim because the life insured, as a result of the disability, is unable to fulfil the occupational demands of the occupation he or she practised for income immediately before he or she became disabled, we will waive the payments for only 24 months. Thereafter, we will continue waiving the payments only if the life insured is also unable to fulfil the occupational demands of another occupation we may reasonably expect him or her to practise despite his or her disability, taking into account his or her education, training and experience.

While the payments are being waived, we may from time to time ask for proof that the life insured is still disabled. We may require the life insured to be examined for this purpose, at our cost. If the life insured recovers to such an extent that he or she is no longer disabled, we will stop waiving the payments.

We will also stop waiving the payments if

- we do not receive the required proof of the life insured's continued disability, or
- the life insured
 - refuses to be examined, or
 - refuses to undergo reasonable treatment on a regular basis, at his or her cost, by a medical doctor, other than the life insured if he or she is a medical doctor, or
 - dies.

If we stop waiving the payments, they must be resumed.

Explanations

Neck or back condition

A disease, disorder, or dysfunction of the vertebrae, spinal cord, intervertebral discs, nerve roots and supporting muscles or ligaments, as well as the direct or indirect consequences of, or the side-effects of any treatment applied for, such disease, disorder, or dysfunction.

Paraplegia

Total, permanent and irrecoverable loss of function of both lower extremities, with or without loss of bowel or bladder function.

Quadriplegia

Total, permanent and irrecoverable loss of function of all four limbs.

Malignant tumours of the spinal cord and vertebral column

The incontrovertible presence of uncontrolled growth and spread of malignant cells, the invasion of normal tissue, and the definite histological evidence of a malignant growth in the spinal cord and vertebral column.

Failed back syndrome after multiple spinal surgery

When the life insured, after the cover for the benefit has begun, must undergo more than one spinal operation on two or more intervertebral disc spaces in the lumbar or cervical area, and despite those operations, still suffers severe back pain as verified by a multidisciplinary pain clinic. Such operations may include discectomy, vertebral fusion and internal fixation.

FutureCover: Death (FS1) & FutureCover: Comprehensive (FS2)

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

Benefit description	<p>For certain events the planholder has the option to purchase additional cover on the life of the insured without proof of good health. The cover amount is set out in the plan overview.</p> <p>The planholder may purchase additional cover under one or more of the benefits available when the planholder exercises an option. However, the planholder may not exercise an option to purchase such additional cover under the Express product option, and additional cover for a benefit may only be purchased under a Classic or Premier product option if that benefit is available under the applicable product option. Refer to the applicable overview chapter in this technical guide for more information about benefits that are available under a specific product option.</p> <p>New business rules will apply when options are exercised, for example rules for cover and age limits and qualifying lives.</p> <p>The list of available benefits will change if we discontinue a benefit, or make other benefits available. The following benefits are currently available:</p> <p>FutureCover: Death</p> <ul style="list-style-type: none"> • Death (DS) • First death (DS80) • Immediate Expenses (DSF3) • Estate Expenses (DEC) • Death income (DI3)* <p>FutureCover: Comprehensive</p> <ul style="list-style-type: none"> • Death (DS) • First death (DS80) • Immediate Expenses (DSF3) • Estate Expenses (DEC) • Comprehensive Disability (CAR3/CSR3) • Comprehensive Disability Plus (CAR4/CSR4) • Comprehensive Impairment (OAI/OSI) • Waiver of payment with future growth at disability (OGG1)* • Waiver of payment without future growth at disability (OPG1)* • Temporary disability income (OIT3)* • Overhead expenses protector (OIB)* • Extended disability income (OIO3)* • Total and permanent disability income (OIR)* • Death income (DI3)* <p>*If additional cover is purchased for this benefit, the cover amount of this benefit will be converted to a lump sum in order to calculate the effective option amount.</p>
Type of benefit	Standalone
When will this benefit end?	<p>This benefit will end</p> <ul style="list-style-type: none"> • 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 • when the full cover amount has been exercised or forfeited.

Cover limits per life insured	Scholars and students may qualify for a limited amount of cover*, as described under "Financial underwriting" in the underwriting chapters. Otherwise the limits below apply. Minimum: R200 000 Maximum: R10 000 000*
<small>*Subject to financial underwriting</small>	

Age limits	Benefit start age Minimum: <ul style="list-style-type: none">• Payment patterns other than fixed compulsory growth: 15 next birthday• Fixed compulsory growth: 30 next birthday Maximum: <ul style="list-style-type: none">• 55 next birthday for FutureCover: Death• 54 next birthday for FutureCover: Comprehensive
Benefit cease age 65 next birthday, but limited to a maximum term of 12 years. Under Term cover products the term of a benefit is limited to a maximum of the selected term of the plan.	

Qualifying lives	The following lives do not qualify: <ul style="list-style-type: none">• Rate group 1• Housewives/house husbands• Pensioners• Unemployed persons Other lives may qualify, subject to age limits and underwriting.
Payment and cover growth	If a plan has cover growth, the cover amount as well as the available option amounts will grow in accordance with the cover growth on the plan.
Guarantee period	As selected for the plan.

Option events

The events at which an option may be exercised and the available maximum option amount are set out below. The available option amount will be limited to ensure that the total option amount exercised and forfeited does not exceed the cover amount.

Option event	Available maximum option amount
Every 3rd plan anniversary from the date the plan begins	25% of cover amount
Marriage	25% of cover amount
Birth or adoption of a child	25% of cover amount
The life insured purchasing a home	The smaller of <ul style="list-style-type: none"> • 50% of the cover amount, and • the value of the bond or the increase in the value of the bond
The life insured starting employment in a chosen field of study for the first time after successful completion of tertiary education	25% of the cover amount
Child's tertiary education	The smaller of <ul style="list-style-type: none"> • 25% of the cover amount, and • the number of years of future attendance at an institution multiplied by the sum of the 1st year's tuition fees plus the 1st year's accommodation fees provided by the institution
Increase in the life insured's personal liability as a result of business activities	The smaller of <ul style="list-style-type: none"> • 50% of the cover amount, and • the amount of the increase in the life insured's liability
Increase in the life insured's interest in a partnership	The smaller of <ul style="list-style-type: none"> • 50% of the cover amount, and • the amount of the increase in the life insured's interest in the partnership
Increase in the life insured's value to a company as a key individual	The smaller of <ul style="list-style-type: none"> • 50% of the cover amount, and • the amount of the increase in the life insured's value to the company as a key individual
Plan anniversary at expiry of the benefit	The remaining percentage of the cover amount. This amount should still comply with the minimum new business requirements applicable at that stage.

Exercising an option

The planholder must apply to exercise an option within 2 months of the date the option event occurred.

When the planholder exercises an option, he or she must take out a new plan.

There are regular option dates on every 3rd plan anniversary from the date the plan begins. The planholder must exercise at least one option to the value of at least 25% of the cover amount during a period of 3 years that ends on an option date. If the cover start date of this benefit is later than the date the plan begins, the first period may be less than 3 years. If, within 2 months after an option date, the planholder has not exercised any options, or the planholder has exercised one or more options with a total value of less than 25% of the cover amount, the planholder will forfeit the percentage that he or she did not exercise. The forfeited percentage will not be available for future options.

The cover amount and payment will not be reduced when an option is exercised or forfeited. The cover amount represents the total option amount available during the term of the benefit, not the option amount still available.

We will still require the following for the life insured, at the time when the planholder exercises an option:

- a cotinine test for non-smokers;
- financial underwriting;
- occupational underwriting;
- underwriting for risky part-time activities;
- overseas underwriting, where applicable.

The life insured's rating factors at the time of exercising the option will also apply. These include a rating factor for raised body mass (BMI), depending on the life insured's BMI at the time.

The available option amount may be reduced due to financial underwriting.

Explanations

Marriage

A marriage, civil or customary union as recognised by the laws of the Republic of South Africa, or a union recognised as marriage in accordance with the principles of any religion. The life insured must be a party to the marriage.

Birth or adoption of a child

The birth or legal adoption of a child where the life insured is the parent of the child.

Child's tertiary education

The child must be financially dependent on the life insured and must be registered for study at a recognised tertiary education institution.

Tertiary education

An educational qualification with a rating of level 5 and above according to the National Qualifications Framework, or its replacement. This includes a university degree, a national higher diploma from a recognised university of technology, or a teaching diploma from a recognised teaching college.

Increase in the life insured's personal liability as a result of business activities

The life insured incurs additional monetary liability as a result of starting a new business, or increases his or her personal liability for business debts by at least 33%.

Increase in the life insured's interest in a partnership

The life insured enters into a professional partnership, or increases his or her share in a partnership or other business by at least 33%.

Increase in the life insured's value to a company as a key individual

The life insured's value to a company as a key individual increases by at least 33%.

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Income protection benefits

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

Any reference to age 70 refers to the plan anniversary before or on the life insured's 70th birthday.

We have a variety of benefits available to protect your income in the event of your sickness, disability or impairment.

You can take these benefits, excluding the rider benefits, on their own or in various combinations to provide cover for your specific needs.

Main disability income benefits

The following main disability income benefits are available*:

- Sickness Income and Sickness Income Plus
- Temporary Income and Temporary Income Plus
- Accidental Temporary Income Plus
- Overhead Expenses
- Extended Income and Extended Income Plus
- Accidental Extended Income Plus
- Impairment Income

* Subject to the qualifying criteria of each benefit

Optional rider benefits for main disability income benefits

To provide even wider cover, you can choose optional rider benefits with certain main disability income benefits, as indicated below:

With Sickness Income and Sickness Income Plus:

- Hospital Protector*
- Spouse Protector
- Child Protector

*If the main benefit has a waiting period of 7 days or 14 days

With Temporary Income and Temporary Income Plus:

- Spouse Protector
- Child Protector

With Accidental Temporary Income Plus:

- Spouse Protector
- Child Protector

With Extended Income, Extended Income Plus and Accidental Extended Income Plus:

- Lump Sum Conversion Option

With Impairment Income:

- Spouse Protector
- Child Protector
- Lump Sum Conversion Option

The optional rider benefits cannot be taken on their own but can only be added to the relevant main benefits.

Other income benefits

The following income benefits are also available under our Income Protector range:

- Severe Illness Income
- Death Income

Benefit combinations not allowed

The following benefit combinations are not allowed on the same plan. All other combinations are allowed.

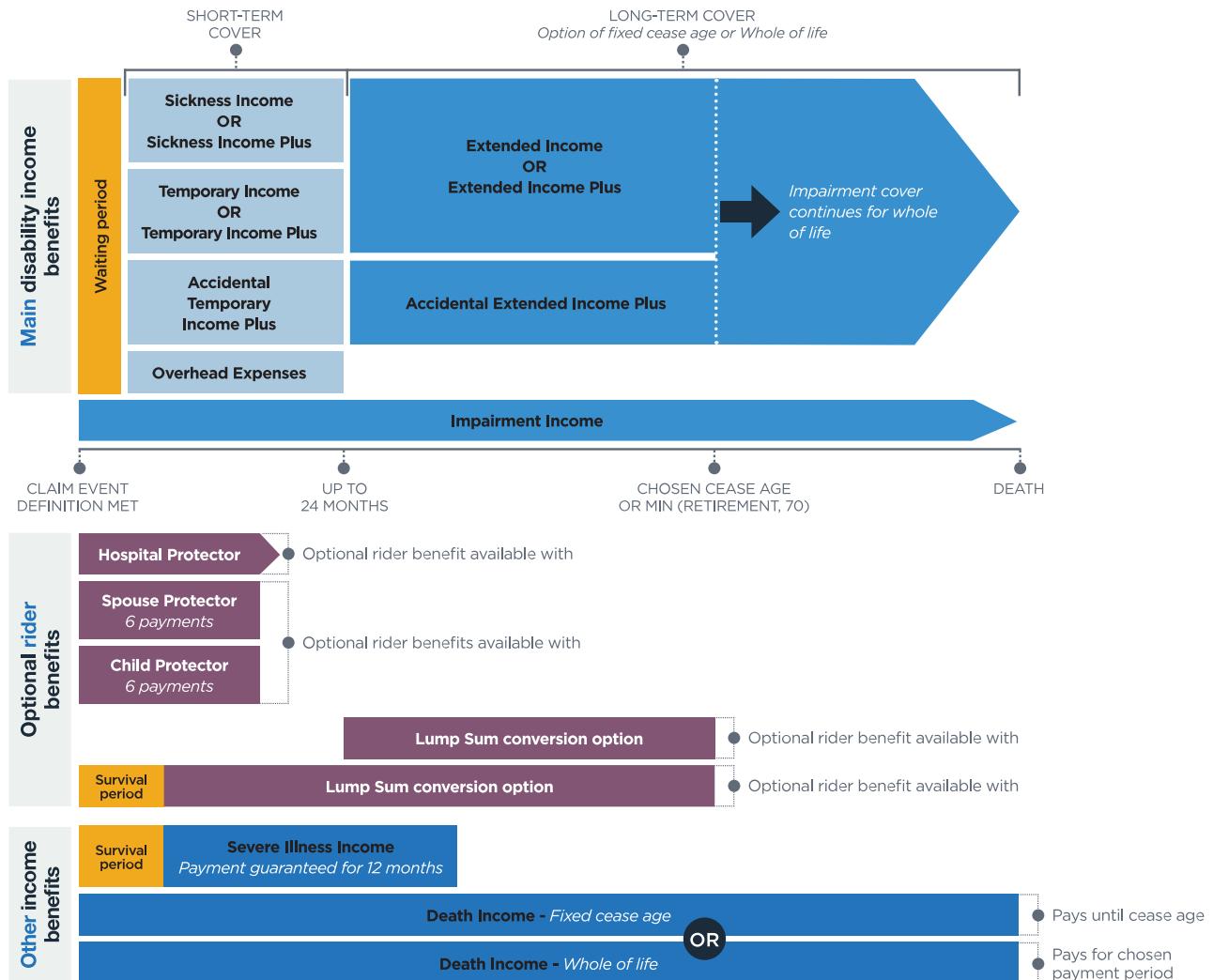
More than one instance of the same benefit, for example:

- More than one Sickness Income benefit. (However, Sickness Income and Sickness Income Plus can be taken together)
- Two Severe illness income benefits

A Sickness Income or Sickness Income Plus benefit together with a Temporary Income or Temporary Income Plus benefit.

The bigger picture

An illustration of our benefits according to the categories as discussed above:



Why income protection?

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

Your greatest asset is probably your ability to earn an income, which provides a certain lifestyle and the ability to take care of your dependants. That's why it's so important to protect your income against unforeseen events such as illness or injury, and to provide for your dependents after your death. For example, you may need a six-week recovery period after a serious operation, or have to stay at home for 3 months after breaking your leg in a motor vehicle accident and may not be able to earn an income. As a result, you may not be able to make your mortgage and credit card payments, or pay your clothing or furniture accounts. At times such as these, an income paid by income protection benefits will be vital.

The need to protect your income is better met with monthly income protection rather than lump sum benefits. However, a lump sum benefit has its place in financial planning, and sometimes a combination of income protection and lump sum benefits is required to meet your specific needs.

With our income protection benefits the following applies:

- There is no need for complex calculations about how much lump sum cover will be enough in order to provide an income for a required period, and the uncertainty surrounding fluctuating interest rates and changing markets is removed.
- You can decide upfront to what extent you want to cover your monthly income and for how long. Our income protection benefits are even suitable for very young clients who need long-term protection of their income.
- You can cover your ability to earn an income over the short or long term.
- You can select cover growth to offer protection against inflation.
- You can protect your income during times when the paid sick leave provided by your employer is not enough to recover fully and you need to take unpaid leave, or supplement the income paid by your group cover if your group cover is not sufficient. You need protection if you were to lose all your income, but also if you should lose a part of your income because you can only return to work for a few hours per day.
- If you are a business owner and unable to work for an extended period, it could result in a major loss of income. Income protection can make it possible to employ someone to run the business in your absence.
- You can also cover events that could negatively affect your income. Like taking time off work to care for a sick or injured child or paying for additional help, e.g. a nurse. Likewise, you might want to take time off work when your spouse suffers a severe illness, or after the unfortunate event of a spouse passing on. Or you may need additional income in the event that you need unexpected care after a period of hospitalisation. Our Spouse Protector, Child Protector and Hospital Protector rider benefits have been designed to financially assist in times such as these.
- You may want the option to convert your future income into a lump sum, in which case our Lump Sum Conversion Option rider benefit provides additional flexibility and enhanced value.
- With our Severe Illness Income benefit you can provide a temporary boost to your income during the emotional and stressful time following the diagnosis of a severe illness.
- With our Death Income benefit you can provide for your family in the event of your death and ensure that the money will last, without placing the extra burden on them to make difficult financial decisions while coping with their loss.

Main income benefits

Sickness Income and Sickness Income Plus

Sickness Income and Sickness Income Plus benefits provide short term cover for sick leave and for guaranteed permanent impairments.

They are only available for specific qualifying professional and graduated clients.

In the professional market segment, a Sickness Income or Sickness Income Plus benefit with a 7-day waiting period is considered to be more appropriate than traditional income protection with a short waiting period. Self-employed professionals or professionals in private practice may have no protection in the form of paid sick leave, and are therefore particularly vulnerable, especially those who "sell their time".

Why take the Sickness Income or the Sickness Income Plus benefit?

Simple claims process:

- You do not need to prove loss of income to claim a benefit.

Comprehensive cover:

- The Sickness Income benefit covers sick leave and severe impairment events. The Sickness Income Plus benefit will cover the same and includes less severe impairments as well.
- Under the sick leave cover, you will receive an income for every day that you are off sick from the end of the waiting period, including weekends and public holidays. However, if a 7day waiting period applies, you will receive a benefit for every day that you are off sick from the first day of your sick leave.
- If you return to work but are unable to fulfil your usual duties, you may receive a partial benefit payment to compensate for any loss of income.
- Under the impairment cover, you will receive a monthly payment until the end of the applicable maximum payment period.
- The benefit is available until age 60, 65 or 70 next birthday, and pays up to 3, 6, 12, 23 or 24 monthly income payments for related claims, depending on the benefit payment period and waiting period you selected.
- A Sickness Income or Sickness Income Plus benefit can be used in conjunction with an Extended Income or Extended Income Plus benefit, to provide continuous term or whole life cover from the end of the waiting period.
- You can add optional rider benefits, like the Hospital Protector, Spouse Protector and Child Protector.

Special Features:

- Free cover
- Automatic waiver of payment
- Extended sick leave cover
- Proof free additional cover for qualifying standard lives

Flexibility:

- You can be covered whether working in your own business or for a company.
- If you are a business owner, you have the option of covering key staff members in your business or practice.
- You can take the Sickness Income and Sickness Income Plus benefit together with our other income protection benefits (excluding the Temporary Income and Temporary Income Plus benefit), giving you a flexible solution.

Peace of mind:

- You can insure a certain percentage of your income. This means that you know exactly what you are covered for to ensure that you are able to enjoy a certain lifestyle.

Temporary Income and Temporary Income Plus

Temporary Income and Temporary Income Plus benefits provide short term cover for occupational disability resulting in the loss of all or some income, as well as for guaranteed permanent impairments. If a waiting period of 7 days, 14 days or 1 month has been chosen for this benefit, a benefit may also be claimed if you suffer certain guaranteed payment events, irrespective of whether you are disabled or not, and irrespective of whether you have a loss of income or not.

These benefits are available to self-employed as well as employed clients, with qualifying occupations.

Why take the Temporary Income or Temporary Income Plus benefit?

Simple claims process:

- You do not need to prove loss of income when you claim for a Guaranteed Payment Event or an impairment claim event.

Comprehensive cover:

- The Temporary Income benefit covers occupational disability, guaranteed payment events and severe impairments. The Temporary Income Plus benefit covers the same and includes less severe impairments as well.
- Under occupational disability cover, these benefits will pay if you become disabled to the extent that you are continuously unable to fulfil a substantial and material part of the duties of the regular occupation you practised for income immediately before the disability, resulting in a loss of some or all of such income.
- If you return to work but are unable to fulfil your usual duties, you may receive a partial benefit payment for the remainder of the payment period while you have a loss of income.
- The benefit provides cover for guaranteed payment, if the waiting period is 7 days, 14 days or one month. The guaranteed payment events include a catch-all sick leave event.
- The benefit also covers a comprehensive list of permanent impairment events.
- The benefit pays up to 21, 23 or 24 monthly income payments, depending on the waiting period you selected.
- Cover is available until age 60, 65 or 70 next birthday.

Special Features:

- Free cover
- Automatic waiver of payment
- Extended occupational disability cover
- Proof free additional cover for qualifying standard lives

Flexibility:

- You can be covered whether working in your own business or for a company.
- You can take the Temporary Income and Temporary Income Plus benefits together with our other income protection benefits (excluding the Sickness Income and Sickness Income Plus benefits), giving you a flexible solution.

Peace of mind:

- You can insure a certain percentage of your income. This means that you know exactly what you are covered for to ensure that you are able to enjoy a certain lifestyle.

Accidental Temporary Income Plus

The Accidental Temporary Income Plus benefit provides short term accidental cover for occupational disability resulting in the loss of all or some income, as well as for guaranteed permanent impairments. If a waiting period of 7 days, 14 days or 1 month has been chosen for this benefit, a benefit may also be claimed if you suffer certain guaranteed payment events from accidental causes, irrespective of whether you are disabled or not, and irrespective of whether you have a loss of income or not.

This benefit will cater for those who don't qualify for full cover due to their medical history, but is also available for lives who do qualify for full cover.

Why take the Accidental Temporary Income Plus benefit?

Simple application process:

- No medical underwriting applies.

Simple claims process:

- You do not need to prove loss of income when you claim for a Guaranteed Payment Event or an impairment claim event.

Comprehensive cover:

- The benefit covers occupational disability, guaranteed payment events, severe impairments and less severe impairments, if from accidental causes.
- Under occupational disability cover, it will pay if you become disabled to the extent you are continuously unable to fulfil a substantial and material part of the duties of the regular occupation you practised for income immediately before the disability, resulting in a loss of some or all of such income.

- If you return to work but are unable to fulfil your usual duties, you may receive a partial benefit payment for the remainder of the payment period while you have a loss of income.
- The benefit provides cover for guaranteed payment events if the waiting period is 7 days, 14 days or one month. The guaranteed payment events include a catch-all sick leave event.
- The benefit also covers a comprehensive list of permanent impairment events.
- The benefit pays up to 21, 23 or 24 monthly income payments, depending on the waiting period you selected.
- Cover is available until age 60, 65 or 70 next birthday.

Special Features

- Free cover
- Automatic waiver of payment
- Extended occupational disability cover

Flexibility:

- You are covered whether working in your own business or for a company.
- You can take the Accidental Temporary Income Plus benefit together with our other income protection benefits, giving you a flexible solution.

Peace of mind:

- You can insure a certain percentage of your income. This means that you know exactly what you are covered for to ensure that you are able to enjoy a certain lifestyle.

Overhead expenses

This benefit provides short term occupational disability cover for the business owner or a key person within a business that results in less income being generated in the affected business in order to pay for the overhead expenses. It also includes a list of guaranteed payment events.

Why take the Overhead expenses benefit?

- This benefit pays if you become disabled to the extent that you are continuously unable to fulfil a substantial and material part of the duties you normally and regularly fulfilled in the affected business immediately before becoming so disabled that less business income gets generated in the affected business to pay for the overhead expenses.
- This benefit includes a list of guaranteed payment events, including a catch-all sick leave event, which guarantees pay-out for a certain period of time without the need to prove loss of income.
- An Overhead expenses benefit can make it possible to employ someone to run the business in your absence.
- You can cover up to 100% of the overhead expenses of your business. This means that you know exactly what you are covered for to ensure that you are able to continue with the business in the case of your own or a key person's inability to work.
- We will waive the payments for your plan while we are paying a claim to ensure that all the benefits on your plan will continue uninterrupted.
- This benefit can be taken in conjunction with any of our other income protection benefits, to cover temporary or permanent inability to work.
- You can cover yourself or a key person in your business.
- Cover is available until age 60, 65 or 70 next birthday.

Extended Income and Extended Income Plus

These benefits provide long term cover for occupational disability resulting in a loss of some or all income, as well as for guaranteed permanent impairments, after a waiting period of 24 months. They can be taken in conjunction with the short term income benefits, to ensure that the client also has long term cover.

Why take the Extended Income or Extended Income Plus benefit?

Comprehensive cover:

- The Extended Income benefit covers occupational disability and severe impairment events. The Extended Income Plus benefit covers the same and includes less severe impairments as well.
- The occupational disability cover pays if you become disabled to the extent that you are continuously unable to fulfil a substantial and material part of the duties of the regular occupation you practised for income immediately before the disability, resulting in a loss of some or all of such income.
- The impairment cover will pay if you suffer one of the claim events covered under the impairment category. There is no need to prove loss of income and it will pay until the end of the benefit's selected cease age, or until death for whole life benefits.
- For the whole of life cease age option, the waiting period will be waived from age 70.

Special Features:

- Free cover
 - Automatic waiver of payment
 - Extended occupational disability cover
 - Proof free additional cover for qualifying standard lives
 - Built-in future cover for young lives

Flexibility:

- You can choose cover until age 60, 65 or 70 next birthday, or for whole of life.
- You can take the benefit on its own or with any of our other income protection benefits.

Peace of mind:

- You can insure a certain percentage of your income. This means that you know exactly what you are covered for to ensure that you are able to continue to enjoy a certain lifestyle.

Accidental Extended Income Plus

This benefit provides long term accidental cover for occupational disability resulting in a loss of some or all income, as well as for guaranteed permanent impairments, after a waiting period of 24 months. It can be taken in conjunction with the short term income benefits, to ensure that the client also has long term cover.

It caters for those who don't qualify for full cover due to their medical history, but is also available for lives who do qualify for full cover.

Why take the Accidental Extended Income Plus benefit?**Simple application process:**

- No medical underwriting applies.

Comprehensive cover:

- The Accidental Extended Income Plus benefit covers occupational disability, severe impairment events and less severe impairment events, due to accidental causes.
- The occupational disability cover pays if you become disabled to the extent that you are continuously unable to fulfil a substantial and material part of the duties of the regular occupation you practised for income immediately before the disability, resulting in a loss of some or all of such income.
- The impairment cover will pay if you suffer one of the claim events covered under the impairment category. There is no need to prove loss of income and it will pay until the end of the benefit's selected cease age, or until death for whole life benefits.
- For the whole of life cease age option, the waiting period will be waived from age 70.

Special Features:

- Free cover
- Automatic waiver of payment
- Extended occupational disability cover

Flexibility:

- You can choose cover until age 60, 65 or 70 next birthday, or for whole of life.
- You can take the benefit on its own or with any of our other income protection benefits.

Peace of mind:

- You can insure a certain percentage of your income. This means that you know exactly what you are covered for to ensure that you are able to continue to enjoy a certain lifestyle.

Impairment Income

The Impairment Income benefit pays a monthly income until the benefit's selected cease age or until death for whole life benefits.

This benefit is suitable for lives who do not qualify for the above income benefits but do qualify for impairment cover e.g. pilots, students, housewives and pensioners.

Why take the Impairment Income benefit?

Comprehensive cover

- The benefit covers severe and less severe impairment events.
- No waiting period applies – the benefit will pay once the contractual claim event definition has been met and the ten day survival period has expired. The survival period will only be applied to conditions where the prognosis of survival beyond ten days is not certain, based on the available medical evidence.
- Once a claim is admitted, the benefit will pay until the end of the benefit's selected cease age, or until death for whole life benefits.

Special Features:

- Free cover
- Automatic waiver of payment
- Proof free additional cover for qualifying standard lives

Flexibility:

- You can choose cover until age 60, 65 or 70 next birthday, or for whole of life.
- You can take the benefit on its own or with any of our other income protection benefits.

Peace of mind:

- You can insure a certain monthly income. This means that you know exactly what you are covered for to ensure that you are able to continue to enjoy a certain lifestyle.

Optional rider benefits

Hospital Protector

A benefit may be claimed if the life insured is admitted to hospital for at least 4 consecutive days.

The rider benefit can be taken with the Sickness Income and Sickness Income Plus main benefits if a 7 or 14 day waiting period has been selected for these main benefits.

The cover it provides is not the same as that of a medical scheme or gap cover product. It is therefore not a substitute for medical scheme membership or gap cover benefits.

Why take the Hospital Protector rider benefit?

- The benefit will be valuable to help pay for unexpected out of pocket expenses incurred after a hospital visit
- The benefit pay-out will be for every consecutive day in hospital from the first day of admission.
- The benefit will pay for up to 183 days in hospital, in a 365 day cycle.
- No waiting periods or blanket pre-existing exclusion clauses will apply. Any exclusion clauses that apply to the main benefit will rather also be applied to the rider benefit, to ensure transparency and peace of mind.

Spouse Protector

A benefit may be claimed if the life insured's spouse is diagnosed with a defined severe illness or dies. If we admit a claim, we will make 6 monthly income payments.

The rider benefit can be taken with the Sickness Income, Sickness Income Plus, Temporary Income ,Temporary Inocme Plus, Accidental Temporary Income Plus and Impairment Income benefits.

(It can also be added as a rider to an existing Sickness (IS3) and/or Temporary Disability Income (OIT3) benefit.)

Why take the Spouse Protector rider benefit?

- It can assist the life insured financially when he or she has to take time off work to care for a spouse suffering from a severe illness, or to take time off following his or her death.
- It can supplement the life insured's income to pay for additional expenses if their spouse becomes ill or dies.
- Automatic Waiver of Payment while a claim is in payment.

Child Protector

A benefit may be claimed if the life insured's child suffers a defined severe illness or injury. If we admit a claim, we will make 6 monthly income payments.

The rider benefit can be taken with the Sickness Income, Sickness Income Plus, Temporary Income, Temporary Income Plus, Accidental Temporary Income Plus and Impairment Income benefits.

(It can also be added as a rider to an existing Sickness (IS3) and/or Temporary Disability Income (OIT3) benefit.)

Why take the Child Protector rider benefit?

- It can assist the life insured financially when he or she has to take time off work to care for a sick child or have to pay for additional help.
- We cover biological, legally adopted and step children.
- Any new children will automatically be covered from their first birthday, subject to certain waiting periods and pre-existing clauses.
- Adult children can also be covered.
- Automatic Waiver of Payment while claim is in payment.

Lump Sum Conversion Option

This rider benefit provides you with the option to convert your future income payments on the main benefit to a lump sum amount should you become totally and permanently occupationally disabled or 100% impaired.

The rider benefit can be taken with the Extended Income, Extended Income Plus, Accidental Extended Income Plus and Impairment Income benefits.

Why take the Lump Sum Conversion Option rider benefit?

- It provides the flexibility to choose a lump sum rather than an income, if you have lump sum needs at time of claim.
- If the option is exercised, future income payments will be converted to a lump sum using market related rates at the time, to ensure a fair conversion.
- It guarantees the period for which the income will be paid if you qualify for the option but decide to not exercise it, and die within this period.

Other income protection benefits

Severe Illness Income

The Severe Illness Income benefit pays a monthly income in the event of you suffering a defined severe illness.

Why take the Severe Illness Income benefit?

- The Severe Illness Income benefit provides a monthly payment for a guaranteed period of 12 months, which can help you meet additional monthly costs following the diagnosis of a severe illness.
- If you do not recover and the additional expenses continue over the long term, the one-year payment period enables you to take stock and reprioritise your expenses and replan your budget so that these will be sustainable in the long run.
- The benefit pays either 50% or 100% of the monthly cover amount, depending on the seriousness of the illness.
- You can choose cover until age 65 or for whole of life.
- You do not need to prove loss of income to claim a benefit.
- You can take the benefit on its own or with any of our other income protection benefits.

Death income

The Death income benefit pays a monthly income to your dependents in the event of your death.

Why take the Death income benefit?

- A monthly payment rather than a lump sum benefit will give you the peace of mind that the provision for your dependents is enough and will not run out.
- You can remove the burden for your dependents to have the financial responsibility of investing and managing a lump sum while coping with your death.
- The income payments are payable until you would have turned a certain age, which is selected upfront, or if you have selected a benefit with whole life cover, until the end of the selected income payment period .
- The age until when income payments must be made can be selected as 65 or 90 next birthday. In this case a minimum income payment period of 5 years applies. This means that we will pay for at least 5 years, even if you die shortly before the benefit cease age.

- The Death income benefit is also available with whole life cover and an income payment period from as short as 1 year to as long as 25 years. In this case the income payments will be made for the selected income payment period only.
- The benefit pays out tax-free, even though it may be payable over the long term.

Availability of benefits

The benefits in this chapter are available under our Income protector product, which is available on our Premier product option.

Individual insurance

The Overhead expenses benefit is not available for individual insurance. All the other benefits in this chapter are available.

Business insurance

Refer to the *Business insurance* chapter for information about availability of benefits.

Sickness Income (IS4) and Sickness Income Plus (IS5)

These benefits are available under our Income Protector product which is available under our Premier product option.

Benefit description	<p>These benefits provide short term cover for sick leave and for permanent impairments. Both types of cover are provided regardless of whether income is still earned over that period or not. The benefits are only available to certain qualifying professional and graduated clients.</p> <ul style="list-style-type: none"> • The Sickness Income benefit provides cover for sick leave and severe impairment events. • The Sickness Income Plus benefit provides cover for sick leave, severe impairment events and less severe impairment events.
Optional rider benefits	<p>Available rider benefits:</p> <ul style="list-style-type: none"> • Spouse protector • Child protector • Hospital protector * <p>An additional payment will be charged for a rider benefit.</p> <p>* only available if the waiting period on the main benefit is 7 or 14 days</p>
Special features	<p>Special features are features that are automatically included for a benefit. The following special features apply:</p> <ul style="list-style-type: none"> • Free cover • Automatic waiver of payment • Extended sick leave cover • Proof free additional cover for qualifying standard lives <p>Refer to the chapter <i>Payments, payment patterns, guarantees and cover</i> for more information about Free cover.</p> <p>More information on automatic waiver of payment, extended sick leave cover and proof free additional cover is provided further in this section.</p>
Type of benefit	Standalone
When will cover for this benefit end?	<p>Cover will end:</p> <ul style="list-style-type: none"> • at midnight before the cover end date set out in the plan overview, or • if this benefit or the plan ends for any reason before the cover end date, or • if the life insured dies.
Cover limits per life insured	<p>Minimum: R3 000 per month</p> <p>Maximum: R250 000 per month*, limited to the sliding scale percentage of the life insured's monthly gross professional income (GPI)**.</p>
<p>*Subject to financial underwriting</p> <p>**Refer to the underwriting chapters for the sliding scales and the definitions of gross professional income.</p>	
Benefit payment period	<p>Choice between the following, where any combination of benefit payment period and waiting period is allowed, subject to underwriting:</p> <ul style="list-style-type: none"> • 24 months (available if a 7 or 14 day waiting period is chosen)

-
- 23 months (available if a 1 month waiting period is chosen)
 - 12 months
 - 6 months
 - 3 months
-

Age limits	Benefit start age Minimum: • 18 next birthday for payment patterns other than fixed compulsory growth • Fixed compulsory growth: 30 next birthday Maximum: • 5 years before the benefit cease age
	Benefit cease age Choice between: • 60 next birthday • 65 next birthday • 70 next birthday
Qualifying lives	The benefits are only available to certain qualifying professionals and graduated clients. Lives who comply with the following may qualify subject to age limits and underwriting: <ul style="list-style-type: none"> • must be employed, either self-employed or by an employer, and • must practise a qualifying occupation, as determined by us, and • must have a 3 year degree, or an equivalent or higher qualification, and • must qualify for disability classes A, B or C.
Guarantee period	The initial guarantee period is 5 years.
Waiting period options	Choice between the following, subject to underwriting: <ul style="list-style-type: none"> • 7 days (disability class A) • 14 days (disability class A and or B) • 1 month (disability class A, B or C)

What this benefit provides

This benefit provides cover for:

- sick leave, up to retirement or the cover end date of the benefit, whichever is earlier, and
- permanent impairment claim events.

Claim event for sick leave

A benefit may be claimed if the life insured is on sick leave.

Sick leave is a medically recommended period of time during which the life insured, as a result of a bodily injury, illness or other cause or condition necessitating medical or dental treatment, is totally and continuously unable to practise his or her occupation, including during any period of normal leave.

If the life insured is a qualifying student, sick leave is a medically recommended period of time during which the life insured, as a result of a bodily injury, illness or other cause or condition necessitating medical or dental treatment, is totally and continuously unable to engage in his or her studies, including during a holiday period while still enrolled in his or her studies.

The above is the contractual definition for sick leave.

What is a qualifying student?

A qualifying student is a full-time student in at least their 4th academic year studying toward an NQF-level 8 or higher qualification.

A student progresses to the next academic year when they successfully pass a tertiary study year.

Extended sick leave cover

If the life insured stops working for any reason other than retiring or becoming a qualifying student, for example, taking a sabbatical, becoming a housewife or being retrenched, we will continue to cover the life insured for sick leave for up to 12 months from the date he or she stopped working.

During this 12-month period, sick leave will be regarded as a medically recommended period of time during which the life insured, as a result of a bodily injury, illness or other cause or condition necessitating medical or dental treatment, is totally and continuously unable to practise the occupation the life insured practised immediately before he or she stopped working.

Extended sick leave cover will only apply if the sick leave is not as a result of any of the following conditions:

- depression or dysthymia, whether as an episode or disorder, or as part of the symptom complex of another psychiatric diagnosis;
- post-traumatic stress disorder;
- fibromyalgia;
- chronic fatigue syndrome and its synonyms;
- a neck or back condition, unless it is one of the following: paraplegia; quadriplegia; malignant tumours of the spinal cord and vertebral column; or failed back syndrome after multiple spinal surgery, provided the extent of the functional impairment arising from the failed back syndrome is verified by a specialist that we will nominate;
- any orthopaedic condition based mainly on pain, discomfort, loss of sensation, loss of range of motion, or any combination thereof;
- any decline in cognitive functioning that is not supported by objective evidence of organic pathology;
- an injury or illness that directly or indirectly resulted from, or is traceable to, any of the above causes;
- a complication that directly or indirectly is attributable to any of the above causes, or to such an injury or illness;
- a side-effect of treatment for any of the above causes, or for such an injury or illness, or for such a complication.

Qualifying students

If the life insured is a qualifying student and successfully completes his or her studies, but does not yet start working, we will continue to cover him or her for sick leave as if he or she is still a qualifying student, for up to 12 months from the date he or she stopped studying. This extended sick leave cover will only apply if the sick leave is not as a result of any of the above listed conditions.

What benefit will be provided for sick leave?

If we admit a claim, we will make an income payment of up to 100% of the cover amount set out in the plan overview.

If benefit growth is applicable to the plan, the cover amount and the payment for the benefit will continue to be increased each year as set out in the plan overview under "Benefit and payment growth". We will continue making monthly benefit payments for as long as the planholder has the right to claim payment.

Claim event for impairment

A benefit may be claimed if the life insured meets the contractual definition of any of the impairment claim events indicated in the impairment claim event table.

These impairment claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated at the end of the Income Protection benefits chapter in the section "Impairment Claim Events for Short Term Benefits". [ImpairmentClaimEventsShortTermBenefits](#)

What benefit will be provided for impairment?

If we admit a claim, we will make a monthly income payment equal to the percentage of the cover amount linked to the particular claim event as set out in the impairment claim event table. The current cover amount is set out in the plan overview. For multiple claims, we may pay a lower percentage than indicated in the table.

If benefit growth is applicable to the plan, the cover amount and the payment for the benefit will continue to be increased each year as set out in the plan overview under "Benefit and payment growth". We will continue making income payments for as long as you have the right to claim payment.

Admittance of a claim

The general conditions for admittance of a claim are set out in the *General Information* chapter.

The planholder will be responsible for the cost of any medical proof we might require when a claim is submitted.

If the life insured travels or lives outside South Africa when the claim event occurs, we will require the medical proof issued in a foreign country to be in English to consider a claim.

Admittance of a claim for sick leave

We will admit a claim only if:

- the life insured practises his or her occupation or is on normal leave at the time that the claim event occurs, or for a qualifying student, if the life insured is enrolled in his or her studies at the time that the claim event occurs. An exception to this is if the requirements for extended sick leave cover are met, and
- the sick leave has lasted continuously for the entire waiting period. However, if the period between consecutive periods of sick leave resulting from the same cause is shorter than the waiting period, we will consider a claim once the consecutive periods of sick leave add up to the waiting period, and
- the claim event occurs before the earlier of retirement and the cover end date of the benefit.

Admittance of a claim for impairment

We will admit a claim only if:

- the impairment is caused directly and solely by a bodily injury or by an illness, and
- the impairment is permanent, after the life insured has undergone optimal, reasonable treatment, and
- the waiting period has expired, and
- we have not previously admitted a claim for the same claim event, except if the claim event is listed under "Musculoskeletal system" in the impairment claim event table, and the claim is for a different limb, and
- the claim event occurred before the cover end date of the benefit.

The impairment must be permanent, and evaluated according to the principles and ratings of the latest edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. The impairment, and permanence thereof, will be evaluated only 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.

Waiting period for sick leave

The waiting period starts on the date the sick leave starts.

We will not make any income payments during the waiting period, except if the waiting period is 7 days. This means that if we admit a claim, we will only pay for sick leave from the end of the waiting period, except if the waiting period is 7 days, in which case we will pay from the date on which the sick leave starts.

Could the waiting period sometimes be waived?

If we stop making income payments for a sick leave claim and we admit another claim for sick leave, we will waive the waiting period for the new claim if:

- the new claim is related to the previous claim, and
- the life insured meets the contractual definition for sick leave within three months after we have made the last income payment for the previous claim, and
- we have not yet made income payments for the maximum payment period.

We will then continue with the income payments for as long as the planholder has the right to claim payment, but only until we have made income payments for the maximum payment period.

Waiting period for Impairment

The waiting period starts on the date the life insured meets the contractual definition for the impairment claim event. We will not make any income payments for impairment during the waiting period.

When will the income payments start?

We will make the first income payment at the end of the plan month in which we admit the claim. This first income payment will be for the number of days that you have the right to claim payment in that plan month. Thereafter, we will make an income payment at the end of each subsequent plan month, for as long as you have the right to claim payment.

How long will the income payments continue?

The chosen payment period for this benefit is set out in the plan overview. This is the maximum period for which we will make income payments for related claims. This maximum payment period applies for each type of cover provided by this benefit and across all types of cover provided by this benefit. This means that the periods for

which we pay related claims within and across all types of cover will contribute toward the maximum payment period.

We will make the income payments for as long as the planholder has the right to claim payment, but only until the maximum payment period for related claims has been reached, the cover for this benefit ends or the life insured dies, whichever is earliest.

If the planholder no longer has the right to claim payment, we will make the last income payment at the end of the plan month in which the planholders right to claim payment stops. If we have waived the payments for the plan while the planholder has received income payments, the planholder will have to resume the payments for the plan once the income payments stop.

How long will the income payments continue for sick leave?

We will make the income payments for as long as the life insured's sick leave continues, but only until the maximum payment period for related claims has been reached, the cover for this benefit ends or the life insured dies, whichever is earliest.

The last payment will only be for the number of days in the plan month that the planholder has the right to claim payment.

After we have started making the income payments, we may from time to time ask for proof that the life insured's sick leave is still warranted. We may require the life insured to be medically examined for this purpose. We will cover the cost of such a medical reassessment.

If the life insured travels or lives outside South Africa while a claim is in payment, and we require proof that the life insured's sick leave is still warranted, we will require the medical proof issued in a foreign country to be in English. The planholder will be primarily responsible for the cost of medical proof. We will refund the planholder in South African currency for an amount equal to what we usually pay for such medical proof in South Africa.

We will make income payments for sick leave in a foreign country for a maximum period of 12 months. Thereafter, we will consider the continuation of income payments only after the life insured has been medically assessed by a doctor nominated by us, which may require the life insured to travel to South Africa for such an assessment. We will cover the cost of the assessment, but not the travel, accommodation and related costs involved.

If the life insured's sick leave is no longer warranted, we will stop making the income payments. However, if the life insured returns to work after his or her sick leave, but is unable to practise his or her occupation, we may at our discretion make partial income payments for as long as you have the right to claim payment, but only until the maximum payment period for related claims has been reached.

We will also stop making the income payments if:

- we do not receive the required proof of the life insured's sick leave, or
- the life insured
 - refuses to be examined, or
 - refuses to undergo reasonable treatment on a regular basis, at his or her cost, by a medical doctor, other than the life insured if he or she is a medical doctor.

The period of sick leave may not exceed, unless we agree otherwise in writing, the midrange data in the latest edition of the Official Disability Guidelines of the Work Loss Data Institute, or its scientific equivalent. We will use these guidelines as a reference to determine the average period of sick leave for the claim event in question.

If we limit the income payments based on these guidelines, the planholder will have to provide medical proof of the life insured's continued need for sick leave. The planholder will be responsible for the cost of such medical proof.

How long will the income payments continue for impairment cover?

We will make the income payments until the maximum payment period for related claims has been reached, the cover for this benefit ends or the life insured dies, whichever is earliest. For the amputation of finger claim events where a maximum payment period is indicated in the impairment claim event table, we will only pay up to the indicated period.

The last payment will only be for the number of days in the plan month that the planholder has the right to claim payment.

Automatic waiver of payments

We will waive the payments for the plan for as long as we make income payments for sick leave or for 100% of the cover amount. While we waive the payments, no alteration to any of the benefits on the plan is allowed.

Proof-free additional cover

If the plan has cover growth and the plan has been accepted with standard terms (i.e. without loadings or specific exclusions for a life insured), the plan holder has the option each year to request in writing that we increase the

cover amount of this benefit by more than the current cover growth rate, without additional underwriting for the life insured. Any additional cover increases will take place on the plan anniversaries, together with the contractual cover increases.

The following additional requirements must be met before we will grant an additional cover increase as described above:

- The life insured must not be disabled or impaired on the date of the cover increase.
- A claim must not have been admitted, or already submitted, during the 12 months preceding the date of the cover increase.
- The life insured must be younger than 50 years on the date of the cover increase.
- We must receive the plan holder's written request to exercise the option at our head office at least 14 working days before the plan anniversary of the particular year.

The total increase in the cover amount of a benefit for a particular year (the annual cover growth increase plus the proof free increase) will be restricted to the lower of:

- the actual increase in the life insured's income over that year,
- twice the rate that we will use for increases according to the inflation rate that year, and
- 20%.

Multiple claims

This applies if the life insured meets the contractual definition of more than one claim event over the duration of the benefit.

If a life insured meets the contractual definition of sick leave and an impairment claim event at the same time, and the claims are related, we will only pay for the type of cover that will result in the highest payout.

If a life insured meets the contractual definition of sick leave and an impairment claim event at the same time, and the claims are unrelated, we will pay for both types of cover. We will however not pay more than 100% of the cover amount in any month.

We will never pay more than 100% of the cover amount in any month or more than once for the same calendar date.

Multiple claims for impairment cover

This applies if a life insured meets the contractual definition of more than one impairment claim event at the same time. The percentage of the cover amount that we pay for the claim may then be lower than indicated in the impairment claim event table.

We will only admit an impairment claim that is related to previously admitted impairment claims if the new claim event has a higher percentage of the cover amount indicated in the impairment claim event table and the maximum payment period for related claims has not yet been reached. The income payment that we are already making will then be increased to be in line with the higher percentage.

If we admit an impairment claim that is unrelated to previously admitted impairment claims, we may need to reduce the percentage of the cover amount indicated in the impairment claim event table to ensure that we do not pay more than 100% of the cover amount in any month.

Exclusions

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

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

Exclusions for sick leave

If the life insured at any time practises sport as an occupation, or works as a pilot, and is put on sick leave as a result of being unable to perform that occupation, we will not admit a claim.

- We will also not admit a claim if it directly or indirectly resulted from:
- normal pregnancy, or
- normal childbirth, or
- cosmetic surgery, except if it is medically necessary after an accident or bodily injury that occurred while cover for this benefit was in force, or
- a rehabilitation or detoxification program to treat alcohol or drug dependency or abuse, or any medical condition related to such dependency or abuse.

Cover during maternity leave

Maternity leave itself is not a claim event. This benefit does, however, provide cover for sick leave during periods of paid maternity leave. During unpaid maternity leave, cover is provided as described under "Extended sick leave cover".

Cover for caesarean sections

For the purpose of this benefit, we do not consider caesarean sections to be normal childbirth, whether or not the procedure was elective. This benefit therefore provides cover for sick leave as a result of a caesarean section, if all the other requirements for a claim are met, unless the procedure is specifically excluded for the life insured.

Exclusions for impairment

We will not admit a claim if the impairment of the life insured can be substantially removed or improved by surgery or other medical treatment, which we can reasonably expect him or her to undergo, considering the risks involved and the chances of success of such surgery or treatment.

Explanations

Plan month

The first plan month starts on the day when the plan begins. Each following plan month will start on the same day as the first one. A plan month ends at midnight on the day before the next plan month starts.

Normal leave

Normal leave refers to periods of paid leave, like paid annual leave or paid maternity leave.

When is a person retired?

We regard the life insured as retired if he or she is 55 years or older, and does not earn an income over and above a passive income. Passive income refers to income that can continue without the life insured's intervention, for example pension or rental income.

Medically necessary cosmetic surgery

Any surgical intervention that meets all of the following requirements:

- It is needed to restore the normal function of an affected limb, organ or system;
- There is no alternative with equal or better outcomes;
- It is accepted as the best medical practice at the time;
- It is not done for the sake of convenience for either the life insured or relevant medical practitioner;
- It has available outcome studies which are acceptable to us;
- It is not done for any psychiatric, psychological or mental reasons.

What is a related claim?

A claim is related to another claim if there is enough published evidence to show that:

- the medical condition or bodily injury:
 - is the result of the same medical condition or bodily injury that led to the other claim; or
 - has been caused by the same disease process or bodily injury that led to the other claim; and
- it is unlikely that the medical condition or injury would have occurred if it was not for the medical condition or injury that led to the other claim.

Explanations for Sick leave

Neck or back condition

A disease, disorder, or dysfunction of the vertebrae, spinal cord, intervertebral discs, nerve roots and supporting muscles or ligaments, as well as the direct or indirect consequences of, or the side-effects of any treatment applied for, such disease, disorder, or dysfunction.

Paraplegia

Total and permanent loss of function of both lower extremities.

Quadriplegia

Total and permanent loss of function of all four limbs.

Malignant tumours of the spinal cord and vertebral column

The incontrovertible presence of uncontrolled growth and spread of malignant cells, the invasion of normal tissue, and the definite histological evidence of a malignant growth in the spinal cord and vertebral column.

Failed back syndrome after multiple spinal surgery

When the life insured, after the cover for the benefit has begun, must undergo more than one spinal operation on two or more intervertebral disc spaces in the lumbar or cervical area, and despite those operations, still suffers severe back pain as verified by a multidisciplinary pain clinic. Such operations may include discectomy, vertebral fusion and internal fixation.

Impairment claim events table

These impairment claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated at the end of the Income Protection benefits chapter in the section "Impairment Claim Events for Short Term Benefits". [ImpairmentClaimEventsShortTermBenefits](#)

Temporary Income (OIT4) and Temporary Income Plus (OIT5)

These benefits are available under our Income Protector product which is available under our Premier product option.

Benefit description	<p>These benefits provide short term cover for occupational disability resulting in a loss of income and for permanent impairments. Both benefits also include a list of Guaranteed Payment Events, including a catch-all sick leave event, which guarantee payout for a certain period of time without the need to prove loss of income. The benefits are available to employed clients with qualifying occupations.</p> <ul style="list-style-type: none"> • The Temporary Income benefit provides cover for occupational disability, guaranteed payment events and severe impairment events. • The Temporary Income Plus benefit provides cover for occupational disability, guaranteed payment events, severe impairment events and less severe impairment events.
Optional rider benefits	<p>Available rider benefits:</p> <ul style="list-style-type: none"> • Spouse protector • Child protector <p>An additional payment will be charged for a rider benefit.</p>
Special features	<p>Special features are features that are automatically included for a benefit. The following special features apply:</p> <ul style="list-style-type: none"> • Free cover • Automatic waiver of payment • Extended occupational disability cover • Proof free additional cover for qualifying standard lives <p>Refer to the chapter <i>Payments, payment patterns, guarantees and cover</i> for more information about Free cover.</p> <p>More information on automatic waiver of payment, extended occupational disability cover and proof free additional cover is provided further in this section.</p>
Type of benefit	Standalone
When will cover for this benefit end?	<p>It will end</p> <ul style="list-style-type: none"> • at midnight before the cover end date set out in the plan overview, or • if this benefit or the plan ends for any reason before the cover end date, or • if the life insured dies.
Cover limits per life insured	<p>Minimum: R3 000 per month</p> <p>Maximum: R200 000 per month*, limited to the sliding scale percentage of the life insured's gross monthly income**.</p>
<small>*Subject to financial underwriting</small>	

**Refer to the underwriting chapters for the sliding scales and the definitions of gross income.

Benefit payment period	The waiting period determines the maximum payment period for which we will make income payments for related claims:
	<ul style="list-style-type: none"> • 24 months (if a 7 or 14 day waiting period applies) • 23 months (if a 1 month waiting period applies) • 21 months (if a 3 month waiting period applies)
Age limits	Benefit start age Minimum: • 18 next birthday for payment patterns other than fixed compulsory growth • Fixed compulsory growth: 30 next birthday Maximum: • 5 years before the benefit cease age
	Benefit cease age Choice between: <ul style="list-style-type: none"> • 60 next birthday • 65 next birthday • 70 next birthday
Qualifying lives	Lives who comply with the following may qualify, subject to age limits and underwriting: <ul style="list-style-type: none"> • must be employed, either self-employed or by an employer, and • must practise a qualifying occupation, as determined by us
Guarantee period	The initial guarantee period is 5 years.
Waiting period options	Choice between the following, subject to underwriting: <ul style="list-style-type: none"> • 7 days (only available to self-employed lives who qualify for disability classes A, B or C) • 14 days (only available to lives who qualify for disability classes A, B or C) • 1 month* • 3 months* <small>*Available to all disability classes.</small>

What this benefit provides

This benefit provides cover for:

- temporary or permanent occupational disability, up to retirement or the cover end date of the benefit, whichever is earlier, and
- guaranteed payment events, up to retirement or the cover end date of the benefit, whichever is earlier. This cover is provided only if the waiting period is 7 days, 14 days or 1 month, and
- permanent impairment claim events.

Claim event for occupational disability

A benefit may be claimed if the life insured becomes disabled to the extent that he or she is continuously unable to fulfil a substantial and material part of the duties of the regular occupation he or she practised for income immediately before the disability, resulting in a loss of some or all of such income.

If the life insured is a qualifying student when he or she becomes disabled, a benefit may be claimed if the life insured becomes disabled to the extent that he or she will be totally and permanently unable to fulfil the occupational demands of

an occupation we may reasonably expect him or her to have practised, had they not become disabled and had they completed their studies.

The above is the contractual definition for occupational disability.

What is a qualifying student?

A qualifying student is a full-time student in at least their 4th academic year studying toward an NQF-level 8 or higher qualification.

A student progresses to the next academic year when they successfully pass a tertiary study year.

Extended occupational disability cover

If the life insured stops working for any reason other than retiring or becoming a qualifying student, for example, taking a sabbatical, becoming a housewife or being retrenched, we will provide extended occupational disability cover for total and permanent disability for up to 12 months from the date he or she stopped working.

For this cover, total and permanent disability refers to the life insured being totally and permanently unable to fulfil the occupational duties of the regular occupation he or she practised for income immediately before he or she stopped working.

Extended occupational disability cover will only apply if the occupational disability is total and permanent and not as a result of any of the following conditions:

- depression or dysthymia, whether as an episode or disorder, or as part of the symptom complex of another psychiatric diagnosis;
- post-traumatic stress disorder;
- fibromyalgia;
- chronic fatigue syndrome and its synonyms;
- a neck or back condition, unless it is one of the following: paraplegia; quadriplegia; malignant tumours of the spinal cord and vertebral column; or failed back syndrome after multiple spinal surgery, provided the extent of the functional impairment arising from the failed back syndrome is verified by a specialist that we will nominate;
- any orthopaedic condition based mainly on pain, discomfort, loss of sensation, loss of range of motion, or any combination thereof;
- any decline in cognitive functioning that is not supported by objective evidence of organic pathology;
- an injury or illness that directly or indirectly resulted from, or is traceable to, any of the above causes;
- a complication that directly or indirectly is attributable to any of the above causes, or to such an injury or illness;
- a side-effect of treatment for any of the above causes, or for such an injury or illness, or for such a complication.

Qualifying students

If the life insured is a qualifying student and successfully completes his or her studies, but does not yet start working, we will continue to cover him or her for occupational disability as if he or she is still a qualifying student, for up to 12 months from the date he or she stopped studying. This extended occupational disability cover will only apply if the occupational disability is not as a result of any of the above listed conditions.

What benefit will be provided for occupational disability?

If we admit a claim, we will make an income payment of up to 100% of the cover amount. The current cover amount is set out in the plan overview.

If benefit growth is applicable to the plan, the cover amount of and the payment for the benefit will continue to be increased each year as set out in the plan overview under "Benefit and payment growth". We will continue making income payments for as long as you have the right to claim payment.

When we admit a claim, we will limit the amount of the income payment to the cover amount as at the date we admit the claim.

If the life insured's disability results in a loss of only some of the income from his or her regular occupation, we will further limit the amount of the income payment in proportion to the loss of income.

If the disability directly or indirectly results from any of the conditions listed below, we will further limit the amount of the income payment to ensure that this amount, plus any occupational disability income that the life insured might receive from this plan or other individual or group disability income type plans, does not exceed 100% of the life insured's average monthly income after tax. If benefit growth is applicable to the plan, this limited income payment will be increased each year by the benefit growth rate as set out in the plan overview under "Benefit and payment growth".

- depression or dysthymia, whether as an episode or disorder, or as part of the symptom complex of another psychiatric diagnosis;
- post-traumatic stress disorder;
- fibromyalgia;

- chronic fatigue syndrome and its synonyms;
- a neck or back condition, unless it is one of the following: paraplegia; quadriplegia; malignant tumours of the spinal cord and vertebral column; or failed back syndrome after multiple spinal surgery, provided the extent of the functional impairment arising from the failed back syndrome is verified by a specialist that we will nominate;
- any orthopaedic condition based mainly on pain, discomfort, loss of sensation, loss of range of motion, or any combination thereof;
- any decline in cognitive functioning that is not supported by objective evidence of organic pathology;
- an injury or illness that directly or indirectly resulted from, or is traceable to, any of the above causes;
- a complication that directly or indirectly is attributable to any of the above causes, or to such an injury or illness;
- a side-effect of treatment for any of the above causes, or for such an injury or illness, or for such a complication.

We will make an income payment only if the amount we have to pay is at least equal to the smaller of the following, both determined as at the time we consider a claim:

- 10% of the cover amount, and
- the minimum cover amount allowed for new business.

Once we have admitted a claim, and started making income payments, we will not apply this rule even if we reduce the amount of the income payment to less than the above limit.

Claim event for guaranteed payment events

This cover only applies if a waiting period of 7 days, 14 days or 1 month has been chosen for this benefit.

A benefit may be claimed if the life insured meets the contractual definition of any of the guaranteed payment events indicated in the guaranteed payment event table. These events include a catch-all sick leave event.

The guaranteed payment event table can be found at the end of this section.

What benefit will be provided for guaranteed payment events?

If we admit a claim, we will make income payments as if the life insured has met the contractual definition for occupationally disability, for the indicated number of weeks in the guaranteed payment event table. We will assume that the disability starts on the date that the guaranteed payment event occurred and that the life insured has a total loss of income from his or her occupation during this period. We will make the income payments whether or not the life insured is actually disabled and actually has a total loss of income.

Claim event for impairment

A benefit may be claimed if the life insured meets the contractual definition of any of the impairment claim events indicated in the impairment claim event table, whether or not the life insured is unable to do his or her occupation or has a loss of income.

What benefit will be provided for impairment?

If we admit a claim, we will make a monthly income payment equal to the percentage of the cover amount linked to the particular claim event as set out in the impairment claim event table. The current cover amount is set out in the plan overview. For multiple claims, we may pay a lower percentage than indicated in the table.

These impairment claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated at the end of the Income Protection benefits chapter in the section "Impairment Claim Events for Short Term". [ImpairmentClaimEventsShortTermBenefits](#)

If benefit growth is applicable to the plan, the cover amount of and the payment for the benefit will continue to be increased each year as set out in the plan overview under "Benefit and payment growth". We will continue making income payments for as long as you have the right to claim payment.

Admittance of a claim

Besides the conditions for admittance of a claim set out in the general plan provisions, we will admit a claim only if the claim event is caused directly and solely by a bodily injury or by an illness.

The planholder will be responsible for the cost of medical proof and the cost of financial proof of loss of income, if applicable, when a claim is submitted.

If the life insured travels or lives outside South Africa when the claim event occurs, we will require the medical and financial proof issued in a foreign country to be in English to consider a claim.

Admittance of a claim for occupational disability

We will admit a claim only if:

- the life insured practises his or her occupation or is on normal leave at the time that the claim event occurs, or for a qualifying student, if the life insured is enrolled in his or her studies at the time that the claim event occurs. An exception to this is if the requirements for extended occupational disability cover are met, and
- the occupational disability has lasted continuously for the entire waiting period. However, if the period between consecutive periods of disability resulting from the same cause is shorter than the waiting period, we will consider a claim once the consecutive periods of disability add up to the waiting period, and
- the claim event occurs before the earlier of retirement and the cover end date of the benefit.

Admittance of a claim for guaranteed payment events

We will admit a claim for a guaranteed payment event only if:

- the life insured practises his or her occupation or is on normal leave at the time that the claim event occurs, and
- the claim event occurs before the earlier of retirement and the cover end date of the benefit.

For the catch-all sick leave guaranteed payment event, we will admit a claim only if:

- the life insured does not meet the contractual definition of any of the other guaranteed payment events, and
- the sick leave has lasted continuously for the entire waiting period. However, if the period between consecutive periods of sick leave resulting from the same cause is shorter than the waiting period, we will consider a claim once the consecutive periods of sick leave add up to the waiting period, and
- we have not previously admitted a claim for the catch-all sick leave guaranteed payment event that is related to this claim.

For the hospital admission guaranteed payment event, we will admit a claim only if:

- the waiting period has expired; and
- we have not previously admitted a claim for hospital admission that is related to this claim.

For the other guaranteed payment events we will admit a claim only if:

- the waiting period has expired, and
- we have not previously admitted a claim for the same guaranteed payment event, except if the claim is for a different limb.

Admittance of a claim for impairment cover

We will admit a claim only if:

- the impairment is permanent, after the life insured has undergone optimal, reasonable treatment, and
- the waiting period has expired, and
- we have not previously admitted a claim for the same claim event, except if the claim event is listed under "Musculoskeletal system" in the impairment claim event table, and the claim is for a different limb, and
- the claim event occurred before the cover end date of the benefit.

The impairment must be permanent, and evaluated according to the principles and ratings of the latest edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. The impairment, and permanence thereof, will be evaluated only 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.

Waiting period

The chosen waiting period for this benefit is set out in the plan overview. If a waiting period of 7 days or 14 days has been chosen, the plan overview specifies conditions where the waiting period that is applied may be different to the chosen waiting period.

Waiting period for occupational disability

The waiting period starts on the date the life insured meets the contractual definition for occupational disability. For extended occupational disability cover, the waiting period starts on the date the life insured meets the contractual definition for total and permanent disability.

We will not make any income payments for occupational disability during the waiting period. An exception to this is if the chosen waiting period is 7 days and the occupational disability resulted from one of the conditions listed in the plan overview for which we will pay a claim from the date on which the claim event occurred instead of from the end of the waiting period.

Could the waiting period sometimes be waived?

If we stop making income payments for an occupational disability claim and we admit another claim for occupational disability, will waive the waiting period for the new claim if:

- the new claim is related to the previous claim, and
- the life insured meets the contractual definition for occupational disability within three months after we have made the last income payment for the previous claim, and
- we have not yet made income payments for the maximum payment period.

We will then continue with the income payments for as long as you have the right to claim payment, but only until we have made income payments for the maximum payment period.

If the chosen waiting period is three months, we will also waive the waiting period if the life insured is totally and permanently disabled during the last three months before the cover end date of the benefit.

Waiting period for guaranteed events

The waiting period starts on the date the life insured meets the contractual definition for the guaranteed payment event.

We will not make any income payments for assumed occupational disability during the waiting period. This means that if the number of weeks indicated in the guaranteed payment event table is shorter than or equal to the waiting period, we will not admit a claim. If the number of weeks indicated in the table is longer than the waiting period, we will admit a claim for the period in excess of the waiting period.

We will however make income payments for assumed occupational disability during the waiting period when the chosen waiting period is 7 days and the guaranteed payment event meets the criteria of one of the conditions listed in the plan overview for which we will pay a claim from the date on which the claim event occurred instead of from the end of the waiting period.

Waiting period for impairment cover

The waiting period starts on the date the life insured meets the contractual definition for the impairment claim event. We will not make any income payments for impairment during the waiting period.

When will the income payments start?

We will make the first income payment at the end of the plan month in which we admit the claim. This first income payment will be for the number of days that you have the right to claim payment in that plan month. Thereafter, we will make an income payment at the end of each subsequent plan month, for as long as you have the right to claim payment.

How long will the income payments continue?

The waiting period determines the maximum payment period for which we will make income payments for related claims, as indicated in the table below:

Waiting period	Maximum payment period
7 days	24 months
14 days	24 months
1 month	23 months
3 months	21 months

The maximum payment period applies for each type of cover provided by this benefit and across all types of cover provided by this benefit. This means that the periods for which we pay related claims within and across all types of cover will contribute toward the above maximum period.

We will make the income payments for as long as you have the right to claim payment, but only until the maximum payment period for related claims has been reached, the cover for this benefit ends or the life insured dies, whichever is earliest.

If the planholder no longer has the right to claim payment, we will make the last income payment at the end of the plan month in which their right to claim payment stops. If we have waived the payments for the plan while he/she has received income payments, he/she will have to resume the payments for the plan once the income payments stop.

How long will the income payments continue for occupational disability?

We will make the income payments for as long as the life insured's disability and loss of income continue, but only until the maximum payment period for related claims has been reached, the cover for this benefit ends or the life insured dies, whichever is earliest.

The last payment will only be for the number of days in the plan month that you have the right to claim payment.

After we have started making the income payments, we may from time to time ask for proof that the life insured is still disabled, and still has a loss of income. We may require the life insured to be medically examined for this purpose. We

will cover the cost of such a medical reassessment. The planholder will be responsible for the cost of financial proof of loss of income.

If the life insured travels or lives outside South Africa while a claim is in payment, and we require proof that the life insured is still disabled and still has a loss of income, we will require the medical and financial proof issued in a foreign country to be in English. The planholder will be primarily responsible for the cost of medical proof. We will refund the planholder in South African currency for an amount equal to what we usually pay for such medical proof in South Africa. The planholder will be responsible for the cost of financial proof of loss of income.

We will make income payments for disability and loss of income in a foreign country for a maximum period of 12 months. Thereafter, we will consider the continuation of income payments only after the life insured has been medically assessed by a doctor nominated by us, which may require the life insured to travel to South Africa for such an assessment. We will cover the cost of the assessment, but not the travel, accommodation and related costs involved.

If the life insured recovers to such an extent that he or she is no longer disabled, or no longer has a loss of income, we will stop making the income payments.

If the life insured only partially recovers from his or her disability, or still has a loss of income but to a lesser extent, we will reduce the income payments in proportion to the loss of income.

We will also stop making the income payments if:

- we do not receive the required proof of the life insured's continued disability and loss of income, or the life insured
- refuses to be examined, or
- refuses to undergo reasonable treatment on a regular basis, at his or her cost, by a medical doctor, other than the life insured if he or she is a medical doctor.

The period of disability may not exceed, unless we agree otherwise in writing, the midrange data in the latest edition of the Official Disability Guidelines of the Work Loss Data Institute, or its scientific equivalent. We will use these guidelines as a reference to determine the average period of disability for the claim event in question.

If we limit the income payments based on these guidelines, the planholder will have to provide medical proof of the life insured's continued disability. The planholder will be responsible for the cost of such medical proof.

If the life insured starts earning an income from his or her regular occupation or from other individual or group disability income type plans after we have started making the income payments, or if such income is increased, the planholder must notify us of this. We may then reduce the amount of the income payments, or stop them.

If the planholder fails to notify us of this, and we continue to make income payments and continue to waive the payments of the plan, we will be entitled to recover from the planholder the excess income payments and the payments we waived.

How long will the income payments continue for guaranteed payment events?

We will make the income payments for as long as the life insured's assumed occupational disability continues, but only until the maximum payment period for related claims has been reached, the cover for this benefit ends or the life insured dies, whichever is earliest.

For the catch-all sick leave guaranteed payment event, we will not make any income payments for sick leave beyond 3 months or beyond the mid-range data in the latest edition of the Official Disability Guidelines of the Work Loss Data Institute, or its scientific equivalent.

The last payment will only be for the number of days in the plan month that the planholder has the right to claim payment.

How long will the income payments continue for impairment cover?

We will make the income payments until the maximum payment period for related claims has been reached, the cover for this benefit ends or the life insured dies, whichever is earliest. For the amputation of finger claim events where a maximum payment period is indicated in the impairment claim event table, we will only pay up to the indicated period.

The last payment will only be for the number of days in the plan month that the planholder has the right to claim payment.

Automatic waiver of payments

We will waive the payments for the plan for as long as we make income payments for occupational disability, a guaranteed payment event, or for 100% of the cover amount. While we waive the payments, no alteration to any of the benefits on the plan is allowed.

Proof-free additional cover

If the plan has cover growth and the plan has been accepted with standard terms (i.e. without loadings or specific exclusions for a life insured), the plan holder has the option each year to request in writing that we increase the cover amount of this benefit by more than the current cover growth rate, without additional underwriting for the life insured. Any additional cover increases will take place on the plan anniversaries, together with the contractual cover increases.

The following additional requirements must be met before we will grant an additional cover increase as described above:

- The life insured must not be disabled or impaired on the date of the cover increase.
- A claim must not have been admitted, or already submitted, during the 12 months preceding the date of the cover increase.
- The life insured must be younger than 50 years on the date of the cover increase.
- We must receive the plan holder's written request to exercise the option at our head office at least 14 working days before the plan anniversary of the particular year.

The total increase in the cover amount of a benefit for a particular year (the annual cover growth increase plus the proof free increase) will be restricted to the lower of:

- the actual increase in the life insured's income over that year,
- twice the rate that we will use for increases according to the inflation rate that year, and
- 20%.

Multiple claims

This applies if the life insured meets the contractual definition of more than one claim event over the duration of the benefit.

If the life insured meets a contractual definition of more than one type of cover at the same time, we will first admit a claim for the guaranteed payment events. Once the last income payment for this type of cover has been made, we will consider claims for occupational disability and impairment cover.

If a life insured meets the contractual definition of occupational disability and an impairment claim event at the same time, and the claims are related, we will only pay for the type of cover that will result in the highest payout.

If a life insured meets the contractual definition of occupational disability and an impairment claim event at the same time, and the claims are unrelated, we will pay for both types of cover. We will however not pay more than 100% of the cover amount in any month.

We will never pay more than 100% of the cover amount in any month or more than once for the same calendar date.

Multiple claims for guaranteed payment events

We will consider a claim for the catch-all sick leave guaranteed payment event only if the life insured does not meet the contractual definition of any of the other guaranteed payment events.

If the life insured meets the contractual definition of more than one of the other guaranteed payment events at the same time, we will only pay for the guaranteed payment event with the longest period of assumed occupational disability indicated in the guaranteed payment event table.

Multiple claims for impairment cover

This applies if a life insured meets the contractual definition of more than one impairment claim event at the same time. The percentage of the cover amount that we pay for the claim may then be lower than indicated in the impairment claim event table.

We will only admit an impairment claim that is related to previously admitted impairment claims if the new claim event has a higher percentage of the cover amount indicated in the impairment claim event table and the maximum payment period for related claims has not yet been reached. The income payment that we are already making will then be increased to be in line with the higher percentage.

If we admit an impairment claim that is unrelated to previously admitted impairment claims, we may need to reduce the percentage of the cover amount indicated in the impairment claim event table to ensure that we do not pay more than 100% of the cover amount in any month.

Exclusions

General exclusions are set out in the applicable overview chapter in this technical guide. Specific exclusions, if any, are set out in the plan overview, in the special provisions for the life insured.

Exclusions for occupational disability and guaranteed payment events

If the life insured at any time practises sport as an occupation, or works as a pilot, and becomes continuously unable to fulfil a substantial and material part of the duties of that occupation, we will not admit a claim as a result of such inability. This exclusion applies to occupational disability and to the catch-all sick leave guaranteed payment event.

We will also not admit a claim if it directly or indirectly resulted from:

- normal pregnancy, or
- normal childbirth, or

- cosmetic surgery, except if it is medically necessary after an accident or bodily injury that occurred while cover for this benefit was in force, or
- a rehabilitation or detoxification program to treat alcohol or drug dependency or abuse, or any medical condition related to such dependency or abuse.

Cover for maternity leave

Maternity leave itself is not a claim event. This benefit does, however, provide cover for occupational disability and guaranteed payment events during periods of paid maternity leave. During unpaid maternity leave, cover is provided as described under "Extended occupational disability cover".

Cover for caesarean sections

For the purpose of this benefit, we do not consider caesarean sections to be normal childbirth, whether or not the procedure was elective. Such procedures could therefore qualify for a claim for occupational disability or a guaranteed payment event if all other requirements for a claim are met, unless the procedure is specifically excluded for the life insured.

Exclusions for Impairment cover

We will not admit a claim if the impairment of the life insured can be substantially removed or improved by surgery or other medical treatment, which we can reasonably expect him or her to undergo, taking into account the risks involved and the chances of success of such surgery or treatment.

Explanations

What is normal leave?

Normal leave refers to periods of paid leave, like paid annual leave or paid maternity leave.

When is a person retired?

We regard the life insured as retired if he or she is 55 years or older, and does not earn an income over and above a passive income. Passive income refers to income that can continue without the life insured's intervention, for example pension or rental income.

What is a related claim?

A claim is related to another claim if there is enough published evidence to show that:

- the medical condition or bodily injury:
 - is the result of the same medical condition or bodily injury that led to the other claim, or
 - has been caused by the same disease process or bodily injury that led to the other claim, and
- it is unlikely that the medical condition or injury would have occurred if it was not for the medical condition or injury that led to the other claim.

What is a plan month?

The first plan month starts on the day when the plan begins. Each following plan month will start on the same day as the first one. A plan month ends at midnight on the day before the next plan month starts.

What is medically necessary cosmetic surgery?

Any surgical intervention that meets all of the following requirements:

- It is needed to restore the normal function of an affected limb, organ or system;
- There is no alternative with equal or better outcomes;
- It is accepted as the best medical practice at the time;
- It is not done for the sake of convenience for either the life insured or relevant medical practitioner;
- It has available outcome studies which are acceptable to us;
- It is not done for any psychiatric, psychological or mental reasons.

Explanations for occupational disability

Regular occupation

The occupation the life insured practised for income immediately before becoming disabled.

Average monthly income

The monthly income from the life insured's regular occupation, averaged over the 12 months before the claim event took place. If the life insured has a fluctuating income, we will calculate the average monthly income over the 36 months before the claim event took place. For self-employed clients, we will always consider their average monthly income rather than their most recent monthly income.

Income for lives insured in formal employment of an employer

Cost-to-company income which consists of gross taxable income of the life insured including the employer's contributions to a medical scheme, provident fund or pension fund on behalf of the life insured, and the cost of any other benefits paid for by the life insured's employer that form part of the life insured's remuneration package and are reflected in the employer's financial statements.

Income for professional lives insured in practice

Gross professional income for professionals who charge a fee for services is equal to the sum of professional fees and net income from trading activities, less business overhead expenses.

Overhead expenses include the following:

- rent for the business premises;
- water, electricity, telephone;
- regular maintenance services;
- property taxes and mortgage interest for the business premises;
- equipment leasing costs;
- insurance premiums;
- accounting fees;
- salaries of employees;
- other normal and necessary expenses that we agree to include.

Overhead expenses exclude the following:

- depreciation;
- cost of goods or merchandise or additions to inventory;
- cost of furniture or equipment;
- capital payments on outstanding debt;
- expenditure on assets;
- fees on current accounts;
- business rationalisation costs, for example, retrenchment;
- any remuneration or other consideration to the life insured, the planholder, associates in the affected business, and any other person who shares directly or indirectly in the profit of the affected business.

The life insured's share of the overhead expenses is a proportion of the total overhead expenses of the affected business. The proportion is calculated as the business income the life insured generates in the affected business, averaged over the 12 months before the claim event took place, divided by the total business income of the affected business.

Income for other self-employed lives insured

Income or benefits receivable for the life insured's employment, or any services rendered by the life insured, plus the life insured's share of profit in the business.

Neck or back condition

A disease, disorder, or dysfunction of the vertebrae, spinal cord, intervertebral discs, nerve roots and supporting muscles or ligaments, as well as the direct or indirect consequences of, or the side-effects of any treatment applied for, such disease, disorder, or dysfunction.

Paraplegia

Total and permanent loss of function of both lower extremities.

Quadriplegia

Total and permanent loss of function of all four limbs.

Malignant tumours of the spinal cord and vertebral column

The incontrovertible presence of uncontrolled growth and spread of malignant cells, the invasion of normal tissue, and the definite histological evidence of a malignant growth in the spinal cord and vertebral column.

Failed back syndrome after multiple spinal surgery

When the life insured, after the cover for the benefit has begun, must undergo more than one spinal operation on two or more intervertebral disc spaces in the lumbar or cervical area, and despite those operations, still suffers severe back pain as verified by a multidisciplinary pain clinic. Such operations may include discectomy, vertebral fusion and internal fixation.

Guaranteed payment event table

The contractual definitions are indicated in the table below.

Temporary Income and Temporary Income Plus: Guaranteed Payment Event	Period of assumed occupational disability
Hospitalisation	
Hospitalisation for longer than a week	
Contractual definition: Hospitalisation for longer than one week. For the purpose of this benefit, we regard a hospital as an institution that is equipped for the diagnosis of disease, for the curative treatment, both medical and surgical, of the sick and the injured, and for the housing of patients during this process. Hospices and rehabilitation and psychiatric institutions are excluded from this definition for hospital.	1 month
Surgical replacements	
Surgical replacement of a shoulder joint	
Contractual definition: Total replacement of a shoulder joint.	2 months
Surgical replacement of an elbow joint	
Surgical replacement of an elbow joint Contractual definition: Total replacement of an elbow joint.	2 months
Surgical replacement of a wrist joint	
Contractual definition: Total replacement of a wrist joint.	1 month and 2 weeks
Surgical replacement of a hip joint	
Contractual definition: Total replacement of a hip joint.	2 months and 2 weeks
Surgical replacement of a knee joint	
Contractual definition: Total replacement of a knee joint.	2 months
Surgical replacement of an ankle joint	
Contractual definition: Total replacement of an ankle joint	2 months
Fractures	
Fracture of a collar bone with subsequent surgery	
Contractual definition: Fracture of a clavicle requiring open reduction and internal fixation.	1 month and 2 weeks
Fracture of the bone of an upper arm	
Contractual definition: Fracture of a humerus.	2 months
Fracture of a bone in a forearm	
Contractual definition: Fracture of an ulna or radius.	1 month

Temporary Income and Temporary Income Plus: Guaranteed Payment Event	Period of assumed occupational disability
Fracture of a bone in a hand with subsequent surgery, fingers excluded	
fingers excluded Contractual definition: Fracture of a carpal or meta-carpal bone requiring open reduction and internal fixation.	1 month and 2 weeks
Fracture of the bone in an upper leg	
Contractual definition: Fracture of a femur.	3 months
Fracture of a knee cap	
Contractual definition: Fracture of a patella.	1 month and 2 weeks
Fracture of the shin bone of a lower leg	
Contractual definition: Fracture of a tibia.	2 months
Fracture of the calf bone of a lower leg	
Contractual definition: Fracture of a fibula.	1 month
Fracture of a heel bone	
Contractual definition: Fracture of a calcaneus.	1 month and 2 weeks
Skull fracture requiring reconstruction	
Contractual definition: Depressed or displaced skull fracture of the frontal, parietal, temporal, sphenoid or occipital bones requiring surgical correction.	1 month
Fracture of the facial bones requiring reconstructive surgery	
Contractual definition: Fractures of the frontal bones, orbital bones, zygoma, and/or maxilla resulting in maxillofacial reconstructive surgery.	1 month and 2 weeks
Multiple rib fractures with ICU admission	
Contractual definition: Numerous rib fractures, requiring admission to an intensive care unit (ICU), confirmed by a specialist.	1 month and 2 weeks
Multiple rib fractures requiring ventilation	
Contractual definition: Numerous rib fractures, requiring ventilation in an intensive care unit (ICU) in order to sustain a stable blood-gas profile, confirmed by a specialist.	2 months
Stable pelvis fracture	
Contractual definition: Stable fracture of the pelvis, treated without surgery.	2 months
Unstable pelvis fractures	
More than one fracture of the pelvic framework, resulting in instability, and requiring surgical intervention.	3 months
Fracture of the body of a spinal vertebra	
Contractual definition: A compression fracture of the body of a spinal vertebra or avulsion fracture of the spinal vertebra as confirmed on X-rays.	2 months
Fracture of the bony elements of a spinal vertebra, other than the body	
Contractual definition: A fracture of the posterior element of a vertebra, in other words the pedicle, lamina, articular process or transverse process, excluding the spinous process.	2 months
Fracture dislocation of the spine without neurological deficit	

Temporary Income and Temporary Income Plus: Guaranteed Payment Event	Period of assumed occupational disability
Contractual definition: A fracture dislocation of the spine, without neurological deficit, confirmed with supporting evidence by a neurosurgeon or orthopaedic specialist.	1 month and 2 weeks
Fracture dislocation of the spine with neurological deficit	
Contractual definition: A fracture dislocation of the spine, with neurological deficit, confirmed with supporting evidence by a neurosurgeon or orthopaedic specialist.	2 months
Ligament repairs	
Surgical repair of rotator cuff syndrome of the shoulder	
Contractual definition: Surgical repair of rotator cuff syndrome.	2 months
Complete rotator cuff rupture	
Contractual definition: Complete rotator cuff rupture with subsequent surgical repair.	2 months
Knee cruciate ligament reconstruction	
Rupture of the anterior or posterior cruciate ligament of a knee with subsequent surgical repair.	1 month and 2 weeks
Knee medial or lateral ligament repair	
Contractual definition: Rupture of a collateral ligament of a knee with subsequent surgical repair.	1 months and 2 weeks
Complete achilles tendon rupture	
Contractual definition: Complete Achilles tendon rupture with subsequent surgical repair.	2 months
Ankle ligament repair	
Contractual definition: Rupture of an ankle ligament with subsequent surgical repair.	1 month and 2 weeks
Accidents and Injuries	
Abdominal injury with liver rupture, spleen rupture or kidney damage requiring emergency surgical repair	
Contractual definition: Blunt injury to the abdomen resulting in rupture of the liver or spleen, or injury to the kidney, necessitating emergency laparotomy and surgical repair, splenectomy or nephrectomy.	1 month and 2 weeks
Acute disc lesion of the spine	
Contractual definition: An acute slipped intervertebral disc with herniation.	1 month and 2 weeks
Amputation of a hand/loss of use of a hand	
Contractual definition: <ul style="list-style-type: none">• Complete physical severance of a hand at the level of the wrist, or of all five fingers through the metacarpal-phalangeal joints; or• the permanent loss of function of an entire hand from the wrist (distal to the wrist); or• the permanent loss of function of an upper limb, with at least 60% impairment of the limb according to the latest American Medical Association (AMA) guidelines.	3 months
This must be confirmed by a specialist with supporting evidence.	
Amputation of a foot/loss of use of a foot	
Contractual definition: <ul style="list-style-type: none">• The amputation of a foot at the level of the ankle joint by traumatic or surgical means; or• the permanent loss of function of an entire foot from the ankle (distal to the ankle).	3 months

Temporary Income and Temporary Income Plus: Guaranteed Payment Event	Period of assumed occupational disability
This must be confirmed by a specialist with supporting evidence.	
Loss of an eye due to injury	
Contractual definition: Permanent and irreversible loss of vision in one eye due to injury.	1 month
Combination burns	
Contractual definition: A combination of second-degree and third-degree burns that covers more than 80% of the face or hands or feet, confirmed by a surgeon.	2 weeks
Major Burns	
Contractual definition: Third-degree burn wounds, full thickness of the skin, that cover at least 20% of the body surface area, as determined by the Lund and Browder chart or equivalent.	1 month and 2 weeks
Coma	
Contractual definition: A condition of unconsciousness where the life insured: <ul style="list-style-type: none"> • presents with a Glasgow Coma Scale of 8 or less, and is dependent on life-sustaining aids, such as a ventilator and intravenous infusion, for an uninterrupted period of at least 96 hours. 	2 months
Paraplegia	
Contractual definition: The total 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, confirmed by a specialist.	1 month and 2 weeks
Quadriplegia	
Contractual definition: The total loss of muscle function resulting in the loss of use of both arms and both legs due to disease of or injury to the spinal cord or brain, confirmed by a specialist.	3 months
Removal of the neck or lower back intervertebral discs, or fusion of the neck or lower back vertebrae	
Contractual definition: Cervical or lumbar discectomy and/or fusion.	2 months
Fat-embolism of the lungs	
Contractual definition: Fat-embolism of the lungs, confirmed by a ventilation-perfusion (VQ) scan. This must be confirmed by a pulmonologist, physician or anaesthetist.	1 month
Compartment Syndrome	
Contractual definition: Definitive history of compartment syndrome as a result of an acute injury, with permanent motor nerve damage, confirmed by a specialist. This must be confirmed with all of the following supporting evidence: <ul style="list-style-type: none"> • History and clinical signs of compartment syndrome, and Nerve conduction studies. 	3 weeks
Gunshot or penetrating stab wound resulting in theatre debridement	
Contractual definition: Gunshot or penetrating stab wound resulting in theatre debridement, with an operation report provided by a surgeon or trauma surgeon.	1 week
Penetration by a bullet or a sharp object through the skull	
Contractual definition: Penetration by a bullet or a sharp object through the skull, resulting in surgical exploration of the skull under general anaesthetic, with an operation report provided by a surgeon or trauma surgeon.	1 month

Temporary Income and Temporary Income Plus: Guaranteed Payment Event	Period of assumed occupational disability
Penetration by a bullet or sharp object through the chest, resulting in the placement of an underwater drain	
Contractual definition: Penetration by a bullet or a sharp object through the chest, resulting in an underwater drain, with an operation report provided by a surgeon or trauma surgeon.	1 month
Penetration by a bullet or a sharp object through the chest, resulting in a thoracotomy	
Contractual definition: Penetration by a bullet or a sharp object through the chest, resulting in a thoracotomy, with an operation report provided by a surgeon or trauma surgeon.	1 month
Penetration by a bullet or a sharp object through the abdomen	
Contractual definition: Penetration by a bullet or a sharp object through the abdomen, resulting in surgical exploration of the cavity under general anaesthetic, with an operation report provided by a surgeon or trauma surgeon.	1 month
Penetration by a bullet or a sharp object through the neck	
Contractual definition: Penetration by a bullet or a sharp object through the neck, with damage to one or more of the following: subclavian or carotid artery, oesophagus or trachea, with an operation report provided by a surgeon or trauma surgeon.	1 month
Female health	
Hysterectomy	
Contractual definition: Hysterectomy.	1 month and 2 weeks
Double mastectomy	
Contractual definition: Double mastectomy.	1 month
Catch-all event	
Sick leave for any other illness or injury	
Contractual definition: Sick leave arising from any illness or bodily injury other than those already listed in the guaranteed payment event table.	Period of sick leave, limited to 3 months
Sick leave is a medically recommended period of time during which the life insured, as a result of a bodily injury, illness or other cause or condition necessitating medical or dental treatment, is totally and continuously unable to practise his or her occupation, including during any period of normal leave. The period of sick leave may not exceed the midrange data in the latest edition of the Official Disability Guidelines of the Work Loss Data Institute, or its scientific equivalent, that we will use as a reference to determine the average period of sick leave for the claim event in question.	

Impairment claim events table

These impairment claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated at the end of the Income Protection benefits chapter in the section "Impairment Claim Events for Short Term Benefits". [ImpairmentClaimEventsShortTermBenefits](#)

Future medical advances

Some claim events 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 claim events, 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.

Accidental Temporary Income Plus (AIT)

This benefit is available under our Income Protector product which is available under our Premier product option.

Benefit description

This benefit provides short term accidental cover for occupational disability resulting in a loss of income and for permanent impairments. It also includes a list of Guaranteed Payment Events, including a catch-all sick leave event, which guarantee payout for a certain period of time without the need to prove loss of income. The benefit is available to employed clients with qualifying occupations, but especially suitable for clients who are not medically insurable. It provides cover for occupational disability, guaranteed payment events, severe impairment events and less severe impairment events, if any of these are from accidental causes.

Optional rider benefits

Available rider benefits:

- Spouse protector
- Child protector

An additional payment will be charged for a rider benefit.

Special features

Special features are features that are automatically included for a benefit. The following Special features apply:

- Free cover
- Automatic waiver of payment
- Extended occupational disability cover

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

More information on automatic waiver of payment and extended occupational disability cover is provided further in this section.

Type of benefit

Standalone

When will cover for this benefit end?

Cover will end

- at midnight before the cover end date set out in the plan overview, or
- if this benefit or the plan ends for any reason before the cover end date, or
- if the life insured dies.

Cover limits per life insured

Minimum: R3 000 per month

Maximum: R200 000 per month*, limited to the sliding scale percentage of the life insured's gross monthly income**.

*Subject to financial underwriting

**Refer to the underwriting chapters for the sliding scales and the definitions of gross income.

Benefit payment period	The waiting period determines the maximum payment period for which we will make income payments for related claims: <ul style="list-style-type: none"> • 24 months (if a 7 or 14 day waiting period applies) • 23 months (if a 1 month waiting period applies) • 21 months (if a 3 month waiting period applies)
Age limits	<p>Benefit start age</p> <p>Minimum:</p> <ul style="list-style-type: none"> • 18 next birthday for payment patterns other than fixed compulsory growth • Fixed compulsory growth: 30 next birthday <p>Maximum:</p> <ul style="list-style-type: none"> • 5 years before the benefit cease age <p>Benefit cease age</p> <p>Choice between:</p> <ul style="list-style-type: none"> • 60 next birthday • 65 next birthday • 70 next birthday
Qualifying Lives	<p>Lives who comply with the following may qualify, subject to age limits:</p> <ul style="list-style-type: none"> • must be employed, either self-employed or by an employer, and • must practise a qualifying occupation, as determined by us <p>This benefit caters for lives that do not qualify for full cover due to their medical history, but is also available for lives who do qualify for full cover.</p>
Guarantee period	The initial guarantee period is 5 years.
Waiting period options	<p>Choice between the following, subject to underwriting:</p> <ul style="list-style-type: none"> • 7 days * • 14 days* • 1 month • 3 months <p>* Only available to lives who qualify for disability classes A, B or C. The other waiting periods are available for all disability classes.</p>

What this benefit provides

This benefit provides cover for:

- temporary or permanent occupational disability from accidental causes, up to retirement or the cover end date of the benefit, whichever is earlier, and
- guaranteed payment events from accidental causes, up to retirement or the cover end date of the benefit, whichever is earlier. This cover is provided only if the waiting period is 7 days, 14 days or 1 month, and
- permanent impairment claim events from accidental causes.

Claim event for occupational disability

A benefit may be claimed if the life insured becomes disabled to the extent that he or she is continuously unable to fulfil a substantial and material part of the duties of the regular occupation he or she practised for income immediately before the disability, resulting in a loss of some or all of such income.

If the life insured is a qualifying student when he or she becomes disabled, a benefit may be claimed if the life insured becomes disabled to the extent that he or she will be totally and permanently unable to fulfil the occupational demands of an occupation we may reasonably expect him or her to have practised, had they not become disabled and had they completed their studies.

The above is the contractual definition for occupational disability.

What is a qualifying student?

A qualifying student is a full-time student in at least their 4th academic year studying toward an NQF-level 8 or higher qualification.

A student progresses to the next academic year when they successfully pass a tertiary study year.

Extended occupational disability cover

If the life insured stops working for any reason other than retiring or becoming a qualifying student, for example, taking a sabbatical, becoming a housewife or being retrenched, we will provide extended occupational disability cover for total and permanent disability for up to 12 months from the date he or she stopped working.

For this cover, total and permanent disability refers to the life insured being totally and permanently unable to fulfil the occupational duties of the regular occupation he or she practised for income immediately before he or she stopped working.

Extended occupational disability cover will only apply if the occupational disability is total and permanent and not as a result of any of the following conditions:

- a back or neck injury, unless it is one of the following: paraplegia; quadriplegia; or failed back syndrome after multiple spinal surgery, provided the extent of the functional impairment arising from the failed back syndrome is verified by a specialist that we will nominate;
- any orthopaedic injury based mainly on pain, discomfort, loss of sensation, loss of range of motion, or any combination thereof;
- an injury that directly or indirectly resulted from, or is traceable to, any of the above causes;
- a complication that directly or indirectly is attributable to any of the above causes, or to such an injury;
- a side-effect of treatment of any of the above causes, or for such an injury or for such a complication.

Qualifying students

If the life insured is a qualifying student and successfully completes his or her studies, but does not yet start working, we will continue to cover him or her for occupational disability as if he or she is still a qualifying student, for up to 12 months from the date he or she stopped studying. This extended occupational disability cover will only apply if the occupational disability is not as a result of any of the above listed conditions.

What benefit will be provided for occupational disability?

If we admit a claim, we will make an income payment of up to 100% of the cover amount. The current cover amount is set out in the plan overview.

If benefit growth is applicable to the plan, the cover amount of and the payment for the benefit will continue to be increased each year as set out in the plan overview under "Benefit and payment growth". We will continue making income payments for as long as the planholder has the right to claim payment.

When we admit a claim, we will limit the amount of the income payment to the cover amount as at the date we admit the claim.

If the life insured's disability results in a loss of only some of the income from his or her regular occupation, we will further limit the amount of the income payment in proportion to the loss of income.

If the disability directly or indirectly results from any of the conditions listed below, we will further limit the amount of the income payment to ensure that this amount, plus any occupational disability income that the life insured might receive from this plan or other individual or group disability income type plans, does not exceed 100% of the life insured's average monthly income after tax. If benefit growth is applicable to the plan, this limited income payment will be increased each year by the benefit growth rate as set out in the plan overview under "Benefit and payment growth"

- a back or neck injury, unless it is one of the following: paraplegia; quadriplegia; or failed back syndrome after multiple spinal surgery, provided the extent of the functional impairment arising from the failed back syndrome is verified by a specialist that we will nominate;
- any orthopaedic injury based mainly on pain, discomfort, loss of sensation, loss of range of motion, or any combination thereof;
- an injury that directly or indirectly resulted from, or is traceable to, any of the above causes;
- a complication that directly or indirectly is attributable to any of the above causes, or to such an injury;
- a side-effect of treatment of any of the above causes, or for such an injury or for such a complication.

We will make an income payment only if the amount we have to pay is at least equal to the smaller of the following, both determined as at the time we consider a claim:

- 10% of the cover amount, and
- the minimum cover amount allowed for new business.

Once we have admitted a claim, and started making income payments, we will not apply this rule even if we reduce the amount of the income payment to less than the above limit.

Claim event for guaranteed payment events

This cover only applies if a waiting period of 7 days, 14 days or 1 month has been chosen for this benefit.

A benefit may be claimed if the life insured meets the contractual definition of any of the guaranteed payment events indicated in the guaranteed payment event table. These events include a catch-all sick leave event. The guaranteed payment event table is provided at the end of this section.

What benefit will be provided for guaranteed payment events?

If we admit a claim, we will make income payments as if the life insured has met the contractual definition for occupationally disability, for the indicated number of weeks in the guaranteed payment event table. We will assume that the disability starts on the date that the guaranteed payment event occurred and that the life insured has a total loss of income from his or her occupation during this period. We will make the income payments whether or not the life insured is actually disabled and actually has a total loss of income.

Claim event for impairment

A benefit may be claimed if the life insured meets the contractual definition of any of the impairment claim events indicated in the impairment claim event table, whether or not the life insured is unable to do his or her occupation or has a loss of income.

These impairment claim events with their contractual definitions, layman's explanations, where applicable and percentages of the cover amount are indicated at the end of the Income Protection benefits chapter in the section "Impairment Claims for Accidental Benefits" [ImpairmentClaimEventsAccidentalBenefit1](#)

What benefit will be provided for impairment?

If we admit a claim, we will make a monthly income payment equal to the percentage of the cover amount linked to the particular claim event as set out in the impairment claim event table. The cover amount is set out in the plan overview. For multiple claims, we may pay a lower percentage than indicated in the table.

If benefit growth is applicable to the plan, the cover amount of and the payment for the benefit will continue to be increased each year as set out in the plan overview under "Benefit and payment growth". We will continue making income payments for as long as the planholder has the right to claim payment.

Admittance of a claim

Besides the conditions for admittance of a claim set out in the general plan provisions, we will admit a claim only if the claim event is caused directly and solely by a bodily injury due to an accident.

For the purpose of this benefit, we will not recognise any intra- or post-operative complication, or any complication following a medical procedure, as an accident, unless the operation or procedure

- is a direct result of a bodily injury that took place after cover for this benefit has started, and
- takes place within **six** months of such a bodily injury.

The planholder will be responsible for the cost of medical proof and the cost of financial proof of loss of income, if applicable, when a claim is submitted.

If the life insured travels or lives outside South Africa when the claim event occurs, we will require the medical and financial proof issued in a foreign country to be in English to consider a claim.

Admittance of a claim for occupational disability

We will admit a claim only if:

- the life insured practises his or her occupation or is on normal leave at the time that the claim event occurs, or for a qualifying student, if the life insured is enrolled in his or her studies at the time that the claim event occurs. An exception to this is if the requirements for extended occupational disability cover are met, and
- the occupational disability has lasted continuously for the entire waiting period. However, if the period between consecutive periods of disability resulting from the same cause is shorter than the waiting period, we will consider a claim once the consecutive periods of disability add up to the waiting period, and

- the claim event occurs before the earlier of retirement and the cover end date of the benefit.

Admittance of a claim for guaranteed payment events

We will admit a claim for a guaranteed payment event only if:

- the life insured practises his or her occupation or is on normal leave at the time that the claim event occurs, and
- the claim event occurs before the earlier of retirement and the cover end date of the benefit.

For the catch-all sick leave guaranteed payment event, we will admit a claim only if:

- the life insured does not meet the contractual definition of any of the other guaranteed payment events, and
- the sick leave has lasted continuously for the entire waiting period. However, if the period between consecutive periods of sick leave resulting from the same cause is shorter than the waiting period, we will consider a claim once the consecutive periods of sick leave add up to the waiting period, and
- we have not previously admitted a claim for the catch-all sick leave guaranteed payment event that is related to this claim.

For the hospital admission guaranteed payment event, we will admit a claim only if:

- the waiting period has expired, and
- we have not previously admitted a claim for hospital admission that is related to this claim.

For the other guaranteed payment events, we will admit a claim only if:

- the waiting period has expired, and
- we have not previously admitted a claim for the same guaranteed payment event, except if the claim is for a different limb.

Admittance of a claim for impairment cover

We will admit a claim only if:

- the impairment is permanent, after the life insured has undergone optimal, reasonable treatment, and
- the waiting period has expired, and
- we have not previously admitted a claim for the same claim event, except if the claim event is listed under "Musculoskeletal system" in the impairment claim event table, and the claim is for a different limb, and
- the claim event occurred before the cover end date of the benefit.

The impairment must be permanent, and evaluated according to the principles and ratings of the latest edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. The impairment, and permanence thereof, will be evaluated only 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.

Waiting period

The chosen waiting period for this benefit is set out in the plan overview. If a waiting period of 7 days or 14 days has been chosen, the plan overview specifies conditions where the waiting period that is applied may be different to the chosen waiting period.

If a 7 day waiting period has been chosen

If a 7 day waiting period has been chosen, a waiting period of 1 month instead of 7 days will apply for Accidental Temporary Income Plus if the claim event resulted from or is accelerated by any back disorders. However, if the life insured has been treated in a hospital or clinic for 7 days or more by an orthopaedic surgeon or neurosurgeon, the waiting period will still be 7 days.

If a 14 day waiting period has been chosen

If a 14 day waiting period has been chosen, a waiting period of 1 month instead of 14 days will apply for Accidental Temporary Income Plus if the claim event resulted from or is accelerated by any back disorders. However, if the life insured has been treated in a hospital or clinic for 7 days or more by an orthopaedic surgeon or neurosurgeon, the waiting period will still be 14 days.

Waiting period occupational disability

The waiting period starts on the date the life insured meets the contractual definition for occupational disability. For extended occupational disability cover, the waiting period starts on the date the life insured meets the contractual definition for total and permanent disability.

We will not make any income payments for occupational disability during the waiting period. An exception to this is if the chosen waiting period is 7 days and the occupational disability resulted from one of the conditions listed in the plan

overview for which we will pay a claim from the date on which the claim event occurred instead of from the end of the waiting period.

Could the waiting period sometimes be waived?

If we stop making income payments for an occupational disability claim and we admit another claim for occupational disability, we will waive the waiting period for the new claim if:

- the new claim is related to the previous claim; and
- the life insured meets the contractual definition for occupational disability within three months after we have made the last income payment for the previous claim; and
- we have not yet made income payments for the maximum payment period.

We will then continue with the income payments for as long as the planholder has the right to claim payment, but only until we have made income payments for the maximum payment period.

If the chosen waiting period is three months, we will also waive the waiting period if the life insured is totally and permanently disabled during the last three months before the cover end date of the benefit.

Waiting period for guaranteed payment events

The waiting period starts on the date the life insured meets the contractual definition for the guaranteed payment event.

We will not make any income payments for assumed occupational disability during the waiting period. This means that if the number of weeks indicated in the guaranteed payment event table is shorter than or equal to the waiting period, we will not admit a claim. If the number of weeks indicated in the table is longer than the waiting period, we will admit a claim for the period in excess of the waiting period.

We will however make income payments for assumed occupational disability during the waiting period when the chosen waiting period is 7 days and the guaranteed payment event meets the criteria of one of the conditions listed in the plan overview for which we will pay a claim from the date on which the claim event occurred instead of from the end of the waiting period.

Waiting period for impairment cover

The waiting period starts on the date the life insured meets the contractual definition for the impairment claim event. We will not make any income payments for impairment during the waiting period.

When will the income payments start?

We will make the first income payment at the end of the plan month in which we admit the claim. This first income payment will be for the number of days that the planholder has the right to claim payment in that plan month. Thereafter, we will make an income payment at the end of each subsequent plan month, for as long as the planholder has the right to claim payment.

How long will the income payments continue?

The waiting period determines the maximum payment period for which we will make income payments for related claims, as indicated in the table below:

Waiting period	Maximum payment period
7 days	24 months
14 days	24 months
1 month	23 months
3 months	21 months

We will make the income payments for as long as the planholder has the right to claim payment, but only until the maximum payment period for related claims has been reached, the cover for this benefit ends or the life insured dies, whichever is earliest.

If the planholder no longer has the right to claim payment, we will make the last income payment at the end of the plan month in which the planholder's right to claim payment stops. If we have waived the payments for the plan while the planholder has received income payments, the planholder will have to resume the payments for the plan once the income payments stop.

How long will income payments continue for occupational disability?

We will make the income payments for as long as the life insured's disability and loss of income continue, but only until the maximum payment period for related claims has been reached, the cover for this benefit ends or the life insured dies, whichever is earliest.

The last payment will only be for the number of days in the plan month that the planholder has the right to claim payment. After we have started making the income payments, we may from time to time ask for proof that the life insured is still disabled, and still has a loss of income. We may require the life insured to be medically examined for this purpose. We will cover the cost of such a medical reassessment. The planholder will be responsible for the cost of financial proof of loss of income.

If the life insured travels or lives outside South Africa while a claim is in payment, and we require proof that the life insured is still disabled and still has a loss of income, we will require the medical and financial proof issued in a foreign country to be in English. The planholder will be primarily responsible for the cost of medical proof. We will refund the planholder in South African currency for an amount equal to what we usually pay for such medical proof in South Africa. The planholder will be responsible for the cost of financial proof of loss of income.

We will make income payments for disability and loss of income in a foreign country for a maximum period of 12 months. Thereafter, we will consider the continuation of income payments only after the life insured has been medically assessed by a doctor nominated by us, which may require the life insured to travel to South Africa for such an assessment. We will cover the cost of the assessment, but not the travel, accommodation and related costs involved.

If the life insured recovers to such an extent that he or she is no longer disabled, or no longer has a loss of income, we will stop making the income payments.

If the life insured only partially recovers from his or her disability, or still has a loss of income but to a lesser extent, we will reduce the income payments in proportion to the loss of income.

We will also stop making the income payments if:

- we do not receive the required proof of the life insured's continued disability and loss of income, or
- the life insured
 - refuses to be examined, or
 - refuses to undergo reasonable treatment on a regular basis, at his or her cost, by a medical doctor, other than the life insured if he or she is a medical doctor.

The period of disability may not exceed, unless we agree otherwise in writing, the midrange data in the latest edition of the Official Disability Guidelines of the Work Loss Data Institute, or its scientific equivalent. We will use these guidelines as a reference to determine the average period of disability for the claim event in question.

If we limit the income payments based on these guidelines, the planholder will have to provide medical proof of the life insured's continued disability. The planholder will be responsible for the cost of such medical proof.

If the life insured starts earning an income from his or her regular occupation or from other individual or group disability income type plans after we have started making the income payments, or if such income is increased, the planholder must notify us of this. We may then reduce the amount of the income payments, or stop them.

If the planholder fails to notify us of this, and we continue to make income payments and continue to waive the payments of the plan, we will be entitled to recover, from the planholder, the excess income payments and the payments we waived.

How long will income payments continue for guaranteed payment events?

We will make the income payments for as long as the life insured's assumed occupational disability continues, but only until the maximum payment period for related claims has been reached, the cover for this benefit ends or the life insured dies, whichever is earliest.

For the catch-all sick leave guaranteed payment event, we will not make any income payments for sick leave beyond 3 months or beyond the mid-range data in the latest edition of the Official Disability Guidelines of the Work Loss Data Institute, or its scientific equivalent.

The last payment will only be for the number of days in the plan month that the planholder has the right to claim payment.

How long will income payments continue for impairment cover?

We will make the income payments until the maximum payment period for related claims has been reached, the cover for this benefit ends or the life insured dies, whichever is earliest. For the amputation of finger claim events where a maximum payment period is indicated in the impairment claim event table, we will only pay up to the indicated period.

The last payment will only be for the number of days in the plan month that the planholder has the right to claim payment.

Automatic Waiver of payments

We will waive the payments for the plan for as long as we make income payments for occupational disability, a guaranteed payment event, or for 100% of the cover amount. While we waive the payments, no alteration to any of the benefits on the plan is allowed.

Multiple Claims

This applies if the life insured meets the contractual definition of more than one claim event over the duration of the benefit.

If the life insured meets a contractual definition of more than one type of cover at the same time, we will first admit a claim for the guaranteed payment events. Once the last income payment for this type of cover has been made, we will consider claims for occupational disability and impairment cover.

If a life insured meets the contractual definition of occupational disability and an impairment claim event at the same time, and the claims are related, we will only pay for the type of cover that will result in the highest payout.

If a life insured meets the contractual definition of occupational disability and an impairment claim event at the same time, and the claims are unrelated, we will pay for both types of cover. We will however not pay more than 100% of the cover amount in any month.

We will never pay more than 100% of the cover amount in any month or more than once for the same calendar date.

Multiple claims for guaranteed payment events

We will consider a claim for the catch-all sick leave guaranteed payment event only if the life insured does not meet the contractual definition of any of the other guaranteed payment events.

If the life insured meets the contractual definition of more than one of the other guaranteed payment events at the same time, we will only pay for the guaranteed payment event with the longest period of assumed occupational disability indicated in the guaranteed payment event table.

Multiple claims for impairment cover

This applies if a life insured meets the contractual definition of more than one impairment claim event at the same time. The percentage of the cover amount that we pay for the claim may then be lower than indicated in the impairment claim event table.

We will only admit an impairment claim that is related to previously admitted impairment claims if the new claim event has a higher percentage of the cover amount indicated in the impairment claim event table and the maximum payment period for related claims has not yet been reached. The income payment that we are already making will then be increased to be in line with the higher percentage.

If we admit an impairment claim that is unrelated to previously admitted impairment claims, we may need to reduce the percentage of the cover amount indicated in the impairment claim event table to ensure that we do not pay more than 100% of the cover amount in any month.

Exclusions

General exclusions are set out in the applicable overview chapter in this technical guide. Specific exclusions, if any, are set out in the plan overview, in the special provisions for the life insured concerned.

Exclusions for occupational disability and guaranteed payment events

If the life insured at any time practises sport as an occupation, or works as a pilot, and becomes continuously unable to fulfil a substantial and material part of the duties of that occupation, we will not admit a claim as a result of such inability. This exclusion applies to occupational disability and to the catch-all sick leave guaranteed payment event.

We will also not admit a claim if it directly or indirectly resulted from cosmetic surgery, except if it is medically necessary after an accident or bodily injury that occurred while cover for this benefit was in force.

Exclusions for impairment cover

We will not admit a claim if the impairment of the life insured can be substantially removed or improved by surgery or other medical treatment, which we can reasonably expect him or her to undergo, taking into account the risks involved and the chances of success of such surgery or treatment.

Explanations

Plan month

The first plan month starts on the day when the plan begins. Each following plan month will start on the same day as the first one. A plan month ends at midnight on the day before the next plan month starts.

What is medically necessary cosmetic surgery?

Any surgical intervention that meets all of the following requirements:

- It is needed to restore the normal function of an affected limb, organ or system;
- There is no alternative with equal or better outcomes;
- It is accepted as the best medical practice at the time;
- It is not done for the sake of convenience for either the life insured or relevant medical practitioner;
- It has available outcome studies which are acceptable to us;
- It is not done for any psychiatric, psychological or mental reasons.

Related claim

A claim is related to another claim if there is enough published evidence to show that:

- the medical condition or bodily injury is the result of the same medical condition or bodily injury that led to the other claim; and
- it is unlikely that the medical condition or injury would have occurred if it was not for the medical condition or injury that led to the other claim.

Normal leave

Normal leave refers to periods of paid leave, like paid annual leave or paid maternity leave.

When is a person retired?

We regard the life insured as retired if he or she is 55 years or older, and does not earn an income over and above a passive income. Passive income refers to income that can continue without the life insured's intervention, for example pension or rental income.

Explanations for occupational disability

Regular occupation

The occupation the life insured practised for income immediately before becoming disabled.

Average monthly income

The monthly income from the life insured's regular occupation, averaged over the 12 months before the claim event took place. If the life insured has a fluctuating income, we will calculate the average monthly income over the 36 months before the claim event took place. For self-employed clients, we will always consider their average monthly income rather than their most recent monthly income.

Income for lives insured in formal employment of an employer

Cost-to-company income which consists of gross taxable income of the life insured including the employer's contributions to a medical scheme, provident fund or pension fund on behalf of the life insured, and the cost of any other benefits paid for by the life insured's employer that form part of the life insured's remuneration package and are reflected in the employer's financial statements.

Income for professional lives insured in practice

Gross professional income for professionals who charge a fee for services is equal to the sum of professional fees and net income from trading activities, less business overhead expenses.

Overhead expenses include the following:

- rent for the business premises;
- water, electricity, telephone;
- regular maintenance services;
- property taxes and mortgage interest for the business premises;
- equipment leasing costs;
- insurance premiums;
- accounting fees;
- salaries of employees;
- other normal and necessary expenses that we agree to include.

Overhead expenses exclude the following:

- depreciation;
- cost of goods or merchandise or additions to inventory;
- cost of furniture or equipment;
- capital payments on outstanding debt;
- expenditure on assets;

- fees on current accounts;
- business rationalisation costs, for example, retrenchment;
- any remuneration or other consideration to the life insured, the planholder, associates in the affected business, and any other person who shares directly or indirectly in the profit of the affected business.

The life insured's share of the overhead expenses is a proportion of the total overhead expenses of the affected business. The proportion is calculated as the business income the life insured generates in the affected business, averaged over the 12 months before the claim event took place, divided by the total business income of the affected business.

Income for other self-employed lives insured

Income or benefits receivable for the life insured's employment, or any services rendered by the life insured, plus the life insured's share of profit in the business.

Back or neck injury

A disorder or dysfunction of the vertebrae, spinal cord, intervertebral discs, nerve roots and supporting muscles or ligaments, as well as the direct or indirect consequences of, or the side-effects of any treatment applied for, such disorder or dysfunction.

Paraplegia

Total and permanent loss of function of both lower extremities.

Quadriplegia

Total and permanent loss of function of all four limbs.

Failed back syndrome after multiple spinal surgery

When the life insured, after the cover for the benefit has begun, must undergo more than one spinal operation on two or more intervertebral disc spaces in the lumbar or cervical area, and despite those operations, still suffers severe back pain as verified by a multidisciplinary pain clinic. Such operations may include discectomy, vertebral fusion and internal fixation.

Guaranteed payment event table

The contractual definitions are indicated in the table below.

Accidental Temporary Income Plus: Guaranteed Payment Event	Period of assumed occupational disability
Hospitalisation	
Hospitalisation for longer than a week	
Contractual definition: Hospitalisation for longer than one week. For the purpose of this benefit, we regard a hospital as an institution that is equipped for the diagnosis of disease, for the curative treatment, both medical and surgical, of the sick and the injured, and for the housing of patients during this process. Hospices and rehabilitation and psychiatric institutions are excluded from this definition for hospital.	1 month
Surgical replacements	
Surgical replacement of a shoulder joint	
Contractual definition: Total replacement of a shoulder joint.	2 months
Surgical replacement of an elbow joint	
Surgical replacement of an elbow joint Contractual definition: Total replacement of an elbow joint.	2 months
Surgical replacement of a wrist joint	
Contractual definition:	1 month and 2 weeks

Total replacement of a wrist joint.	
Surgical replacement of a hip joint	
Contractual definition: Total replacement of a hip joint.	2 months and 2 weeks
Surgical replacement of a knee joint	
Contractual definition: Total replacement of a knee joint.	2 months
Surgical replacement of an ankle joint	
Contractual definition: Total replacement of an ankle joint	2 months
Fractures	
Fracture of a collar bone with subsequent surgery	
Contractual definition: Fracture of a clavicle requiring open reduction and internal fixation.	1 month and 2 weeks
Fracture of the bone of an upper arm	
Contractual definition: Fracture of a humerus.	2 months
Fracture of a bone in a forearm	
Contractual definition: Fracture of an ulna or radius.	1 month
Fracture of a bone in a hand with subsequent surgery, fingers excluded	
fingers excluded Contractual definition: Fracture of a carpal or meta-carpal bone requiring open reduction and internal fixation.	1 month and 2 weeks
Fracture of the bone in an upper leg	
Contractual definition: Fracture of a femur.	3 months
Fracture of a knee cap	
Contractual definition: Fracture of a patella.	1 month and 2 weeks
Fracture of the shin bone of a lower leg	
Contractual definition: Fracture of a tibia.	2 months
Fracture of the calf bone of a lower leg	
Contractual definition: Fracture of a fibula.	1 month
Fracture of a heel bone	
Contractual definition: Fracture of a calcaneus.	1 month and 2 weeks
Skull fracture requiring reconstruction	
Contractual definition: Depressed or displaced skull fracture of the frontal, parietal, temporal, sphenoid or occipital bones requiring surgical correction.	1 month
Fracture of the facial bones requiring reconstructive surgery	
Contractual definition: Fractures of the frontal bones, orbital bones, zygoma, and/or maxilla resulting in maxillofacial reconstructive surgery.	1 month and 2 weeks
Multiple rib fractures with ICU admission	
Contractual definition: Numerous rib fractures, requiring admission to an intensive care unit (ICU), confirmed by a specialist.	1 month and 2 weeks
Multiple rib fractures requiring ventilation	
Contractual definition:	2 months

Numerous rib fractures, requiring ventilation in an intensive care unit (ICU) in order to sustain a stable blood-gas profile, confirmed by a specialist.	
Stable pelvis fracture	
Contractual definition: Stable fracture of the pelvis, treated without surgery.	2 months
Unstable pelvis fractures	
More than one fracture of the pelvic framework, resulting in instability, and requiring surgical intervention.	3 months
Fracture of the body of a spinal vertebra	
Contractual definition: A compression fracture of the body of a spinal vertebra or avulsion fracture of the spinal vertebra as confirmed on X-rays.	2 months
Fracture of the bony elements of a spinal vertebra, other than the body	
Contractual definition: A fracture of the posterior element of a vertebra, in other words the pedicle, lamina, articular process or transverse process, excluding the spinous process.	2 months
Fracture dislocation of the spine without neurological deficit	
Contractual definition: A fracture dislocation of the spine, without neurological deficit, confirmed with supporting evidence by a neurosurgeon or orthopaedic specialist.	1 month and 2 weeks
Fracture dislocation of the spine with neurological deficit	
Contractual definition: A fracture dislocation of the spine, with neurological deficit, confirmed with supporting evidence by a neurosurgeon or orthopaedic specialist.	2 months
Ligament repairs	
Surgical repair of rotator cuff syndrome of the shoulder	
Contractual definition: Surgical repair of rotator cuff syndrome.	2 months
Complete rotator cuff rupture	
Contractual definition: Complete rotator cuff rupture with subsequent surgical repair.	2 months
Knee cruciate ligament reconstruction	
Rupture of the anterior or posterior cruciate ligament of a knee with subsequent surgical repair.	1 month and 2 weeks
Knee medial or lateral ligament repair	
Contractual definition: Rupture of a collateral ligament of a knee with subsequent surgical repair.	1 months and 2 weeks
Complete achilles tendon rupture	
Contractual definition: Complete Achilles tendon rupture with subsequent surgical repair.	2 months
Ankle ligament repair	
Contractual definition: Rupture of an ankle ligament with subsequent surgical repair.	1 month and 2 weeks
Accidents and Injuries	
Abdominal injury with liver rupture, spleen rupture or kidney damage requiring emergency surgical repair	
Contractual definition: Blunt injury to the abdomen resulting in rupture of the liver or spleen, or injury to the kidney, necessitating emergency laparotomy and surgical repair, splenectomy or nephrectomy.	1 month and 2 weeks
Acute disc lesion of the spine	
Contractual definition: An acute slipped intervertebral disc with herniation.	1 month and 2 weeks
Amputation of a hand/loss of use of a hand	

Contractual definition: <ul style="list-style-type: none">• Complete physical severance of a hand at the level of the wrist, or of all five fingers through the metacarpal-phalangeal joints; or• the permanent loss of function of an entire hand from the wrist (distal to the wrist); or• the permanent loss of function of an upper limb, with at least 60% impairment of the limb according to the latest American Medical Association (AMA) guidelines.	3 months
This must be confirmed by a specialist with supporting evidence.	
Amputation of a foot/loss of use of a foot	
Contractual definition: <ul style="list-style-type: none">• The amputation of a foot at the level of the ankle joint by traumatic or surgical means; or• the permanent loss of function of an entire foot from the ankle (distal to the ankle).	3 months
This must be confirmed by a specialist with supporting evidence.	
Loss of an eye due to injury	
Contractual definition: Permanent and irreversible loss of vision in one eye due to injury.	1 month
Combination burns	
Contractual definition: A combination of second-degree and third-degree burns that covers more than 80% of the face or hands or feet, confirmed by a surgeon.	2 weeks
Major Burns	
Contractual definition: Third-degree burn wounds, full thickness of the skin, that cover at least 20% of the body surface area, as determined by the Lund and Browder chart or equivalent.	1 month and 2 weeks
Coma	
Contractual definition: A condition of unconsciousness where the life insured: <ul style="list-style-type: none">• presents with a Glasgow Coma Scale of 8 or less, and is dependent on life-sustaining aids, such as a ventilator and intravenous infusion, for an uninterrupted period of at least 96 hours.	2 months
Paraplegia	
Contractual definition: The total loss of muscle function resulting in the loss of use of both legs due to injury to the spinal cord or brain, confirmed by a specialist.	1 month and 2 weeks
Quadriplegia	
Contractual definition: The total loss of muscle function resulting in the loss of use of both arms and both legs due to injury to the spinal cord or brain, confirmed by a specialist.	3 months
Removal of the neck or lower back intervertebral discs, or fusion of the neck or lower back vertebrae	
Contractual definition: Cervical or lumbar discectomy and/or fusion.	2 months
Fat-embolism of the lungs	
Contractual definition: Fat-embolism of the lungs, confirmed by a ventilation-perfusion (VQ) scan. This must be confirmed by a pulmonologist, physician or anaesthetist.	1 month
Compartment Syndrome	
Contractual definition:	3 weeks

Definitive history of compartment syndrome as a result of an acute injury, with permanent motor nerve damage, confirmed by a specialist. This must be confirmed with all of the following supporting evidence: <ul style="list-style-type: none"> History and clinical signs of compartment syndrome, and Nerve conduction studies. 	
Gunshot or penetrating stab wound resulting in theatre debridement	
Contractual definition: Gunshot or penetrating stab wound resulting in theatre debridement, with an operation report provided by a surgeon or trauma surgeon.	1 week
Penetration by a bullet or a sharp object through the skull	
Contractual definition: Penetration by a bullet or a sharp object through the skull, resulting in surgical exploration of the skull under general anaesthetic, with an operation report provided by a surgeon or trauma surgeon.	1 month
Penetration by a bullet or sharp object through the chest, resulting in the placement of an underwater drain	
Contractual definition: Penetration by a bullet or a sharp object through the chest, resulting in an underwater drain, with an operation report provided by a surgeon or trauma surgeon.	1 month
Penetration by a bullet or a sharp object through the chest, resulting in a thoracotomy	
Contractual definition: Penetration by a bullet or a sharp object through the chest, resulting in a thoracotomy, with an operation report provided by a surgeon or trauma surgeon.	1 month
Penetration by a bullet or a sharp object through the abdomen	
Contractual definition: Penetration by a bullet or a sharp object through the abdomen, resulting in surgical exploration of the cavity under general anaesthetic, with an operation report provided by a surgeon or trauma surgeon.	1 month
Penetration by a bullet or a sharp object through the neck	
Contractual definition: Penetration by a bullet or a sharp object through the neck, with damage to one or more of the following: subclavian or carotid artery, oesophagus or trachea, with an operation report provided by a surgeon or trauma surgeon.	1 month
Female health	
Hysterectomy	
Contractual definition: Hysterectomy.	1 month and 2 weeks
Double mastectomy	
Contractual definition: Double mastectomy.	1 month

Catch-all event		
Sick leave for any other injury		
Contractual definition: Sick leave arising from any bodily injury or medical condition due to an accident, other than those already listed in the guaranteed payment event table.	Period of sick leave, limited to 3 months	
Sick leave is a medically recommended period of time during which the life insured, as a result of a bodily injury or medical condition necessitating medical or dental treatment, is totally and continuously unable to practise his or her occupation, including during any period of normal leave. The period of sick leave may not exceed the midrange data in the latest edition of the Official Disability Guidelines of the Work Loss Data Institute, or its scientific equivalent, that we will use as a reference to determine the average period of sick leave for the claim event in question. Normal leave refers to periods of paid leave, like paid annual leave or paid maternity leave		

Impairment claim events table

These impairment claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated at the end of the Income Protection benefits chapter in the section "Impairment Claim Events for Accidental Benefits". [ImpairmentClaimEventsAccidentalBenefit1](#)

Future medical advances

Some claim events 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 claim events, 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.

Overhead Expenses (OIB4)

This benefit is available under our Income Protector product which is available under our Premier product option.

Benefit description

This benefit provides short term occupational disability cover for the business owner or a key person within a business that results in less income being generated in the affected business in order to pay for the overhead expenses.

If a 1 month waiting period has been selected, it also includes a list of Guaranteed Payment Events, including a catch-all sick leave event, which guarantee payout for a certain period of time without the need to prove loss of income.

Special features

Special features are features that are automatically included for a benefit. The following Special features apply:

- Free cover
- Automatic waiver of payment

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

More information on automatic waiver of payment is provided further in this section.

Type of benefit

Standalone

When will cover for this benefit end?

Cover will end

- at midnight before the cover end date set out in the plan overview, or
- if this benefit or the plan ends for any reason before the cover end date, or
- if the life insured dies.

Cover limits per life insured

Minimum: R5 000 per month

Maximum: R150 000 per month*, limited to 100% of the life insured's share of the overhead expenses of the business. Refer to "Overhead expenses" under "Explanations" for more information.

*Subject to financial underwriting

Benefit payment period

The maximum payment period for which we will make income payments for related claims is 24 months.

Age limits

Benefit start age

Minimum:

- 18 next birthday for payment patterns other than fixed compulsory growth
- 30 next birthday for fixed compulsory growth

Maximum:

- 5 years before the benefit cease age

Benefit cease age

Choice between:

- 60 next birthday
- 65 next birthday
- 70 next birthday

Qualifying lives	Certain occupations may qualify for this benefit, subject to age limits and underwriting. The benefit is available for the owner of a business as well as for a key person in a business.
Guarantee period	The initial guarantee period is 5 years.
Waiting period options	Choice between the following, subject to underwriting: <ul style="list-style-type: none">• 1 month• 3 months

What benefit will be provided

This benefit provides cover for

- temporary or permanent occupational disability resulting in less business income being generated to pay for overhead expenses, and
- guaranteed payment events if the waiting period is 1 month.

Cover is provided up to the earlier of retirement and the cover end date of the benefit. If the life insured retires before the cover end date of the benefit, it is the planholder's responsibility to request us in writing to cancel this benefit.

Claim event for occupational disability

A benefit may be claimed if the life insured becomes disabled to the extent that he or she is continuously unable to fulfil a substantial and material part of the duties he or she normally and regularly fulfilled in the affected business immediately before becoming so disabled that less business income gets generated in the affected business to pay for the overhead expenses. This is the contractual definition for occupational disability.

What benefit will be provided for occupational disability?

If we admit a claim, we will make an income payment of up to 100% of the cover amount set out in the plan overview.

If benefit growth is applicable to the plan, the cover amount of and the payment for the benefit will continue to be increased each year as set out in the plan overview under "Benefit and payment growth". We will continue making income payments for as long as the planholder has the right to claim payment

We will limit the amount of the income payment to the cover amount as at the date we admit the claim. We will limit the amount of the income payment further to ensure that this amount, plus any remaining contributions to overhead expenses that the life insured can make regardless of his or her disability, does not exceed 100% of the life insured's share of the overhead expenses.

We will make an income payment only if the amount we have to pay is at least equal to the smaller of the following, both determined as at the time we consider a claim:

- 10% of the cover amount, and
- the minimum cover amount allowed for new business

Once we have admitted a claim, and started making income payments, we will not apply this rule even if we reduce the amount of the income payment to less than the above limit.

Claim event for guaranteed payment events

This cover only applies if a waiting period of 1 month has been chosen for this benefit.

A benefit may be claimed if the life insured meets the contractual definition of any of the guaranteed payment events indicated in the guaranteed payment events table. These events include a catch-all sick leave event.

The guaranteed payments event table can be found at the end of this section.

What benefit will be provided for guaranteed payment events?

If we admit a claim, we will make income payments as if the life insured has met the contractual definition for occupational disability for the indicated number of weeks in the guaranteed payment events table. We will assume that the disability starts on the date that the guaranteed payment event occurred. We will make the income payments whether or not the life insured is actually disabled or less business income is generated.

Admittance of a claim

Besides the conditions for admittance of a claim set out in the *General information* chapter, we will admit a claim only if the claim event is caused directly and solely by a bodily injury or by an illness.

We will admit a claim only if:

- the life insured practises his or her occupation or is on normal leave at the time that the claim event occurs, and
- the claim event occurs before the earlier of retirement and the cover end date of the benefit.

The planholder will be responsible for the cost of the financial proof of loss of income.

If the life insured travels or lives outside South Africa when the claim event occurs, we will require the medical and financial proof issued in a foreign country to be in English to consider a claim.

Admittance of a claim for occupational disability

We will admit a claim only if the occupational disability has lasted continuously for the entire waiting period. However, if the period between consecutive periods of disability resulting from the same cause is shorter than the waiting period, we will consider a claim once the consecutive periods of disability add up to the waiting period.

Admittance of a claim for guaranteed events

For the catch-all sick leave guaranteed payment event, we will admit a claim only if:

- the life insured does not meet the contractual definition of any of the other guaranteed payment events, and
- the sick leave has lasted continuously for the entire waiting period. However, if the period between consecutive periods of sick leave resulting from the same cause is shorter than the waiting period, we will consider a claim once the consecutive periods of sick leave add up to the waiting period, and
- we have not previously admitted a claim for the catch-all sick leave guaranteed payment event that is related to this claim.

For the other guaranteed payment events we will admit a claim only if:

- the waiting period has expired, and
- we have not previously admitted a claim for the same guaranteed payment event, except if the claim is for a different limb.

Waiting Period

The chosen waiting period for this benefit is set out in the plan overview.

Waiting period for occupational disability

The waiting period starts on the date the life insured meets the contractual definition of occupational disability. We will not make any income payments for occupational disability during the waiting period.

Could the waiting period sometimes be waived?

If we stop making income payments for an occupational disability claim and we admit another claim for occupational disability, we will waive the waiting period for the new claim if:

- the new claim is related to the previous claim, and
- the life insured meets the contractual definition for occupational disability within three months after we have made the last income payment for the previous claim, and
- we have not yet made income payments for the maximum payment period.

We will then continue with the income payments for as long as the planholder has the right to claim payment, but only until we have made income payments for the maximum payment period.

If the chosen waiting period is three months, we will also waive the waiting period if the life insured is totally and permanently disabled during the last three months before the cover end date of the benefit.

Waiting period for guaranteed events

The waiting period starts on the date the life insured meets the contractual definition for the guaranteed payment event.

We will not make any income payments for assumed disability during the waiting period. This means that we will only admit a claim for the number of weeks indicated in the guaranteed payment events table that are in excess of the waiting period.

When will the income payments start?

We will make the first income payment at the end of the plan month in which we admit the claim. This first income payment will be for the number of days that the planholder has the right to claim payment in that plan month. Thereafter, we will make an income payment at the end of each subsequent plan month, for as long as the planholder has the right to claim payment.

How long will the income payments continue?

The maximum payment period for which we will make income payments for related claims is 24 months.

The maximum payment period applies for each type of cover provided by this benefit and across all types of cover provided by this benefit. This means that the periods for which we pay related claims within and across all types of cover will contribute toward the above maximum period.

We will make the income payments for as long as the planholder has the right to claim payment, but only until the maximum payment period for related claims has been reached, the cover for this benefit ends or the life insured dies, whichever is earliest.

If the planholder no longer has the right to claim payment, we will make the last income payment at the end of the plan month in which his or her right to claim payment stops. If we have waived the payments for the plan while the planholder has received income payments, he or she will have to resume the payments for the plan once the income payments stop.

How long will the income payments continue for occupational disability?

We will make the income payments for as long as the life insured's disability and diminished ability to contribute towards payment of his or her share of the overhead expenses continue, but only until we have paid for the maximum payment period for related claims, or the cover for this benefit ends or the life insured dies, whichever is earliest.

The last payment will only be for the number of days in the plan month that the planholder has the right to claim payment.

After we have started making the income payments, we may from time to time ask for proof of the actual overhead expenses, as well as that the life insured is still disabled, and that his or her ability to contribute towards payment of his or her share of the overhead expenses, is still diminished. We may require the life insured to be medically examined for this purpose. We will cover the cost of such a medical reassessment only after the life insured has been disabled for at least one month.

If the life insured travels or lives outside South Africa while a claim is in payment, and we require proof that the life insured is still disabled, and that his or her ability to contribute towards payment of his or her share of the overhead expenses, is still diminished, we will require the medical proof issued in a foreign country to be in English. The planholder will be primarily responsible for the cost of medical proof. We will refund the planholder in South African currency for an amount equal to what we usually pay for such medical proof in South Africa.

We will make income payments for disability and diminished ability to contribute towards payment of the life insured's share of the overhead expenses in a foreign country for a maximum period of 12 months. Thereafter, we will consider the continuation of income payments only after the life insured has been medically assessed by a doctor nominated by us, which may require the life insured to travel to South Africa for such an assessment. We will cover the cost of the assessment, but not the travel, accommodation and related costs involved.

If the life insured recovers to such an extent that he or she is no longer disabled, or that he or she can again fully contribute towards payment of his or her share of the overhead expenses, we will stop making the income payments. However, if the life insured only partially recovers from his or her disability, we will reduce the income payments accordingly.

We will also stop making the income payments if:

- we do not receive the required proof of
- the actual overhead expenses, or

- the life insured's continued disability and diminished ability to contribute towards payment of his or her share of the overhead expenses, or
- the life insured
- refuses to be examined, or
- refuses to undergo reasonable treatment on a regular basis, at his or her cost, by a medical doctor, other than the life insured if he or she is a medical doctor

The period of disability may not exceed, unless we agree otherwise in writing, the midrange data in the latest edition of the Official Disability Guidelines of the Work Loss Data Institute, or its scientific equivalent. We will use these guidelines as a reference to determine the average period of disability for the claim event in question.

If we limit the income payments based on these guidelines, the planholder will have to provide medical proof of the life insured's continued disability. The planholder will be responsible for the cost of such medical proof.

If, after we have started making the income payments, the life insured's ability to contribute towards payment of his or her share of the overhead expenses is restored or increases, or the overhead expenses have decreased, the planholder must notify us of this. We will then reduce the amount of the income payments, or stop it.

If the planholder fails to notify us of this, and we continue to make income payments and continue to waive the payments of the plan, we will be entitled to recover from the planholder the excess income payments and the payments we waived.

How long will the income payments continue for guaranteed payment events?

We will make the income payments for as long as the life insured's assumed occupational disability continues, but only until the maximum payment period for related claims has been reached, the cover for this benefit ends or the life insured dies, whichever is earliest.

For the catch-all sick leave guaranteed payment event, we will not make any income payments for sick leave beyond 3 months or beyond the mid-range data in the latest edition of the Official Disability Guidelines of the Work Loss Data Institute, or its scientific equivalent.

The last payment will only be for the number of days in the plan month that the planholder has the right to claim payment.

Automatic waiver of payments

We will waive the payments for the plan for as long as we make an income payment. While we waive the payments, no alteration to any of the benefits on the plan is allowed.

Multiple claims

This applies if the life insured meets the contractual definition of more than one claim event over the duration of the benefit.

If the life insured meets the contractual definition of a claim under more than one type of cover at the same time, we will first admit a claim under the guaranteed payment events. Once the last income payment under this type of cover has been made, we will consider a claim under occupational disability, if applicable at the time.

We will never pay more than 100% of the cover amount in any month or more than once for the same calendar date.

Multiple claims for guaranteed payment events

We will consider a claim for the catch-all sick leave guaranteed payment event only if the life insured does not meet the contractual definition of any of the other guaranteed payment events.

If the life insured meets the contractual definition of more than one of the other guaranteed payment events at the same time, we will only pay for the guaranteed payment event with the longest period of assumed occupational disability indicated in the guaranteed payment events table.

Exclusions

General exclusions are set out in the applicable overview chapter in this technical guide. Specific exclusions, if any, are set out in the plan overview, in the special provisions for the life insured concerned.

If the life insured at any time practises sport as an occupation, or works as a pilot, and becomes continuously unable to fulfil a substantial and material part of the duties of that occupation, so that less business income gets generated in the affected business to pay for the overhead expenses, we will not admit a claim as a result of such inability. This exclusion applies to occupational disability and to the catch-all sick leave guaranteed payment event.

We will not admit a claim if it directly or indirectly resulted from

- normal pregnancy, or
- normal childbirth, or
- cosmetic surgery, except if it is medically necessary after an accident or bodily injury that occurred while cover for this benefit was in force, or
- a rehabilitation or detoxification program to treat alcohol or drug dependency or abuse, or any medical condition related to such dependency or abuse

Cover for caesarean sections

For the purpose of this benefit, we do not consider caesarean sections to be normal childbirth, whether or not the procedure was elective. Such procedures could therefore qualify for a claim for occupational disability or a guaranteed payment event if all other requirements for a claim are met, unless the procedure is specifically excluded for the life insured.

Cover during maternity leave

Maternity leave itself is not a claim event. This benefit does, however, provide cover for occupational disability and guaranteed payment events during periods of paid maternity leave.

Explanations

What is a plan month?

The first plan month starts on the day when the plan begins. Each following plan month will start on the same day as the first one. A plan month ends at midnight on the day before the next plan month starts.

What is normal leave?

Normal leave refers to periods of paid leave, like paid annual leave or paid maternity leave.

When is a person retired?

We regard the life insured as retired if he or she is 55 years or older, and does not earn an income over and above a passive income. Passive income refers to income that can continue without the life insured's intervention, for example pension or rental income.

What is total and permanent disability?

The life insured is totally and permanently unable to fulfil the occupational duties he or she normally and regularly fulfilled in the affected business immediately before becoming so disabled that less business income gets generated in the affected business to pay for the life insured's share of the overhead expenses.

What is a related claim?

A claim is related to another claim if there is enough published evidence to show that:

- the medical condition or bodily injury:
 - is the result of the same medical condition or bodily injury that led to the other claim, or
 - has been caused by the same disease process or bodily injury that led to the other claim, and
- it is unlikely that the medical condition or injury would have occurred if it was not for the medical condition or injury that led to the other claim.

What is medically necessary cosmetic surgery?

Any surgical intervention that meets all of the following requirements:

- It is needed to restore the normal function of an affected limb, organ or system,
- There is no alternative with equal or better outcomes,
- It is accepted as the best medical practice at the time,
- It is not done for the sake of convenience for either the life insured or relevant medical practitioner,
- It has available outcome studies which are acceptable to us,
- It is not done for any psychiatric, psychological or mental reasons.

Explanations for occupational disability

Affected business

The business where the life insured fulfilled his or her duties immediately before the disability.

Overhead expenses

Overhead expenses include the following:

- rent for the business premises;
- water, electricity, telephone;
- regular maintenance services;
- property taxes and mortgage interest for the business premises;
- equipment leasing costs;
- insurance premiums;
- accounting fees;
- salaries of employees;
- other normal and necessary expenses that we agree to include.

Overhead expenses exclude the following:

- depreciation;
- cost of goods or merchandise or additions to inventory;
- cost of furniture or equipment;
- capital payments on outstanding debt;
- expenditure on assets;
- fees on current accounts;
- business rationalisation costs, for example, retrenchment;
- any remuneration or other consideration to the life insured, the planholder, associates in the affected business, and any other person who shares directly or indirectly in the profit of the affected business.

The life insured's share of the overhead expenses is a proportion of the total overhead expenses of the affected business. The proportion is calculated as the business income the life insured generates in the affected business, averaged over the 12 months before the claim event took place, divided by the total business income of the affected business.

Guaranteed payment event table

The contractual definitions are indicated in the table below.

Overhead Expenses: Guaranteed Payment Event	Period of assumed occupational disability
Surgical replacements	
Surgical replacement of a shoulder joint	
Contractual definition: Total replacement of a shoulder joint.	2 months
Surgical replacement of an elbow joint	
Surgical replacement of an elbow joint Contractual definition: Total replacement of an elbow joint.	2 months
Surgical replacement of a wrist joint	
Contractual definition: Total replacement of a wrist joint.	1 month and 2 weeks
Surgical replacement of a hip joint	
Contractual definition: Total replacement of a hip joint.	2 months and 2 weeks
Surgical replacement of a knee joint	
Contractual definition: Total replacement of a knee joint.	2 months
Surgical replacement of an ankle joint	
Contractual definition: Total replacement of an ankle joint	2 months
Fractures	
Fracture of a collar bone with subsequent surgery	
Contractual definition: Fracture of a clavicle requiring open reduction and internal fixation.	1 month and 2 weeks
Fracture of the bone of an upper arm	
Contractual definition: Fracture of a humerus.	2 months
Fracture of a bone in a hand with subsequent surgery, fingers excluded	
fingers excluded Contractual definition: Fracture of a carpal or meta-carpal bone requiring open reduction and internal fixation.	1 month and 2 weeks
Fracture of the bone in an upper leg	
Contractual definition: Fracture of a femur.	3 months
Fracture of a knee cap	
Contractual definition: Fracture of a patella.	1 month and 2 weeks
Fracture of the shin bone of a lower leg	
Contractual definition: Fracture of a tibia.	2 months
Fracture of a heel bone	
Contractual definition: Fracture of a calcaneus.	1 month and 2 weeks

Overhead Expenses: Guaranteed Payment Event	Period of assumed occupational disability
Fracture of the facial bones requiring reconstructive surgery	
Contractual definition: Fractures of the frontal bones, orbital bones, zygoma, and/or maxilla resulting in maxillofacial reconstructive surgery.	1 month and 2 weeks
Multiple rib fractures with ICU admission	
Contractual definition: Numerous rib fractures, requiring admission to an intensive care unit (ICU), confirmed by a specialist.	1 month and 2 weeks
Multiple rib fractures requiring ventilation	
Contractual definition: Numerous rib fractures, requiring ventilation in an intensive care unit (ICU) in order to sustain a stable blood-gas profile, confirmed by a specialist.	2 months
Stable pelvis fracture	
Contractual definition: Stable fracture of the pelvis, treated without surgery.	1 month and 2 weeks
Unstable pelvis fractures	
More than one fracture of the pelvic framework, resulting in instability, and requiring surgical intervention.	3 months
Fracture of the body of a spinal vertebra	
Contractual definition: A compression fracture of the body of a spinal vertebra or avulsion fracture of the spinal vertebra as confirmed on X-rays.	2 months
Fracture of the bony elements of a spinal vertebra, other than the body	
Contractual definition: A fracture of the posterior element of a vertebra, in other words the pedicle, lamina, articular process or transverse process, excluding the spinous process.	2 months
Fracture dislocation of the spine without neurological deficit	
Contractual definition: A fracture dislocation of the spine, without neurological deficit, confirmed with supporting evidence by a neurosurgeon or orthopaedic specialist.	1 month and 2 weeks
Fracture dislocation of the spine with neurological deficit	
Contractual definition: A fracture dislocation of the spine, with neurological deficit, confirmed with supporting evidence by a neurosurgeon or orthopaedic specialist.	2 months
Ligament repairs	
Surgical repair of rotator cuff syndrome of the shoulder	
Contractual definition: Surgical repair of rotator cuff syndrome.	2 months
Complete rotator cuff rupture	
Contractual definition: Complete rotator cuff rupture with subsequent surgical repair.	2 months
Knee cruciate ligament reconstruction	
Rupture of the anterior or posterior cruciate ligament of a knee with subsequent surgical repair.	1 month and 2 weeks
Knee medial or lateral ligament repair	
Contractual definition: Rupture of a collateral ligament of a knee with subsequent surgical repair.	1 months and 2 weeks

Overhead Expenses: Guaranteed Payment Event	Period of assumed occupational disability
Complete achilles tendon rupture	
Contractual definition: Complete Achilles tendon rupture with subsequent surgical repair.	2 months
Ankle ligament repair	
Contractual definition: Rupture of an ankle ligament with subsequent surgical repair.	1 month and 2 weeks
Accidents and Injuries	
Abdominal injury with liver rupture, spleen rupture or kidney damage requiring emergency surgical repair	
Contractual definition: Blunt injury to the abdomen resulting in rupture of the liver or spleen, or injury to the kidney, necessitating emergency laparotomy and surgical repair, splenectomy or nephrectomy.	1 month and 2 weeks
Acute disc lesion of the spine	
Contractual definition: An acute slipped intervertebral disc with herniation.	1 month and 2 weeks
Amputation of a hand/loss of use of a hand	
Contractual definition: <ul style="list-style-type: none"> • Complete physical severance of a hand at the level of the wrist, or of all five fingers through the metacarpal-phalangeal joints; or • the permanent loss of function of an entire hand from the wrist (distal to the wrist); or • the permanent loss of function of an upper limb, with at least 60% impairment of the limb according to the latest American Medical Association (AMA) guidelines. <p>This must be confirmed by a specialist with supporting evidence.</p>	3 months
Amputation of a foot/loss of use of a foot	
Contractual definition: <ul style="list-style-type: none"> • The amputation of a foot at the level of the ankle joint by traumatic or surgical means; or • the permanent loss of function of an entire foot from the ankle (distal to the ankle). <p>This must be confirmed by a specialist with supporting evidence.</p>	3 months
Major Burns	
Contractual definition: Third-degree burn wounds, full thickness of the skin, that cover at least 20% of the body surface area, as determined by the Lund and Browder chart or equivalent.	1 month and 2 weeks
Coma	
Contractual definition: A condition of unconsciousness where the life insured: <ul style="list-style-type: none"> • presents with a Glasgow Coma Scale of 8 or less, and <p>is dependent on life-sustaining aids, such as a ventilator and intravenous infusion, for an uninterrupted period of at least 96 hours.</p>	2 months
Paraplegia	
Contractual definition: The total 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, confirmed by a specialist.	1 month and 2 weeks

Overhead Expenses: Guaranteed Payment Event	Period of assumed occupational disability
Quadriplegia	
Contractual definition: The total loss of muscle function resulting in the loss of use of both arms and both legs due to disease of or injury to the spinal cord or brain, confirmed by a specialist. .	3 months
Removal of the neck or lower back intervertebral discs, or fusion of the neck or lower back vertebrae	
Contractual definition: Cervical or lumbar discectomy and/or fusion.	2 months
Female health	
Hysterectomy	
Contractual definition: Hysterectomy.	1 month and 2 weeks
Catch-all event	
Sick leave for any other illness or injury	
Contractual definition: Sick leave arising from any illness or bodily injury other than those already listed in the guaranteed payment event table. Sick leave is a medically recommended period of time during which the life insured, as a result of a bodily injury, illness or other cause or condition necessitating medical or dental treatment, is totally and continuously unable to practise his or her occupation, including during any period of normal leave. The period of sick leave may not exceed the midrange data in the latest edition of the Official Disability Guidelines of the Work Loss Data Institute, or its scientific equivalent, that we will use as a reference to determine the average period of sick leave for the claim event in question. Normal leave refers to periods of paid leave, like paid annual leave or paid maternity leave.	Period of sick leave, limited to 3 months

Extended Income (OIO4) and Extended Income Plus (OIO6)

These benefits are available under our Income Protector product which is available under our Premier product option.

Benefit description	<p>These benefits provide long term cover for occupational disability resulting in a loss of income and for permanent impairments, after a waiting period of 24 months. It also provides cover for joint replacements and trauma claim events from retirement or age 70 whichever is earlier. The benefit is available to employed clients with qualifying occupations.</p> <ul style="list-style-type: none"> • The Extended Income benefit covers occupational disability and severe impairment events. • The Extended Income Plus benefit covers occupational disability, severe impairments events and less severe impairment events.
Optional rider benefit	<p>The following rider benefit may be added to this benefit:</p> <ul style="list-style-type: none"> • Lump Sum Conversion Option <p>An additional payment will be charged for the rider benefit.</p>
Special features	
	<p>Special features are features that are automatically included for a benefit. The following Special features apply:</p> <ul style="list-style-type: none"> • Free cover • Automatic waiver of payment • Extended occupational disability cover • Proof free additional cover for qualifying standard lives • Built-in future cover for young lives <p>Refer to the chapter <i>Payments, payment patterns, guarantees and cover</i> for more information about Free cover.</p> <p>More information on automatic waiver of payment, extended occupational disability cover and proof free additional cover is provided further in this section.</p> <p>For more information on built-in cover for young lives please see the applicable chapter in the lump sum disability section of the technical guide.</p>
Type of benefit	Standalone
When will cover for this benefit end?	<p>Cover will end</p> <ul style="list-style-type: none"> • at midnight before the cover end date set out in the plan overview, or • if this benefit or the plan ends for any reason before the cover end date, or • if the life insured dies.
Cover limits per life insured	<p>Minimum: R3 000 per month</p> <p>Maximum: R200 000 per month*, limited to the sliding scale percentage of the life insured's gross monthly income.**</p>

Young professionals in certain occupations may qualify for cover of more than the percentage of monthly income above. For a young professional to qualify for a higher cover amount he or she must also:

- qualify for rate group 5, and
- be actively at work, and
- be younger than age 30 next birthday.

The electronic *Calculating Disability and Sickness maximums* on SanPort can be used for these calculations.

*Subject to financial underwriting

**Refer to the underwriting chapters for the sliding scales and the definitions of gross income.

Benefit payment period	Refer to "How long will the income payments continue?" in this section.
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Age limits	Benefit start age
Minimum:	<ul style="list-style-type: none"> • 18 next birthday for payment patterns other than fixed compulsory growth • Fixed compulsory growth: 30 next birthday
Maximum:	<ul style="list-style-type: none"> • 5 years before the benefit cease age • 65 next birthday for the whole life option

Benefit cease age

Choice between:

- 60 next birthday
- 65 next birthday
- 70 next birthday
- Whole of life

Qualifying lives	Lives who comply with all of the following may qualify, subject to age limits and underwriting: <ul style="list-style-type: none"> • must be employed, either self-employed or by an employer, and • must practise a qualifying occupation, as determined by us.
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Guarantee period	The initial guarantee period is 5 years.
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Waiting period options	This benefit has a built-in waiting period of 24 months. For the whole life cease age option, the waiting period will be waived from age 70.
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What this benefit provides

This benefit provides cover for

- temporary or permanent occupational disability, up to retirement, age 70 or the cover end date of the benefit, whichever is earlier, and
- joint replacement and trauma impairment claim events, from retirement or age 70, whichever is earlier, and
- permanent impairment claim events.

Claim event for occupational disability

A benefit may be claimed if the life insured becomes disabled to the extent that he or she is continuously unable to fulfil a substantial and material part of the duties of the regular occupation he or she practised for income immediately before the disability, resulting in a loss of some or all of such income.

If the life insured is a qualifying student when he or she becomes disabled, a benefit may be claimed if the life insured becomes disabled to the extent that he or she will be totally and permanently unable to fulfil the occupational demands of an occupation we may reasonably expect him or her to have practised, had they not become disabled and had they completed their studies.

The above is the contractual definition for occupational disability.

What is a qualifying student?

A qualifying student is a full-time student in at least their 4th academic year studying toward an NQF-level 8 or higher qualification.

A student progresses to the next academic year when they successfully pass a tertiary study year.

Extended occupational disability cover

If the life insured stops working for any reason other than retiring or becoming a qualifying student, for example, taking a sabbatical, becoming a housewife or being retrenched, we will provide extended occupational disability cover for total and permanent disability for up to 12 months from the date he or she stopped working.

For this cover, total and permanent disability refers to the life insured being totally and permanently unable to fulfil the occupational duties of the regular occupation he or she practised for income immediately before he or she stopped working.

Extended occupational disability cover will only apply if the occupational disability is total and permanent and not as a result of any of the following conditions:

- depression or dysthymia, whether as an episode or disorder, or as part of the symptom complex of another psychiatric diagnosis;
- post-traumatic stress disorder;
- fibromyalgia;
- chronic fatigue syndrome and its synonyms;
- a neck or back condition, unless it is one of the following: paraplegia; quadriplegia; malignant tumours of the spinal cord and vertebral column; or failed back syndrome after multiple spinal surgery, provided the extent of the functional impairment arising from the failed back syndrome is verified by a specialist that we will nominate;
- any orthopaedic condition based mainly on pain, discomfort, loss of sensation, loss of range of motion, or any combination thereof;
- any decline in cognitive functioning that is not supported by objective evidence of organic pathology;
- an injury or illness that directly or indirectly resulted from, or is traceable to, any of the above causes;
- a complication that directly or indirectly is attributable to any of the above causes, or to such an injury or illness;
- a side-effect of treatment for any of the above causes, or for such an injury or illness, or for such a complication.

Qualifying students

If the life insured is a qualifying student and successfully completes his or her studies, but does not yet start working, we will continue to cover him or her for occupational disability as if he or she is still a qualifying student, for up to 12 months from the date he or she stopped studying. This extended occupational disability cover will only apply if the occupational disability is not as a result of any of the above listed conditions.

What benefit will be provided for occupational disability?

If we admit a claim, we will make an income payment of up to 100% of the cover amount. The current cover amount is set out in the plan overview.

If benefit growth is applicable to the plan, the cover amount of and the payment for the benefit will continue to be increased each year as set out in the plan overview under "Benefit and payment growth". We will continue making income payments for as long as the planholder has the right to claim payment.

When we admit a claim, we will limit the amount of the income payment to the cover amount as at the date we admit the claim.

If the life insured's disability results in a loss of only some of the income from his or her regular occupation, we will further limit the amount of the income payment in proportion to the loss of income.

If the disability directly or indirectly results from any of the conditions listed below, we will further limit the amount of the income payment to ensure that this amount, plus any occupational disability income that the life insured might receive from other individual or group disability income type plans, does not exceed 75% of the life insured's average monthly income after tax. If benefit growth is applicable to the plan, this limited income payment will be increased each year by the benefit growth rate as set out in the plan overview under "Benefit and payment growth".

- depression or dysthymia, whether as an episode or disorder, or as part of the symptom complex of another psychiatric diagnosis;
- post-traumatic stress disorder;

- fibromyalgia;
- chronic fatigue syndrome and its synonyms;
- a neck or back condition, unless it is one of the following: paraplegia; quadriplegia; malignant tumours of the spinal cord and vertebral column; or failed back syndrome after multiple spinal surgery, provided the extent of the functional impairment arising from the failed back syndrome is verified by a specialist that we will nominate;
- any orthopaedic condition based mainly on pain, discomfort, loss of sensation, loss of range of motion, or any combination thereof;
- any decline in cognitive functioning that is not supported by objective evidence of organic pathology;
- an injury or illness that directly or indirectly resulted from, or is traceable to, any of the above causes;
- a complication that directly or indirectly is attributable to any of the above causes, or to such an injury or illness;
- a side-effect of treatment for any of the above causes, or for such an injury or illness, or for such a complication.

We will make an income payment only if the amount we have to pay is at least equal to the smaller of the following, both determined as at the time we consider a claim:

- 10% of the cover amount, and
- the minimum cover amount allowed for new business.

Once we have admitted a claim, and started making income payments, we will not apply this rule even if we reduce the amount of the income payment to less than the above limit.

Claim event for impairment

A benefit may be claimed if the life insured meets the contractual definition of any of the impairment claim events indicated in the impairment claim event table, whether or not the life insured is unable to do his or her occupation or has a loss of income.

These impairment claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated at the end of the Income Protection benefits chapter in the section "Impairment Claim Events for Long Term Benefits". [ImpairmentClaimEventsLongTermBenefits](#)

What benefit will be provided for impairment?

If we admit a claim, we will make a monthly income payment equal to the percentage of the cover amount linked to the particular claim event as set out in the impairment claim event table. For multiple claims, we may pay a lower percentage than indicated in the table.

If benefit growth is applicable to the plan, the cover amount of and the payment for the benefit will continue to be increased each year as set out in the plan overview under "Benefit and payment growth". We will continue making income payments for as long as the planholder has the right to claim payment.

Admittance of a claim

Besides the conditions for admittance of a claim set out in the general plan provisions, we will admit a claim only if the claim event is caused directly and solely by a bodily injury or by an illness.

The planholder will be responsible for the cost of medical proof and the cost of financial proof of loss of income when a claim is submitted.

If the life insured travels or lives outside South Africa when the claim event occurs, we will require the medical and financial proof issued in a foreign country to be in English to consider a claim.

Admittance of a claim for occupational disability

We will admit a claim only if:

- the life insured practises his or her occupation or is on normal leave at the time that the claim event occurs, or for a qualifying student, if the life insured is enrolled in his or her studies at the time that the claim event occurs. An exception is if the requirements for extended occupational disability cover are met; and
- the occupational disability has lasted continuously for the entire waiting period. However, if the period between consecutive periods of disability resulting from the same cause is shorter than the waiting period, we will consider a claim once the consecutive periods of disability add up to the waiting period, and
- the claim event occurs before retirement, age 70 or the cover end date of the benefit, whichever is earlier.

Admittance of a claim for impairment cover

We will admit a claim only if:

- the impairment is permanent, after the life insured has undergone optimal, reasonable treatment, and
- the waiting period has expired, and

- we have not previously admitted a claim for the same claim event, except if the claim event is listed under "Musculoskeletal system" in the impairment claim event table, and the claim is for a different limb, and
- the claim event occurred before the cover end date of the benefit.

The impairment must be permanent, and evaluated according to the principles and ratings of the latest edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. The impairment, and permanence thereof, will be evaluated only 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.

Waiting period

This benefit has a built-in waiting period of 24 months.

Waiting period for occupational disability

The waiting period starts on the date the life insured meets the contractual definition for occupational disability. For extended occupational disability cover, the waiting period starts on the date the life insured meets the contractual definition for total and permanent disability. We will not make any income payments for occupational disability during the waiting period.

Could the waiting period sometimes be waived?

If we stop making income payments for an occupational disability claim and we admit another claim for occupational disability, we will waive the waiting period for the new claim if:

- the new claim is related to the previous claim; and
- the life insured meets the contractual definition for occupational disability within three months after we have made the last income payment for the previous claim.

If the cease age is not whole life, we will waive the waiting period if the life insured is totally and permanently disabled during the 24 months before the cover end date.

Waiting period for impairment cover

The waiting period starts on the date the life insured meets the contractual definition for the impairment claim event. We will not make any income payments for impairment during the waiting period.

The waiting period will only apply until the earlier of retirement and age 70.

Could the waiting period sometimes be waived?

If the life insured also has any of the benefits listed below, and during the waiting period of this benefit, we stop making income payments on the other benefit because the maximum payment period has been reached, we will waive the remainder of the waiting period of this benefit. This will be done if the payments on the other benefit were made for the same medical condition that resulted in a claim for this benefit:

- Sickness Income
- Sickness Income Plus
- Temporary Income
- Temporary Income Plus

If the cover amount of this benefit is greater than the cover amount of the other benefit, the above concession will only apply on the smaller amount.

When will the income payments start?

We will make the first income payment at the end of the plan month in which we admit the claim. The first income payment will be for the number of days the planholder has the right to claim payment in that plan month. Thereafter, we will make an income payment at the end of each subsequent plan month, for as long as the planholder has the right to claim payment.

How long will the income payments continue?

We will make the income payments for as long as the planholder has the right to claim payment.

If the planholder no longer has the right to claim payment, we will make the last income payment at the end of the plan month in which their right to claim payment stops. If we have waived the payments for the plan while the planholder has received income payments, the planholder will have to resume the payments for the plan once the income payments stop.

If fixed compulsory payment growth is applicable to the plan and we admit a claim for this benefit within 5 years from the cover end date set out in the plan overview, we will not stop making the income payments when the cover end date is reached, despite anything to the contrary for this benefit in this chapter. We will continue making the income payments for up to 5 years from the date on which the claim has been admitted, as long as the life insured is still disabled. This only applies as long as compulsory payment growth is applicable to the plan.

How long will the income payments continue for occupational disability?

We will make the income payments for as long as the life insured's disability and loss of income continue, but only until age 70, the cover end date of this benefit or the death of the life insured, whichever is earliest.

The last payment will only be for the number of days in the plan month that the planholder has the right to claim payment.

If the cease age is whole of life and we have made income payments for occupational disability until age 70, we will re-assess the claim at age 70 to determine whether the life insured qualifies for further income payments for impairment cover.

After we have started making the income payments, we may from time to time ask for proof that the life insured is still disabled, and still has a loss of income. We may require the life insured to be medically examined for this purpose. We will cover the cost of such a medical reassessment. The planholder will be responsible for the cost of financial proof of loss of income.

If the life insured travels or lives outside South Africa while a claim is in payment, and we require proof that the life insured is still disabled and still has a loss of income, we will require the medical and financial proof issued in a foreign country to be in English. The planholder will be primarily responsible for the cost of medical proof. We will refund the planholder in South African currency for an amount equal to what we usually pay for such medical proof in South Africa. The planholder will be responsible for the cost of financial proof of loss of income.

We will make income payments for disability and loss of income in a foreign country for a maximum period of 12 months. Thereafter, we will consider the continuation of income payments only after the life insured has been medically assessed by a doctor nominated by us, which may require the life insured to travel to South Africa for such an assessment. We will cover the cost of the assessment, but not the travel, accommodation and related costs involved.

If the life insured recovers to such an extent that he or she is no longer disabled, or no longer has a loss of income, we will stop making the income payments.

If the life insured only partially recovers from his or her disability, or still has a loss of income but to a lesser extent, we will reduce the income payments in proportion to the loss of income.

We will also stop making the income payments if:

- we do not receive the required proof of the life insured's continued disability and loss of income, or
- the life insured
 - refuses to be examined, or
 - refuses to undergo reasonable treatment on a regular basis, at his or her cost, by a medical doctor, other than the life insured if he or she is a medical doctor.

The period of disability may not exceed, unless we agree otherwise in writing, the midrange data in the latest edition of the Official Disability Guidelines of the Work Loss Data Institute, or its scientific equivalent. We will use these guidelines as a reference to determine the average period of disability for the claim event in question.

If we limit the income payments based on these guidelines, the planholder will have to provide medical proof of the life insured's continued disability. The planholder will be responsible for the cost of such medical proof.

If the life insured starts earning an income from his or her regular occupation or from other individual or group disability income type plans after we have started making the income payments, or if such income is increased, the planholder must notify us of this. We may then reduce the amount of the income payments, or stop them.

If the planholder fails to notify us of this, and we continue to make income payments and continue to waive the payments of the plan, we will be entitled to recover from the planholder the excess income payments and the payments we waived.

How long will the income payments continue for impairment cover?

We will make the income payments until midnight before the cover end date set out in the plan overview, or until the life insured dies, if this is earlier.

For claim events that are only covered from the earlier of retirement and age 70, we will make income payments up to the indicated payment period only.

The last payment will only be for the number of days in the plan month that the planholder has the right to claim payment.

Automatic waiver of payments

If the cease age is not whole life we will waive the payments for the plan for as long as we make income payments for occupational disability or for 100% of the cover amount. While we waive the payments, no alteration to any of the benefits on the plan is allowed.

If the cease age is whole life, we will waive the payments for the plan for as long as we make income payments for occupational disability or for the maximum percentage of the cover amount. The maximum percentage is 100% before age 70 and 50% from age 70. From age 70, we will waive the payment while a claim is in payment for 50% of the cover amount. While we waive the payments, no alteration to any of the benefits on the plan is allowed.

Proof-free additional cover

If the plan has cover growth and the plan has been accepted with standard terms (i.e. without loadings or specific exclusions for a life insured), the plan holder has the option each year to request in writing that we increase the cover amount of this benefit by more than the current cover growth rate, without additional underwriting for the life insured. Any additional cover increases will take place on the plan anniversaries, together with the contractual cover increases.

The following additional requirements must be met before we will grant an additional cover increase as described above:

- The life insured must not be disabled or impaired on the date of the cover increase.
- A claim must not have been admitted, or already submitted, during the 12 months preceding the date of the cover increase.
- The life insured must be younger than 50 years on the date of the cover increase.
- We must receive the plan holder's written request to exercise the option at our head office at least 14 working days before the plan anniversary of the particular year.

The total increase in the cover amount of a benefit for a particular year (the annual cover growth increase plus the proof free increase) will be restricted to the lower of:

- the actual increase in the life insured's income over that year,
- twice the rate that we will use for increases according to the inflation rate that year, and
- 20%.

Multiple claims

This applies if the life insured meets the contractual definition of more than one claim event over the duration of the benefit.

If a life insured meets the contractual definition of occupational disability and an impairment claim event at the same time, and the claims are related, we will only pay for the type of cover that will result in the highest payout.

If a life insured meets the contractual definition of occupational disability and an impairment claim event at the same time, and the claims are unrelated, we will pay for both types of cover. We will however not pay more than 100% of the cover amount in any month.

We will never pay more than 100% of the cover amount in any month or more than once for the same calendar date.

Multiple claims for impairment cover

This applies if a life insured meets the contractual definition of more than one impairment claim event at the same time. The percentage of the cover amount that we pay for the claim may then be lower than indicated in the impairment claim event table.

We will only admit an impairment claim that is related to previously admitted impairment claims if the new claim event has a higher percentage of the cover amount indicated in the impairment claim event table. The income payment that we are already making will then be increased to be in line with the higher percentage.

If the cease age is not whole life and we admit an impairment claim that is unrelated to previously admitted impairment claims, we may need to reduce the percentage of the cover amount indicated in the impairment claim event table to ensure that we do not pay more than 100% of the cover amount in any month.

If the cease age is whole life and we admit an impairment claim that is unrelated to previously admitted impairment claims, we may need to reduce the percentage of the cover amount indicated in the claim event table to ensure that we do not pay more than the maximum percentage of the cover amount in any month. The maximum percentage is 100% before age 70 and 50% after age 70.

We will never pay more than the maximum percentage of the cover amount in any month. The maximum percentage is 100% before age 70 and 50% after age 70.

Exclusions

General exclusions are set out in the applicable overview chapter in this technical guide. Specific exclusions, if any, are set out in the plan overview, in the special provisions for the life insured concerned.

Exclusions for occupational disability

If the life insured at any time practises sport as an occupation, or works as a pilot, and becomes continuously unable to fulfil a substantial and material part of the duties of that occupation, we will not admit a claim as a result of such inability.

We will also not admit a claim if it directly or indirectly resulted from

- normal pregnancy, or
- normal childbirth.

Exclusions for impairment cover

We will not admit a claim if the impairment of the life insured can be substantially removed or improved by surgery or other medical treatment, which we can reasonably expect him or her to undergo, taking into account the risks involved and the chances of success of such surgery or treatment.

Exclusion period for joint replacements

A 5-year exclusion period from the cover start date of the benefit is applicable to the following claim events resulting from natural causes:

- Total hip replacement;
- Total knee replacement;
- Total shoulder replacement;
- Total ankle replacement.

A claim for any of these claim events, resulting from natural causes, can only be submitted if the claim event occurred at least 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 5-year exclusion period will apply to the increased part of the cover amount from the date of the increase.

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

Conversion options

The payment will not reduce when the cover for occupational disability ends. If the life insured stops working before the cover for occupational disability ends, and plans to never work again, conversion options are available for this benefit. Conversion options may however not necessarily result in a lower payment.

Explanations

Plan month

The first plan month starts on the day when the plan begins. Each following plan month will start on the same day as the first one. A plan month ends at midnight on the day before the next plan month starts.

What is normal leave?

Normal leave refers to periods of paid leave, like paid annual leave or paid maternity leave

When is a person retired?

We regard the life insured as retired if he or she is 55 years or older, and does not earn an income over and above a passive income. Passive income refers to income that can continue without the life insured's intervention, for example pension or rental income.

What is a related claim?

A claim is related to another claim if there is enough published evidence to show that:

- the medical condition or bodily injury:
 - is the result of the same medical condition or bodily injury that led to the other claim; or
 - has been caused by the same disease process or bodily injury that led to the other claim; and
- it is unlikely that the medical condition or injury would have occurred if it was not for the medical condition or injury that led to the other claim.

Explanations for occupational disability

Regular occupation

The occupation the life insured practised for income immediately before becoming disabled.

Average monthly income

The monthly income from the life insured's regular occupation, averaged over the 12 months before the claim event took place. If the life insured has a fluctuating income, we will calculate the average monthly income over the 36 months before the claim event took place. For self-employed clients, we will always consider their average monthly income rather than their most recent monthly income.

What is a qualifying student?

A qualifying student is a full-time student in at least their 4th academic year studying toward an NQF-level 8 or higher qualification.

A student progresses to the next academic year when they successfully pass a tertiary study year.

Income for lives insured in formal employment of an employer

Cost-to-company income which consists of gross taxable income of the life insured including the employer's contributions to a medical scheme, provident fund or pension fund on behalf of the life insured, and the cost of any other benefits paid for by the life insured's employer that form part of the life insured's remuneration package and are reflected in the employer's financial statements.

Income for professional lives insured in practice

Gross professional income for professionals who charge a fee for services is equal to the sum of professional fees and net income from trading activities, less business overhead expenses.

Overhead expenses include the following:

- rent for the business premises;
- water, electricity, telephone;
- regular maintenance services;
- property taxes and mortgage interest for the business premises;
- equipment leasing costs;
- insurance premiums;
- accounting fees;
- salaries of employees;
- other normal and necessary expenses that we agree to include.

Overhead expenses exclude the following:

- depreciation;
- cost of goods or merchandise or additions to inventory;

- cost of furniture or equipment;
- capital payments on outstanding debt;
- expenditure on assets;
- fees on current accounts;
- business rationalisation costs, for example, retrenchment;
- any remuneration or other consideration to the life insured, the planholder, associates in the affected business, and any other person who shares directly or indirectly in the profit of the affected business.

The life insured's share of the overhead expenses is a proportion of the total overhead expenses of the affected business. The proportion is calculated as the business income the life insured generates in the affected business, averaged over the 12 months before the claim event took place, divided by the total business income of the affected business.

Income for other self-employed lives insured

Income or benefits receivable for the life insured's employment, or any services rendered by the life insured, plus the life insured's share of profit in the business.

Neck or back condition

A disease, disorder, or dysfunction of the vertebrae, spinal cord, intervertebral discs, nerve roots and supporting muscles or ligaments, as well as the direct or indirect consequences of, or the side-effects of any treatment applied for, such disease, disorder, or dysfunction.

Paraplegia

Total and permanent loss of function of both lower extremities.

Quadriplegia

Total and permanent loss of function of all four limbs.

Malignant tumours of the spinal cord and vertebral column

The incontrovertible presence of uncontrolled growth and spread of malignant cells, the invasion of normal tissue, and the definite histological evidence of a malignant growth in the spinal cord and vertebral column.

Failed back syndrome after multiple spinal surgery

When the life insured, after the cover for the benefit has begun, must undergo more than one spinal operation on two or more intervertebral disc spaces in the lumbar or cervical area, and despite those operations, still suffers severe back pain as verified by a multidisciplinary pain clinic. Such operations may include discectomy, vertebral fusion and internal fixation.

Impairment claim events

Impairment claim events that apply throughout

These impairment claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated at the end of the Income Protection benefits chapter in the section "Impairment Claim Events for Long Term Benefits". [ImpairmentClaimEventsLongTermBenefits](#)

Impairment claim events from the earlier of retirement and age 70

The impairment claim events indicated in the table below are only covered from the earlier of retirement and age 70. The claim event must therefore have occurred on or after this date. Before this date, these claim events are covered by Sickness Income, Sickness Income Plus, Temporary Income and Temporary Income Plus, if applicable to the life insured, and if not specifically excluded for the life insured. If the cease age is whole life the percentage of the cover amount for these claim events is not dependent on the age of the life insured.

Extended Income and Extended Income Plus: Impairment claim events from the earlier of retirement and age 70	Percentage of cover amount	Payment period in months
Joint replacements		
Total hip replacement*		

Extended Income and Extended Income Plus: Impairment claim events from the earlier of retirement and age 70	Percentage of cover amount	Payment period in months
Contractual definition: Total surgical replacement of the hip joint with a prosthesis, confirmed by an orthopaedic surgeon. This must be supported by surgical reports.	50	4
<i>Layman's explanation:</i> <i>Surgical total hip joint replacement with an artificial joint, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.</i>		
Hip fracture surgery		
Contractual definition: Open surgical repair with internal fixation or prosthesis of a fracture of the femur neck, femur head or acetabulum. This must be confirmed by a specialist with supporting evidence.	50	4
<i>Layman's explanation:</i> <i>Hip repair involving the stabilising of broken bones with surgical screws, nails, rods or plates, or alternatively with artificial joints of the broken part – femur neck, femur head or acetabulum (all parts forming the hip). This must be confirmed by a specialist with supporting evidence.</i>		
Total knee replacement*		
Contractual definition: Total surgical replacement of the knee joint with a prosthesis, confirmed by an orthopaedic surgeon. This must be supported by surgical reports.	50	4
<i>Layman's explanation:</i> <i>Surgical total knee joint replacement with an artificial joint, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.</i>		
Total shoulder replacement*		
Contractual definition: Total surgical replacement of the knee joint with a prosthesis, confirmed by an orthopaedic surgeon. This must be supported by surgical reports.	50	4
<i>Layman's explanation:</i> <i>Surgical total shoulder joint replacement with an artificial joint, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.</i>		
Total ankle replacement*		
Contractual definition: Total surgical replacement of the ankle joint with a prosthesis, confirmed by an orthopaedic surgeon. This must be supported by surgical reports.	50	4
<i>Layman's explanation:</i> <i>Surgical total ankle joint replacement with artificial parts, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.</i>		
Trauma		
Gunshot wounds or penetrating stab wounds		
Contractual definition: Gunshot or penetrating stab wound resulting in theatre debridement, with an operation report provided by a surgeon or trauma surgeon.	50	1
<i>Layman's explanation:</i> <i>Gunshot or penetrating stab wound, with removal of dead, damaged or infected tissue in theatre to improve the healing potential of the remaining healthy tissue. An operation report must be provided by a specialist (surgeon or trauma surgeon).</i>		

Extended Income and Extended Income Plus: Impairment claim events from the earlier of retirement and age 70	Percentage of cover amount	Payment period in months
Contractual definition: Penetration by a bullet or a sharp object through the skull, resulting in surgical exploration of the skull under general anaesthetic, with an operation report provided by a surgeon or trauma surgeon.	50	2
<i>Layman's explanation:</i> <i>Penetration by a bullet or a sharp object through the skull, resulting in an operation opening up the skull to determine and repair damage caused by the penetrating injury of the skull (surgical exploration of the skull) under general anaesthetic. An operation report must be provided by a specialist (surgeon or trauma surgeon).</i>		
Contractual definition: Penetration by a bullet or a sharp object through the chest, resulting in an underwater drain, with an operation report provided by a surgeon or trauma surgeon.	50	2
<i>Layman's explanation:</i> <i>Penetration by a bullet or a sharp object through the chest, resulting in the placement of a tube into the chest (underwater drain) to drain air, fluid or blood from the space around the lung and thus allowing the lung to expand. An operation report must be provided by a specialist (surgeon or trauma surgeon).</i>		
Contractual definition: Penetration by a bullet or a sharp object through the chest, resulting in a thoracotomy, with an operation report provided by a surgeon or trauma surgeon.	50	3
<i>Layman's explanation:</i> <i>Penetration by a bullet or a sharp object through the chest, resulting in an operation with an incision into the chest wall (a thoracotomy). An operation report must be provided by a specialist (surgeon or trauma surgeon).</i>		
Contractual definition: Penetration by a bullet or a sharp object through the abdomen, resulting in surgical exploration of the cavity under general anaesthetic, with an operation report provided by a surgeon or trauma surgeon.	50	2
<i>Layman's explanation:</i> <i>Penetration by a bullet or a sharp object through the abdomen, resulting in an operation of the belly to assess damage caused by the injury to internal organs or blood vessels (surgical exploration of the cavity) under general anaesthetic. An operation report must be provided by a specialist (surgeon or trauma surgeon).</i>		
Contractual definition: Penetration by a bullet or a sharp object through the neck, with damage to one or more of the following: subclavian or carotid artery, oesophagus or trachea, with an operation report provided by a surgeon or trauma surgeon.	50	2
<i>Layman's explanation:</i> <i>Penetration by a bullet or a sharp object through the neck, with damage to one or more of the following blood vessels or organs:</i> <ul style="list-style-type: none"> - The subclavian arteries, which are a pair of large arteries in the chest that supply blood to the chest, head, neck, shoulder and arms, or - The carotid arteries, which are major blood vessels in the neck that supply blood to the brain, neck, and face, or - The food pipe (oesophagus), which is a muscular tube that moves food and liquids from the throat to the stomach, or - The windpipe (trachea). <i>An operation report must be provided by a specialist (surgeon or trauma surgeon).</i>		
Multiple rib fractures		

Extended Income and Extended Income Plus: Impairment claim events from the earlier of retirement and age 70	Percentage of cover amount	Payment period in months
Contractual definition: Multiple rib fractures with ICU admission: Numerous rib fractures, requiring admission to an intensive care unit (ICU), confirmed by a specialist.	50	2
Contractual definition: Multiple rib fractures requiring ventilation: Numerous rib fractures, requiring ventilation in an intensive care unit in order to sustain a stable blood-gas profile, confirmed by a specialist.	50	2
Pelvis fracture		
Contractual definition: More than one fracture of different bones of the pelvic framework, confirmed by an orthopaedic specialist or surgeon.	50	2
<i>Layman's explanation:</i> <i>A pelvic fracture is a break of the bony structure of the pelvis. For this claim event there must be more than one fracture of different bones of the pelvic framework. This must be confirmed by a specialist (orthopaedic specialist or surgeon)</i>		
Unstable pelvis fracture		
Contractual definition: More than one fracture of the pelvic framework, resulting in instability, and requiring surgical intervention, confirmed by an orthopaedic specialist or surgeon.	50	3
<i>Layman's explanation:</i> <i>A pelvic fracture is a break of the bony structure of the pelvis. For this claim event there must be more than one fracture of the pelvic framework, resulting in instability of the pelvic ring, and requiring surgical intervention. This must be confirmed by a specialist (orthopaedic specialist or surgeon).</i>		
Compression fracture		
Contractual definition: A compression fracture of more than 50% of a spinal vertebra with documented spinal cord injury or myelopathy, confirmed by a neurosurgeon or orthopaedic specialist.	50	2
<i>Layman's explanation:</i> <i>When the bone of a vertebral body collapses, it is called a compression fracture. For this claim event there must be a compression fracture of more than 50% of a spinal vertebra leading to collapse of the vertebra with documented spinal cord injury or compression of the nerves of the spinal cord. This must be confirmed by a specialist (neurosurgeon or orthopaedic specialist).</i>		
Fracture dislocation of the spine		
Contractual definition: A fracture dislocation of the spine, without neurological deficit, confirmed with supporting evidence by a neurosurgeon or orthopaedic specialist.	50	2
<i>Layman's explanation:</i> <i>A fracture is a break or crack in the bone. A dislocation occurs when 2 bones are out of place at the joint that connects them. A fracture dislocation of the spine, without neurological deficit, is when this occurs in the vertebral column, but the life insured has no signs of altered function due to the weaker function of the spinal cord. There must be objective evidence of the dislocation on the imaging of the spine. This must be confirmed with supporting evidence by a specialist (neurosurgeon or orthopaedic specialist).</i>		

Extended Income and Extended Income Plus: Impairment claim events from the earlier of retirement and age 70	Percentage of cover amount	Payment period in months
Contractual definition: A fracture dislocation of the spine, with neurological deficit, confirmed with supporting evidence by a neurosurgeon or orthopaedic specialist.	50	3
Layman's explanation: <i>A fracture is a break or crack in the bone. A dislocation occurs when 2 bones are out of place at the joint that connects them. A fracture dislocation of the spine, with neurological deficit, is when this occurs in the vertebral column and the life insured has signs of altered function due to the weaker function of the spinal cord. There must be objective evidence of the dislocation on the imaging of the spine. This must be confirmed with supporting evidence by a specialist (neurosurgeon or orthopaedic specialist).</i>		
Compression or avulsion fractures		
Contractual definition: Compression or avulsion fractures without joint dislocation on two or more vertebrae, confirmed with supporting evidence by a neurosurgeon or orthopaedic specialist.	50	2
Layman's explanation: <i>When the bone of a back bone (vertebra) collapses, it is called a compression fracture. An avulsion fracture is an injury to the bone in a location where a ligament attaches to the bone. When an avulsion fracture occurs, the tendon or ligament pulls off a piece of the bone. This claim event covers compression or avulsion fractures without dislocation (the movement of the joints on two or more of the bones of the spine (vertebrae)) of two or more vertebrae. This must be confirmed with supporting evidence by a specialist (neurosurgeon or orthopaedic specialist).</i>		
Liver rupture		
Contractual definition: Rupture of the liver, necessitating emergency laparotomy and surgical repair, with an operation report provided by a surgeon.	50	2
Layman's explanation: <i>Bursting of the liver due to an accident or injury to the belly by a blunt object or surface, which leads to an emergency operation to repair the liver. An operation report must be provided by a specialist (surgeon).</i>		
Spleen rupture		
Contractual definition: Rupture of the spleen, necessitating emergency laparotomy and surgical repair or splenectomy, with an operation report provided by a surgeon.	50	2
Layman's explanation: <i>Bursting of the spleen due to an accident or injury to the belly by a blunt object or surface, which leads to an emergency operation to repair or remove the spleen. An operation report must be provided by a specialist (surgeon).</i>		
Post-traumatic fat-embolism of the lungs		

Extended Income and Extended Income Plus: Impairment claim events from the earlier of retirement and age 70	Percentage of cover amount	Payment period in months
<p>Contractual definition: Fat-embolism of the lungs, confirmed by a ventilation-perfusion (VQ) scan. This must be confirmed by a pulmonologist, physician or anaesthetist.</p> <p>Layman's explanation: <i>This claim event covers fat-embolism of the lungs.</i></p> <p><i>An embolism is when a lump of material, in this case fat material, is dislodged and travels into the bloodstream, which then blocks blood vessels and leads to catastrophic events in the body. This must be confirmed by a specialist (pulmonologist, physician or anaesthetist).</i></p>	50	2
Compartment syndrome		
<p>Contractual definition: Definitive history of compartment syndrome as a result of an acute injury, with permanent motor nerve damage, confirmed by a specialist. This must be confirmed with all of the following supporting evidence:</p> <ul style="list-style-type: none"> • History and clinical signs of compartment syndrome, and • Nerve conduction studies. <p>Layman's explanation: <i>Compartment syndrome is a condition of severe tissue compression, which has resulted from an acute injury. This compression in a closed muscle compartment results in permanent damage to the nerves of the affected muscles.</i></p> <p><i>This claim event covers a definitive history of compartment syndrome as a result of an acute injury, with permanent motor nerve damage, confirmed by a specialist. The evidence required for this claim event is specified in the contractual definition above.</i></p>	50	1
Combination burns		
<p>Contractual definition: A combination of 2nd and 3rd degree burns that covers more than 80% of the face or hands or feet, confirmed by a surgeon.</p> <p>Layman's explanation: <i>A combination of less severe (2nd degree) and severe (3rd degree) burns that covers more than 80% of the face or hands or feet. This must be confirmed by a specialist (surgeon).</i></p> <p><i>2nd degree burns are burn wounds to the outer skin layer and the layer directly under this.</i></p> <p><i>3rd degree burns are burn wounds to all three layers of the skin.</i></p>	50	2

*A 5-year exclusion period, as described under "Exclusions", applies to this claim event.

Future medical advances

Some claim events 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 claim events, 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.

Accidental Extended Income Plus (AIO)

This benefit is available under our Income Protector product which is available under our Premier product option.

Benefit description

This benefit provides long term accidental cover for occupational disability resulting in a loss of income and for permanent impairments, after a waiting period of 24 months. It also provides cover for joint replacements and trauma claim events from retirement or age 70, whichever is the earliest.

The benefit is available to employed clients with qualifying occupations but especially suitable for clients who are not medically insurable.

It provides cover for occupational disability, severe impairment events and less severe impairment events, if any of these are from accidental causes.

Optional rider benefit

The following rider benefit may be added to this benefit:

- Lump Sum Conversion Option

An additional payment will be charged for the rider benefit.

Special features

Special features are features that are automatically included for a benefit. The following Special features apply:

- Free cover
- Automatic waiver of payment
- Extended occupational disability cover

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

More information on automatic waiver of payment and extended occupational disability cover is provided further in this section.

Type of benefit

Standalone

When will cover for this benefit end?

Cover will end

- at midnight before the cover end date set out in the plan overview, or
- if this benefit or the plan ends for any reason before the cover end date, or
- if the life insured dies.

Cover limits per life insured

Minimum: R3 000 per month

Maximum: R200 000 per month*, limited to the sliding scale percentage of the life insured's gross monthly income**.

*Subject to financial underwriting

**Refer to the underwriting chapters for the sliding scales and the definitions of gross income.

Benefit payment period

Refer to "How long will the income payments continue?" in this section.

Age limits

Benefit start age

- | | |
|----------|--|
| Minimum: | <ul style="list-style-type: none"> • 18 next birthday for payment patterns other than fixed compulsory growth • Fixed compulsory growth: 30 next birthday. |
|----------|--|

- Maximum:
- 5 years before the benefit cease age
 - 65 next birthday for the whole life option

Benefit cease age

Choice between:

- 60 next birthday
- 65 next birthday
- 70 next birthday
- Whole of life

Qualifying lives

Lives who comply with all of the following may qualify, subject to age limits and underwriting:

- must be employed, either self-employed or by an employer, and
- must practise a qualifying occupation, as determined by us.

This benefit caters for lives that do not qualify for full cover due to their medical history, but is also available for lives who do qualify for full cover.

Guarantee period

The initial guarantee period is 5 years.

Waiting period options

This benefit has a built-in waiting period of 24 months.

What this benefit provides

This benefit provides cover for

- temporary or permanent occupational disability, up to retirement, age 70 or the cover end date of the benefit, whichever is earlier, and
- joint replacement and trauma impairment claim events, from retirement or age 70, whichever is earlier, and
- permanent impairment claim events.

All of the above apply to accidental causes only.

Claim event for occupational disability

A benefit may be claimed if the life insured becomes disabled to the extent that he or she is continuously unable to fulfil a substantial and material part of the duties of the regular occupation he or she practised for income immediately before the disability, resulting in a loss of some or all of such income.

If the life insured is a qualifying student when he or she becomes disabled, a benefit may be claimed if the life insured becomes disabled to the extent that he or she will be totally and permanently unable to fulfil the occupational demands of an occupation we may reasonably expect him or her to have practised, had they not become disabled and had they completed their studies.

The above is the contractual definition for occupational disability.

What is a qualifying student?

A qualifying student is a full-time student in at least their 4th academic year studying toward an NQF-level 8 or higher qualification.

A student progresses to the next academic year when they successfully pass a tertiary study year.

Extended occupational disability cover

If the life insured stops working for any reason other than retiring or becoming a qualifying student, for example, taking a sabbatical, becoming a housewife or being retrenched, we will provide extended occupational disability cover for total and permanent disability for up to 12 months from the date he or she stopped working.

For this cover, total and permanent disability refers to the life insured being totally and permanently unable to fulfil the occupational duties of the regular occupation he or she practised for income immediately before he or she stopped working.

Extended occupational disability cover will only apply if the occupational disability is total and permanent and not as a result of any of the following conditions:

- a back or neck injury, unless it is one of the following: paraplegia; quadriplegia; or failed back syndrome after multiple spinal surgery, provided the extent of the functional impairment arising from the failed back syndrome is verified by a specialist that we will nominate;
- any orthopaedic injury based mainly on pain, discomfort, loss of sensation, loss of range of motion, or any combination thereof;
- an injury that directly or indirectly resulted from, or is traceable to, any of the above causes;
- a complication that directly or indirectly is attributable to any of the above causes, or to such an injury;
- a side-effect of treatment of any of the above causes, or for such an injury or for such a complication.

Qualifying students

If the life insured is a qualifying student and successfully completes his or her studies, but does not yet start working, we will continue to cover him or her for occupational disability as if he or she is still a qualifying student, for up to 12 months from the date he or she stopped studying. This extended occupational disability cover will only apply if the occupational disability is not as a result of any of the above listed conditions.

What benefit will be provided for occupational disability?

If we admit a claim, we will make an income payment of up to 100% of the cover amount as set out in the plan overview.

If benefit growth is applicable to the plan, the cover amount of and the payment for the benefit will continue to be increased each year as set out in the plan overview under "Benefit and payment growth". We will continue making income payments for as long as the planholder has the right to claim payment.

When we admit a claim, we will limit the amount of the income payment to the cover amount as at the date we admit the claim.

If the life insured's disability results in a loss of only some of the income from his or her regular occupation, we will further limit the amount of the income payment in proportion to the loss of income.

If the disability directly or indirectly results from any of the conditions listed below, we will further limit the amount of the income payment to ensure that this amount, plus any occupational disability income that the life insured might receive from other individual or group disability income type plans, does not exceed 75% of the life insured's average monthly income after tax. If benefit growth is applicable to the plan, this limited income payment will be increased each year by the benefit growth rate as set out in the plan overview under "Benefit and payment growth".

- a back or neck injury, unless it is one of the following: paraplegia; quadriplegia; or failed back syndrome after multiple spinal surgery, provided the extent of the functional impairment arising from the failed back syndrome is verified by a specialist that we will nominate;
- any orthopaedic injury based mainly on pain, discomfort, loss of sensation, loss of range of motion, or any combination thereof;
- an injury that directly or indirectly resulted from, or is traceable to, any of the above causes;
- a complication that directly or indirectly is attributable to any of the above causes, or to such an injury;
- a side-effect of treatment of any of the above causes, or for such an injury or for such a complication.

We will make an income payment only if the amount we have to pay is at least equal to the smaller of the following, both determined as at the time we consider a claim:

- 10% of the cover amount, and
- the minimum cover amount allowed for new business.

Once we have admitted a claim, and started making income payments, we will not apply this rule even if we reduce the amount of the income payment to less than the above limit.

Claim event for impairment

A benefit may be claimed if the life insured meets the contractual definition of any of the impairment claim events indicated in the impairment claim event table, whether or not the life insured is unable to do his or her occupation or has a loss of income.

These impairment claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated at the end of the Income Protection benefits chapter in the section "Impairment Claim Events for Accidental Benefits". [ImpairmentClaimEventsAccidentalBenefit](#)

What benefit will be provided for impairment?

If we admit a claim, we will make a monthly income payment equal to the percentage of the cover amount linked to the particular claim event as set out in the impairment claim event table. For multiple claims, we may pay a lower percentage than indicated in the table.

If benefit growth is applicable to the plan, the cover amount of and the payment for the benefit will continue to be increased each year as set out in the plan overview under "Benefit and payment growth". We will continue making income payments for as long as the planholder has the right to claim payment.

Admittance of a claim

Besides the general conditions for admittance of a claim are set out in the *General information* chapter, we will admit a claim only if the claim event is caused directly and solely by a bodily injury due to an accident.

The planholder will be responsible for the cost of medical proof and the cost of financial proof of loss of income, if applicable, when a claim is submitted.

If the life insured travels or lives outside South Africa when the claim event occurs, we will require the medical and financial proof issued in a foreign country to be in English to consider a claim.

Admittance of a claim for occupational disability

We will admit a claim only if:

- the life insured practises his or her occupation or is on normal leave at the time that the claim event occurs, or for a qualifying student, if the life insured is enrolled in his or her studies at the time that the claim event occurs. An exception is if the requirements for extended occupational disability cover are met; and
- the occupational disability has lasted continuously for the entire waiting period. However, if the period between consecutive periods of disability resulting from the same cause is shorter than the waiting period, we will consider a claim once the consecutive periods of disability add up to the waiting period, and
- the claim event occurs before retirement, age 70 or the cover end date of the benefit, whichever is earlier.

Admittance of a claim for impairment cover

We will admit a claim only if:

- the impairment is permanent, after the life insured has undergone optimal, reasonable treatment, and
- the waiting period has expired, and
- we have not previously admitted a claim for the same claim event, except if the claim event is listed under "Musculoskeletal system" in the impairment claim event table, and the claim is for a different limb, and
- the claim event occurred before the cover end date of the benefit.

The impairment must be permanent, and evaluated according to the principles and ratings of the latest edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. The impairment, and permanence thereof, will be evaluated only 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.

Waiting period

This benefit has a built-in waiting period of 24 months.

Waiting period for occupational disability

The waiting period starts on the date the life insured meets the contractual definition for occupational disability. For extended occupational disability cover, the waiting period starts on the date the life insured meets the contractual definition for total and permanent disability. We will not make any income payments for occupational disability during the waiting period.

Could the waiting period sometimes be waived?

If we stop making income payments for an occupational disability claim and we admit another claim for occupational disability, we will waive the waiting period for the new claim if:

- the new claim is related to the previous claim; and
- the life insured meets the contractual definition for occupational disability within three months after we have made the last income payment for the previous claim.

If the cease age is not whole life, we will waive the waiting period if the life insured is totally and permanently disabled during the 24 months before the cover end date.

Waiting period for impairment cover

The waiting period starts on the date the life insured meets the contractual definition for the impairment claim event. We will not make any income payments for impairment during the waiting period.

The waiting period will only apply until the earlier of retirement and age 70.

Could the waiting period sometimes be waived?

If the life insured also has Accidental Temporary Income Plus, and during the waiting period of this benefit, we stop making income payments on Accidental Temporary Income Plus because its maximum payment period has been reached, we will waive the remainder of the waiting period of this benefit. This will be done if the payments on Accidental Temporary Income Plus were made for the same medical condition that resulted in a claim for this benefit.

If the cover amount of this benefit is greater than the cover amount of Accidental Temporary Income Plus, the above concession will only apply on the smaller amount.

When will the income payments start?

We will make the first income payment at the end of the plan month in which we admit the claim. This first income payment will be for the number of days that the planholder has the right to claim payment in that plan month. Thereafter, we will make an income payment at the end of each subsequent plan month, for as long as the planholder has the right to claim payment.

How long will the income payments continue?

We will make the income payments for as long as the planholder has the right to claim payment.

If the planholder no longer has the right to claim payment, we will make the last income payment at the end of the plan month in which the planholder's right to claim payment stops. If we have waived the payments for the plan while the planholder has received income payments, the planholder will have to resume the payments for the plan once the income payments stop.

How long will the income payments continue for occupational disability?

We will make the income payments for as long as the life insured's disability and loss of income continue, but only until age 70, the cover end date of this benefit or the death of the life insured, whichever is earliest.

The last payment will only be for the number of days in the plan month that the planholder has the right to claim payment.

If the cease age is whole life and we have made income payments for occupational disability until age 70, we will reassess the claim at age 70 to determine whether the life insured qualifies for further income payments for impairment cover.

After we have started making the income payments, we may from time to time ask for proof that the life insured is still disabled, and still has a loss of income. We may require the life insured to be medically examined for this purpose. We will cover the cost of such a medical reassessment. The planholder will be responsible for the cost of financial proof of loss of income.

If the life insured travels or lives outside South Africa while a claim is in payment, and we require proof that the life insured is still disabled and still has a loss of income, we will require the medical and financial proof issued in a foreign country to be in English. The planholder will be primarily responsible for the cost of medical proof. We will refund the planholder in South African currency for an amount equal to what we usually pay for such medical proof in South Africa. The planholder will be responsible for the cost of financial proof of loss of income.

We will make income payments for disability and loss of income in a foreign country for a maximum period of 12 months. Thereafter, we will consider the continuation of income payments only after the life insured has been medically assessed by a doctor nominated by us, which may require the life insured to travel to South Africa for such an assessment. We will cover the cost of the assessment, but not the travel, accommodation and related costs involved.

If the life insured recovers to such an extent that he or she is no longer disabled, or no longer has a loss of income, we will stop making the income payments.

If the life insured only partially recovers from his or her disability, or still has a loss of income but to a lesser extent, we will reduce the income payments in proportion to the loss of income.

We will also stop making the income payments if:

- we do not receive the required proof of the life insured's continued disability and loss of income, or
- the life insured
 - refuses to be examined, or
 - refuses to undergo reasonable treatment on a regular basis, at his or her cost, by a medical doctor, other than the life insured if he or she is a medical doctor.

The period of disability may not exceed, unless we agree otherwise in writing, the midrange data in the latest edition of the Official Disability Guidelines of the Work Loss Data Institute, or its scientific equivalent. We will use these guidelines as a reference to determine the average period of disability for the claim event in question.

If we limit the income payments based on these guidelines, the planholder will have to provide medical proof of the life insured's continued disability. The planholder will be responsible for the cost of such medical proof.

If the life insured starts earning an income from his or her regular occupation or from other individual or group disability income type plans after we have started making the income payments, or if such income is increased, The planholder must notify us of this. We may then reduce the amount of the income payments, or stop them.

If the planholder fails to notify us of this, and we continue to make income payments and continue to waive the payments of the plan, we will be entitled to recover from the planholder the excess income payments and the payments we waived.

How long will the income payments continue for impairment cover?

We will make the income payments until midnight before the cover end date set out in the plan overview, or until the life insured dies, if this is earlier.

For claim events that are only covered from the earlier of retirement and age 70, we will make income payments up to the indicated payment period only.

The last payment will only be for the number of days in the plan month that the planholder has the right to claim payment.

Automatic waiver of payments

We will waive the payments for the plan for as long as we make income payments for occupational disability or for 100% of the cover amount. While we waive the payments, no alteration to any of the benefits on the plan is allowed.

If the cease age is whole life, we will waive the payments for the plan for as long as we make income payments for occupational disability or for the maximum percentage of the cover amount. The maximum percentage is 100% before age 70 and 50% from age 70. From age 70, we will waive the payment while a claim is in payment for 50% of the cover amount. While we waive the payments, no alteration to any of the benefits on the plan is allowed.

Multiple claims

This applies if the life insured meets the contractual definition of more than one claim event over the duration of the benefit.

If a life insured meets the contractual definition of occupational disability and an impairment claim event at the same time, and the claims are related, we will only pay for the type of cover that will result in the highest payout.

If a life insured meets the contractual definition of occupational disability and an impairment claim event at the same time, and the claims are unrelated, we will pay for both types of cover. We will however not pay more than 100% of the cover amount in any month.

We will never pay more than 100% of the cover amount in any month or more than once for the same calendar date.

Multiple claims for impairment cover

This applies if a life insured meets the contractual definition of more than one impairment claim event at the same time. The percentage of the cover amount that we pay for the claim may then be lower than indicated in the impairment claim event table.

We will only admit an impairment claim that is related to previously admitted impairment claims if the new claim event has a higher percentage of the cover amount indicated in the impairment claim event table. The income payment that we are already making will then be increased to be in line with the higher percentage.

If we admit an impairment claim that is unrelated to previously admitted impairment claims, we may need to reduce the percentage of the cover amount indicated in the impairment claim event table to ensure that we do not pay more than 100% of the cover amount in any month.

If the cease age is whole life and we admit an impairment claim that is unrelated to previously admitted impairment claims, we may need to reduce the percentage of the cover amount indicated in the claim event table to ensure that we do not pay more than the maximum percentage of the cover amount in any month. The maximum percentage is 100% before age 70 and 50% after age 70.

We will never pay more than the maximum percentage of the cover amount in any month. The maximum percentage is 100% before age 70 and 50% after age 70.

Exclusions

General exclusions are set out in the applicable overview chapter in this technical guide. Specific exclusions, if any, are set out in the plan overview, in the special provisions for the life insured concerned.

Exclusions for occupational disability

If the life insured at any time practises sport as an occupation, or works as a pilot, and becomes continuously unable to fulfil a substantial and material part of the duties of that occupation, we will not admit a claim as a result of such inability.

Exclusions for impairment

We will not admit a claim if the impairment of the life insured can be substantially removed or improved by surgery or other medical treatment, which we can reasonably expect him or her to undergo, taking into account the risks involved and the chances of success of such surgery or treatment.

Conversion options

The payment will not reduce when the cover for occupational disability ends. If the life insured stops working before the cover for occupational disability ends, and plans to never work again, conversion options are available for this benefit. Conversion options may however not necessarily result in a lower payment.

Explanations

When is a person retired?

We regard the life insured as retired if he or she is 55 years or older, and does not earn an income over and above a passive income. Passive income refers to income that can continue without the life insured's intervention, for example pension or rental income.

What is normal leave?

Normal leave refers to periods of paid leave, like paid annual leave or paid maternity leave.

What is a related claim?

A claim is related to another claim if there is enough published evidence to show that:

- the medical condition or bodily injury is the result of the same medical condition or bodily injury that led to the other claim; and
- it is unlikely that the medical condition or injury would have occurred if it was not for the medical condition or injury that led to the other claim.

What is a plan month?

The first plan month starts on the day when the plan begins. Each following plan month will start on the same day as the first one. A plan month ends at midnight on the day before the next plan month starts.

Conversion option

Payments will not reduce when the cover for occupational disability ends. If the life insured stops working before the cover for occupational disability ends, and plans to never work again, he/she may contact their intermediary about conversion options for this benefit. Conversion options may however not necessarily result in a lower payment.

Explanations for occupational disability

Regular occupation

The occupation the life insured practised for income immediately before becoming disabled.

Average monthly income

The monthly income from the life insured's regular occupation, averaged over the 12 months before the claim event took place. If the life insured has a fluctuating income, we will calculate the average monthly income over the 36 months before the claim event took place. For self-employed clients, we will always consider their average monthly income rather than their most recent monthly income.

Income for lives insured in formal employment of an employer

Cost-to-company income which consists of gross taxable income of the life insured including the employer's contributions to a medical scheme, provident fund or pension fund on behalf of the life insured, and the cost of any other benefits paid for by the life insured's employer that form part of the life insured's remuneration package and are reflected in the employer's financial statements.

Income for professional lives insured in practice

Gross professional income for professionals who charge a fee for services is equal to the sum of professional fees and net income from trading activities, less business overhead expenses.

Overhead expenses include the following:

- rent for the business premises;
- water, electricity, telephone;
- regular maintenance services;
- property taxes and mortgage interest for the business premises;
- equipment leasing costs;
- insurance premiums;
- accounting fees;
- salaries of employees;
- other normal and necessary expenses that we agree to include.

Overhead expenses exclude the following:

- depreciation;
- cost of goods or merchandise or additions to inventory;
- cost of furniture or equipment;
- capital payments on outstanding debt;
- expenditure on assets;
- fees on current accounts;
- business rationalisation costs, for example, retrenchment;
- any remuneration or other consideration to the life insured, the planholder, associates in the affected business, and any other person who shares directly or indirectly in the profit of the affected business.

The life insured's share of the overhead expenses is a proportion of the total overhead expenses of the affected business. The proportion is calculated as the business income the life insured generates in the affected business, averaged over the 12 months before the claim event took place, divided by the total business income of the affected business.

Income for other self-employed lives insured

Income or benefits receivable for the life insured's employment, or any services rendered by the life insured, plus the life insured's share of profit in the business.

Back or neck injury

A disorder or dysfunction of the vertebrae, spinal cord, intervertebral discs, nerve roots and supporting muscles or ligaments, as well as the direct or indirect consequences of, or the side-effects of any treatment applied for, such disorder or dysfunction.

Paraplegia

Total and permanent loss of function of both lower extremities.

Quadriplegia

Total and permanent loss of function of all four limbs.

Failed back syndrome after multiple spinal surgery

When the life insured, after the cover for the benefit has begun, must undergo more than one spinal operation on two or more intervertebral disc spaces in the lumbar or cervical area, and despite those operations, still suffers severe back

pain as verified by a multidisciplinary pain clinic. Such operations may include discectomy, vertebral fusion and internal fixation.

Impairment claim event tables

Impairment claim events that apply throughout

These impairment claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated at the end of the Income Protection benefits chapter in the section "Impairment Claim Events for Accidental Benefits". [ImpairmentClaimEventsAccidentalBenefit](#)

Impairment claim events from the earlier of retirement and age 70

The impairment claim events indicated in the table below are only covered from the earlier of retirement and age 70. The claim event must therefore have occurred on or after this date. Before this date, these claim events are covered by Accidental Temporary Income Plus, if applicable to the life insured.

Accidental Extended Income Plus: Impairment claim events from the earlier of retirement and age 70	Percentage of cover amount	Payment period in months
Joint replacements		
Total hip replacement		
<p>Contractual definition:</p> <p>Total surgical replacement of the hip joint with a prosthesis, confirmed by an orthopaedic surgeon. This must be supported by surgical reports.</p> <p><i>Layman's explanation:</i></p> <p><i>Surgical total hip joint replacement with an artificial joint, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.</i></p>	50	4
Hip fracture surgery		
<p>Contractual definition:</p> <p>Open surgical repair with internal fixation or prosthesis of a fracture of the femur neck, femur head or acetabulum. This must be confirmed by a specialist with supporting evidence.</p> <p><i>Layman's explanation:</i></p> <p><i>Hip repair involving the stabilising of broken bones with surgical screws, nails, rods or plates, or alternatively with artificial joints of the broken part – femur neck, femur head or acetabulum (all parts forming the hip). This must be confirmed by a specialist with supporting evidence.</i></p>	50	4
Total knee replacement		
<p>Contractual definition:</p> <p>Total surgical replacement of the knee joint with a prosthesis, confirmed by an orthopaedic surgeon. This must be supported by surgical reports.</p> <p><i>Layman's explanation:</i></p> <p><i>Surgical total knee joint replacement with an artificial joint, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.</i></p>	50	4
Total shoulder replacement		
<p>Contractual definition:</p> <p>Total surgical replacement of the shoulder joint with a prosthesis, confirmed by an orthopaedic surgeon. This must be supported by surgical reports.</p> <p><i>Layman's explanation:</i></p>	50	4

Accidental Extended Income Plus: Impairment claim events from the earlier of retirement and age 70	Percentage of cover amount	Payment period in months
<i>Surgical total shoulder joint replacement with an artificial joint, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.</i>		
Total ankle replacement		
<p>Contractual definition: Total surgical replacement of the ankle joint with a prosthesis, confirmed by an orthopaedic surgeon. This must be supported by surgical reports.</p> <p>Layman's explanation: <i>Surgical total ankle joint replacement with artificial parts, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.</i></p>	50	4
Trauma		
Gunshot wounds or penetrating stab wounds		
<p>Contractual definition: Gunshot or penetrating stab wound resulting in theatre debridement, with an operation report provided by a surgeon or trauma surgeon.</p> <p>Layman's explanation: <i>Gunshot or penetrating stab wound, with removal of dead, damaged or infected tissue in theatre to improve the healing potential of the remaining healthy tissue. An operation report must be provided by a specialist (surgeon or trauma surgeon).</i></p>	50	1
<p>Contractual definition: Penetration by a bullet or a sharp object through the skull, resulting in surgical exploration of the skull under general anaesthetic, with an operation report provided by a surgeon or trauma surgeon.</p> <p>Layman's explanation: <i>Penetration by a bullet or a sharp object through the skull, resulting in an operation opening up the skull to determine and repair damage caused by the penetrating injury of the skull (surgical exploration of the skull) under general anaesthetic. An operation report must be provided by a specialist (surgeon or trauma surgeon).</i></p>	50	2
<p>Contractual definition: Penetration by a bullet or a sharp object through the chest, resulting in an underwater drain, with an operation report provided by a surgeon or trauma surgeon.</p> <p>Layman's explanation: <i>Penetration by a bullet or a sharp object through the chest, resulting in the placement of a tube into the chest (underwater drain) to drain air, fluid or blood from the space around the lung and thus allowing the lung to expand. An operation report must be provided by a specialist (surgeon or trauma surgeon).</i></p>	50	2
<p>Contractual definition: Penetration by a bullet or a sharp object through the chest, resulting in a thoracotomy, with an operation report provided by a surgeon or trauma surgeon.</p> <p>Layman's explanation: <i>Penetration by a bullet or a sharp object through the chest, resulting in an operation with an incision into the chest wall (a thoracotomy). An operation report must be provided by a specialist (surgeon or trauma surgeon).</i></p>	50	3

Accidental Extended Income Plus: Impairment claim events from the earlier of retirement and age 70	Percentage of cover amount	Payment period in months
<p>Contractual definition: Penetration by a bullet or a sharp object through the abdomen, resulting in surgical exploration of the cavity under general anaesthetic, with an operation report provided by a surgeon or trauma surgeon.</p> <p>Layman's explanation: <i>Penetration by a bullet or a sharp object through the abdomen, resulting in an operation of the belly to assess damage caused by the injury to internal organs or blood vessels (surgical exploration of the cavity) under general anaesthetic. An operation report must be provided by a specialist (surgeon or trauma surgeon).</i></p>	50	2
<p>Contractual definition: Penetration by a bullet or a sharp object through the neck, with damage to one or more of the following: subclavian or carotid artery, oesophagus or trachea, with an operation report provided by a surgeon or trauma surgeon.</p> <p>Layman's explanation: <i>Penetration by a bullet or a sharp object through the neck, with damage to one or more of the following blood vessels or organs:</i></p> <ul style="list-style-type: none"> – <i>The subclavian arteries, which are a pair of large arteries in the chest that supply blood to the chest, head, neck, shoulder and arms, or</i> – <i>The carotid arteries, which are major blood vessels in the neck that supply blood to the brain, neck, and face, or</i> – <i>The food pipe (oesophagus), which is a muscular tube that moves food and liquids from the throat to the stomach, or</i> – <i>The windpipe (trachea).</i> <p><i>An operation report must be provided by a specialist (surgeon or trauma surgeon).</i></p>	50	2
Multiple rib fractures		
<p>Contractual definition: Multiple rib fractures with ICU admission: Numerous rib fractures, requiring admission to an intensive care unit (ICU), confirmed by a specialist.</p>	50	2
<p>Contractual definition: Multiple rib fractures requiring ventilation: Numerous rib fractures, requiring ventilation in an intensive care unit in order to sustain a stable blood-gas profile, confirmed by a specialist.</p>	50	3
Pelvis fracture		
<p>Contractual definition: More than one fracture of different bones of the pelvic framework, confirmed by an orthopaedic specialist or surgeon.</p> <p>Layman's explanation: <i>A pelvic fracture is a break of the bony structure of the pelvis. For this claim event there must be more than one fracture of different bones of the pelvic framework. This must be confirmed by a specialist (orthopaedic specialist or surgeon).</i></p>	50	2
Unstable pelvis fracture		
<p>Contractual definition: More than one fracture of the pelvic framework, resulting in instability, and requiring surgical intervention, confirmed by an orthopaedic specialist or surgeon.</p> <p>Layman's explanation:</p>	50	3

Accidental Extended Income Plus: Impairment claim events from the earlier of retirement and age 70	Percentage of cover amount	Payment period in months
<p>A pelvic fracture is a break of the bony structure of the pelvis. For this claim event there must be more than one fracture of the pelvic framework, resulting in instability of the pelvic ring, and requiring surgical intervention. This must be confirmed by a specialist (orthopaedic specialist or surgeon).</p>		
<p>Compression fracture</p> <p>Contractual definition: A compression fracture of more than 50% of a spinal vertebra with documented spinal cord injury or myelopathy, confirmed by a neurosurgeon or orthopaedic specialist.</p> <p>Layman's explanation: <i>When the bone of a vertebral body collapses, it is called a compression fracture. For this claim event there must be a compression fracture of more than 50% of a spinal vertebra leading to collapse of the vertebra with documented spinal cord injury or compression of the nerves of the spinal cord. This must be confirmed by a specialist (neurosurgeon or orthopaedic specialist).</i></p>	50	2
<p>Fracture dislocation of the spine</p> <p>Contractual definition: A fracture dislocation of the spine, without neurological deficit, confirmed with supporting evidence by a neurosurgeon or orthopaedic specialist.</p> <p>Layman's explanation: <i>A fracture is a break or crack in the bone. A dislocation occurs when 2 bones are out of place at the joint that connects them. A fracture dislocation of the spine, without neurological deficit, is when this occurs in the vertebral column, but the life insured has no signs of altered function due to the weaker function of the spinal cord. There must be objective evidence of the dislocation on the imaging of the spine. This must be confirmed with supporting evidence by a specialist (neurosurgeon or orthopaedic specialist).</i></p>	50	2
<p>Contractual definition: A fracture dislocation of the spine, with neurological deficit, confirmed with supporting evidence by a neurosurgeon or orthopaedic specialist.</p> <p>Layman's explanation: <i>A fracture is a break or crack in the bone. A dislocation occurs when 2 bones are out of place at the joint that connects them. A fracture dislocation of the spine, with neurological deficit, is when this occurs in the vertebral column and the life insured has signs of altered function due to the weaker function of the spinal cord. There must be objective evidence of the dislocation on the imaging of the spine. This must be confirmed with supporting evidence by a specialist (neurosurgeon or orthopaedic specialist).</i></p>	50	3
<p>Compression or avulsion fractures</p> <p>Contractual definition: Compression or avulsion fractures without joint dislocation on two or more vertebrae, confirmed with supporting evidence by a neurosurgeon or orthopaedic specialist.</p> <p>Layman's explanation: <i>When the bone of a back bone (vertebra) collapses, it is called a compression fracture. An avulsion fracture is an injury to the bone in a location where a ligament attaches to the bone. When an avulsion fracture occurs, the tendon or ligament pulls off a piece of the bone. This claim event covers compression or avulsion fractures without dislocation (the movement of the joints on two or more of the bones of the spine (vertebrae)) of two or more vertebrae. This</i></p>	50	2

Accidental Extended Income Plus: Impairment claim events from the earlier of retirement and age 70	Percentage of cover amount	Payment period in months
<i>must be confirmed with supporting evidence by a specialist (neurosurgeon or orthopaedic specialist).</i>		
Liver rupture Contractual definition: Rupture of the liver, necessitating emergency laparotomy and surgical repair, with an operation report provided by a surgeon. <i>Layman's explanation:</i> <i>Bursting of the liver due to an accident or injury to the belly by a blunt object or surface, which leads to an emergency operation to repair the liver. An operation report must be provided by a specialist (surgeon).</i>	50	2
Spleen rupture Contractual definition: Rupture of the spleen, necessitating emergency laparotomy and surgical repair or splenectomy, with an operation report provided by a surgeon. <i>Layman's explanation:</i> <i>Bursting of the spleen due to an accident or injury to the belly by a blunt object or surface, which leads to an emergency operation to repair or remove the spleen. An operation report must be provided by a specialist (surgeon).</i>	50	2
Post-traumatic fat-embolism of the lungs Contractual definition: Fat-embolism of the lungs, confirmed by a ventilation-perfusion (VQ) scan. This must be confirmed by a pulmonologist, physician or anaesthetist. <i>Layman's explanation:</i> <i>This claim event covers fat-embolism of the lungs.</i> <i>An embolism is when a lump of material, in this case fat material, is dislodged and travels into the bloodstream, which then blocks blood vessels and leads to catastrophic events in the body. This must be confirmed by a specialist (pulmonologist, physician or anaesthetist).</i>	50	2
Compartment syndrome Contractual definition: Definitive history of compartment syndrome as a result of an acute injury, with permanent motor nerve damage, confirmed by a specialist. This must be confirmed with all of the following supporting evidence: <ul style="list-style-type: none"> • History and clinical signs of compartment syndrome, and • Nerve conduction studies. <i>Layman's explanation:</i> <i>Compartment syndrome is a condition of severe tissue compression, which has resulted from an acute injury. This compression in a closed muscle compartment results in permanent damage to the nerves of the affected muscles.</i> <i>This claim event covers a definitive history of compartment syndrome as a result of an acute injury, with permanent motor nerve damage, confirmed by a specialist. The evidence required for this claim event is specified in the contractual definition above.</i>	50	1
Combination burns Contractual definition: A combination of 2nd and 3rd degree burns that covers more than 80% of the face or hands or feet, confirmed by a surgeon.	50	2

Accidental Extended Income Plus: Impairment claim events from the earlier of retirement and age 70	Percentage of cover amount	Payment period in months
<p><i>Layman's explanation:</i> <i>A combination of less severe (2nd degree) and severe (3rd degree) burns that covers more than 80% of the face or hands or feet. This must be confirmed by a specialist (surgeon).</i></p> <p><i>2nd degree burns are burn wounds to the outer skin layer and the layer directly under this.</i></p> <p><i>3rd degree burns are burn wounds to all three layers of the skin.</i></p>		

Future medical advances

Some claim events 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 claim events, 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.

Impairment Income (OII)

This benefit is available under our Income Protector product which is available under our Premier product option.

Benefit description

This benefit provides cover for:

- permanent impairment claim events and
- joint replacement and trauma impairment claim events.

It does not provide cover for occupational disability.

Optional rider benefits

Available rider benefits:

- Spouse protector
- Child protector
- Lump sum conversion option

An additional payment will be charged for a rider benefit.

Special features

Special features are features that are automatically included for a benefit. The following special features apply:

- Free cover
- Automatic waiver of payment
- Proof-free additional cover for qualifying standard lives

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

More information on automatic waiver of payment and proof free additional cover is provided further in this section.

Type of benefit

Standalone

When will cover for this benefit end?

Cover will end

- at midnight before the cover end date set out in the plan overview, or
- if the benefit or the plan ends for any reason before the cover end date, or
- if the life insured dies.

Cover limits per life insured

Minimum: R3 000 per month

Maximum: R200 000 per month*, limited to the sliding scale percentage of the life insured's monthly gross income (GI)**.

*Subject to financial underwriting

**Refer to the underwriting chapters for the sliding scales and the definitions of gross income.

Benefit payment period	Refer to "How long will the income payments continue?" in this section.
Age limits	<p>Benefit start age</p> <p>Minimum: • 18 next birthday for payment patterns other than fixed compulsory growth • Fixed compulsory growth: 30 next birthday</p> <p>Maximum: • 5 years before the benefit cease age • 65 next birthday for the whole life option</p> <p>Benefit cease age</p> <p>Choice between:</p> <ul style="list-style-type: none"> • 60 next birthday • 65 next birthday • 70 next birthday • Whole of life
Qualifying lives	This benefit is suitable for lives who do not qualify for occupational disability cover, but do qualify for impairment cover e.g. pilots, students, housewives, etc.
Guarantee period	The initial guarantee period is 5 years.
Waiting period options	There is no waiting period for this benefit.

What benefit will be provided?

If we admit a claim, we will make a monthly income payment equal to the percentage of the cover amount linked to the particular claim event as set out in the claim event table. For multiple claims, we may pay a lower percentage than indicated in the table.

If benefit growth is applicable to the plan, the cover amount of and the payment for the benefit will continue to be increased each year as set out in the plan overview under "Benefit and payment growth". We will continue making income payments for as long as the planholder has the right to claim payment.

Claim event

A benefit may be claimed if the life insured meets the contractual definition of any of the impairment claim events indicated in the claim event table.

These impairment claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated at the end of the Income Protection benefits chapter in the section "Impairment Claim Events for Long Term Benefits". [ImpairmentClaimEventsLongTermBenefits](#)

Admittance of a claim

Besides the conditions for admittance of a claim set out in the *General information* chapter, we will admit a claim only if

- the impairment is caused directly and solely by a bodily injury or by an illness;
- the impairment is permanent, after the life insured has undergone optimal, reasonable treatment;
- we have not previously admitted a claim for the same claim event, except if the claim event is listed under "Musculoskeletal system" in the claim event table, and the claim is for a different limb;

- the life insured survived more than ten days from the date the contractual claim event definition has been met. The survival period will only be applied to conditions where the prognosis of survival beyond ten days is not certain, based on the available medical evidence.

The impairment must be permanent, and evaluated according to the principles and ratings of the latest edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. The impairment, and permanence thereof, will be evaluated only 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.

The planholder will be responsible for the cost of medical proof when a claim is submitted.

If the life insured travels or lives outside South Africa when the claim event occurs, we will require the medical proof issued in a foreign country to be in English to consider a claim.

Waiting period

This benefit does not have a waiting period. A survival period of 10 days will apply from the date the contractual claim event definition has been met. The survival period will only be applied to conditions where the prognosis of survival beyond ten days is not certain, based on the available medical evidence.

When will the income payments start?

We will make the first income payment at the end of the plan month in which we admit the claim. This first income payment will be for the number of days from the date the claim has been admitted to the date of this first payment. Thereafter, we will make an income payment at the end of each subsequent plan month, for as long as the planholder has the right to claim payment.

What is a plan month?

The first plan month starts on the day when the plan begins. Each following plan month will start on the same day as the first one. A plan month ends at midnight on the day before the next plan month starts.

How long will the income payments continue?

We will make the income payments until midnight before the cover end date set out in the plan overview, or until the life insured dies, if this is earlier. For claim events where a maximum pay-out period is indicated in the claim event table, we will only pay up to the indicated period.

The last payment will only be for the number of days in the plan month that the planholder has the right to claim payment.

If fixed compulsory payment growth is applicable to the plan and we admit a claim for this benefit within 5 years from the cover end date set out in the plan overview, we will not stop making the income payments when the cover end date is reached, despite anything to the contrary for this benefit in this chapter. We will continue making the income payments for up to 5 years from the date on which the claim has been admitted, as long as the life insured is still disabled. This only applies as long as compulsory payment growth is applicable to the plan.

Automatic waiver of payments

If the monthly income payment is for 100% of the cover amount, we will waive the payments for the plan for as long as we make the income payments. While we will waive the payments, no alteration to any of the benefits on the plan is allowed.

If the cease age is whole life and the monthly income payment is for the maximum percentage of the cover amount, we will waive the payments for the plan for as long as we make the income payments. The maximum percentage is 100% before age 70 and 50% from age 70. While we waive the payments, no alteration to any of the benefits on the plan is allowed.

Proof-free additional cover

If the plan has cover growth and the plan has been accepted with standard terms (i.e. without loadings or specific exclusions for a life insured), the plan holder has the option each year to request in writing that we increase the cover amount of this benefit by more than the current cover growth rate, without additional underwriting for the life insured. Any additional cover increases will take place on the plan anniversaries, together with the contractual cover increases.

The following additional requirements must be met before we will grant an additional cover increase as described above:

- The life insured must not be disabled or impaired on the date of the cover increase.
- A claim must not have been admitted, or already submitted, during the 12 months preceding the date of the cover increase.
- The life insured must be younger than 50 years on the date of the cover increase.
- We must receive the plan holder's written request to exercise the option at our head office at least 14 working days before the plan anniversary of the particular year.

The total increase in the cover amount of a benefit for a particular year (the annual cover growth increase plus the proof free increase) will be restricted to the lower of:

- the actual increase in the life insured's income over that year,
- twice the rate that we will use for increases according to the inflation rate that year, and
- 20%.

Multiple claims

This applies if the life insured meets the contractual definition of more than one claim event over the duration of the benefit. We may then pay a lower percentage of the cover amount than indicated in the claim event table.

We will only admit a claim that is related to previously admitted claims if the new claim event has a higher percentage of the cover amount indicated in the claim event table. The income payment that we are already making will then be increased to be in line with the higher percentage.

If cease age is not whole life and we admit a claim that is unrelated to previously admitted claims, we may need to reduce the percentage of the cover amount indicated in the claim event table to ensure that we do not pay more than 100% of the cover amount in any month.

We will never pay more than 100% of the cover amount in any month or more than once for the same calendar date.

If the cease age is whole life and we admit a claim that is unrelated to previously admitted claims, we may need to reduce the percentage of the cover amount indicated in the claim event table to ensure that we do not pay more than the maximum percentage of the cover amount in any month. The maximum percentage is 100% before age 70 and 50% after age 70.

We will never pay more than the maximum percentage of the cover amount in any month. The maximum percentage is 100% before age 70 and 50% after age 70.

What is a related claim?

A claim is related to another claim if there is enough published evidence to show that:

- the medical condition or bodily injury:
 - is the result of the same medical condition or bodily injury that led to the other claim; or
 - has been caused by the same disease process or bodily injury that led to the other claim; and
- it is unlikely that the medical condition or injury would have occurred if it was not for the medical condition or injury that led to the other claim.

Exclusions

General exclusions are set out in the applicable overview chapter in this technical guide. Specific exclusions, if any, are set out in the plan overview, in the special provisions for the life insured concerned.

We will not admit a claim if the impairment of the life insured can be substantially removed or improved by surgery or other medical treatment, which we can reasonably expect him or her to undergo, taking into account the risks involved and the chances of success of such surgery or treatment.

Exclusion period for joint replacements

A 5-year exclusion period from the cover start date of the benefit is applicable to the following claim events resulting from natural causes:

- Total hip replacement;
- Total knee replacement;
- Total shoulder replacement;

- Total ankle replacement.

A claim for any of these claim events, resulting from natural causes, can only be submitted if the claim event occurred at least 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 5-year exclusion period will apply to the increased part of the cover amount from the date of the increase.

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

Impairment claim events

Impairment claim events that apply throughout

These impairment claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated at the end of the Income Protection benefits chapter in the section "Claim Events for Long Term Benefits". [ImpairmentClaimEventsLongTermBenefits](#)

Impairment claim event table

The claim events indicated in the table below are payable for the indicated period only.

Impairment claim events	Before age 70		From age 70	
	Percentage of cover amount	Payment period	Percentage of cover amount	Payment period
Joint replacements				
Total hip replacement*				
Contractual definition: Total surgical replacement of the hip joint with a prosthesis, confirmed by an orthopaedic surgeon. This must be supported by surgical reports. <i>Layman's explanation:</i> <i>Surgical total hip joint replacement with an artificial joint, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.</i>	100	2 months and 2 weeks	50	4 months
Hip fracture surgery				
Contractual definition: Open surgical repair with internal fixation or prosthesis of a fracture of the femur neck, femur head or acetabulum. This must be confirmed by a specialist with supporting evidence. <i>Layman's explanation:</i> <i>Hip repair involving the stabilising of broken bones with surgical screws, nails, rods or plates, or alternatively with artificial joints of the broken part – femur neck, femur head or acetabulum (all parts forming the hip). This must be confirmed by a specialist with supporting evidence.</i>	100	2 months and 2 weeks	50	4 months

Impairment claim events	Before age 70		From age 70	
	Percentage of cover amount	Payment period	Percentage of cover amount	Payment period
Total knee replacement*				
Contractual definition: Total surgical replacement of the knee joint with a prosthesis, confirmed by an orthopaedic surgeon. This must be supported by surgical reports. <i>Layman's explanation:</i> <i>Surgical total knee joint replacement with an artificial joint, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.</i>	100	2 months	50	4 months
Total shoulder replacement*				
Contractual definition: Total surgical replacement of the shoulder joint with a prosthesis, confirmed by an orthopaedic surgeon. This must be supported by surgical reports. <i>Layman's explanation:</i> <i>Surgical total shoulder joint replacement with an artificial joint, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.</i>	100	2 months	50	4 months
Total ankle replacement*				
Contractual definition: Total surgical replacement of the ankle joint with a prosthesis, confirmed by an orthopaedic surgeon. This must be supported by surgical reports. <i>Layman's explanation:</i> <i>Surgical total ankle joint replacement with artificial parts, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.</i>	100	2 months	50	4 months
Trauma				
Gunshot wounds or penetrating stab wounds				
Contractual definition: Gunshot or penetrating stab wound resulting in theatre debridement, with an operation report provided by a surgeon or trauma surgeon. <i>Layman's explanation:</i> <i>Gunshot or penetrating stab wound, with removal of dead, damaged or infected tissue in theatre to improve the healing potential of the remaining healthy tissue. An operation report must be provided by a specialist (surgeon or trauma surgeon).</i>	100	1 week	50	1 month

Impairment claim events	Before age 70		From age 70	
	Percentage of cover amount	Payment period	Percentage of cover amount	Payment period
<p>Contractual definition: Penetration by a bullet or a sharp object through the skull, resulting in surgical exploration of the skull under general anaesthetic, with an operation report provided by a surgeon or trauma surgeon.</p> <p><i>Layman's explanation:</i> <i>Penetration by a bullet or a sharp object through the skull, resulting in an operation opening up the skull to determine and repair damage caused by the penetrating injury of the skull (surgical exploration of the skull) under general anaesthetic. An operation report must be provided by a specialist (surgeon or trauma surgeon).</i></p>	100	1 month	50	2 months
<p>Contractual definition: Penetration by a bullet or a sharp object through the chest, resulting in an underwater drain, with an operation report provided by a surgeon or trauma surgeon.</p> <p><i>Layman's explanation:</i> <i>Penetration by a bullet or a sharp object through the chest, resulting in the placement of a tube into the chest (underwater drain) to drain air, fluid or blood from the space around the lung and thus allowing the lung to expand. An operation report must be provided by a specialist (surgeon or trauma surgeon).</i></p>	100	1 month	50	2 months
<p>Contractual definition: Penetration by a bullet or a sharp object through the chest, resulting in a thoracotomy, with an operation report provided by a surgeon or trauma surgeon.</p> <p><i>Layman's explanation:</i> <i>Penetration by a bullet or a sharp object through the chest, resulting in an operation with an incision into the chest wall (a thoracotomy). An operation report must be provided by a specialist (surgeon or trauma surgeon).</i></p>	100	1 month	50	3 months
<p>Contractual definition: Penetration by a bullet or a sharp object through the abdomen, resulting in surgical exploration of the cavity under general anaesthetic, with an operation report provided by a surgeon or trauma surgeon.</p> <p><i>Layman's explanation:</i> <i>Penetration by a bullet or a sharp object through the abdomen, resulting in an operation of the belly to assess damage caused by the injury to internal organs or blood vessels (surgical exploration of the cavity) under general anaesthetic. An operation report must be provided by a specialist (surgeon or trauma surgeon).</i></p>	100	1 month	50	2 months

Impairment claim events	Before age 70		From age 70	
	Percentage of cover amount	Payment period	Percentage of cover amount	Payment period
<p>Contractual definition: Penetration by a bullet or a sharp object through the neck, with damage to one or more of the following: subclavian or carotid artery, oesophagus or trachea, with an operation report provided by a surgeon or trauma surgeon.</p> <p><i>Layman's explanation:</i> <i>Penetration by a bullet or a sharp object through the neck, with damage to one or more of the following blood vessels or organs:</i></p> <ul style="list-style-type: none"> – <i>The subclavian arteries, which are a pair of large arteries in the chest that supply blood to the chest, head, neck, shoulder and arms, or</i> – <i>The carotid arteries, which are major blood vessels in the neck that supply blood to the brain, neck, and face, or</i> – <i>The food pipe (oesophagus), which is a muscular tube that moves food and liquids from the throat to the stomach, or</i> – <i>The windpipe (trachea).</i> <p><i>An operation report must be provided by a specialist (surgeon or trauma surgeon).</i></p>	100	1 month	50	2 months
Multiple rib fractures				
<p>Contractual definition: Multiple rib fractures with ICU admission: Numerous rib fractures, requiring admission to an intensive care unit (ICU), confirmed by a specialist.</p> <p>Contractual definition: Multiple rib fractures requiring ventilation: Numerous rib fractures, requiring ventilation in an intensive care unit in order to sustain a stable blood-gas profile, confirmed by a specialist.</p>	100	1 month and 2 weeks	50	2 months
Pelvis fracture				
<p>Contractual definition: More than one fracture of different bones of the pelvic framework, confirmed by an orthopaedic specialist or surgeon.</p> <p><i>Layman's explanation:</i> <i>A pelvic fracture is a break of the bony structure of the pelvis. For this claim event there must be more than one fracture of different bones of the pelvic framework. This must be confirmed by a specialist (orthopaedic specialist or surgeon).</i></p>	100	2 months	50	2 months

Impairment claim events	Before age 70		From age 70	
	Percentage of cover amount	Payment period	Percentage of cover amount	Payment period
Unstable pelvis fracture				
Contractual definition: More than one fracture of the pelvic framework, resulting in instability, and requiring surgical intervention, confirmed by an orthopaedic specialist or surgeon.	100	3 months	50	3 months
<i>Layman's explanation:</i> <i>A pelvic fracture is a break of the bony structure of the pelvis. For this claim event there must be more than one fracture of the pelvic framework, resulting in instability of the pelvic ring, and requiring surgical intervention. This must be confirmed by a specialist (orthopaedic specialist or surgeon).</i>				
Compression fracture				
Contractual definition: A compression fracture of more than 50% of a spinal vertebra with documented spinal cord injury or myelopathy, confirmed by a neurosurgeon or orthopaedic specialist.	100	2 months	50	2 months
<i>Layman's explanation:</i> <i>When the bone of a vertebral body collapses, it is called a compression fracture. For this claim event there must be a compression fracture of more than 50% of a spinal vertebra leading to collapse of the vertebra with documented spinal cord injury or compression of the nerves of the spinal cord. This must be confirmed by a specialist (neurosurgeon or orthopaedic specialist).</i>				
Fracture dislocation of the spine				
Contractual definition: A fracture dislocation of the spine, without neurological deficit, confirmed with supporting evidence by a neurosurgeon or orthopaedic specialist.	100	1 month and 2 weeks	50	2 months
<i>Layman's explanation:</i> <i>A fracture is a break or crack in the bone. A dislocation occurs when 2 bones are out of place at the joint that connects them. A fracture dislocation of the spine, without neurological deficit, is when this occurs in the vertebral column, but the life insured has no signs of altered function due to the weaker function of the spinal cord. There must be objective evidence of the dislocation on the imaging of the spine. This must be confirmed with supporting evidence by a specialist (neurosurgeon or orthopaedic specialist).</i>				

Impairment claim events	Before age 70		From age 70	
	Percentage of cover amount	Payment period	Percentage of cover amount	Payment period
<p>Contractual definition: A fracture dislocation of the spine, with neurological deficit, confirmed with supporting evidence by a neurosurgeon or orthopaedic specialist.</p> <p><i>Layman's explanation:</i> <i>A fracture is a break or crack in the bone. A dislocation occurs when 2 bones are out of place at the joint that connects them. A fracture dislocation of the spine, with neurological deficit, is when this occurs in the vertebral column and the life insured has signs of altered function due to the weaker function of the spinal cord. There must be objective evidence of the dislocation on the imaging of the spine. This must be confirmed with supporting evidence by a specialist (neurosurgeon or orthopaedic specialist).</i></p>	100	2 months	50	3 months
Compression or avulsion fractures				
<p>Contractual definition: Compression or avulsion fractures without joint dislocation on two or more vertebrae, confirmed with supporting evidence by a neurosurgeon or orthopaedic specialist.</p> <p><i>Layman's explanation:</i> <i>When the bone of a back bone (vertebra) collapses, it is called a compression fracture. An avulsion fracture is an injury to the bone in a location where a ligament attaches to the bone. When an avulsion fracture occurs, the tendon or ligament pulls off a piece of the bone. This claim event covers compression or avulsion fractures without dislocation (the movement of the joints on two or more of the bones of the spine (vertebrae)) of two or more vertebrae. This must be confirmed with supporting evidence by a specialist (neurosurgeon or orthopaedic specialist).</i></p>	100	2 months	50	2 months
Liver rupture				
<p>Contractual definition: Rupture of the liver, necessitating emergency laparotomy and surgical repair, with an operation report provided by a surgeon.</p> <p><i>Layman's explanation:</i> <i>Bursting of the liver due to an accident or injury to the belly by a blunt object or surface, which leads to an emergency operation to repair the liver. An operation report must be provided by a specialist (surgeon).</i></p>	100	1 month and 2 weeks	50	2 months
Spleen rupture				
<p>Contractual definition: Rupture of the spleen, necessitating emergency laparotomy and surgical repair or splenectomy, with an operation report provided by a surgeon.</p> <p><i>Layman's explanation:</i></p>	100	1 month and 2 weeks	50	2 months

Impairment claim events	Before age 70		From age 70	
	Percentage of cover amount	Payment period	Percentage of cover amount	Payment period
<i>Bursting of the spleen due to an accident or injury to the belly by a blunt object or surface, which leads to an emergency operation to repair or remove the spleen. An operation report must be provided by a specialist (surgeon).</i>				
Post-traumatic fat-embolism of the lungs				
Contractual definition: Fat-embolism of the lungs, confirmed by a ventilation-perfusion (VQ) scan. This must be confirmed by a pulmonologist, physician or anaesthetist.	100	1 month	50	2 months
<i>Layman's explanation:</i> <i>This claim event covers fat-embolism of the lungs.</i>				
<i>An embolism is when a lump of material, in this case fat material, is dislodged and travels into the bloodstream, which then blocks blood vessels and leads to catastrophic events in the body. This must be confirmed by a specialist (pulmonologist, physician or anaesthetist).</i>				
Compartment syndrome				
Contractual definition: Definitive history of compartment syndrome as a result of an acute injury, with permanent motor nerve damage, confirmed by a specialist. This must be confirmed with all of the following supporting evidence: <ul style="list-style-type: none"> • History and clinical signs of compartment syndrome, and • Nerve conduction studies. <i>Layman's explanation:</i> <i>Compartment syndrome is a condition of severe tissue compression, which has resulted from an acute injury. This compression in a closed muscle compartment results in permanent damage to the nerves of the affected muscles.</i>	100	3 weeks	50	1 month
<i>This claim event covers a definitive history of compartment syndrome as a result of an acute injury, with permanent motor nerve damage, confirmed by a specialist. The evidence required for this claim event is specified in the contractual definition above.</i>				

Impairment claim events	Before age 70		From age 70	
	Percentage of cover amount	Payment period	Percentage of cover amount	Payment period
Combination burns				
Contractual definition: A combination of 2nd and 3rd degree burns that covers more than 80% of the face or hands or feet, confirmed by a surgeon. <i>Layman's explanation:</i> <i>A combination of less severe (2nd degree) and severe (3rd degree) burns that covers more than 80% of the face or hands or feet. This must be confirmed by a specialist (surgeon).</i> <i>2nd degree burns are burn wounds to the outer skin layer and the layer directly under this.</i> <i>3rd degree burns are burn wounds to all three layers of the skin.</i>	100	2 weeks	50	2 months

*A 5-year exclusion period, as described under "Exclusions", applies to this claim event.

Future medical advances

Some claim events 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 claim events, 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.

Hospital Protector

Rider benefit

This is an optional rider benefit which can be chosen with the Sickness Income and Sickness Income Plus main benefits, and cannot be purchased on its own. It is only available if the main benefit has a 7 or 14 day waiting period.

An additional payment will be charged for this rider benefit.

The cover it provides is not the same as that of a medical scheme or gap cover product. It is therefore not a substitute for medical scheme membership or gap cover benefits.

Rider benefit description

A benefit may be claimed if the life insured on the main benefit is hospitalised for at least four consecutive days.

Once the life insured is discharged, any future hospitalisation must be for another four consecutive days before we will consider another claim.

Type of rider benefit

Standalone

When will cover for this rider benefit end?

It will end

- at midnight before the cover end date set out in the plan overview, or
- if this rider benefit, the main benefit or the plan ends for any reason before the cover end date.

Special features

Special features are features that are automatically included for a benefit. The following special feature applies:

- Free cover

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

Age limits
Benefit start age

As for the main benefit

Benefit cease age

As for the main benefit

Qualifying lives

As for the main benefit

Guarantee period

As for the main benefit.

Waiting period

None

What benefit will be provided?

If we admit a claim, we will make an income payment of up to 100% of the cover amount of the main benefit. The main benefit refers to the benefit for which this rider benefit has been chosen.

Once the life insured is discharged, any future hospitalisation must be for another four consecutive days before we will consider another claim.

We will not make income payments for more than 183 days in hospital in total, in a cycle of 365 days. The first cycle of 365 days will start on the first day of hospitalisation for which the first claim under this rider benefit was admitted.

Any income benefits that we will make for this rider benefit will not affect or be affected by any income payments we will make for the main benefit.

The Hospital Protector is not a benefit of a medical scheme or gap cover product. The cover it provides is not the same as that of a medical scheme or gap cover product. It is therefore not a substitute for medical scheme membership or gap cover benefits.

Admittance of a claim

The general conditions for admittance of a claim are set out in the *General information* chapter. We will only assess hospitalisation claims during or after hospitalisation has occurred, not prior to admission.

Waiting period

This rider benefit does not have a waiting period.

When will the income payments start?

We will make the first income payment at the end of the plan month in which we admit the claim. The first income payment will be for the number of days the life insured has been continuously hospitalised, from the first day of hospitalisation to the date of this first payment. Thereafter, we will make an income payment at the end of each subsequent plan month, for as long as the planholder has the right to claim payment.

How long will the income payments continue?

We will make income payments for as long as the life insured is hospitalised, but only until:

- he or she is discharged, or
- we have paid for a maximum of 183 days in a cycle of 365 days, or
- the cover end date of the benefit

If we stop making income payments due to reaching the maximum number of days in a cycle of 365 days, we will resume income payments once a new cycle starts, if the life insured is still continually hospitalised at the time.

The last income payment will only be for the number of days in the plan month that the planholder has the right to claim payment.

Exclusions

We will not admit a claim if it directly or indirectly resulted from

- normal pregnancy, or
- normal childbirth, or
- cosmetic surgery, except if it is medically necessary after an accident or bodily injury that occurred while cover for this benefit was in force, or
- a rehabilitation or detoxification program to treat alcohol or drug dependency or abuse, or any medical condition related to such dependency or abuse.

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

Any specific exclusion or other special provision that is set out under "Special provisions for this life insured" in the plan overview for the main benefit, will also apply to this rider benefit.

Explanations

What is a plan month?

The first plan month starts on the day when the plan begins. Each following plan month will start on the same day as the first one. A plan month ends at midnight on the day before the next plan month starts.

Hospital

For the purpose of this benefit, we regard a hospital as an institution that is equipped for the diagnosis of disease, for the curative treatment, both medical and surgical, of the sick and the injured, and for the housing of patients during this process. Hospices and rehabilitation and psychiatric institutions are excluded from this definition for hospital.

Spouse protector

Rider benefit

This is an optional rider benefit which can be chosen with the following main benefits:

- Sickness Income
- Sickness Income Plus
- Temporary Income
- Temporary Income Plus
- Accidental Temporary Income Plus
- Impairment Income

(It can also be added as a rider to existing Sickness IS3 and/or Temporary Disability Income OIT3)

It cannot be purchased on its own.

An additional payment will be charged for this rider benefit.

Rider benefit description

A benefit may be claimed if the spouse of the life insured on the main benefit dies, or is diagnosed with any of the severe illnesses covered by this rider benefit.

If we admit a claim, we will make 6 monthly income payments. Each income payment will be equal to the cover amount of the main benefit for which this protector rider benefit has been chosen.

We will waive the payments for the plan for as long as we make an income payment.

SCIDEP

The table below indicates 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).

Claim event	% of the cover amount for a severity level			
	Level A Most severe	Level B	Level C	Level D Least severe
Cancer, except the cancers excluded by SCIDEP	100	100	100	100
Myocardial infarction (Heart attack)	100	100	100	100
Stroke resulting in permanent impairment	100	100	100	100
Coronary artery bypass graft (CABG)	100	100	100	100

Special features

Special features are features that are automatically included for a benefit. The following special features apply:

- Free cover
- Automatic waiver of payment

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

More information on automatic waiver of payment is provided further in this section.

Type of rider benefit	Standalone
When will cover for this rider benefit end?	<p>It will end</p> <ul style="list-style-type: none"> • 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 • if we admit a claim.
Cover amount	Equal to the cover amount of the main benefit for which this rider benefit is chosen.
Benefit payment period	If we admit a claim, we will make 6 monthly income payments.
Age limits	<p>Benefit start age No minimum benefit start age applies for a spouse of the life insured on the main benefit, but the life insured on the main benefit must be younger than 55 age next birthday when the rider benefit is added.</p> <p>Benefit cease age Where the main benefit has a fixed cease age, the Spouse Protector will end at the same time as the main benefit for which this rider benefit was chosen. Where the main benefit has a Whole life cease age, the Spouse Protector will end on the plan anniversary before or on the main life insured's 70th birthday.</p>
Qualifying spouses	See the definition of a spouse under "Explanations" for more information.
Guarantee period	As for the main benefit.
Waiting period	A waiting period that phases in over 2 years applies to natural causes.

What benefit will be provided?

If we admit a claim, we will make 6 monthly income payments. Each income payment will be equal to the cover amount of the benefit for which this protector rider benefit has been chosen, which is set out in the plan overview.

We will waive the payments for the plan for as long as we make an income payment. While we waive the payments, no alteration to any of the benefits on the plan is allowed.

Claim event

A benefit may be claimed if the spouse of the life insured on the main benefit dies, or is diagnosed with any of the severe illnesses indicated in the claim event table below. The main benefit refers to the benefit for which this rider benefit has been chosen.

Claim events
Cancers, tumours, leukaemias and lymphomas
Cancer (stage I to IV)

Claim events
Cancers, tumours, leukaemias and lymphomas
Acute lymphoblastic leukaemia
Acute myeloblastic leukaemia
Bone marrow transplant
Brain tumour (Grade II to IV on WHO classification)
Carcinoid syndrome with evidence of liver metastasis of atypical carcinoid tumour
Chronic lymphocytic leukaemia (stage 0 to IV on the Rai classification system)
Chronic myeloid leukaemia (without or with bone marrow transplant)
Hairy cell leukaemia
Hodgkin's or non-Hodgkin's lymphoma (stage I to IV on Ann Arbor classification system)
Malignant melanoma (with invasion beyond the epidermis or T1N0M0 to stage IV)
Multiple myeloma (stage I to III on the Durie-Salmon scale)
Prostate cancer (T1a-c N0M0, Gleason score ≥7 to Prostate cancer stage IV)
Any non-melanoma skin cancer (stage III or stage IV)
Brain tumour treated with chemotherapy
Recurrent benign brain tumour showing symptoms
Inoperable benign brain tumour with progression
Brain tumour having undergone open brain surgery
Brain tumour with permanent neurological deficit
Cardiovascular conditions: heart, blood vessels and stroke
Heart transplant
Heart valve replacement irrespective of technique
Cardiomyopathy at class IV NYHA and EF less than 30%
Major surgery to dissect and surgically graft an aortic aneurysm
Primary pulmonary hypertension
Left ventricular aneurysm repaired surgically
Coronary artery disease with coronary artery bypass graft for one or more arteries
Mild heart attack of specified severity
Moderate heart attack of specified severity
Heart attack with permanent mild impairment in function
Heart attack with permanent severe impairment in function
Stroke with almost full recovery, or mild, moderate or severe impairment
Connective tissue
Progressive systemic sclerosis (scleroderma)
Advanced or progressive rheumatoid arthritis despite optimal treatment
Systemic lupus erythematosus with multiple organ impairment
Sarcoidosis with multiple organ involvement
Ear, nose and throat
Total and permanent loss of hearing in both ears
Gastrointestinal system
Chronic persistent hepatitis classified as Child-Pugh class A or worse
Sclerosing cholangitis classified as Child-Pugh class A or worse
End-stage liver failure
Liver or pancreas transplant
Complete pancreatectomy
Lymph and blood

Claim events
Bone marrow transplant
Musculoskeletal system
Paraplegia, hemiplegia, diplegia or quadriplegia
Loss of use of or loss of both hands
Loss of use of or loss of both feet
Loss of use of or loss of more than one limb
Nervous system and psychiatric disorders
Status epilepticus resulting in permanent neurological impairment
Guillain-Barre with permanent neurological deficit
Permanent and complete inability to communicate or comprehend language symbols
Permanent hemiparesis or hemiparalysis secondary to trauma or surgery
Motor neuron disease
Progressive muscular dystrophy
Coma resulting in permanent neurological deficit
Advanced multiple sclerosis
Advanced Parkinson's disease
Myasthenia gravis with severe permanent impairment
Alzheimer's disease
Medically certified institutionalisation for a mental and behavioural disorder for at least 6 months continuously
Renal disorders
Chronic, irreversible kidney failure requiring and already having undergone regular dialysis treatment
Kidney transplant
Respiratory disorders
Recurrent pulmonary embolism, with associated pulmonary hypertension
Chronic irreversible lung disease with severe impairment
Lung or heart-lung transplant
Vision
Total and permanent loss of sight in both eyes
Infections
Accidental HIV infection
Clinical manifestation of Aids supported by a positive HIV test result
Cerebral malaria resulting in permanent neurological impairment
Injuries, accidents and poison
Full thickness burns involving more than 30% of the body surface area
Traumatic injuries resulting in a comatose state requiring mechanical ventilation persistent for longer than 96 hours
Spinal injury resulting in paraplegia, diplegia, hemiplegia, quadriplegia or cauda equina syndrome
Catch-all*
General catch-all
Terminal illness catch-all

*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.

The table below indicates 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).

Claim event	% of the cover amount for a severity level			
	Level A Most severe	Level B	Level C	Level D Least severe
Cancer, except the cancers excluded by SCIDEP	100	100	100	100
Myocardial infarction (Heart attack)	100	100	100	100
Stroke resulting in permanent impairment	100	100	100	100
Coronary artery bypass graft (CABG)	100	100	100	100

Admittance of a claim

The conditions for admittance of a claim are set out in the General information chapter.

We will admit a maximum of one claim for this rider benefit.

The planholder will be responsible for the cost of medical proof when a claim is submitted.

If the life insured travels or lives outside South Africa when the claim event occurs, we will require the medical proof issued in a foreign country to be in English to consider a claim.

Waiting period

We will not admit a claim during the first 12 months from the date on which this rider benefit has been added to the plan. We will also not admit a claim during the first 12 months from the date on which the spouse has met the definition of a spouse, as described under "Explanations".

If the claim event occurred after 12 months but within 24 months from the date on which this rider benefit has been added to the plan, or from the date on which the spouse has met the definition of a spouse, as described under "Explanations", and we admit the claim, we will only pay 50% of the cover amount of the main benefit.

If the claim event occurred after 24 months from the date on which this rider benefit has been added to the plan, or from the date on which the spouse has met the definition of a spouse, as described under "Explanations", and we admit the claim, we will pay the full cover amount of the main benefit.

If the cover amount of the main benefit is increased, other than through benefit growth, these waiting periods will apply to the increase in the cover amount from the effective date. They will apply to the full cover amount if the plan is reinstated after an earlier lapse.

No waiting period will apply if the claim event occurs as a result of an accident.

When will the income payments start?

We will make the first income payment at the end of the plan month in which we admit the claim. Thereafter, we will make an income payment at the end of the subsequent 5 plan months.

Exclusions

We will not admit a claim for

- cancer if it is
 - any premalignant condition, or any condition with low malignant potential, or classified as borderline malignancy, or
 - any cancer in situ, or
 - any skin cancer, except malignant melanoma that has been histologically classified as T1N0M0 or worse, or
 - any tumour of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0;
- acute coronary syndromes, including but not limited to angina;
- aortic surgery if it is done on the branches of the aorta;
- a stroke if it is
 - a transient ischaemic attack (TIA), or
 - a vascular disease affecting the eye or optic nerve, or
 - migraine and vestibular disorders;
- liver failure if cirrhosis is due to alcohol or substance abuse;
- Alzheimer's disease if dementia is induced by other conditions and substances.

We will not admit a claim for a claim event resulting from any condition that existed for the spouse before the date on which this rider benefit has been added to the plan. We will also not admit a claim for a claim event resulting from any condition that existed for the spouse before the date on which the spouse has met the definition of a spouse, as described under "Explanations". If the cover amount of the main benefit is increased, other than through benefit growth, and we admit a claim for a claim event resulting from any condition that existed for the spouse before the increase, we will limit the amount of the income payment to what it was before the increase.

We will not admit a claim if death is caused by suicide, also during insanity, committed before or within 24 months from the date on which this rider benefit has been added to the plan. This waiting period will also apply from the date on which the spouse has met the definition of a spouse, as described under "Explanations". If the cover amount of the main benefit is increased, other than through benefit growth, the waiting period will also apply to the increase in the cover amount from the effective date of the increase. The waiting period will apply to the full cover amount from the reinstatement date if the plan is reinstated after an earlier lapse. The claimant must prove that the spouse did not commit suicide.

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

Explanations

Where "life insured" is used in any of these definitions, except in the definition for "Spouse", it refers to the spouse of the life insured on the main benefit.

Spouse

A person to whom the life insured on the main benefit is legally married, or with whom the life insured on the main benefit has concluded an agreement recognised as a marriage in accordance with any law or custom, provided that in the case of a marriage by law or custom, he or she lives with that person as if legally married.

Plan Month

The first plan month starts on the day when the plan begins. Each following plan month will start on the same day as the first one. A plan month ends at midnight on the day before the next plan month starts.

Aortic artery surgery

The excision and replacement of a portion of the thoracic or abdominal aorta with a graft, due to an aneurism or damage to the aorta. Catheter or keyhole techniques to repair the aneurism or damage are included

New York Heart Association (NYHA) functional classification of cardiac disease

A specialist physician or cardiologist must do the classification during a clinical examination according to the following criteria:

Class	Description
I	<ul style="list-style-type: none"> • Individual has cardiac disease, not resulting in limitation of physical activity. • Ordinary physical activity does not cause undue fatigue, palpitations, shortness of breath or anginal pain.
II	<ul style="list-style-type: none"> • Individual has cardiac disease, resulting in slight limitation of physical activity. • Is comfortable at rest and in the performance of ordinary, light, daily activities. • Greater than ordinary physical activity, such as heavy physical exertion, results in fatigue, palpitations, shortness of breath or anginal pain..

Class	Description
III	<ul style="list-style-type: none"> • Individual has cardiac disease, resulting in marked limitation of physical activity. • Is comfortable at rest. • Ordinary physical activity results in fatigue, palpitations, shortness of breath or anginal pain.
IV	<ul style="list-style-type: none"> • Individual has cardiac disease, resulting in inability to carry on any physical activity without discomfort. • Symptoms of inadequate cardiac output, pulmonary congestion, systemic congestion, or anginal syndrome may be present, even at rest. • If physical activity is undertaken, discomfort is increased.

Stroke resulting in permanent impairment

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 three months or longer after the event must confirm that the life insured has a whole person impairment (WPI) of class 1 (1% – 10%) or more.

WPI figures are calculated according to the principles and ratings of the latest edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment.

Heart valve surgery

Open-heart surgery to replace or repair a diseased heart valve.

Coronary artery bypass graft (CABG)

The undergoing of surgery, regardless of the surgical method, to correct the narrowing of, or blockage to, any one coronary artery by means of a bypass graft.

Heart attack

A heart attack 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 acute myocardial infarction. Post procedure myocardial infarction is included, provided it meets the below requirements. Other acute coronary syndromes, including but not limited to angina, are not covered by this description.

- Compatible clinical symptoms
- Characteristic electrocardiographical (ECG) changes, which can either be myocardial ischaemia that may progress to myocardial infarction or new pathological Q waves, described as:
 - 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.
 - new pathological Q waves:
 - any new Q wave in leads V1 through V3, or
 - 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, or
 - the appearance of a new complete bundle branch block.
- Raised cardiac biomarkers, which include 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

Renal Failure

Chronic irreversible end-stage renal failure, as a result of which regular peritoneal dialysis or haemodialysis is required on a long-term basis.

Liver Failure

End-stage liver failure due to cirrhosis or chronic progressive liver disease, with objective evidence of jaundice, esophageal varices and ascites.

End-stage lung disease

Diagnosis by a pulmonologist of end-stage chronic obstructive lung disease, interstitial lung disease or pneumoconiosis, requiring home oxygen therapy, and one of the following:

- cor pulmonale, or
- diffusion capacity (DCO) of less than 40%, or
- forced expiratory volume in one second (FEV1) or forced vital capacity (FVC) of less than one litre.

To optimise patient co-operation and ensure reliable and consistent results, all lung function measurements must

- be done by a registered pulmonologist,
- be done on a calibrated apparatus, and
- include at least three flow volume curves with less than 5% inter-test variability

Bone marrow failure (aplastic anaemia)

An acquired abnormality of blood cell production with total aplasia of the bone marrow as confirmed by a consultant haematologist, requiring one of the following:

- regular transfusion with whole blood or other blood products for anaemia or thrombocytopenia (transfusion dependant), or
- immunosuppressive therapy, or
- bone marrow transplantation preceded by total bone marrow ablation.

Organ transplant

Any of the following:

- receiving a heart transplant, human or mechanical, or confirmation of being on a recognised national South African transplant waiting list, awaiting a heart transplantation;
- receiving a kidney, lung, liver or pancreas transplantation, or confirmation of being on a recognised national South African transplant waiting list, awaiting a kidney, lung, liver or pancreas transplantation;
- receiving a bone marrow transplantation where the bone marrow transplantation is preceded by total bone marrow ablation.

The above must be confirmed by a specialist with supporting evidence.

Cancer

A malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukaemia, lymphoma and sarcoma.

Benign brain tumour that is inoperable or recurrent or results in permanent neurological impairment

A benign brain tumour that is inoperable or recurrent, or which causes permanent neurological impairment, excluding cognitive impairment.

Motor neuron disease

The motor neuron diseases (MND) are a group of progressive neurological disorders that destroy motor neurons, which are the cells that control essential voluntary muscle activity such as speaking, walking, breathing, and swallowing. The diagnosis must be confirmed by a specialist and evidenced by typical findings in electromyography and electroneurography.

Multiple sclerosis

A neurologist must diagnose multiple sclerosis. There must be a reliable history of at least two episodes of neurological deficit, and objective clinical signs of lesions at more than one different anatomical region within the central nervous system. Special investigations, like magnetic resonance imaging, must support the diagnosis.

Coma

A condition of unconsciousness where the life insured

- presents with a Glasgow Coma Scale of 8 or less, and
- is dependent on life-sustaining aids, such as a ventilator and intravenous infusion, for an uninterrupted period of at least 96 hours.

Parkinson's disease

A neurologist must confirm a clinical diagnosis of Parkinson's disease, with advanced stage of rigidity, abnormal gait and uncontrollable tremor despite optimal treatment.

Alzheimer's disease

A specialist must diagnose Alzheimer's disease according to the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria. Memory and cognitive impairment must be to such a degree that the life insured needs constant supervision and help in self-care.

Loss of vision in both eyes

Permanent, irreversible and total loss of vision in both eyes with sharpness of vision of 6/60 or worse in the better eye when measured with the use of visual aids.

Hearing loss

Permanent, irreversible and total loss of hearing in both ears. This means that the average hearing levels, tested with hearing aids when applicable, at audible frequencies is less than 90 decibels.

Loss of limb function

All percentages of loss of function are calculated per limb according to principles and ratings of the latest edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment.

Muscular dystrophy

Diagnosis of a recognised muscular dystrophy, which is progressive in nature, by a consultant neurologist, and which cause the irreversible inability to perform, without assistance, three or more of the following activities of daily living:

- bathing;
- dressing;
- using the toilet;
- eating;
- moving in or out of bed or a chair.

Paraplegia

Total, permanent and irrecoverable loss of function of both lower extremities, with or without loss of bowel or bladder function.

Quadriplegia

Total, permanent and irrecoverable loss of function of all four limbs.

Burns

Third-degree burn wounds, full thickness of the skin, that cover at least 20% of the body surface.

Accidental HIV infection

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

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

- the transfusion of infected blood or blood products from a transfusion service that we recognise, on or after the cover start date;
- an accidental needlestick injury or cut in the execution of the life insured's duties as a full time medical student, or normal professional duties as a medical or dental practitioner or nurse, registered with the Health Professions Council of South Africa (HPCSA), or the South African Nursing Council. The incident must have been recorded in writing in the workplace, for example with the Superintendent if in a hospital. An HIV test must have been performed within 24 hours to confirm the HIV negative status of the life insured at the time of the incident, as well as the HIV status of the patient with whom the incident took place. There must be proof that the life insured has been started on a course of anti-retroviral drugs. A subsequent HIV test must have been performed within 6 months after the incident to confirm the change in the life insured's HIV status from negative to positive;
- receiving a transplanted organ where the organ has previously been infected with the HI virus;
- rape or indecent assault. The offence must have been reported to the South African Police Services (SAPS) and a case number and/or a criminal case must have been opened. An HIV test must have been performed within 24 hours to confirm the HIV negative status of the life insured at the time of the assault. A medical examination must have been performed within 24 hours after the incident, confirming the rape or indecent assault. There must be proof that the life insured has been started on a course of anti-retroviral drugs. A subsequent HIV test must have been performed within 6 months after the incident to confirm the change in the life insured's HIV status from negative to positive;
- a violent crime. The offence must have been reported to the SAPS and a case number and/or criminal case must have been opened. A medical examination must have been performed within 24 hours after the incident, confirming the crime. Medically documented proof of acute trauma and suspicion of HIV infection must have been submitted, as well as an HIV test that proves that the life insured was HIV negative at the time of the crime. There must be proof that the life insured has been started on a course of anti-retroviral drugs. A subsequent HIV test must have been performed within 6 months after the incident to confirm the change in the life insured's HIV status from negative to positive;
- a road traffic accident. The accident must have been reported to the SAPS and a case number and/or criminal case must have been opened. A medical examination must have been performed within 24 hours after the incident, confirming the accident. Medically documented proof of acute trauma and suspicion of HIV infection must have been submitted, as well as an HIV test that proves that the life insured was HIV negative at the time of the accident.

There must be proof that the life insured has been started on a course of anti-retroviral drugs. A subsequent HIV test must have been performed within 6 months after the incident to confirm the change in the life insured's HIV status from negative to positive. If the accidental HIV infection is a result of emergency assistance at the scene of the accident, an affidavit by the SAPS or an eyewitness to prove the assistance of the life insured must have been submitted.

Sero-positive rheumatoid arthritis

Rheumatoid arthritis causing pain and deformity in at least three major joints, excluding joints in hands and feet, despite optimal treatment such as long-term corticosteroid therapy, disease modifying drugs and cytotoxics.

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

Cancer (stage I to IV)

Any stage I to IV cancer as per the American Joint Committee for Cancer, positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue.

This claim event excludes the following conditions unless specified below in the claim event table above: 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.

Acute lymphoblastic leukaemia

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

Acute myeloblastic leukaemia

Acute myeloid leukaemia, confirmed by bone marrow biopsy.

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 to IV on WHO classification)

Brain cancer, World Health Organisation (WHO) Grade II to IV, with or without neurological deficit, 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 to IV on the Rai classification system)

Chronic lymphocytic leukaemia, from stage 0 to IV on the Rai classification system, confirmed by bone marrow biopsy.

Chronic myeloid leukaemia (without or with bone marrow transplant)

- Chronic myeloid leukaemia, confirmed by bone marrow biopsy without bone marrow transplant; or
- 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 to IV on Ann Arbor classification system)

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

Malignant melanoma (with invasion beyond the epidermis or T1N0M0 to stage IV)

Malignant melanoma with invasion beyond the epidermis, classified with appropriate evidence by an oncologist from stage I to stage IV.

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

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

Prostate cancer (T1a-c N0M0, Gleason score ≥7 to Prostate cancer stage IV)

Prostate cancer, confirmed histologically starting from stage II or T1a-c N0M0, Gleason score ≥ 7 to 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 or stage IV

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

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.

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 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.

Cardiovascular conditions: heart, blood vessels and stroke**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.

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.

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.

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.

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

The undergoing of surgery to correct the narrowing of, or blockage to, one 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 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%.

Stroke with almost full recovery or mild, moderate or severe impairment

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 this claim event the following are not covered: 1) Transient ischaemic attack; 2) Vascular disease affecting the eye or optic nerve; 3) Migraine and vestibular disorders.

Stroke is covered from stroke with almost full recovery, with little residual symptoms or signs, or worse. Stroke with almost full recovery is measured by the ability to do all basic and advanced activities of daily living (ADLs), or a whole person impairment (WPI) of 10% or less.

The ADLs are indicated in the tables "Basic activities of daily living for severe illness income benefit" and "Advanced activities of daily living for severe illness income benefit" later in this document. WPI figures will be calculated according to the latest edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment.

Connective tissue

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.

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 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 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.

Ear, nose and throat

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 audiotmetric 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.

Gastrointestinal system

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.

Complete pancreatectomy

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

Lymph and blood

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.

Musculoskeletal system

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 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 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 more than one limb

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

Nervous system and psychiatric disorders

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 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.

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 income benefit" later in this document. Permanence will be established after 3 months.

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 income benefit" later in this document. Permanence will be established after 3 months.

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.

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.

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 income benefit" later in this document. Permanence will be assessed after 3 months.

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 income benefit" in this document. Permanence will be established after 3 months.

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 income benefit" later in this document. Permanence will be established after 3 months.

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

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.

Respiratory disorders

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 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.

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.

Vision

Total and permanent loss of sight in both eyes

The total and permanent loss of sight in both eyes, with all of the following: 1) Visual acuity of 6/30 or worse for both eyes when measured with the use of visual aids; 2) Reports by an ophthalmologist. Permanent implies all reasonable treatment should have been undergone.

Infections

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 transplanted 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 resulting in permanent neurological impairment

Confirmed diagnosis of cerebral malaria with all of the following: 1) Blood tests showing parasitemia count of more than 5%; 2) Permanent neurological deficit, as measured by a whole person impairment (WPI) of 11% or more according to the latest American Medical Association's Guides to the Evaluation of Permanent Impairment. This will be measured after 3 months.

Injuries, accidents and poison

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.

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.

Catch-all**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.

Basic activities of daily living for severe illness income benefit

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 income benefit

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

Child protector

Rider benefit

This is an optional rider benefit which can be chosen with the following main benefits:

- Sickness Income
- Sickness Income Plus
- Temporary Income
- Temporary Income Plus
- Accidental Temporary Income Plus and
- Impairment Income

(It can also be added as a rider to existing Sickness IS3 and/or Temporary Disability Income OIT3)

It cannot be purchased on its own.

An additional payment will be charged for this rider benefit.

Rider benefit description

A benefit may be claimed if a child of the life insured on the main benefit suffers any of the illnesses or injuries covered by this rider benefit.

If we admit a claim, we will make 6 monthly income payments. Each income payment will be equal to the cover amount of the benefit for which this protector rider benefit has been chosen.

We will waive the payments for the plan for as long as we make an income payment.

SCIDEP

The table below indicates 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).

Claim event	% of the cover amount for a severity level			
	Level A Most severe	Level B	Level C	Level D Least severe
Cancer, except the cancers excluded by SCIDEP	100	100	100	100
Myocardial infarction (Heart attack)	100	100	100	100
Stroke resulting in permanent impairment	100	100	100	100
Coronary artery bypass graft (CABG)	100	100	100	100

The claim event "Coronary artery bypass graft (CABG)" in the table above is covered under the claim event "Surgery to major blood vessel: aorta, carotid, pulmonary, coronary or femoral artery" as described under "Explanations"

Special features

Special features are features that are automatically included for a benefit. The following special features apply:

- Free cover
- Automatic waiver of payment

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

More information on automatic waiver of payment is provided further in this section.

Type of rider benefit	Standalone
When will cover for this rider benefit end?	<p>Cover will end</p> <ul style="list-style-type: none"> • 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 • if we admit a third claim.
Cover amount	Equal to the cover amount of the main benefit for which this rider benefit is chosen.
Benefit payment period	If we admit a claim, we will make 6 monthly income payments.
Age limits	<p>Benefit start age A child will be covered from his/her 1st birthday.</p> <p>Benefit cease age Where the main benefit was taken with a fixed cease age, the Child Protector will end at the same time as the main benefit for which this rider benefit is chosen.</p> <p>Where the main benefit was taken with the whole life option, the Child Protector will end on the plan anniversary before or on the main life insured's 70th birthday.</p> <p>We will, however, admit a claim for juvenile rheumatoid arthritis or cystic fibrosis only if these claim events occur before a child's 19th birthday.</p>
Qualifying children	See the definition of a child under "Explanations" for more information.
Guarantee period	As for the main benefit.
Waiting period	A waiting period that phases in over 2 years applies to natural causes.

Claim event

A benefit may be claimed if a child of the life insured on the main benefit suffers any of the illnesses or injuries indicated in the table below. The main benefit refers to the benefit for which this rider benefit has been chosen.

Claim event	Claim event explained in layman's terms*
Surgery to major blood vessel: aorta, carotid, pulmonary, coronary or femoral artery	Fixing a damaged section of a major blood vessel.
Cardiomyopathy	An enlarged heart with very poor function.
Stroke resulting in permanent impairment	Paralysis of one side of the body due to a blood clot or bleeding on the brain.

Open-heart surgery	Repairing a heart valve or hole in the heart, usually after rheumatic fever or discovering a birth defect. This is done by open-heart surgery, in other words, the chest is cut open.
Heart attack	Heart attack.
Primary pulmonary hypertension (PPH)	Abnormal blood flow and abnormal pressure in the lungs.
Renal failure	Chronic kidney failure.
Liver failure	Chronic failure of the liver with yellow jaundice.
End-stage lung disease	End-stage lung disease that requires the use of oxygen at home.
Bone marrow failure (aplastic anaemia)	A disease that permanently damages the bone marrow. This will require regular blood transfusions, chemotherapy or a bone marrow transplant.
Organ transplant	Applies if the child receives a transplanted kidney, heart, liver, lung, pancreas or bone marrow, or is on a waiting list for a kidney, heart, liver, lung or pancreas transplant.
Cancer, except the cancers excluded under "Exclusions"	Cancer, excluding most skin cancers and very early stages of some cancers that recover completely with minimal treatment.
Benign brain tumour that is inoperable or recurrent or results in permanent neurological impairment	A brain tumour that is not cancerous, but impossible to operate or keeps coming back after surgery or results in permanent brain damage.
Motor neuron disease	A disease that affects the muscles in the body, including the ability to speak, walk and swallow.
Multiple sclerosis	A disease that damages the nerves in the brain and spinal cord. Also known as MS.
Loss of vision in both eyes	Total and permanent blindness in both eyes.
Hearing loss	Total and permanent deafness in both ears.
Loss of speech	Permanently losing the ability to speak; muteness. Not due to psychiatric reasons.
Permanent colostomy or ileostomy	The need to permanently wear a bag for stools.
Head injury	Serious head injury, requiring surgery.
Paraplegia	Permanently lame in both legs, requiring the use of a wheelchair.
Quadriplegia	Permanently lame in both legs and both arms.
Accidental HIV infection	HIV infection / AIDS that is acquired accidentally through one of the events described in the explanation.
Bacterial meningitis or encephalitis with permanent impairment	A severe and contagious form of meningitis that results in permanent damage to the brain or nerves.
Cerebral malaria	Malaria affecting the brain, and resulting in permanent damage to the brain or nerves.
Rabies	A deadly infection after being bitten by a dog or other animal with mad dog disease.
Juvenile rheumatoid arthritis	An autoimmune disease that affects the joints in children younger than 16 causing pain and deformity in large joints, not only the hands.
Cystic fibrosis	A genetic disorder affecting multiple organs including the lungs. Also known as Mucoviscidosis.

*The explanations provided in this column are intended only to give a better understanding of the claim events in the first column. They are not to be used in the legal interpretation of the claim events. The definitions of the claim events as described under "Explanations" are the only contractual definitions applicable.

Admittance of a claim

Besides the conditions for admittance of a claim set out in the *General information* chapter, we will admit a claim only if

- the claim event occurs after a child's 1st birthday;

- the child survived a claim event for an illness or an injury by more than 96 hours, except if the claim event is for bacterial meningitis or encephalitis with permanent impairment, or rabies. For these claim events the child must have survived the claim event by more than 48 hours.

We will admit a claim for juvenile rheumatoid arthritis or cystic fibrosis only if these claim events occur before a child's 19th birthday.

We will admit a maximum of three claims for this rider benefit, with a maximum of one claim per child. If the planholder has fewer than three children and we have already admitted a claim for each child, it is the planholder's responsibility to request us in writing to cancel this rider benefit.

The planholder will be responsible for the cost of medical proof when a claim is submitted.

If the life insured travels or lives outside South Africa when the claim event occurs, we will require the medical proof issued in a foreign country to be in English to consider a claim.

Waiting period

We will not admit a claim during the first 12 months from the date on which this rider benefit has been added to the plan. We will also not admit a claim during the first 12 months from the date on which the child has met the definition of a child as described under "Explanations".

If the claim event occurred after 12 months but within 24 months from the date on which this rider benefit has been added to the plan, or from the date on which the child has met the definition of a child, as described under "Explanations", and we admit the claim, we will only pay 50% of the cover amount of the main benefit.

If the claim event occurred after 24 months from the date on which this rider benefit has been added to the plan, or from the date on which the child has met the definition of a child, as described under "Explanations", and we admit the claim, we will pay the full cover amount of the main benefit.

If the cover amount of the main benefit is increased, other than through benefit growth, these waiting periods will apply to the increase in the cover amount from the effective date. They will apply to the full cover amount if the plan is reinstated after an earlier lapse.

No waiting period will apply if the claim event occurs as a result of an accident.

When will the income payments start?

We will make the first income payment at the end of the plan month in which we admit the claim. Thereafter, we will make an income payment at the end of the subsequent 5 plan months.

Exclusions

We will not admit a claim for

- cancer if it is
 - any cancer in situ, or
 - any skin cancer, except malignant melanoma that has been histologically classified as T1N0M0 or worse, or
 - any tumour of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0;
- any premalignant condition, or any condition with low malignant potential, or any condition classified as borderline malignancy;
- a stroke if it is
 - a transient ischaemic attack (TIA), or
 - a vascular disease affecting the eye or optic nerve, or
 - migraine and vestibular disorders;
- liver failure if cirrhosis is due to alcohol or substance abuse;
- a benign brain tumour where the permanent impairment is cognitive impairment only;
- loss of speech if it is due to psychiatric reasons;
- juvenile rheumatoid arthritis if it is only in the hands, fingers and feet; congenital conditions.

We will not admit a claim for a claim event resulting from any condition that existed for a child before the date on which this rider benefit has been added to the plan. We will also not admit a claim for a claim event resulting from any condition that existed for a child before the date on which the life insured on the main benefit has become the parent of that child. If the cover amount of the main benefit is increased, other than through benefit growth, and we admit a claim for a claim event resulting from any condition that existed for a child before the increase, we will limit the amount of the income payment to what it was before the increase.

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

Explanations

Where "life insured" is used in any of these definitions, except in the definition for "Child", it refers to a child of the life insured on the main benefit.

Child

A biological, legally adopted or step child of the life insured on the main benefit.

Surgery to major blood vessel: aorta, carotid, pulmonary, coronary or femoral artery

The excision and replacement of a portion of the thoracic or abdominal aorta, pulmonary artery, carotid artery, femoral artery or any coronary artery with a graft, due to an aneurism or damage to the blood vessel. Catheter or keyhole techniques to repair the aneurism or damage are included.

Coronary artery bypass graft (CABG)

The undergoing of surgery, regardless of the surgical method, to correct the narrowing of, or blockage to, any one coronary artery by means of a bypass graft.

Cardiomyopathy

Signs and symptoms of cardiomyopathy with functional impairment resulting in symptoms of heart failure at rest despite optimal treatment, as confirmed by a cardiologist.

Stroke resulting in permanent impairment

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 three months or longer after the event must confirm that the life insured has a whole person impairment (WPI) of class 1 (1% – 10%) or more.

WPI figures are calculated according to the principles and ratings of the latest edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment.

Open-heart surgery

Open-heart surgery with sternotomy to replace or repair a diseased heart valve or heart septum defect, or to reposition any of the major heart vessels.

Heart attack

A heart attack 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 acute myocardial infarction. Post procedure myocardial infarction is included, provided it meets the below requirements. Other acute coronary syndromes, including but not limited to angina, are not covered by this description.

Compatible clinical symptoms.

Characteristic electrocardiographical (ECG) changes, which can either be myocardial ischaemia that may progress to myocardial infarction or new pathological Q waves, described as:

- 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.
- new pathological Q waves:
 - any new Q wave in leads V1 through V3, or
 - 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, or
 - the appearance of a new complete bundle branch block.

Raised cardiac biomarkers, which include 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	> 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

Primary pulmonary hypertension (PPH)

A haemodynamic and pathophysiological condition defined as an increase in mean pulmonary arterial pressure (PAP) of greater than or equal to 25 mmHg at rest as assessed by right heart catheterization.

Renal failure

Chronic irreversible end-stage renal failure, as a result of which regular peritoneal dialysis or haemodialysis is required on a long-term basis.

Liver failure

End-stage liver failure due to cirrhosis or chronic progressive liver disease, with objective evidence of jaundice, esophageal varices and ascites.

End-stage lung disease

Diagnosis by a pulmonologist of end-stage chronic obstructive lung disease, interstitial lung disease or pneumoconiosis, requiring home oxygen therapy, and one of the following:

cor pulmonale, or

diffusion capacity (DCO) of less than 40%, or

forced expiratory volume in one second (FEV1) or forced vital capacity (FVC) of less than one litre.

To optimise patient co-operation and ensure reliable and consistent results, all lung function measurements must

be done by a registered pulmonologist,
be done on a calibrated apparatus, and
include at least three flow volume curves with less than 5% inter-test variability.

Bone marrow failure (aplastic anaemia)

An acquired abnormality of blood cell production with total aplasia of the bone marrow as confirmed by a consultant haematologist, requiring one of the following:

- regular transfusion with whole blood or other blood products for anaemia or thrombocytopenia (transfusion dependant), or
- immunosuppressive therapy, or
- bone marrow transplantation preceded by total bone marrow ablation.

Organ transplant

Any of the following:

- receiving a heart transplant, human or mechanical, or confirmation of being on a recognised national South African transplant waiting list, awaiting a heart transplantation;
- receiving a kidney, lung, liver or pancreas transplantation, or confirmation of being on a recognised national South African transplant waiting list, awaiting a kidney, lung, liver or pancreas transplantation;
- receiving a bone marrow transplantation; the bone marrow transplantation being preceded by total bone marrow ablation.

The above must be confirmed by a specialist with supporting evidence.

Cancer

A malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukaemia, lymphoma and sarcoma.

Benign brain tumour that is inoperable or recurrent or results in permanent neurological impairment

A benign brain tumour that is inoperable or recurrent, or which causes permanent neurological impairment, excluding cognitive impairment.

Motor neuron disease

The motor neuron diseases (MND) are a group of progressive neurological disorders that destroy motor neurons, which are the cells that control essential voluntary muscle activity such as speaking, walking, breathing, and swallowing. The diagnosis must be confirmed by a specialist and evidenced by typical findings in electromyography and electroneurography.

Multiple sclerosis

A neurologist must diagnose multiple sclerosis. There must be a reliable history of at least two episodes of neurological deficit, and objective clinical signs of lesions at more than one different anatomical region within the central nervous system. Special investigations, like magnetic resonance imaging, must support the diagnosis.

Loss of vision in both eyes

Permanent, irreversible and total loss of vision in both eyes with sharpness of vision of 6/60 or worse in the better eye when measured with the use of visual aids.

Hearing loss

Permanent, irreversible and total loss of hearing in both ears. This means that the average hearing levels, tested with hearing aids when applicable, at audible frequencies is less than 90 decibels.

Loss of speech

Permanent, irreversible and total loss of the ability to speak, due to disease or injury, as established over a continuous period of 3 months. An appropriate medical consultant must confirm the diagnosis.

Permanent colostomy or ileostomy

The presence of a permanent colostomy or ileostomy with a stoma bag.

Head injury

A head injury requiring surgery in the form of a craniotomy, decompression holes to drain a brain bleeding or open reduction of a depressed skull fracture.

Paraplegia

Total, permanent and irrecoverable loss of function of both lower extremities, with or without loss of bowel or bladder function.

Quadriplegia

Total, permanent and irrecoverable loss of function of all four limbs.

Accidental HIV infection

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

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

- the transfusion of infected blood or blood products from a transfusion service that we recognise, on or after the cover start date;
- an accidental needlestick injury or cut 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.

Bacterial meningitis or encephalitis with permanent impairment

Bacterial meningitis or encephalitis confirmed by a medical specialist, supported by appropriate cerebrospinal fluid investigations that results in permanent neurological deficit.

Cerebral malaria

Cerebral malaria as confirmed by a medical specialist in the presence of Plasmodium falciparum parasites on peripheral blood smears, resulting in permanent neurological deficit.

Rabies

Confirmation by a medical specialist that the life insured has presented with the clinical manifestations of rabies contracted from an infected animal.

Juvenile rheumatoid arthritis

Rheumatoid arthritis in a child of 16 years or younger, causing pain and deformity despite optimal treatment, in at least three major joints bilaterally, in other words, shoulders, elbows, wrists, hips, knees, or ankles. This must be confirmed by a rheumatologist with appropriate radiological evidence of deformity.

Cystic fibrosis

Clinical features of cystic fibrosis, diagnosed by a medical specialist and confirmed by a sweat test and/or genetic test.

Plan month

The first plan month starts on the day when the plan begins. Each following plan month will start on the same day as the first one. A plan month ends at midnight on the day before the next plan month starts.

Lump Sum Conversion Option

Rider benefit

This is an optional rider benefit which can be chosen with the following main benefits:

- Extended Income
- Extended Income Plus
- Accidental Extended Income Plus
- Impairment Income

It cannot be purchased on its own.

An additional payment will be charged for this rider benefit.

Rider benefit description

This rider benefit provides the option to convert future income payments on the main benefit to a lump sum amount. If the client exercises the option, we will pay a lump sum amount instead of the monthly income payments. The main benefit refers to the benefit for which this rider benefit has been chosen.

The rider benefit also guarantees the receipt of any remaining income payments until the end of a specified period, if the option event occurred but the option was not exercised and the life insured dies before the end of the specified period.

Type of rider benefit

Standalone

When will cover for this rider benefit end?

It will end

- once the option provided by this rider benefit has been exercised, or
 - at midnight before the cover end date of this rider benefit set out in the plan overview, or
 - if this rider benefit, the main benefit or the plan ends for any reason before the cover end date.
-

Age limits
Benefit start age

The maximum entry age is as per the main benefit.

Benefit cease age

For main benefits with a fixed cease age the Lump sum conversion option will end 1 month before the main benefit ends.

Where the main benefit has a whole life cease age, the Lump Sum Conversion Option will end 1 month before age 70. Age 70 refers to the plan anniversary before or on the main life insured's 70th birthday.

Qualifying lives

As for the main benefit

Guarantee period

As for the main benefit.

Option event

The option can be exercised if we admit a claim on the main benefit for:

- total and permanent occupational disability, if covered by the main benefit, or
- impairment cover that pays 100% of the cover amount.

If the main benefit has a 24-month waiting period, the claim on the main benefit will only be admitted once the waiting period for the main benefit has expired. Please refer to the chapters of the main benefit for more information.

When can the option be exercised?

The option can be exercised at any time from the option event until this rider benefit's cover end date set out in the plan overview.

How will the lump sum be calculated?

The lump sum will be equal to the present value of the remaining income payments until the earlier of the cover end date of the main benefit and the plan anniversary before or on the life insured's 70th birthday. The remaining income payments will be discounted at a rate in line with market-related interest rates at the time of the calculation. If benefit growth is applicable to the plan, it will be included in the calculation.

After the option has been exercised

Once the option has been exercised, this rider benefit will be removed from the plan.

If the main benefit's cover end date is a fixed date, the main benefit will also be removed from the plan.

If the main benefit's cover end date is at death, the main benefit will not be removed from the plan once the option has been exercised, but will not provide any further income payments until the plan anniversary before or on the life insured's 70th birthday. If the main benefit is still in force at the plan anniversary before or on the life insured's 70th birthday and the claim on the main benefit was for an impairment claim event, we will resume the income payments on the main benefit at this point, at the level indicated in the main benefit. If the life insured qualifies for a new claim on the main benefit on or after this point, such a claim will be payable as a monthly income.

If we waived the payments for the plan because of the claim that we have admitted on the main benefit, the planholder will need to resume the plan payments once the option has been exercised.

If the option was not exercised

If the option event occurred but the option was not exercised, we will pay income benefits on the main benefit for as long as the planholder has the right to claim payment.

Guarantee on early death

If the life insured dies while we are making these income payments, any remaining income payments until the earlier of the cover end date of the main benefit and the plan anniversary before or on the life insured's 70th birthday will be discounted and paid as a lump sum. This lump sum will be paid to the appointed beneficiary or to the planholder's estate, after which the main benefit will end.

Admittance of a claim

If a 24-month waiting period does not apply to the main benefit, you may exercise the option only if the life insured survived more than 10 days from the date on which the contractual claim event definition on the main benefit has been met.

The survival period will only be applied to conditions where the prognosis of survival beyond 10 days is not certain, based on the available medical evidence.

Built-in Future Cover for Young Lives

This option enables young insured lives who purchased medically underwritten long term occupational disability income cover the opportunity to buy an equivalent amount of life cover with little or no medical underwriting at certain future life events.

This additional feature is automatically included in the following income benefits:

- Extended Income (OIO4)
- Extended Income Plus (OIO6)

It may also be included in certain Extended Disability Income (OIO3) benefits if it is referred to in the particular benefit's contract documents.

Refer to the *Disability and impairment benefits* chapter for more information on Built-in Future Cover for Young Lives.

Severe Illness Income (TIW3)

This benefit is available under our Income Protector product which is available under our Premier product option.

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".

Special features

Special features are features that are automatically included for a benefit. The following special feature applies:

- Free cover

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

Type of benefit

Standalone

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
- if the life insured dies.

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
- if the life insured dies.

Cover limits per life insured

Minimum: R1 000 per month

Maximum: R50 000 per month*, limited to 25% of the life insured's gross monthly income. Refer to the *Underwriting for Classic and Premier* chapter for the definitions of gross income.

*Subject to financial underwriting

Benefit payment period

If we admit a claim, we will make 12 monthly income payments.

Age limits	Benefit start age Minimum: Payment patterns other than fixed compulsory growth: 18 next birthday Fixed compulsory growth: 30 next birthday Maximum: 60 next birthday for benefit selected with a fixed term 65 next birthday for benefit selected with whole life cover
	Benefit cease age 65 next birthday for benefit selected with a fixed term. At death for benefit selected with whole life cover.
Qualifying lives	The following lives do not qualify: <ul style="list-style-type: none">• Housewives/house husbands• Scholars• Students• Pensioners• Unemployed persons. Other lives may qualify, subject to age limits and underwriting.
Guarantee period	The initial guarantee period is 5 years.

What benefit will be provided?

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.

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.

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:

- Angioplasty with or without stenting of one or more coronary arteries;
- Stroke with full recovery;
- Compartment syndrome with permanent motor nerve damage.

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.

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.

When will the income payments start?

We will make the first income payment at the end of the plan month in which we admit the claim. Thereafter, we will make an income payment at the end of each subsequent plan month.

How long will the income payments continue?

We will make the income payments monthly for a period of 12 months. If we admit a claim within 12 months from the cover end date set out in the plan overview, we will not stop making the income payments when the cover end date is reached. We will continue making the income payments until we have made 12 payments in total.

If the life insured dies after we have admitted a claim but before we have made all 12 income payments for the claim, we will pay the remaining income payments as a lump sum to the life insured's estate.

Claim events and claim event percentages

The table below indicates 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".

Claim event	Claim event percentage for indicated severity level			
	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)	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 table 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 this 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 column contains the claim event percentage linked to the particular claim event.

Claim event	Claim event percentage (% of cover amount)
Cancers, tumours, leukaemias and lymphomas	
Pancreatic cancer stage I to IV	100
Oesophageal cancer stage I to IV	100
Stomach cancer stage I to IV	100
Lung cancer stage I to IV	100
Liver cancer stage I to IV	100
Bile duct cancer stage I to IV	100
Mesothelioma stage I to IV	100
Tongue cancer stage I to IV	100
Hypopharyngeal cancer stage I to IV	100
Retroperitoneal cancer stage I to IV	100
Omental cancer stage I to IV	100
Mesenteric cancer stage I to IV	100
Acute lymphoblastic leukaemia	100
Acute myeloblastic leukaemia	100
Basal cell skin carcinoma or squamous cell skin carcinoma (stage I or II) having undergone a skin graft or skin flap	50
Bone marrow transplant	100
Brain tumour (Grade II on WHO classification)	100
Brain tumour (Grade III or IV on WHO classification)	100
Carcinoid syndrome	50
Carcinoid syndrome with evidence of liver metastasis of atypical carcinoid tumour	100
Chronic lymphocytic leukaemia (stage 0 or I on the Rai classification system)	100
Chronic lymphocytic leukaemia (stage II on the Rai classification system)	100
Chronic lymphocytic leukaemia (stage III on the Rai classification system)	100
Chronic lymphocytic leukaemia (stage IV on the Rai classification system)	100

Claim event	Claim event percentage (% of cover amount)
Chronic myeloid leukaemia (no bone marrow transplant)	100
Chronic myeloid leukaemia (with bone marrow transplant)	100
Hairy cell leukaemia	100
Hodgkin's or non-Hodgkin's lymphoma (stage I on Ann Arbor classification system)	100
Hodgkin's or non-Hodgkin's lymphoma (stage II on Ann Arbor classification system)	100
Hodgkin's or non-Hodgkin's lymphoma (stage III or IV on Ann Arbor classification system)	100
Malignant melanoma with invasion beyond the epidermis or T1N0M0	100
Malignant melanoma stage II	100
Malignant melanoma stage III or IV	100
Multiple myeloma (stage I or II on the Durie-Salmon scale)	100
Multiple myeloma (stage III on the Durie-Salmon scale)	100
Myelodysplastic syndrome	50
Partial mastectomy for ductal or lobular carcinoma in situ	100
Total mastectomy for breast pathology	100
Prostate cancer – T1a-c N0M0, Gleason score 2-6	50
Prostate cancer – T1a-c N0M0, Gleason score ≥7	100
Prostate cancer – T2N0M0, Gleason score 2-6	100
Prostate cancer – T2N0M0, Gleason score ≥7	100
Prostate cancer – T3N0M0, Gleason score 2-6	100
Prostate cancer – T3N0M0, Gleason score ≥7	100
Prostate cancer stage IV	100
Any non-melanoma skin cancer stage III	100
Any non-melanoma skin cancer stage IV	100
Benign brain tumour treated surgically	50
Brain tumour treated with chemotherapy	100
Brain tumour treated with radiotherapy	50
Recurrent benign brain tumour showing symptoms	100
Inoperable benign brain tumour	50
Inoperable benign brain tumour with progression	100
Brain tumour having undergone open brain surgery	100
Brain tumour with permanent neurological deficit	100
Acoustic neuroma resulting in neurological deficit	50
Pituitary tumour with surgical resection	50
Benign endocrine tumours having undergone surgical excision	50
Brain abscess having undergone surgical drainage	50
Amyloidosis	50
Catch-all stage I cancer	100
Catch-all stage II cancer	100
Catch-all stage III or IV cancer	100

Claim event	Claim event percentage (% of cover amount)
Early cancer	
A neuro-endocrine tumour of low malignant potential	50
Carcinoma in situ of one or both ovaries	50
Carcinoma in situ of one or both ovaries for which an oophorectomy has been performed	50
Cervical intraepithelial neoplasia grade III (CIN 3), or carcinoma in situ of the cervix	50
Cervical intraepithelial neoplasia grade III (CIN 3), or carcinoma in situ of the cervix for which a hysterectomy has been performed	50
Carcinoma in situ of the larynx	50
Carcinoma in situ of the larynx for which a total laryngectomy has been performed	50
Carcinoma in situ of the oesophagus for which surgery to remove the tumour has been performed	50
Carcinoma in situ of the stomach	50
Carcinoma in situ of the stomach for which a partial or total gastrectomy has been performed	50
Carcinoma in situ of the urinary bladder	50
Carcinoma in situ of the vagina or vulva	50
Carcinoma in situ of the vagina or vulva for which surgery defined as a skin flap or skin graft has been performed	50
Lobular carcinoma in situ or ductal carcinoma in situ of the breast resulting in chemotherapy, lumpectomy or breast conserving surgery	50
Catch-all carcinoma in situ of any other internal organ or body structure	50
Cardiovascular conditions: heart, blood vessels and stroke	
Heart transplant	100
Heart valve replacement irrespective of technique	100
Any heart valve surgery such as valvuloplasty or valvotomy irrespective of technique	100
Cardiomyopathy at class III NYHA and EF less than 40%	100
Cardiomyopathy at class IV NYHA and EF less than 30%	100
Takotsubo cardiomyopathy	50
Transcoronary ablation of septal hypertrophy	100
Pericardectomy irrespective of technique	100
Arrhythmia having undergone pathway ablation	50
Arrhythmia having undergone a permanent pacemaker insertion	50
Arrhythmia having undergone a permanent defibrillator insertion	100
Peripheral arterial disease requiring angioplasty, stent or bypass graft of one peripheral artery	100
Peripheral arterial disease requiring angioplasty, stent or bypass graft of more than one peripheral artery	100
Loss of use of or loss of one foot due to peripheral arterial disease	50
Loss of use of or loss of one hand due to peripheral arterial disease	100
Angioplasty with or without stenting of one carotid artery	100
Angioplasty with or without stenting of bilateral carotid arteries	100
Carotid arterial disease: narrowing of at least one carotid artery requiring either bypass graft or endarterectomy	100
Endovascular surgery or stent to repair any thoracic or abdominal aortic aneurysm	100
Surgical repair of an ileofemoral aneurysm or stenosis	100
Surgical repair of any aneurysm or stenosis of major arterial branches of the aorta	100
Major surgery to dissect and surgically graft an aortic aneurysm	100
Primary pulmonary hypertension	100

Claim event	Claim event percentage (% of cover amount)
Surgery for atrial septal defects or ventricular septal defects	50
Surgical repair of coarctation of the aorta	50
Left ventricular aneurysm repaired surgically	100
Surgery for atrial myxoma	100
Subarachnoid haemorrhage without neurological impairment	50
Arteriovenous malformation treated with radiological intervention	50
Arteriovenous malformation treated with open surgery craniotomy	100
Angioplasty with or without stenting of one or more coronary arteries	50
Coronary artery disease with coronary artery bypass graft for up to two arteries	100
Coronary artery disease with coronary artery bypass graft for three or more arteries	100
Mild heart attack	100
Mild heart attack of specified severity	100
Moderate heart attack of specified severity	100
Heart attack with permanent mild impairment in function	100
Heart attack with permanent severe impairment in function	100
Takayasu's disease	50
Superior sagittal sinus thrombosis	100
Cavernous sinus thrombosis	100
Non-healing venous ulcer of more than 3 months duration despite treatment by a vascular surgeon, with documented evidence of deep venous insufficiency	50
Post thrombotic leg with syndrome	50
Giant cell arteritis	50
Persistent giant cell arteritis despite optimal therapy	50
Stroke with full recovery	50
Stroke with almost full recovery	100
Stroke with mild impairment	100
Stroke with moderate impairment	100
Stroke with severe impairment	100
Connective tissue	
Progressive systemic sclerosis (scleroderma)	100
Seropositive rheumatoid arthritis	100
Advanced or progressive rheumatoid arthritis despite optimal treatment	100
Systemic lupus erythematosis (SLE)	100
Systemic lupus erythematosis with multiple organ impairment	100
Sarcoidosis	50
Sarcoidosis with multiple organ involvement	100
Polyarteritis nodosa	50
Wegener's granulomatosis	100
Ear, nose and throat	
Mastoiditis requiring mastoidectomy	50
Total and permanent loss of hearing in one ear	50
Permanent binaural hearing loss of more than 60%	100
Permanent binaural hearing loss of more than 75%	100
Total and permanent loss of hearing in both ears	100
Recipient of cochlear or middle ear implant	50
Otosclerosis resulting in hearing loss after failed surgery	50

Claim event	Claim event percentage (% of cover amount)
Chronic osteomyelitis of the sinuses	50
Endocrine system	
Diagnosis of thyrotoxic crisis	50
Diagnosis of acromegaly	50
Diagnosis of Addisonian crisis	50
Diagnosis of parathyroid tetany	50
Diagnosis of Simmonds' disease	50
Diagnosis of Conn's syndrome	50
Diagnosis of primary Cushing's disease	50
Diagnosis of diabetes insipidus	50
Diagnosis of type I diabetes	50
Diabetes mellitus type II with permanent renal impairment	50
Diabetic retinopathy stage III	50
Diabetic retinopathy stage IV	50
Gastrointestinal system	
Tracheoesophageal fistula having undergone surgery	50
Crohn's disease or ulcerative colitis with prolonged advanced therapy	50
Crohn's disease or ulcerative colitis with recurrent surgery	100
Crohn's disease or ulcerative colitis with a permanent colostomy or ileostomy	100
Hemicolectomy	50
Total colectomy (removal of the ascending, descending and transverse colon)	100
Any disease or disorder requiring partial hepatectomy	50
Chronic persistent hepatitis classified as Child-Pugh class A or worse	100
Sclerosing cholangitis classified as Child-Pugh class A or worse	100
End-stage liver failure	100
Liver or pancreas transplant	100
Amyloidosis of the liver and spleen	50
Complete pancreatectomy	100
Primary biliary cirrhosis	100
Chronic pancreatitis	50
Loss of more than one third of the tongue	50
Chronic rectal fistula	50
Proven acute peritonitis requiring surgical intervention (excluding appendectomy)	50
Irreparable abdominal or inguinal hernia	50
Lymph and blood	
Chronic blood disorders requiring constant blood replacements	100
Severe aplastic anaemia	100
Bone marrow transplant	100
Diffuse intravascular clotting	50
Idiopathic thrombocytopenic purpura with splenectomy	50
Chronic anaemia despite optimal treatment needing blood transfusion every second week	50
Autoimmune haemolytic anaemia with splenectomy	50
Essential thrombocythaemia	50

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

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

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

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

*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.

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

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

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**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.

Pericardectomy 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.

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" later in 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

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

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**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**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.

Hemicolecction

A hemicolecction, 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**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 $10 \times 10^9/L$; 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 thrombocythosis

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

Musculoskeletal system

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

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" later in 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" later in 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" later in 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 mechanical 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" later in 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" later in 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" later in 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

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**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

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

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**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

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 total and permanent loss of sight in both eyes, with all of the following: 1) Visual acuity of 6/30 or worse for both eyes when measured with the use of visual aids; 2) Reports by an ophthalmologist. 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

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

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

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

Death income (DI3)

This benefit is available under our Income Protector product which is available under our Premier product option.

Benefit description	A benefit may be claimed at the death of the life insured. If we admit a claim, we will make an income payment equal to the cover amount set out in the plan overview. We will continue making monthly income payments for as long as an appointed beneficiary has the right to claim payment.				
Special features	Special features are features that are automatically included for a benefit. The following special feature applies: <ul style="list-style-type: none">• Free cover Refer to the chapter <i>Payments, payment patterns, guarantees and cover</i> for more information about Free cover.				
Type of benefit	Standalone				
When will cover for this benefit end?	<p>Benefit with a fixed term Cover will end</p> <ul style="list-style-type: none">• 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. <p>Benefit with whole life cover Cover is provided for whole of life. However, the cover will end</p> <ul style="list-style-type: none">• after we have made the income payments for the chosen income payment period, or• if the plan ends for any reason before the cover end date.				
Age limits	<p>Benefit start age</p> <table> <tr> <td>Minimum:</td> <td> <ul style="list-style-type: none">• Premier: 18 next birthday• Fixed compulsory growth: 30 next birthday </td> </tr> <tr> <td>Maximum:</td> <td> <ul style="list-style-type: none">• Benefit with a fixed term: 10 years before the benefit cease age• Benefit with whole life cover: 80 next birthday </td> </tr> </table> <p>Benefit cease age</p> <ul style="list-style-type: none">• Benefit with a fixed term: Choice between 65 or 90 next birthday• Benefit with whole life cover: At death	Minimum:	<ul style="list-style-type: none">• Premier: 18 next birthday• Fixed compulsory growth: 30 next birthday	Maximum:	<ul style="list-style-type: none">• Benefit with a fixed term: 10 years before the benefit cease age• Benefit with whole life cover: 80 next birthday
Minimum:	<ul style="list-style-type: none">• Premier: 18 next birthday• Fixed compulsory growth: 30 next birthday				
Maximum:	<ul style="list-style-type: none">• Benefit with a fixed term: 10 years before the benefit cease age• Benefit with whole life cover: 80 next birthday				
Income payment period	<p>Benefit with a fixed term</p> <ul style="list-style-type: none">• Up to age 65 next birthday for a selected benefit cease age of 65 next birthday• Up to age 90 next birthday for a selected benefit cease age of 90 next birthday <p>A minimum income payment period of 5 years applies, even if the life insured dies shortly before the benefit cease age.</p> <p>Benefit with whole life cover</p> <p>Choice between the following: 1, 2, 5, 10, 15, 20 or 25 years.</p>				

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: Benefit with a fixed term: R3 000 per month
 Benefit with whole life cover
 • Income payment period 1 year: R15 000 per month
 • Income payment period 2 years: R8 000 per month
 • Income payment period 5 years or more: R3 000 per month

Maximum: None*

*Subject to financial underwriting

Qualifying lives Subject to age limits and underwriting.

Beneficiaries At least one beneficiary must be appointed for this benefit, but up to 10 are allowed. The total percentage allocated to beneficiaries for a Death income benefit must be 100%. Refer to the *General information* chapter for the conditions for appointment of beneficiaries.

Guarantee period The initial guarantee period is 5 years.

Waiting period No waiting period applies. However, a suicide exclusion of 24 months applies from the cover start date of the benefit, or the date the plan has been reinstated after an earlier lapse or the cover amount of the benefit is increased, other than through benefit growth. Refer to "Exclusions" for this benefit for more information.

What benefit will be provided?

If we admit a claim, we will make an income payment equal to the cover amount set out in the plan overview. We will continue making income payments for as long as an appointed beneficiary has the right to claim payment.

If we admit a claim and benefit growth is applicable to the plan, the cover amount of this benefit will continue to be increased each year as set out in the plan overview under "Benefit and payment growth".

Appointment of beneficiary compulsory

The appointment of one or more beneficiaries to receive the income payments is compulsory for this benefit. After the death of the life insured an appointed beneficiary will have to accept the appointment as beneficiary before we can start making the income payments.

The planholder may cancel or change the appointment of a beneficiary at any time. The appointment, cancellation or change must be in writing and signed by the planholder, and must reach our head office before the death of the life insured.

Admittance of a claim

The conditions for admittance of a claim are set out in the *General information* chapter.

Exclusions

We will not admit a claim if death is caused by suicide, also during insanity, committed before or within 24 months from the cover start date of the benefit or the date the plan has been reinstated after an earlier lapse. If the cover amount is increased, other than through benefit growth, this waiting period will also apply to the increase in the cover amount from the effective date of the increase. The claimant must prove that the life insured did not commit suicide.

Other general exclusions, if applicable, are set out in the applicable overview chapter in this technical guide. Specific exclusions, if any, are set out in the plan overview, in the special provisions for the life insured concerned.

When will the income payments start?

We will make the first income payment at the end of the plan month in which we admit the claim. The first income payment will be for the number of plan months from the date of the claim event to the date of this first payment. We will not pay any interest on this amount. Thereafter, we will make an income payment at the end of each subsequent plan month, for as long as an appointed beneficiary has the right to claim payment.

How long will the income payments continue?

Benefit with a fixed term

We will make the income payments until midnight before the cover end date set out in the plan overview. However, if we admit a claim within five years from the cover end date, we will not stop making the income payments when the cover end date is reached, but will continue making the income payments until five years after the date of the claim event.

Benefit with whole life cover

We will make the income payments for the chosen income payment period, which is set out in the plan overview.

What will happen if an appointed beneficiary dies?

Benefit with a fixed term

If we admit a claim and an appointed beneficiary is no longer alive, the life insured's estate will have the option to appoint another beneficiary or to take a lump sum. The lump sum will be equal to the present value of the income payments that would have been made until the cover end date, discounted at a rate in line with long-term interest rates at the time of the calculation.

If an appointed beneficiary dies after we have already started making the income payments, we will pay the remaining income payments as a lump sum to the beneficiary's estate. The lump sum will be equal to the present value of the remaining income payments that would have been made until the cover end date, discounted at a rate in line with long-term interest rates at the time of the calculation.

Benefit with whole life cover

If we admit a claim and an appointed beneficiary is no longer alive, the life insured's estate will have the option to appoint another beneficiary or to take a lump sum. The lump sum will be equal to the present value of the income payments that would have been made until the end of the chosen income payment period, discounted at a rate in line with long-term interest rates at the time of the calculation.

If an appointed beneficiary dies after we have already started making the income payments, we will pay the remaining income payments as a lump sum to the beneficiary's estate. The lump sum will be equal to the present value of the remaining income payments that would have been made until the end of the chosen income payment period, discounted at a rate in line with long-term interest rates at the time of the calculation.

Explanations

Plan month

The first plan month starts on the day when the plan begins. Each following plan month will start on the same day as the first one. A plan month ends at midnight on the day before the next plan month starts.

Impairment Claim Events for Short Term Benefits

The impairment claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated in the table below for the following benefits:

- Sickness Income
- Sickness Income Plus
- Temporary Income
- Temporary Income Plus
- The guaranteed payment events table can be found at the following link
[GuaranteedpaymenteventShortTerm](#)

The contractual definitions will apply when we consider a claim. The layman's explanations are provided for a better understanding of the claim events but will not be used in the legal interpretation of the claim events.

For multiple claims, we may pay a lower percentage than indicated in the table below.

Impairment Claim Events Table

Impairment Claim event	Percentage of cover amount %	
Cardiovascular system	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
Valvular heart disease, cardiomyopathy		
<p>Contractual definition: Severe valvular heart disease or cardiomyopathy, meeting the following criteria:</p> <ul style="list-style-type: none"> • New York Heart Association (NYHA) class III on optimal treatment, and • One of the following: <ul style="list-style-type: none"> • Maximal effort test of 4 to 6 metabolic equivalents (METS), or • Ejection fraction (EF) of less than 45%, or • Valve gradient and/or valve area classified as severe. <p>This must be confirmed by a cardiologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers severe disease of the heart valves or diseases of the heart muscle, where the heart muscle becomes enlarged, thick, or rigid (cardiomyopathy). This results in a weaker heart, with the heart being less able to pump blood through the body and maintain a normal electrical rhythm. This can lead to heart failure, where the symptoms progress to a stage where even with light activity there is tiredness, shortness of breath or heart palpitations (referred to as class III New York Heart Association classification of heart failure).</i> </p> <p><i>This claim event must meet the criteria as described in the contractual definition above, and must be confirmed by a specialist (cardiologist).</i></p>	-	50
<p>Contractual definition: Severe valvular heart disease or cardiomyopathy, meeting the following criteria:</p> <ul style="list-style-type: none"> • New York Heart Association (NYHA) class IV on optimal treatment, and • One of the following: <ul style="list-style-type: none"> • Maximal effort test of less than 4 metabolic equivalents (METS), or 	100	100

Impairment Claim event	Percentage of cover amount %	
<p>Impairment Claim event</p> <ul style="list-style-type: none"> • Ejection fraction (EF) of less than 40%, or • Valve gradient and/or valve area classified as severe. <p>This must be confirmed by a cardiologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers severe disease of the heart valves or diseases of the heart muscle, where the heart muscle becomes enlarged, thick, or rigid (cardiomyopathy). This results in a weaker heart, with the heart being less able to pump blood through the body and maintain a normal electrical rhythm. This can lead to heart failure, where the symptoms progress to a stage where at rest there is tiredness, shortness of breath or heart palpitations (referred to as class IV New York Heart Association classification of heart failure).</i></p> <p><i>This claim event must meet the criteria as described in the contractual definition above, and must be confirmed by a specialist (cardiologist).</i></p>	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
<p>Ischaemic heart disease</p> <p>Contractual definition: Ischaemic heart disease with cardiac failure, meeting the following criteria:</p> <ul style="list-style-type: none"> • New York Heart Association (NYHA) class III on optimal treatment, and • Maximal effort test of 4 to 6 metabolic equivalents (METS), and • One of the following: <ul style="list-style-type: none"> • Left ventricular ejection fraction (LVEF) of less than 45%, or • Moderate diastolic dysfunction, as determined by a cardiologist, taking into account the cause of the dysfunction, extent of ventricular hypertrophy, and mitral inflow pattern as determined by echocardiography. <p>This must be confirmed by a cardiologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers blockage of the arteries supplying blood to the heart muscles (ischaemic heart disease), complicated by the heart being less able to pump blood to supply the needs of the body (cardiac failure), where the symptoms progress to a stage where even with light activity there is tiredness, shortness of breath or heart palpitations (referred to as class III New York Heart Association classification of heart failure).</i></p> <p><i>This claim event must meet the criteria as described in the contractual definition above, and must be confirmed by a specialist (cardiologist).</i></p>	-	50
<p>Contractual definition: Ischaemic heart disease with cardiac failure, meeting the following criteria:</p> <ul style="list-style-type: none"> • New York Heart Association (NYHA) class IV on optimal treatment, and • Maximal effort test of less than 4 metabolic equivalents (METS), and • One of the following: <ul style="list-style-type: none"> • Left ventricular ejection fraction (LVEF) of less than 40%, or • Severe diastolic dysfunction, as determined by a cardiologist, taking into account the cause of the dysfunction, extent of ventricular hypertrophy, and mitral inflow pattern as determined by echocardiography. 	100	100

Impairment Claim event	Percentage of cover amount %	
Heart transplant	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
<p>This must be confirmed by a cardiologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers blockage of the arteries supplying blood to the heart muscles (ischaemic heart disease), complicated by the heart being less able to pump blood to supply the needs of the body (cardiac failure), where the symptoms progress to a stage where at rest there is tiredness, shortness of breath or heart palpitations (referred to as class IV New York Heart Association classification of heart failure).</i></p> <p><i>This claim event must meet the criteria as described in the contractual definition above, and must be confirmed by a specialist (cardiologist).</i></p>		
<p>Contractual definition:</p> <ul style="list-style-type: none"> • The undergoing of a complete heart transplant as a recipient, or • Confirmation of being on a recognised national South African transplant waiting list, awaiting a complete heart transplant. <p>This must be confirmed by a specialist with supporting evidence.</p> <p><i>Layman's explanation:</i> <i>This claim event covers:</i> <ul style="list-style-type: none"> – <i>The undergoing of a complete heart transplant as a recipient, to replace a diseased heart, or</i> – <i>Confirmation of being on a recognised national South African transplant waiting list, awaiting a complete heart transplant.</i> <p><i>This must be confirmed by a specialist with supporting evidence.</i></p> </p>	100	100

Impairment Claim event	Percentage of cover amount %	
Pericardial disease	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
<p>Contractual definition: Pericardial disease with cardiac failure, meeting the following criteria:</p> <ul style="list-style-type: none"> • Confirmed irreversible pericardial disease by a specialist, and • New York Heart Association (NYHA) class III on optimal treatment, and • One of the following: <ul style="list-style-type: none"> • Maximal effort test of 4 to 6 metabolic equivalents (METS), or • Left ventricular ejection fraction (LVEF) of less than 45% <p>This must be confirmed by a cardiologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers pericardial disease with cardiac failure, meeting the criteria as described in the contractual definition above. This must be confirmed by a specialist (cardiologist).</i></p> <p><i>The pericardium is a sac that holds the heart in place and helps it to work properly. The sac is made of two thin layers of tissue that enclose the heart. Various conditions can affect and cause disease of these layers, leading to it becoming scarred and thickened and complicated by the heart being less able to pump blood to supply the needs of the body (cardiac failure), where the symptoms progress to a stage where even with light activity there is tiredness, shortness of breath or heart palpitations (referred to as class III New York Heart Association classification of heart failure).</i></p>	-	50
<p>Contractual definition: Pericardial disease with cardiac failure, meeting the following criteria:</p> <ul style="list-style-type: none"> • Confirmed irreversible pericardial disease by a specialist, and • New York Heart Association (NYHA) class IV on optimal treatment, and • One of the following: <ul style="list-style-type: none"> • Maximal effort test of less than 4 metabolic equivalents (METS), or • Left ventricular ejection fraction (LVEF) of less than 40%. <p>This must be confirmed by a cardiologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers pericardial disease with cardiac failure, meeting the criteria as described in the contractual definition above. This must be confirmed by a specialist (cardiologist).</i></p> <p><i>The pericardium is a sac that holds the heart in place and helps it to work properly. The sac is made of two thin layers of tissue that enclose the heart. Various conditions can affect and cause disease of these layers, leading to it becoming scarred and thickened and complicated by the heart being less able to pump blood to supply the needs of the body (cardiac failure), where the symptoms progress to a stage where at rest there is tiredness, shortness of breath or heart palpitations (referred to as class IV New York Heart Association classification of heart failure).</i></p>	100	100

Impairment Claim event	Percentage of cover amount %	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
Arrhythmia <p>Contractual definition: Arrhythmia with moderate impairment, meeting the following criteria: Arrhythmia on optimal treatment that results in</p> <ul style="list-style-type: none"> • New York Heart Association (NYHA) class III shortness of breath, and • One of the following: <ul style="list-style-type: none"> • 4 or less metabolic equivalents (METS) with maximal effort test, or • Documented arrhythmia that fails to respond to optimal treatment, and leads to frequent fainting. <p>This must be confirmed by a cardiologist, physician or electrophysiologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers arrhythmia with moderate impairment, meeting the criteria as described in the contractual definition above. This must be confirmed by a specialist (cardiologist, physician or electrophysiologist).</i></p> <p><i>Arrhythmia is an abnormal beat of the heart that can be too slow or too fast. This can present with moderate impairment, which can result in the following on optimal treatment:</i></p> <ul style="list-style-type: none"> – Heart failure, where the symptoms progress to a stage where even with light activity there is tiredness, shortness of breath or heart palpitations (referred to as class III New York Heart Association classification of heart failure), and – One of the following: <ul style="list-style-type: none"> – Reduced exercise effort test meeting specified criteria, or <p><i>Documented arrhythmia that fails to respond to optimal treatment, and leads to frequent fainting.</i></p>	-	50	
 <p>Contractual definition: Arrhythmia with severe impairment, meeting the following criteria: Arrhythmia on optimal treatment that results in</p> <ul style="list-style-type: none"> • New York Heart Association (NYHA) class IV shortness of breath, and • 2 or less metabolic equivalents (METS) with maximal effort test. <p>This must be confirmed by a cardiologist, physician or electrophysiologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers arrhythmia with severe impairment, meeting the criteria as described in the contractual definition above. This must be confirmed by a specialist (cardiologist, physician or electrophysiologist).</i></p> <p><i>Arrhythmia is an abnormal beat of the heart that can be too slow or too fast. This can present with severe impairment, which can result in the following on optimal treatment:</i></p> <ul style="list-style-type: none"> – Heart failure where the symptoms progress to a stage where at rest there is tiredness, shortness of breath or heart palpitations (referred to as class IV New York Heart Association classification of heart failure), and – Reduced exercise effort test meeting specified criteria. 	100	100	

Impairment Claim event	Percentage of cover amount %	
Hypertension	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
<p>Contractual definition: Hypertension with renal impairment, meeting the following criteria:</p> <ul style="list-style-type: none"> • Stage II hypertension despite optimal treatment, and • Creatinine clearance of less than 50% of normal value for age. <p>This must be confirmed by a physician, nephrologist or cardiologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers high blood pressure with impaired kidney function, meeting the following criteria:</i></p> <ul style="list-style-type: none"> – Persistent blood pressure reading of 140/90 or higher despite optimal medical treatment, and – Specialised laboratory test measuring kidney function (creatinine clearance) of less than 50% of normal value for age. <p><i>This must be confirmed by a specialist (physician, nephrologist or cardiologist).</i></p>	-	50
<p>Contractual definition: Hypertension with severe renal impairment, meeting the following criteria:</p> <ul style="list-style-type: none"> • Stage III hypertension despite optimal treatment, and • Creatinine clearance of less than 20% of normal value for age. <p>This must be confirmed by a physician, nephrologist or cardiologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers high blood pressure with impaired kidney function, meeting the following criteria:</i></p> <ul style="list-style-type: none"> – Persistent blood pressure reading of 160/100 up to 179/109 despite optimal medical treatment, and – Specialised laboratory test measuring kidney function (creatinine clearance) of less than 20% of normal value for age. <p><i>This must be confirmed by a specialist (physician, nephrologist or cardiologist).</i></p>	100	100
Diseases of the aorta	100	100
<p>Contractual definition: Diseases of the aorta with severe impairment, meeting the following criteria:</p> <p>Confirmed irreversible aortic disease by a cardiologist, cardiothoracic or vascular surgeon, with</p> <ul style="list-style-type: none"> • Persistent symptoms despite compliance with medication, and • New York Heart Association (NYHA) class IV. <p><i>Layman's explanation:</i> <i>This claim event covers disease of the main artery supplying oxygen rich blood to the body (called the aorta), meeting the following criteria:</i></p> <ul style="list-style-type: none"> – Confirmed by a specialist (cardiologist, cardiothoracic or vascular surgeon) that the disease is irreversible with persistent symptoms despite compliance with optimal medical treatment, and 		

Impairment Claim event	Percentage of cover amount %	
Peripheral arterial disease	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
<p><i>Heart failure, where the symptoms progress to a stage where at rest there is tiredness, shortness of breath or heart palpitations (referred to as class IV New York Heart Association classification of heart failure).</i></p>		
<p>Contractual definition: Peripheral arterial disease with moderate impairment, with abnormal Doppler readings, cold leg, rubor and pain on exercise. This must be confirmed by a vascular surgeon.</p> <p>Layman's explanation: <i>This claim event covers peripheral arterial disease with moderate impairment, meeting the following criteria:</i></p> <ul style="list-style-type: none"> – Abnormal specialised test measuring blood flow in arteries (Doppler), and – Cold and discoloured and painful leg. <p><i>This must be confirmed by a specialist (vascular surgeon).</i></p> <p><i>Peripheral arterial disease is a problem with blood flow to the limbs due to narrowing of the arteries in the limbs.</i></p>	-	50
<p>Contractual definition: Peripheral arterial disease with severe impairment despite optimal treatment, meeting the following criteria:</p> <ul style="list-style-type: none"> • No palpable pulses, confirmed by absent Doppler readings, or • Severe vascular ulceration, or • Gangrene. <p>Layman's explanation: <i>This claim event covers peripheral arterial disease with severe impairment, meeting the following criteria:</i></p> <ul style="list-style-type: none"> – No palpable pulses confirmed by a specialised test measuring blood flow in arteries (Doppler), or – Severe ulcers due to poor blood flow, or – Death of tissue (gangrene). <p><i>This must be confirmed by a specialist (vascular surgeon).</i></p> <p><i>Peripheral arterial disease is a problem with blood flow to the limbs due to narrowing of the arteries in the limbs.</i></p>	100	100
Peripheral venous disease		
<p>Contractual definition: Peripheral venous disease with severe impairment despite optimal treatment, with severe deep and widespread vascular ulceration. This must be confirmed by a vascular surgeon.</p> <p>Layman's explanation:</p>	-	50

Impairment Claim event	Percentage of cover amount %	
Primary pulmonary artery hypertension	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
<p><i>This claim event covers peripheral venous disease with severe impairment despite optimal treatment, with severe deep and widespread ulcers due to poor blood flow.</i></p> <p><i>This must be confirmed by a specialist (vascular surgeon).</i></p> <p><i>Peripheral venous disease is a disease causing blockage of the blood vessels (veins) carrying blood from the arms and legs to the heart.</i></p>		
<p>Contractual definition: Severe primary pulmonary artery hypertension despite optimal medical treatment, with mean pulmonary artery pressure 40-70 mmHg, and at least New York Heart Association (NYHA) class III classification of cardiac impairment. This must be confirmed by a physician.</p> <p><i>Layman's explanation:</i> <i>This claim event covers severe high blood pressure in the lung arteries despite optimal treatment, meeting the following criteria:</i></p> <ul style="list-style-type: none"> – Specified artery pressure as in the contractual definition above, and – Symptoms have progressed to a stage where even with light activity there is tiredness, shortness of breath or heart palpitations (referred to as class III New York Heart Association classification of heart failure). <p><i>This must be confirmed by a specialist (physician).</i></p>	-	50
<p>Contractual definition: Severe primary pulmonary artery hypertension despite optimal medical treatment, with mean pulmonary artery pressure exceeding 70 mmHg, and at least New York Heart Association (NYHA) class IV classification of cardiac impairment. This must be confirmed by a physician.</p> <p><i>Layman's explanation:</i> <i>This claim event covers severe high blood pressure in the lung arteries despite optimal treatment, meeting the following criteria:</i></p> <ul style="list-style-type: none"> – Specified artery pressure as in the contractual definition above, and – Symptoms have progressed to a stage where at rest there is tiredness, shortness of breath or heart palpitations (referred to as class IV New York Heart Association classification of heart failure). <p><i>This must be confirmed by a specialist (physician).</i></p>	100	100
Blood system		
Anaemia		
<p>Contractual definition: Severe treatment resistant anaemia despite optimal medical treatment, meeting the following criteria:</p> <ul style="list-style-type: none"> • Hb less than 8 g/dL, and • Requiring 2 or more units of blood or blood products every 4 to 6 weeks. 	-	50

Impairment Claim event	Percentage of cover amount %	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
<p>This must be confirmed by a physician or haematologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers persistent low oxygen carrying capacity of red blood cell count despite optimal medical treatment (referred to as treatment resistant anaemia), meeting the following criteria:</i></p> <ul style="list-style-type: none"> – Low blood count meeting specific criteria for oxygen carrying capacity of red blood cells, and – Evidence of blood transfusions of 2 or more units every 4 to 6 weeks. <p><i>This must be confirmed by a specialist (physician or haematologist).</i></p>			
<p>Contractual definition: Life threatening, treatment resistant anaemia despite optimal treatment, meeting the following criteria:</p> <ul style="list-style-type: none"> • Hb less than 8 g/dL, and • Requiring 2 or more units of blood or blood products every 2 weeks. <p>This must be confirmed by a physician or haematologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers persistent low oxygen carrying capacity of red blood cell count despite optimal medical treatment (referred to as treatment resistant anaemia), meeting the following criteria:</i></p> <ul style="list-style-type: none"> – Low blood count meeting specific criteria for oxygen carrying capacity of red blood cells, and – Evidence of blood transfusions of 2 or more units every 2 weeks. <p><i>This must be confirmed by a specialist (physician or haematologist).</i></p>	100	100	
White blood cell disorder			
<p>Contractual definition: Severe white blood cell disorder, meeting the following criteria:</p> <ul style="list-style-type: none"> • More than 1 hospitalisation per year for acute bacterial infection and an absolute neutrophil count of between 250 and 500, or • Lymphoma or leukaemia requiring 1 or 2 chemotherapy cycles per year. <p>This must be confirmed by a physician or haematologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers persistent low oxygen carrying capacity of red blood cell count despite optimal medical treatment (referred to as treatment resistant anaemia), meeting the following criteria:</i></p> <ul style="list-style-type: none"> – Low blood count meeting specific criteria for oxygen carrying capacity of red blood cells, and – Evidence of blood transfusions of 2 or more units every 2 weeks. <p><i>This must be confirmed by a specialist (physician or haematologist).</i></p>	-		50

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
<p>Contractual definition: Severe white blood cell disorder, meeting the following criteria:</p> <ul style="list-style-type: none"> • Whole person impairment (WPI) of at least 35% despite optimal medical treatment, or • Lymphoma or leukaemia requiring 3 to 6 chemotherapy cycles per year. <p>This must be confirmed by a physician or haematologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers severe white blood cell disorder, meeting the following criteria:</i> <ul style="list-style-type: none"> – Whole person impairment (WPI) of at least 35% despite optimal medical treatment, or – Cancer of infection-fighting cells of the immune system (lymphoma) or cancer of white blood cells (leukaemia), requiring 3 to 6 chemotherapy cycles per year. <p><i>This must be confirmed by a specialist (physician or haematologist).</i></p> </p>	100	100
<p>Clotting disorder</p> <p>Contractual definition: Severe clotting disorder, meeting the following criteria:</p> <ul style="list-style-type: none"> • Persistent despite optimal medical and surgical treatment, and • Resulting in end organ failure of one of the following, as described in this document for this benefit: <ul style="list-style-type: none"> • Respiratory failure • Cardiac failure end-stage • Kidney failure end-stage • Liver failure (which is not described in this document). <p>This must be confirmed by a specialist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers severe clotting disorder, meeting the criteria in the contractual definition above. This must be confirmed by a specialist.</i></p> <p><i>Clotting disorder occurs when the body is unable to make components that are required by the body for blood to clot. When severe, this disorder can lead to severe bleeding from various sites, which can ultimately lead to multiple organ damage.</i></p>	100	100

Impairment Claim event	Percentage of cover amount %	
Respiratory system	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
Respiratory failure		
<p>Contractual definition: Severe respiratory failure, meeting the following criteria: Confirmed chronic respiratory disease despite optimal medical treatment, resulting in impaired airflow, meeting the following criteria:</p> <ul style="list-style-type: none"> • Forced expiratory volume in one second (FEV1) of less than 50%, or • Forced vital capacity (FVC) of less than 50%, or • Impaired diffusion with diffusion capacity (DCO) of less than 50%, or • Impaired exercise tolerance with maximal effort test of 4 to 6 metabolic equivalents (METS). <p>This must be confirmed by a pulmonologist or physician.</p> <p><i>Layman's explanation:</i> <i>This claim event covers severe chronic disease of the lungs, optimally treated but resulting in respiratory failure (lungs not being able to meet the oxygen requirements of the body), with impaired airflow. This must meet the criteria described in the contractual definition above and must be confirmed by a specialist (pulmonologist or physician).</i></p>	-	50
<p>Contractual definition: Severe respiratory failure, meeting the following criteria: Confirmed chronic respiratory disease despite optimal medical treatment, resulting in impaired airflow with</p> <ul style="list-style-type: none"> • Forced expiratory volume in one second (FEV1) of less than 40%, or • Forced vital capacity (FVC) of less than 40%, or • Impaired diffusion with diffusion capacity (DCO) of less than 40%, or • Impaired exercise tolerance with maximal effort test of less than 4 metabolic equivalents (METS). <p>This must be confirmed by a pulmonologist or physician.</p> <p><i>Layman's explanation:</i> <i>This claim event covers severe chronic disease of the lungs, resulting in respiratory failure (lungs not being able to meet the oxygen requirements of the body), with impaired airflow. This must meet the criteria described in the contractual definition above and must be confirmed by a specialist (pulmonologist or physician).</i></p>	100	100
Lung transplant		
<p>Contractual definition:</p> <ul style="list-style-type: none"> • The undergoing of a complete lung transplant as a recipient, or • Confirmation of being on a recognised national South African transplant waiting list, awaiting a complete lung transplant. <p>This must be confirmed by a specialist with supporting evidence.</p> <p><i>Layman's explanation:</i></p>	100	100

Impairment Claim event	Percentage of cover amount %	
Central nervous system	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
<p>Coma</p> <p>This claim event covers:</p> <ul style="list-style-type: none"> – The undergoing of a complete lung transplant as a recipient, to replace a diseased lung, or – Confirmation of being on a recognised national South African transplant waiting list, awaiting a complete lung transplant. <p>This must be confirmed by a specialist with supporting evidence.</p>		
<p>Hemiplegia</p> <p>Contractual definition: A condition of unconsciousness not induced by sedation, where the life insured presents with a Glasgow Coma Scale reading of 8 or less for an uninterrupted period of at least 96 hours.</p> <p>This must be confirmed by a specialist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers coma, where there is a state of unconsciousness not induced by medication causing a state of sleep. Specific criteria must be met, as described in the contractual definition above. This must be confirmed by a specialist.</i></p>	100	100
<p>Diplegia</p> <p>Contractual definition: 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.</p> <p>The following is required:</p> <ul style="list-style-type: none"> • Radiological evidence such as a computed tomography (CT) scan or magnetic resonance imaging (MRI), and <p>Must be confirmed by a neurologist or neurosurgeon.</p>	100	100
<p><i>Layman's explanation:</i> <i>This claim event covers diplegia, meeting the criteria in the contractual definition above. This must be confirmed by a specialist (neurologist or neurosurgeon).</i></p> <p><i>Diplegia is a total and permanent weakness of the same part on both sides of the body, which can be as a result of a disease or injury.</i></p>	100	100

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
Paraplegia		
<p>Contractual definition: The total and permanent loss of muscle function resulting in the loss of use of both legs due to disease or injury to the spinal cord or brain.</p> <p>The following is required:</p> <ul style="list-style-type: none"> • Radiological evidence such as a computed tomography (CT) scan or magnetic resonance imaging (MRI), and <p>Must be confirmed by a neurologist or neurosurgeon.</p>	100	100
Quadriplegia		
<p>Contractual definition: The total and permanent loss of muscle function resulting in the loss of use of both arms and both legs due to disease or injury to the spinal cord or brain.</p> <p>The following is required:</p> <ul style="list-style-type: none"> • Radiological evidence such as a computed tomography (CT) scan or magnetic resonance imaging (MRI), and <p>Must be confirmed by a neurologist or neurosurgeon.</p>	100	100
Epilepsy		
<p>Contractual definition: Uncontrolled epilepsy, meeting the following criteria:</p> <ul style="list-style-type: none"> • Documented epileptic attacks confirmed by an abnormal electro-encephalogram (EEG) reading, and • Attacks must be observed to be more than 3 per week, and be resistant to optimal therapy as confirmed by drug serum-level testing. <p>This must be confirmed by a neurologist or physician.</p> <p><i>Layman's explanation:</i> <i>This claim event covers uncontrolled convulsions or seizures, meeting the criteria in the contractual definition above. This must be confirmed by a specialist (neurologist or physician).</i></p>	-	50

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
<p>Contractual definition: Frequent status epilepticus, meeting the following criteria: In spite of sustained optimal treatment and documented compliance of treatment, there must be</p> <ul style="list-style-type: none"> • at least 3 documented episodes of status epilepticus within the last 12 months, or • 12 or more grand mal seizures per month, within the last 4 consecutive months. <p>This will be assessed by all of the following evidence:</p> <ul style="list-style-type: none"> • Electro-encephalograms (EEGs), and • Drug serum levels which must show compliance, and • Documented evidence of epileptic attacks on clinical records, and • Evidence of emergency treatment administered. <p>This must be confirmed by a neurologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers frequent status epilepticus, meeting the criteria in the contractual definition above. This must be confirmed by a specialist (neurologist).</i></p> <p><i>Status epilepticus is a single seizure lasting for more than 5 minutes, or 2 or more seizures within a 5-minute period without the person returning to normal between them.</i></p>	100	100
<p>Parkinson's disease</p> <p>Contractual definition: Advanced Parkinson's disease confirmed by a neurologist, meeting the following criteria:</p> <ul style="list-style-type: none"> • Appropriate clinical signs and symptoms, and • Permanent inability to perform independently at least 3 basic activities of daily living (ADLs). These ADLs are indicated in the table "Basic activities of daily living for impairment cover" later in this document. <p>Permanence will be assessed after requirements for reasonable treatment has been met.</p> <p><i>Layman's explanation:</i> <i>This claim event covers advanced Parkinson's disease, meeting the criteria in the contractual definition above. This must be confirmed by a specialist (neurologist).</i></p> <p><i>Parkinson's disease is a degenerative brain condition that leads to various symptoms, like tremor of the hands and head, a slow gait with shuffling feet, inability to show emotions, and a forward-falling posture.</i></p>	100	100

Impairment Claim event	Percentage of cover amount %	
Cognitive dementia	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
<p>Contractual definition: Early onset cognitive dementia due to organic brain disease (pre-senile dementia), meeting the following criteria: The diagnosis of cognitive dementia before age 65 (pre-senile dementia), confirmed by a neurologist or psychiatrist.</p> <p>There must be evidence of all of the following:</p> <ul style="list-style-type: none"> Typical findings in cognitive tests as per the latest Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria or 2 consecutive Global Clinical Dementia Rating (CDR) ratings of at least 1.0, and Supportive findings on neuro-imaging, and Permanent inability to perform independently at least 3 advanced activities of daily living (ADLs), or the need for assistance by a caregiver. These ADLs are indicated in the table "Advanced activities of daily living for impairment cover" later in this document. <p>Permanence will be established after 3 months.</p> <p><i>Layman's explanation:</i> <i>This claim event covers the early onset of a decline in thinking and memory function (cognitive function) not in keeping with what is normal for the age and occurring before age 65 (pre-senile dementia). This must be as a result of a disease of the brain, and not due to a psychological cause. This must be confirmed by a specialist (neurologist or psychiatrist).</i></p> <p>There must be evidence of all of the following:</p> <ul style="list-style-type: none"> Typical findings in specialised testing for memory and thinking called cognitive tests (as per the latest DSM criteria or 2 consecutive CDR ratings of at least 1.0), and Supportive findings on specialised radiological testing (neuro-imaging), and Permanent inability to perform independently at least 3 advanced activities of daily living, as indicated later in this document for this benefit, or the need for assistance by a caregiver. <p>Permanence will be established after 3 months.</p>	-	50

Impairment Claim event	Percentage of cover amount %	
Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus	
<p>Contractual definition: Early onset cognitive dementia due to organic brain disease (pre-senile dementia), meeting the following criteria: The diagnosis of cognitive dementia before age 65 (pre-senile dementia), with profound impairment, confirmed by a neurologist or psychiatrist.</p> <p>There must be evidence of all of the following:</p> <ul style="list-style-type: none"> Typical findings in cognitive tests as per the latest Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria or two consecutive Global Clinical Dementia Rating (CDR) ratings of at least 3.0, and Supportive findings on neuro-imaging, and Permanent inability to perform independently at least 3 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 impairment cover" later in this document. <p>Permanence will be established after 3 months.</p> <p><i>Layman's explanation:</i> <i>This claim event covers the early onset of a decline in thinking and memory function (cognitive function), not in keeping with what is normal for the age and occurring before age 65 (pre-senile dementia). This must be as a result of a disease of the brain, and not due to a psychological cause. This must be confirmed by a specialist (neurologist or psychiatrist).</i></p> <p>There must be evidence of all of the following:</p> <ul style="list-style-type: none"> Typical findings in specialised testing for memory and thinking called cognitive tests (as per the latest DSM criteria or 2 consecutive CDR ratings of at least 3.0), and Supportive findings on specialised radiological testing (neuro-imaging), and Permanent inability to perform independently at least 3 basic activities of daily living, as indicated later in this document for this benefit, or the need for 24-hour supervision by a caregiver. <p>Permanence will be established after 3 months.</p>	100	100
Cranial nerve V		
<p>Contractual definition: Cranial nerve V pathology with severe trigeminal neuralgia, meeting the following criteria: The diagnosis of treatment resistant, severe unilateral or bilateral facial neuralgic pain by a neurologist, with evidence of treatment resistance as well as the need for decompression surgery.</p> <p><i>Layman's explanation:</i> <i>The trigeminal nerve (the 5th cranial nerve) is a nerve responsible for sensation in the face and functions such as biting and chewing.</i></p> <p><i>This claim event covers severe chronic pain in this nerve area, meeting the following criteria: Diagnosis by a specialist (neurologist) of treatment resistant, severe one-sided or both-sided facial nerve pain, with evidence of treatment resistance as well as the need for decompression surgery.</i></p>	-	45

Impairment Claim event	Percentage of cover amount %	
Cranial nerve VII	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
<p>Contractual definition: Cranial nerve VII paralysis with severe unilateral upper motor neuron facial paralysis, involving more than 75% of the facial muscles, and inability to control eyelid closure. This must be confirmed by a neurologist.</p> <p><i>Layman's explanation:</i> <i>The facial nerve (the 7th cranial nerve) controls the muscles of facial expression, and functions in taste sensations of two-thirds of the tongue.</i></p> <p><i>This claim event covers paralysis of this nerve with upper motor neuron facial paralysis of more than 75% of the facial muscles and inability to close eyelids. This must be confirmed by a specialist (neurologist).</i></p>	-	50
<p>Contractual definition: Cranial nerve VIII paralysis or imbalance with moderately severe equilibrium impairment, with limitations of all activities of daily living (ADLs), and requiring permanent assistance with self-care. These ADLs are indicated in the tables "Basic activities of daily living for impairment cover" and "Advanced activities of daily living for impairment cover" later in this document. This must be confirmed by a neurologist or ear, nose and throat surgeon.</p> <p><i>Layman's explanation:</i> <i>The 8th cranial nerve transmits sound and balance information from the inner ear to the brain.</i></p> <p><i>This claim event covers paralysis of this nerve with moderate balance disturbance, with limitations in all activities of daily living (ADLs) and requiring permanent assistance with self-care. This must be confirmed by a specialist (neurologist or ear, nose and throat surgeon).</i></p>	-	50
<p>Contractual definition: Cranial nerve VIII paralysis or imbalance with severe equilibrium impairment, with limitations of all activities of daily living (ADLs), requiring permanent assistance with self-care and permanent confinement to a bed or wheelchair. These ADLs are indicated in the tables "Basic activities of daily living for impairment cover" and "Advanced activities of daily living for impairment cover" later in this document. This must be confirmed by a neurologist.</p> <p><i>Layman's explanation:</i> <i>The 8th cranial nerve transmits sound and balance information from the inner ear to the brain.</i></p> <p><i>This claim event covers paralysis of this nerve with severe balance disturbance, with limitations in all activities of daily living (ADLs) and requiring permanent assistance with self-care and permanent confinement to a bed or wheelchair. This must be confirmed by a specialist (neurologist).</i></p>	-	75

Impairment Claim event	Percentage of cover amount %	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
Cranial nerves IX, X or XII			
Contractual definition: Cranial nerves IX, X or XII paralysis or dysarthria or dysphagia, with moderately severe dysarthria or dysphagia with hoarseness, nasal regurgitation and aspiration of fluids. This must be confirmed by a neurologist.	-		25
<i>Layman's explanation:</i> <i>This claim event covers paralysis of cranial nerves 9, 10 or 12, with moderate difficulty with swallowing, hoarseness, difficulty with speech, accidental inhalation of fluids into the lungs or airway or passage of food through the nasal passages. This must be confirmed by a specialist (neurologist).</i>			
Contractual definition: Cranial nerves IX, X or XII paralysis or dysarthria or dysphagia, with severe functional inability to swallow without choking and with the need for assistance and suctioning. This must be confirmed by a neurologist.	-		75
<i>Layman's explanation:</i> <i>This claim event covers paralysis of cranial nerves 9, 10 or 12, with severe inability to swallow without choking with the need for assistance and suctioning. This must be confirmed by a specialist (neurologist).</i>			
Neurologic impairment of respiration			
Contractual definition: Neurologic impairment of respiration, where the life insured is capable of spontaneous respiration, but is restricted to sitting, standing or limited ambulation. This must be confirmed by a neurologist.	-		50
<i>Layman's explanation:</i> <i>This claim event covers impairment of breathing due to neurological cause or reason, where the life insured is capable of spontaneous breathing, but is restricted to sitting or standing with limited ambulation. This must be confirmed by a specialist (neurologist).</i>			
Contractual definition: Neurologic impairment of respiration with severe functional impairment where the life insured is capable of spontaneous respiration, but to such a limited degree that he or she is permanently confined to a bed. This must be confirmed by a neurologist.	-		75
<i>Layman's explanation:</i> <i>This claim event covers impairment of breathing due to neurological cause or reason, where the life insured is capable of spontaneous breathing, but is limited to such a degree that he or she is permanently confined to a bed. This must be confirmed by a specialist (neurologist).</i>			
Contractual definition: Neurologic impairment of respiration to such an extent that there is no spontaneous respiration. This must be confirmed by a neurologist.	100		100

Impairment Claim event	Percentage of cover amount %	
Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus	
<i>Layman's explanation:</i> <i>This claim event covers impairment of breathing due to neurological cause or reason, where the life insured is incapable of spontaneous breathing. This must be confirmed by a specialist (neurologist).</i>		
Gastro-intestinal system		
Gastro-intestinal tract disease		
<p>Contractual definition: Gastro-intestinal tract disease, meeting the following criteria: Anatomic loss or alteration in gastro-intestinal tract, as a result of an organic cause, with any of the following:</p> <ul style="list-style-type: none"> • Symptoms uncontrolled by adequate treatment and 15% weight loss below accepted desirable weight for a period exceeding a year, or • Permanent stoma, or • Anatomic loss or alteration in gastro-intestinal tract, with persistent, irreducible and irreparable protrusion of a hernia after surgery, with bowel dysfunction and limitation in activities of daily living. <p>This must be confirmed by a surgeon, physician or gastroenterologist.</p> <p><i>Layman's explanation:</i> <i>The gastro-intestinal tract is an organ system within humans which takes in food, digests it to extract and absorb energy and nutrients, and expels the remaining waste as faeces.</i> <i>This claim event covers loss of a part of this system, or disease of this system, not due to a psychological cause.</i></p>	-	50
<p><i>The following criteria must be met:</i></p> <ul style="list-style-type: none"> – Loss due to trauma or surgery of a part of this system with evidence of disease and symptoms uncontrolled by adequate treatment with weight loss, as specified in the contractual definition above, despite optimal medical treatment, or – Permanent stoma (artificial opening in the gut), or – Persistent, irreducible and irreparable part of the bowel that protrudes through a weakness in the abdominal wall (hernia) after surgery, with bowel dysfunction and limitation in activities of daily living. <p><i>This must be confirmed by a specialist (surgeon, physician or gastroenterologist).</i></p>		

Impairment Claim event	Percentage of cover amount %	
Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus	
<p>Contractual definition: Gastro-intestinal tract disease, meeting the following criteria: Anatomic loss or alteration in gastro-intestinal tract, as a result of an organic cause, with symptoms uncontrolled by adequate treatment, and 25% weight loss below accepted desirable weight. This must be confirmed by a surgeon, physician or gastroenterologist.</p> <p><i>Layman's explanation:</i> <i>The gastro-intestinal tract is an organ system within humans which takes in food, digests it to extract and absorb energy and nutrients, and expels the remaining waste as faeces. This claim event covers loss of a part of this system, or disease of this system, not due to a psychological cause.</i></p> <p><i>The following criteria must be met:</i> <i>Loss due to trauma or surgery of a part of this system with evidence of disease and symptoms uncontrolled by adequate treatment with weight loss, as specified in the contractual definition above, despite optimal medical treatment. This must be confirmed by a specialist (surgeon, physician or gastroenterologist).</i></p>	100	100
Loss of bowel function		
<p>Contractual definition: Permanent colostomy as a result of loss of bowel function, as a result of traumatic or medical conditions and confirmed by a specialist.</p> <p><i>Layman's explanation:</i> <i>A surgical operation in which the colon is shortened to remove a damaged or diseased part and the cut end diverted to create a permanent opening in the abdominal wall. This must be confirmed by a specialist.</i></p>	-	50
<p>Contractual definition: Complete and permanent faecal incontinence not amenable to medical treatment, as a result of an organic cause, confirmed by a specialist.</p> <p><i>Layman's explanation:</i> <i>Faecal incontinence is the inability to control bowel movements, causing stool (faeces) to leak unexpectedly from the rectum.</i></p> <p><i>This claim event covers faecal incontinence when the condition is permanent with a total loss of control (thus complete). It must not be amenable to medical treatment and not due to a psychological cause. This must be confirmed by a specialist.</i></p>	100	100
Chronic liver disease		
<p>Contractual definition: Severe chronic liver disease despite optimal medical treatment and confirmed by a gastroenterologist, with abnormal liver function tests, as evidenced by at least two of the following:</p> <ul style="list-style-type: none"> • Albumin 28-35 mg/L • INR 1.71-2.20 • Bilirubin 34-50 umol/l 	-	50

Impairment Claim event	Percentage of cover amount %	
Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus	
<p>• Ascites.</p> <p><i>Layman's explanation:</i> <i>This claim event covers severe chronic liver disease despite optimal medical treatment, meeting the criteria as described in the contractual definition above. This must be confirmed by a specialist (gastroenterologist).</i></p> <p><i>Ascites is the abnormal accumulation of fluid in the abdominal cavity.</i></p>		
<p>Contractual definition: Severe progressive chronic liver disease despite optimal medical treatment, confirmed by a gastroenterologist and meeting the following criteria:</p> <ul style="list-style-type: none"> • Objective evidence of jaundice, and • Ascites or bleeding oesophageal varices within the last year, and • 25% weight loss below accepted desirable weight. <p><i>Layman's explanation:</i> <i>This claim event covers severe worsening chronic liver disease despite optimal medical treatment, meeting the following criteria:</i> <ul style="list-style-type: none"> – Objective evidence of a medical condition with yellowing of the skin or whites of the eyes, arising from excess of the pigment bilirubin (jaundice), and – Abnormal accumulation of fluid in the abdominal cavity (ascites) or bleeding enlarged veins in the food pipe (oesophagus) within the last year, and – 25% weight loss below accepted desirable weight. <p><i>This must be confirmed by a specialist (gastroenterologist).</i></p> <p><i>The oesophagus (food pipe) is a muscular tube that moves food and liquids from the throat to the stomach.</i></p> </p>	100	100
Liver transplant		
<p>Contractual definition:</p> <ul style="list-style-type: none"> • The undergoing of a complete liver transplant as a recipient, or • Confirmation of being on a recognised national South African transplant waiting list, awaiting a complete liver transplant. <p><i>This must be confirmed by a specialist with supporting evidence.</i></p> <p><i>Layman's explanation:</i> <i>This claim event covers:</i> <ul style="list-style-type: none"> – The undergoing of a complete liver transplant as a recipient, to replace a diseased liver, or – Confirmation of being on a recognised national South African transplant waiting list, awaiting a complete liver transplant. <p><i>This must be confirmed by a specialist with supporting evidence.</i></p> </p>	100	100
Biliary tract disease		

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
<p>Contractual definition: Irreparable biliary tract obstruction with persistent jaundice despite optimal medical treatment, confirmed by a gastroenterologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers irreparable biliary tract obstruction with persistent jaundice. This must be confirmed by a specialist (gastroenterologist).</i></p> <p><i>Biliary obstruction is when one of the ducts that carry bile from the liver to the intestine via the gallbladder becomes blocked. Irreparable biliary tract obstruction with persistent jaundice is when the obstruction is irreparable and jaundice persists despite optimal medical treatment.</i></p>	100	100
Pancreas transplant		
<p>Contractual definition:</p> <ul style="list-style-type: none"> • The undergoing of a complete pancreas transplant as a recipient, or • Confirmation of being on a recognised national South African transplant waiting list, awaiting a complete pancreas transplant. <p><i>This must be confirmed by a specialist with supporting evidence.</i></p> <p><i>Layman's explanation:</i> <i>This claim event covers:</i> <ul style="list-style-type: none"> – The undergoing of a complete pancreas transplant as a recipient, to replace a diseased pancreas, or – Confirmation of being on a recognised national South African transplant waiting list, awaiting a complete pancreas transplant. <p><i>This must be confirmed by a specialist with supporting evidence.</i></p> </p>	100	100
Endocrine system		
Disorders of the hypothalamic pituitary axis		
<p>Contractual definition: Disorders of the hypothalamic pituitary axis, with permanent whole person impairment (WPI) exceeding 26% despite optimal medical treatment. This must be confirmed by an endocrinologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers disorders of the hypothalamic pituitary axis, with permanent whole person impairment exceeding 26% despite optimal medical treatment. This must be confirmed by a specialist (endocrinologist).</i></p> <p><i>The hypothalamic pituitary axis plays key roles in controlling hormone secretion that has an effect on other organs in the body.</i></p>	-	50
Hypoadrenalinism		
Contractual definition:	-	50

Impairment Claim event	Percentage of cover amount %	
Hyperadrenocorticism	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
<p>Hypoadrenalism, with permanent whole person impairment (WPI) exceeding 30% despite optimal medical treatment. This must be confirmed by an endocrinologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers hypoadrenalism, with permanent whole person impairment exceeding 30% despite optimal medical treatment. This must be confirmed by a specialist (endocrinologist).</i></p> <p><i>Hypoadrenalism is a condition in which the adrenal glands do not produce adequate amounts of steroid hormones. The adrenal glands are small glands located on the top end of the kidney that produce important hormones in the body.</i></p>		
<p>Contractual definition: Hyperadrenocorticism, with permanent whole person impairment (WPI) exceeding 30% despite optimal medical treatment. This must be confirmed by an endocrinologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers hyperadrenocorticism, with permanent whole person impairment exceeding 30% despite optimal medical treatment. This must be confirmed by a specialist (endocrinologist).</i></p> <p><i>Hyperadrenocorticism, which is often called Cushing's syndrome, is an extremely complex condition that involves many areas of the body. It results from an excess of a hormone called cortisol and its effects on the human body.</i></p>	-	50
<p>Contractual definition: Phaeochromocytoma, with permanent whole person impairment (WPI) exceeding 30% despite optimal medical treatment. This must be confirmed by an endocrinologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers phaeochromocytoma, with permanent whole person impairment exceeding 30% despite optimal medical treatment. This must be confirmed by a specialist (endocrinologist).</i></p> <p><i>Pheochromocytoma is a rare tumour of adrenal gland tissue. It results in the release of too many of the hormones that control heart rate, metabolism, and blood pressure.</i></p> <p><i>The adrenal glands are small glands located on the top end of the kidney that produce important hormones in the body.</i></p>	-	50
<p>Contractual definition: Diabetes mellitus: type I or II with moderate to severe organ impairment, confirmed by a specialist and meeting the following criteria:</p> <ul style="list-style-type: none"> • Kidney functions impaired, which will be assessed under kidney failure events 	-	50

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
<ul style="list-style-type: none"> • Retinopathy with visual impairment, which will be assessed under visual impairment events • Ischaemic heart disease, which will be assessed under ischaemic heart disease with cardiac failure. <p><i>Layman's explanation:</i> <i>Diabetes mellitus is a disorder in which blood sugar (glucose) levels are abnormally high because the body does not produce enough insulin to meet its needs.</i></p> <p><i>This claim event covers type I or II with moderate to severe organ impairment, meeting the criteria described in the contractual definition above. This must be confirmed by a specialist.</i></p> <p><i>Diabetic retinopathy is caused by damage to the blood vessels in the tissue at the back of the eye (retina). Poorly controlled blood sugar is a risk factor.</i></p>		
Contractual definition: Diabetes mellitus: type I or II with severe organ impairment, confirmed by a specialist and meeting the following criteria: <ul style="list-style-type: none"> • Kidney functions impaired, which will be assessed under kidney failure events • Retinopathy with visual impairment, which will be assessed under visual impairment events • Ischaemic heart disease, which will be assessed under ischaemic heart disease with cardiac failure. <p><i>Layman's explanation:</i> <i>Diabetes mellitus is a disorder in which blood sugar (glucose) levels are abnormally high because the body does not produce enough insulin to meet its needs.</i></p> <p><i>This claim event covers type I or II with severe organ impairment, meeting the criteria in the contractual definition above. This must be confirmed by a specialist.</i></p> <p><i>Diabetic retinopathy is caused by damage to the blood vessels in the tissue at the back of the eye (retina). Poorly controlled blood sugar is a risk factor.</i></p>	100	100

Impairment Claim event	Percentage of cover amount %	
Catch-all for other disorders of the endocrine system	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
<p>Contractual definition: Any disorder of the endocrine system not specified in the other listed events for the endocrine system, that is confirmed by an endocrinologist, with permanent whole person impairment (WPI) exceeding 30% despite optimal medical treatment.</p> <p>Layman's explanation: <i>The endocrine system has eight major glands, which make hormones. Hormones affect the functions of the entire body. Any disease of a gland can cause imbalances in the body which can be from mild to serious.</i></p> <p><i>This claim event covers any disorder of any of these glands not specified in the listed events that is confirmed by a specialist (endocrinologist), with permanent whole person impairment exceeding 30% despite optimal medical treatment.</i></p>	-	50
<p>Contractual definition: Any disorder of the endocrine system not specified in the listed events for the endocrine system, that is confirmed by an endocrinologist, with permanent whole person impairment (WPI) exceeding 40% despite optimal medical treatment.</p> <p>Layman's explanation: <i>The endocrine system has eight major glands, which make hormones. Hormones affect the functions of the entire body. Any disease of a gland can cause imbalances in the body which can be from mild to serious.</i></p> <p><i>This claim event covers any disorder of any of these glands not specified in the listed events that is confirmed by a specialist (endocrinologist), with permanent whole person impairment exceeding 40% despite optimal medical treatment.</i></p>	100	100
Renal system		
Kidney failure		
<p>Contractual definition: Kidney failure with moderate impairment, meeting the following criteria: The diagnosis of permanent kidney failure by a nephrologist or urologist, with evidence of a creatinine clearance of 28 to 42 ml per minute despite adequate medical treatment.</p> <p>Layman's explanation: <i>Kidney failure refers to failure of the kidneys to function properly.</i></p> <p><i>This claim event covers kidney failure with moderate impairment, meeting the criteria in the contractual definition above. This must be confirmed by a specialist (nephrologist or urologist).</i></p>	-	50
<p>Contractual definition: Kidney failure with severe impairment, meeting the following criteria: The diagnosis of permanent kidney failure by a nephrologist or urologist, with evidence of a creatinine clearance of less than 28 ml per minute, or the need for more than 8 hours of dialysis per week.</p>	100	100

Impairment Claim event	Percentage of cover amount %	
<i>Layman's explanation:</i> <i>Kidney failure refers to failure of the kidneys to function properly.</i>		
<i>This claim event covers kidney failure with severe impairment, meeting the criteria in the contractual definition above. This must be confirmed by a specialist (nephrologist or urologist).</i>		
Kidney transplant	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
Contractual definition: <ul style="list-style-type: none">• 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. <i>This must be confirmed by a specialist with supporting evidence.</i>	100	100
<i>Layman's explanation:</i> <i>This claim event covers:</i> <ul style="list-style-type: none">– <i>The undergoing of a complete kidney transplant as a recipient, to replace a diseased kidney, or</i>– <i>Confirmation of being on a recognised national South African transplant waiting list, awaiting a complete kidney transplant.</i> <i>This must be confirmed by a specialist with supporting evidence.</i>		
Loss of bladder function	-	45
Contractual definition: Loss of bladder function due to organic cause, which despite optimal medical treatment requires frequent catheterisation (at least weekly). This must be confirmed by a urologist. <i>Layman's explanation:</i> <i>This claim event covers loss of bladder function, not due to a psychological cause. The life insured must require frequent catheterisation (at least weekly) despite optimal medical treatment. This must be confirmed by a specialist (urologist).</i> <i>Catheterisation is when a plastic tube (a catheter) is inserted into the bladder to provide urinary drainage.</i>		
Bladder or urethral disease	100	100
Contractual definition: Bladder or urethral disease of organic cause resulting in complete urinary incontinence, which despite optimal medical treatment, requires indwelling catheterisation. This must be confirmed by an urologist. <i>Layman's explanation:</i> <i>This claim event covers bladder or urethral disease, not due to a psychological cause. The following criteria must be met:</i>		

Impairment Claim event	Percentage of cover amount %	
Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus	
<ul style="list-style-type: none"> – The disease must result in uncontrolled leakage of urine despite optimal medical treatment, and – It must require permanent catheterisation to provide continuous urinary drainage. <p><i>This must be confirmed by a specialist (urologist).</i></p> <p><i>Catheterisation is when a plastic tube (a catheter) is inserted into the bladder to provide urinary drainage.</i></p>		
Surgical removal of the bladder		
Contractual definition: The surgical excision of the bladder by a surgeon, confirmed with a surgical report by an urologist or surgeon.	100	100
<p><i>Layman's explanation:</i> <i>This claim event covers the removal of the entire bladder by surgery. A surgical report from a specialist (urologist or surgeon) needs to confirm this.</i></p>		
Musculoskeletal system		
Amputation of a thumb		
Contractual definition: The amputation of a thumb, at the interphalangeal level and proximal to the joint, by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	-	30*
<p><i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of a thumb at the first joint. This must be confirmed by a specialist with supporting evidence.</i></p>		
Amputation of three fingers other than the thumb		
Contractual definition: The amputation of 3 fingers other than the thumb on the same hand, at the proximal interphalangeal joint or more proximal than this joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	-	15*
<p><i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of 3 fingers, excluding the thumb on the same hand, at the level of the middle knuckles. This must be confirmed by a specialist with supporting evidence.</i></p>		
Amputation of three fingers, including the thumb		
Contractual definition: The amputation of 3 fingers, including the thumb, on the same hand, at the proximal interphalangeal joint or more proximal than this joint by traumatic or	-	45*

Impairment Claim event	Percentage of cover amount %	
Amputation of four fingers other than the thumb	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
surgical means. This must be confirmed by a specialist with supporting evidence. <i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of 3 fingers including the thumb on the same hand – the thumb at the first joint and the other fingers at the level of the middle knuckles. This must be confirmed by a specialist with supporting evidence.</i>		
Amputation of a hand	-	70
Contractual definition: The amputation of 4 fingers other than the thumb on the same hand, at the proximal interphalangeal joint or more proximal than this joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence. <i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of 4 fingers excluding the thumb on the same hand, at the level of the middle knuckles. This must be confirmed by a specialist with supporting evidence.</i>		
Loss of use of a hand	-	70
Contractual definition: <ul style="list-style-type: none">• The permanent loss of function of an entire hand from the wrist (distal to the wrist), or• The permanent loss of function of an upper limb, with at least 60% impairment of the limb according to the latest American Medical Association (AMA) guidelines. This must be confirmed by a specialist with supporting evidence. <i>Layman's explanation:</i> <i>This claim event covers:</i> <ul style="list-style-type: none">– <i>The permanent loss of function of an entire hand from the wrist, or</i>– <i>The permanent loss of use of an arm (upper limb), meeting the criteria in the contractual definition above.</i> <i>This must be confirmed by a specialist with supporting evidence.</i>		
Amputation of an arm below the elbow		

Impairment Claim event	Percentage of cover amount %	
Loss of use of an arm	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
<p>Contractual definition: The amputation of an arm distal to the elbow by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.</p> <p>Layman's explanation: <i>The surgical or traumatic removal or severance of an arm below the elbow. This must be confirmed by a specialist with supporting evidence.</i></p>	-	75
<p>Contractual definition:</p> <ul style="list-style-type: none"> • The permanent loss of function of an entire arm from the shoulder (distal to the shoulder), or • The permanent loss of function of an upper limb, with at least 90% impairment of the limb according to the latest American Medical Association (AMA) guidelines. <p>This must be confirmed by a specialist with supporting evidence.</p> <p>Layman's explanation: <i>This claim event covers:</i></p> <ul style="list-style-type: none"> – <i>The permanent loss of use of an entire arm from the shoulder, or</i> – <i>The permanent loss of use of an arm (upper limb), meeting the criteria in the contractual definition above.</i> <p><i>This must be confirmed by a specialist with supporting evidence.</i></p>	-	75
Amputation of an arm above the elbow	-	80
<p>Contractual definition: The amputation of an arm proximal to the elbow by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.</p> <p>Layman's explanation: <i>The surgical or traumatic removal or severance of an arm above the elbow. This must be confirmed by a specialist with supporting evidence.</i></p>	-	80
Amputation of a foot	-	30
<p>Contractual definition: The amputation of a foot at the level of the ankle joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.</p> <p>Layman's explanation: <i>The surgical or traumatic removal or severance of a foot at the ankle joint. This must be confirmed by a specialist with supporting evidence.</i></p>	-	30

Impairment Claim event	Percentage of cover amount %	
Loss of use of a foot	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
<p>Contractual definition: The permanent loss of function of an entire foot from the ankle (distal to the ankle). This must be confirmed by a specialist with supporting evidence.</p> <p><i>Layman's explanation:</i> <i>The permanent loss of use of an entire foot from the ankle. This must be confirmed by a specialist with supporting evidence.</i></p>	-	30
Amputation of a leg below the knee	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
<p>Contractual definition: The amputation of a leg distal to the knee joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.</p> <p><i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of a leg below the knee. This must be confirmed by a specialist with supporting evidence.</i></p>	-	50
Loss of use of a lower leg	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
<p>Contractual definition:</p> <ul style="list-style-type: none"> • The permanent loss of function of an entire leg from below the knee (below and distal to the knee joint), or • The permanent loss of function of a lower limb, with at least 60% impairment of the limb according to the latest American Medical Association (AMA) guidelines. <p>This must be confirmed by a specialist with supporting evidence.</p> <p><i>Layman's explanation:</i> <i>This claim event covers:</i> <ul style="list-style-type: none"> – <i>The permanent loss of use of an entire leg from below the knee, or</i> – <i>The permanent loss of use of a leg (lower limb), meeting the criteria in the contractual definition above.</i> <p><i>This must be confirmed by a specialist with supporting evidence.</i></p> </p>	-	50
Loss of use of a leg	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
<p>Contractual definition:</p> <ul style="list-style-type: none"> • The permanent loss of function of an entire leg (proximal and distal to the knee joint), or • The permanent loss of function of a lower limb, with at least 90% impairment of the limb according to the latest American Medical Association (AMA) guidelines. <p>This must be confirmed by a specialist with supporting evidence.</p> <p><i>Layman's explanation:</i> <i>This claim event covers:</i> <ul style="list-style-type: none"> – <i>The permanent loss of use of an entire leg, or</i> </p>	-	75

Impairment Claim event	Percentage of cover amount %	
Amputation of a leg above the knee	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
<p>– <i>The permanent loss of use of a leg (lower limb), meeting the criteria in the contractual definition above.</i></p> <p><i>This must be confirmed by a specialist with supporting evidence.</i></p>		
<p>Amputation or loss of a combination of two limbs or an eye</p> <p>Contractual definition: The amputation or loss of any 2 of the following, due to the same cause, provided they are not part of the same limb:</p> <ul style="list-style-type: none"> • Amputation of a hand • Amputation of an arm below the elbow • Amputation of an arm above the elbow • Amputation of a foot • Amputation of a leg below the knee • Amputation of a leg above the knee • Loss of an eye. <p>Each amputation or loss must meet the definition of the individual claim event as described in this table and must be confirmed by a specialist with supporting evidence.</p>	100	100
<p>Loss of use of a combination of two limbs or an eye</p> <p>Contractual definition: The permanent loss of function of any 2 of the following, due to the same cause, provided they are not part of the same limb:</p> <ul style="list-style-type: none"> • Loss of use of a hand • Loss of use of an arm • Loss of use of a foot • Loss of use of a lower leg • Loss of use of a leg • Total loss of vision of one eye or hemianopia of one eye. <p>Each loss must meet the definition of the individual claim event as described in this table and must be confirmed by a specialist with supporting evidence.</p>	100	100
<p>Chronic back and neck pain</p> <p>Contractual definition:</p>	-	25

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
<p>Chronic back or neck pain, where the neck and back are both part of the spine. Only one claim for spinal pain will be allowed per spinal region.</p> <p>The spinal regions are the following:</p> <ul style="list-style-type: none"> • The cervical region (C1 to C7), and • The thoracic region (T1 to T12), and • The lumbosacral region (L1 to S1). <p>The C7 to T1 joint will be classified in the cervical region, and the T12 to L1 joint in the lumbosacral region.</p> <p>One of the following four diagnoses must be made as the cause of chronic pain:</p> <ul style="list-style-type: none"> • 50% compression of a vertebral body, or • Clinically significant radiculopathy, verified by an imaging study that confirms a herniated disc at the level and side as found clinically, and verified by electrodiagnostic testing, or • Alteration of motion segment integrity (instability), using flexion and extension radiographs, or • A back or cervical operation comprising laminectomy, discectomy or fusion, or a combination thereof. <p>In all four of the above diagnoses the clinical findings, pain distribution and findings on special examinations must make pathophysiological sense. The chronic pain will be evaluated by the following criteria:</p> <ul style="list-style-type: none"> • pain questionnaires, and • pain diagrams, and • analgesic medication usage. <p>This must be confirmed by an orthopaedic specialist or neurosurgeon with supporting evidence.</p> <p><i>Layman's explanation:</i> <i>Long-standing back and neck pain (where the neck and the back are both part of the spine). Only one claim for spinal pain will be allowed per spinal section.</i></p> <p><i>The spinal sections are:</i></p> <ul style="list-style-type: none"> – <i>Cervical – holds up the head</i> – <i>Thoracic – ribs are attached</i> – <i>Lumbar – lower back.</i> <p><i>The pain must be due to one of the following causes:</i></p> <ul style="list-style-type: none"> – <i>A back bone (vertebra) having lost half of its height due to compression.</i> – <i>Compression of a vertebral body is when one or more back bones (vertebrae) collapse into itself and become squashed (compressed), or</i> – <i>Significant signs of a pinched nerve, which is confirmed by specialised testing (MRI and electrodiagnostic testing), or</i> – <i>Proven instability of vertebrae on x-rays, or</i> – <i>A back or neck operation as stipulated in the contractual definition above.</i> 		

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
<i>This must be confirmed by a specialist (orthopaedic specialist or neurosurgeon), with the evidence provided as stipulated in the contractual definition above.</i>		
Cancer		
Malignant tumours of the spinal cord and vertebral column		
Contractual definition: The incontrovertible presence of uncontrolled growth and spread of malignant cells, the invasion of normal tissue, and the definite histological evidence of a malignant growth in the spinal cord and vertebral column. This must be confirmed by an oncologist, with supporting objective evidence.	-	50
<i>Layman's explanation:</i> <i>Cancer of the spinal cord or vertebral column, confirmed by taking a sample of tissue of the area and confirming the presence of cancerous cells in these areas. A clinical report is required from a specialist (oncologist).</i>		
Stage III cancer		
Contractual definition: Any stage III cancer, confirmed by an oncologist with supporting objective evidence, with the permanent inability to do 2 or more basic activities of daily living (ADLs) and 2 or more advanced activities of daily living (ADLs). These ADLs are indicated in the tables "Basic activities of daily living for impairment cover" and "Advanced activities of daily living for impairment cover" later in this document.	100	100
<i>Layman's explanation:</i> <i>This claim event covers stage III cancer, meeting the criteria in the contractual definition above. A clinical report is required from a specialist (oncologist).</i>		
<i>Cancer prevents cells from dying when they should and causes new cells to form when the body does not need them. These cells are able to invade other tissues and spread to other parts of the body through the blood and lymph systems.</i>		
<i>Stage III cancer is cancer with regional spread - the cancer has spread within the general region in which it first began, and into the lymph nodes but not to other parts of the body.</i>		
Stage IV cancer		
Contractual definition: Any stage IV cancer, confirmed by an oncologist with supporting objective evidence.	100	100
<i>Layman's explanation:</i> <i>Cancer prevents cells from dying when they should and causes new cells to form when the body does not need them. These cells are able to invade other tissues and spread to other parts of the body through the blood and lymph systems.</i>		
<i>This claim event covers stage IV cancer, which is cancer with distant spread (cancer that has spread to other parts of the body). A clinical report is required from a specialist (oncologist).</i>		

Impairment Claim event	Percentage of cover amount %	
Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus	
Visual system		
Total loss of vision of one eye or hemianopia of one eye		
<p>Contractual definition: Total and permanent loss of vision of one eye or permanent hemianopia of one eye as a result of an organic cause, confirmed by an ophthalmologist with supporting evidence.</p> <p><i>Layman's explanation:</i> <i>This claim event covers the total and permanent loss of vision of one eye or permanent loss of either the left or right half of the visual field of one eye, not due to a psychological cause. This must be confirmed by a specialist (ophthalmologist) with supporting documents.</i></p>	-	25
Loss of an eye		
<p>Contractual definition: Complete enucleation of one eye due to injury or disease, confirmed by an ophthalmologist with supporting evidence.</p> <p><i>Layman's explanation:</i> <i>The complete removal of one eye from its socket as a result of trauma or surgery, confirmed by a specialist (ophthalmologist) with supporting documents.</i></p>	-	50
Partial loss of vision of both eyes		
<p>Contractual definition: Permanent bilateral visual impairment of 50% as a result of an organic cause, confirmed by an ophthalmologist with supporting evidence and meeting the following criteria:</p> <ul style="list-style-type: none"> • A reading of at least 20/125 (or equivalent measure) in each eye, or • Diabetic retinopathy grade III or grade IIII retinopathy as a result of a chronic disease in each eye, or • A visual field loss to a 20° radius of each eye. <p><i>Layman's explanation:</i> <i>This claim event covers permanent decreased vision of 50%, not due to a psychological cause. It must meet the criteria described in the contractual definition above and must be confirmed by a specialist (ophthalmologist).</i></p>	-	50

Impairment Claim event	Percentage of cover amount %	
Total loss of vision of both eyes or blindness of both eyes	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
<p>Contractual definition: Total and permanent loss of vision in both eyes or blindness of both eyes by visual acuity or retinal pathology or visual field measurements, as a result of an organic cause, confirmed by an ophthalmologist with supporting evidence and meeting the following criteria:</p> <p>Bilateral visual impairment of 70%, with evidence of 1 of the following:</p> <ul style="list-style-type: none"> • A reading of at least 20/200 (or equivalent measure) in each eye, or • Diabetic retinopathy grade IV or grade IV retinopathy as a result of a chronic disease of each eye, or • Permanent hemianopia of both eyes, or • A visual field loss to a 10° radius of each eye. <p><i>Layman's explanation:</i> <i>This claim event covers the total and permanent loss of vision of both eyes or blindness of both eyes, not due to a psychological cause. It must meet the criteria described in the contractual definition above, and must be confirmed by a specialist (ophthalmologist).</i></p>	100	100
Hearing		
Total loss of hearing in one ear		
<p>Contractual definition: The total and permanent loss of hearing in one ear as confirmed by an ear, nose and throat surgeon, with objective audiology evidence, recording an average loss of at least 70dB across all measured frequencies.</p>	-	25
Partial loss of hearing in both ears		
<p>Contractual definition: The permanent loss of hearing of 60% or more in both ears as confirmed by an ear, nose and throat surgeon, with objective audiology evidence, recording an average loss of 70-87dB across all measured frequencies.</p>	-	50
Total loss of hearing in both ears		
<p>Contractual definition: The total and permanent loss of hearing in both ears as confirmed by an ear, nose and throat surgeon with objective audiology evidence, recording an average loss of greater than 87dB across all measured frequencies.</p>	100	100
Speech		
Aphasia		
<p>Contractual definition: Total and permanent loss of the ability to speak as a result of an organic brain disease, confirmed by a neurosurgeon or neurologist.</p> <p><i>Layman's explanation:</i></p>	100	100

Impairment Claim event	Percentage of cover amount %	
<i>This claim event covers the total and permanent loss of the ability to speak, not due to a psychological cause. This must be confirmed by a specialist (neurosurgeon or neurologist).</i>		
Partial loss of speech	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
Contractual definition: Partial and permanent loss of the ability to speak as a result of organic ear, nose and throat (ENT) disease, affecting daily activity, confirmed by an ear, nose and throat specialist. <i>Layman's explanation:</i> <i>This claim event covers the partial and permanent loss of the ability to speak as a result of confirmed disease of the ear, nose and throat organ, not due to a psychological cause. This must be confirmed by a specialist (ear, nose and throat specialist).</i>	-	50
Total loss of speech	100	100
Contractual definition: Total and permanent loss of the ability to speak as a result of organic ear, nose and throat (ENT) disease, confirmed by an ear, nose and throat specialist. <i>Layman's explanation:</i> <i>This claim event covers the total and permanent loss of the ability to speak as a result of confirmed disease of the ear, nose and throat organ, not due to a psychological cause. This must be confirmed by a specialist (ear, nose and throat specialist).</i>		
Psychiatric conditions		
Psychiatric condition		
Contractual definition: Psychiatric condition with frequent, extended admissions, meeting the following criteria: <ul style="list-style-type: none"> • Institutionalised in a registered psychiatric facility at least 3 times during the last 12 months, with each admission lasting for longer than 6 weeks, and • Global Assessment Function (GAF) score of less than 40, and • Must be confirmed by a specialist. OR Psychiatric condition with one prolonged admission: The diagnosis of a psychiatric disorder, as per the latest Diagnostic and Statistical Manual of Mental Disorders (DSM) classification, meeting the following criteria: <ul style="list-style-type: none"> • Institutionalised in a registered psychiatric facility for more than 6 consecutive months, and • Undergoing of constant supervision with a permanent caregiver, and • Global Assessment Function (GAF) score of 30 or less, and • Must be confirmed by at least 2 independent psychiatric reports by the relevant specialists. 	-	50

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
<p>Contractual definition: Psychiatric condition with permanent institutionalisation: The diagnosis of a psychiatric disorder, as per the latest Diagnostic and Statistical Manual of Mental Disorders (DSM) classification, meeting the following criteria:</p> <ul style="list-style-type: none"> • Permanent institutionalisation in a registered psychiatric facility, and • Undergoing of constant supervision with a permanent caregiver, and • Global Assessment Function (GAF) score of 30 or less, and • Must be confirmed by at least 2 independent psychiatric reports by the relevant specialists. 	100	100
Face and skin		
Facial disfigurement		
<p>Contractual definition: Severe facial disfigurement despite more than two corrective facial surgical procedures by a registered plastic or maxillo facial surgeon, resulting in social withdrawal. The severity of the disfigurement and the social withdrawal must be confirmed by the relevant specialists.</p>	-	50
Third-degree burns		
<p>Contractual definition: Third-degree burns, full thickness of the skin, covering at least 20% of the total body surface, confirmed by a surgeon.</p> <p><i>Layman's explanation:</i> <i>Burn wounds to all three layers of the skin which affect at least 20% of the body's surface, as measured with a Lund and Browder chart, or a similar chart. This must be confirmed by a specialist (surgeon).</i></p>	-	50
<p>Contractual definition: Third-degree burns, full thickness of the skin, covering at least 30% of the total body surface, confirmed by a surgeon.</p> <p><i>Layman's explanation:</i> <i>Burn wounds to all three layers of the skin which affect at least 30% of the body's surface, as measured with a Lund and Browder chart, or a similar chart. This must be confirmed by a specialist (surgeon).</i></p>	100	100
HIV		
Advanced HIV		
<p>Contractual definition:</p> <ul style="list-style-type: none"> • Advanced HIV despite optimal treatment by a relevant HIV medical practitioner and full adherence to prescribed antiretroviral therapy for more than 3 years, a permanent CD4 cell count of less than 50 measured 6 months apart and a positive PCR, or • Advanced HIV despite optimal treatment by a relevant HIV medical practitioner and full adherence to prescribed antiretroviral therapy for more than 3 years, a persistent 	100	100

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
<p>CD4 cell count of less than 200 measured 6 months or more apart and a positive PCR;</p> <p>AND</p> <p>At least one of the following diseases must be diagnosed:</p> <ul style="list-style-type: none"> • Kaposi's sarcoma, or • Pneumocystis jirovecii pneumonia (PJP), or • Confirmed progressive multifocal leukoencephalopathy, or • Active extra-pulmonary tuberculosis, or • Cryptococcosis, or • Disseminated non-tuberculous mycobacteria infection, or • Confirmed diagnosis of any other condition as defined as stage 4 on the World Health Organisation (WHO) clinical criteria list. <p><i>Layman's explanation:</i></p> <ul style="list-style-type: none"> – Human immune virus (HIV) infection optimally treated by a doctor who manages patients with HIV. Despite the life insured's compliance to treatment for more than 3 years, the CD4 test (blood test for immune cells) remains below 50 continuously when measured every 6 months, and the PCR test (a specialised HIV detection blood test) remains positive, or – HIV infection optimally treated by a doctor who manages patients with HIV. Despite the life insured's compliance to treatment for more than 3 years, the CD4 test (blood test for immune cells) remains below 200 continuously when measured every 6 months, and the PCR test (a specialised HIV detection blood test) remains positive; <p>AND</p> <p>One of the following diseases must be diagnosed:</p> <ul style="list-style-type: none"> – Kaposi sarcoma (KS), which is a cancer that causes patches of abnormal tissue to grow under the skin, in the lining of the mouth, nose and throat, in lymph nodes, or in other organs, or – Pneumocystis jirovecii pneumonia (PJP), which is a type of pneumonia caused by a fungal infection, or – Progressive multiple leukoencephalopathy, which is a serious disease of the brain that causes progressive damage or inflammation of the white matter of the brain in many areas, or – Active extra-pulmonary tuberculosis, which is active tuberculosis in organs of the body other than the lungs, or – Cryptococcosis, which is a disease caused by fungus which is inhaled and spreads to the brain, or – Disseminated non-tuberculous mycobacteria infection, which is a widespread infection in the body by organisms which are related to the tuberculosis family, but which does not cause tuberculosis, or Confirmed diagnosis of any other condition, with a World Health Organisation classification of severe stage of HIV infection (stage IV). 		

Impairment Claim event	Percentage of cover amount %	
Activities of daily living / Catch-all / Frail care	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
Contractual definition: The permanent inability to perform independently 2 or more basic activities of daily living (ADLs) and 2 or more advanced activities of daily living (ADLs). These ADLs are indicated in the tables "Basic activities of daily living for impairment cover" and "Advanced activities of daily living for impairment cover" later in this document. This must be confirmed by the treating health professional.	-	50
Contractual definition: The permanent inability to perform independently 3 or more basic activities of daily living (ADLs). These ADLs are indicated in the table "Basic activities of daily living for impairment cover" later in this document. This must be confirmed by the treating health professional.	100	100

*This claim event is payable for a period of up to 12 months or up to the payment period, whichever is shorter.

Basic activities of daily living for impairment cover

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

Advanced activities of daily living for impairment cover

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

Impairment Claim Events for Long Term Benefits

The impairment claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated in the table below for the following benefits:

- Extended Income
- Extended Income Plus
- Impairment Income
- Impairment claim events from the early of retirement and age 70 can be found at the following link [ImpairmentClaimEventsLongTerm](#)

The contractual definitions will apply when we consider a claim. The layman's explanations are provided for a better understanding of the claim events but will not be used in the legal interpretation of the claim events.

For multiple claims, we may pay a lower percentage than indicated in the table below.

Benefits with a fixed cease age:

Only the percentages in the column headed *before age 70* are applicable.

Whole life benefits:

At age 70, the percentages of the cover amount in the claim event table will reduce by 50%, as indicated in the column headed *from age 70*. For claims that we admit before age 70, the income payment will reduce by 50% at age 70, in line with the reduced percentages that apply from age 70. For claims that we admit from age 70, the reduced percentages will apply from the start. The payment for the benefit will however not be reduced.

Impairment Claim Events Table

Impairment Claim event	Percentage of cover amount					
	Extended Income		Extended Income Plus		Impairment Income	
Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70	From age 70
Cardiovascular system						
Valvular heart disease, cardiomyopathy						
Contractual definition: Severe valvular heart disease or cardiomyopathy, meeting the following criteria:	-	-	50	25	50	25
<ul style="list-style-type: none"> • New York Heart Association (NYHA) class III on optimal treatment, and • One of the following: <ul style="list-style-type: none"> • Maximal effort test of 4 to 6 metabolic equivalents (METS), or • Ejection fraction (EF) of less than 45%, or • Valve gradient and/or valve area classified as severe. <p>This must be confirmed by a cardiologist.</p>						
<p><i>Layman's explanation:</i></p> <p><i>This claim event covers severe disease of the heart valves or diseases of the heart muscle, where the heart muscle becomes enlarged, thick, or rigid (cardiomyopathy). This results in a weaker heart, with the heart being less able to pump blood through the body and maintain a normal electrical rhythm. This can lead to heart failure, where the symptoms progress to a stage where even with light activity there is tiredness, shortness of breath or heart palpitations (referred to as class III New York Heart Association classification of heart failure).</i></p>						

Impairment Claim event	Percentage of cover amount					
	Extended Income		Extended Income Plus		Impairment Income	
Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70	Before age 70
<i>This claim event must meet the criteria as described in the contractual definition above, and must be confirmed by a specialist (cardiologist).</i>						
<p>Contractual definition: Severe valvular heart disease or cardiomyopathy, meeting the following criteria:</p> <ul style="list-style-type: none"> • New York Heart Association (NYHA) class IV on optimal treatment, and • One of the following: <ul style="list-style-type: none"> • Maximal effort test of less than 4 metabolic equivalents (METS), or • Ejection fraction (EF) of less than 40%, or • Valve gradient and/or valve area classified as severe. <p>This must be confirmed by a cardiologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers severe disease of the heart valves or diseases of the heart muscle, where the heart muscle becomes enlarged, thick, or rigid (cardiomyopathy). This results in a weaker heart, with the heart being less able to pump blood through the body and maintain a normal electrical rhythm. This can lead to heart failure, where the symptoms progress to a stage where at rest there is tiredness, shortness of breath or heart palpitations (referred to as class IV New York Heart Association classification of heart failure).</i></p> <p><i>This claim event must meet the criteria as described in the contractual definition above, and must be confirmed by a specialist (cardiologist).</i></p>	100	50	100	50	100	50
Ischaemic heart disease						
<p>Contractual definition: Ischaemic heart disease with cardiac failure, meeting the following criteria:</p> <ul style="list-style-type: none"> • New York Heart Association (NYHA) class III on optimal treatment, and • Maximal effort test of 4 to 6 metabolic equivalents (METS), and • One of the following: <ul style="list-style-type: none"> • Left ventricular ejection fraction (LVEF) of less than 45%, or • Moderate diastolic dysfunction, as determined by a cardiologist, taking into account the cause of the dysfunction, extent of ventricular hypertrophy, and mitral inflow pattern as determined by echocardiography. <p>This must be confirmed by a cardiologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers blockage of the arteries supplying blood to the heart muscles (ischaemic heart disease), complicated by the heart being less able to pump blood to supply the needs of the body (cardiac failure), where the symptoms progress to a stage where even with light activity there is tiredness, shortness of breath or heart palpitations (referred to as class III New York Heart Association classification of heart failure).</i></p> <p><i>This claim event must meet the criteria as described in the contractual definition above, and must be confirmed by a specialist (cardiologist).</i></p>	-	-	50	25	50	25

Impairment Claim event	Percentage of cover amount					
	Extended Income		Extended Income Plus		Impairment Income	
Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70	
Contractual definition: Ischaemic heart disease with cardiac failure, meeting the following criteria: <ul style="list-style-type: none"> • New York Heart Association (NYHA) class IV on optimal treatment, and • Maximal effort test of less than 4 metabolic equivalents (METS), and • One of the following: <ul style="list-style-type: none"> • Left ventricular ejection fraction (LVEF) of less than 40%, or • Severe diastolic dysfunction, as determined by a cardiologist, taking into account the cause of the dysfunction, extent of ventricular hypertrophy, and mitral inflow pattern as determined by echocardiography. <i>This must be confirmed by a cardiologist.</i> Layman's explanation: <i>This claim event covers blockage of the arteries supplying blood to the heart muscles (ischaemic heart disease), complicated by the heart being less able to pump blood to supply the needs of the body (cardiac failure), where the symptoms progress to a stage where at rest there is tiredness, shortness of breath or heart palpitations (referred to as class IV New York Heart Association classification of heart failure).</i> <i>This claim event must meet the criteria as described in the contractual definition above, and must be confirmed by a specialist (cardiologist).</i>	100	50	100	50	100	50
Heart transplant Contractual definition: <ul style="list-style-type: none"> • The undergoing of a complete heart transplant as a recipient, or • Confirmation of being on a recognised national South African transplant waiting list, awaiting a complete heart transplant. <i>This must be confirmed by a specialist with supporting evidence.</i> Layman's explanation: <i>This claim event covers:</i> <ul style="list-style-type: none"> – The undergoing of a complete heart transplant as a recipient, to replace a diseased heart, or – Confirmation of being on a recognised national South African transplant waiting list, awaiting a complete heart transplant. <i>This must be confirmed by a specialist with supporting evidence.</i>	100	50	100	50	100	50

Impairment Claim event	Percentage of cover amount					
	Extended Income		Income Plus		Impairment Income	
Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70	Before age 70
Pericardial disease						
Contractual definition: Pericardial disease with cardiac failure, meeting the following criteria: <ul style="list-style-type: none"> • Confirmed irreversible pericardial disease by a specialist, and • New York Heart Association (NYHA) class III on optimal treatment, and • One of the following: <ul style="list-style-type: none"> • Maximal effort test of 4 to 6 metabolic equivalents (METS), or • Left ventricular ejection fraction (LVEF) of less than 45% This must be confirmed by a cardiologist.	-	-	50	25	50	25
<i>Layman's explanation:</i> <i>This claim event covers pericardial disease with cardiac failure, meeting the criteria as described in the contractual definition above. This must be confirmed by a specialist (cardiologist).</i>						
<i>The pericardium is a sac that holds the heart in place and helps it to work properly. The sac is made of two thin layers of tissue that enclose the heart. Various conditions can affect and cause disease of these layers, leading to it becoming scarred and thickened and complicated by the heart being less able to pump blood to supply the needs of the body (cardiac failure), where the symptoms progress to a stage where even with light activity there is tiredness, shortness of breath or heart palpitations (referred to as class III New York Heart Association classification of heart failure).</i>						
Contractual definition: Pericardial disease with cardiac failure, meeting the following criteria: <ul style="list-style-type: none"> • Confirmed irreversible pericardial disease by a specialist, and • New York Heart Association (NYHA) class IV on optimal treatment, and • One of the following: <ul style="list-style-type: none"> • Maximal effort test of less than 4 metabolic equivalents (METS), or • Left ventricular ejection fraction (LVEF) of less than 40%. This must be confirmed by a cardiologist.	100	50	100	50	100	50
<i>Layman's explanation:</i> <i>This claim event covers pericardial disease with cardiac failure, meeting the criteria as described in the contractual definition above. This must be confirmed by a specialist (cardiologist).</i>						
<i>The pericardium is a sac that holds the heart in place and helps it to work properly. The sac is made of two thin layers of tissue that enclose the heart. Various conditions can affect and cause disease of these layers, leading to it becoming scarred and thickened and complicated by the heart being less able to pump blood to supply the needs of the body (cardiac failure), where the symptoms progress to a stage where at rest there is tiredness, shortness of breath or heart palpitations (referred to as class IV New York Heart Association classification of heart failure).</i>						

Impairment Claim event	Percentage of cover amount					
	Extended Income		Income Plus		Impairment Income	
Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70	From age 70
Arrhythmia						
Contractual definition: Arrhythmia with moderate impairment, meeting the following criteria: Arrhythmia on optimal treatment that results in	-	-	50	25	50	25
<ul style="list-style-type: none"> • New York Heart Association (NYHA) class III shortness of breath, and • One of the following: <ul style="list-style-type: none"> • 4 or less metabolic equivalents (METS) with maximal effort test, or • Documented arrhythmia that fails to respond to optimal treatment, and leads to frequent fainting. <p>This must be confirmed by a cardiologist, physician or electrophysiologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers arrhythmia with moderate impairment, meeting the criteria as described in the contractual definition above. This must be confirmed by a specialist (cardiologist, physician or electrophysiologist).</i></p> <p><i>Arrhythmia is an abnormal beat of the heart that can be too slow or too fast. This can present with moderate impairment, which can result in the following on optimal treatment:</i></p> <ul style="list-style-type: none"> – Heart failure, where the symptoms progress to a stage where even with light activity there is tiredness, shortness of breath or heart palpitations (referred to as class III New York Heart Association classification of heart failure), and – One of the following: <ul style="list-style-type: none"> – Reduced exercise effort test meeting specified criteria, or <p><i>Documented arrhythmia that fails to respond to optimal treatment, and leads to frequent fainting.</i></p>						
Contractual definition: Arrhythmia with severe impairment, meeting the following criteria: Arrhythmia on optimal treatment that results in	100	50	100	50	100	50
<ul style="list-style-type: none"> • New York Heart Association (NYHA) class IV shortness of breath, and • 2 or less metabolic equivalents (METS) with maximal effort test. <p>This must be confirmed by a cardiologist, physician or electrophysiologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers arrhythmia with severe impairment, meeting the criteria as described in the contractual definition above. This must be confirmed by a specialist (cardiologist, physician or electrophysiologist).</i></p> <p><i>Arrhythmia is an abnormal beat of the heart that can be too slow or too fast. This can present with severe impairment, which can result in the following on optimal treatment:</i></p> <ul style="list-style-type: none"> – Heart failure where the symptoms progress to a stage where at rest there is tiredness, shortness of breath or heart palpitations (referred to as class IV New York Heart Association classification of heart failure), and – Reduced exercise effort test meeting specified criteria. 						

Impairment Claim event	Percentage of cover amount					
	Extended Income		Income Plus		Impairment Income	
Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70	Before age 70
Hypertension						
Contractual definition: Hypertension with renal impairment, meeting the following criteria: • Stage II hypertension despite optimal treatment, and • Creatinine clearance of less than 50% of normal value for age. This must be confirmed by a physician, nephrologist or cardiologist.	-	-	50	25	50	25
<i>Layman's explanation:</i> <i>This claim event covers high blood pressure with impaired kidney function, meeting the following criteria:</i> – Persistent blood pressure reading of 140/90 or higher despite optimal medical treatment, and – Specialised laboratory test measuring kidney function (creatinine clearance) of less than 50% of normal value for age. <i>This must be confirmed by a specialist (physician, nephrologist or cardiologist).</i>						
Contractual definition: Hypertension with severe renal impairment, meeting the following criteria: • Stage III hypertension despite optimal treatment, and • Creatinine clearance of less than 20% of normal value for age. This must be confirmed by a physician, nephrologist or cardiologist.	100	50	100	50	100	50
<i>Layman's explanation:</i> <i>This claim event covers high blood pressure with impaired kidney function, meeting the following criteria:</i> – Persistent blood pressure reading of 160/100 up to 179/109 despite optimal medical treatment, and – Specialised laboratory test measuring kidney function (creatinine clearance) of less than 20% of normal value for age. <i>This must be confirmed by a specialist (physician, nephrologist or cardiologist).</i>						
Diseases of the aorta						
Contractual definition: Diseases of the aorta with severe impairment, meeting the following criteria: Confirmed irreversible aortic disease by a cardiologist, cardiothoracic or vascular surgeon, with • Persistent symptoms despite compliance with medication, and • New York Heart Association (NYHA) class IV. <i>Layman's explanation:</i> <i>This claim event covers disease of the main artery supplying oxygen rich blood to the body (called the aorta), meeting the following criteria:</i> – Confirmed by a specialist (cardiologist, cardiothoracic or vascular surgeon) that the disease is irreversible with persistent symptoms despite compliance with optimal medical treatment, and	100	50	100	50	100	50

Impairment Claim event	Percentage of cover amount					
	Extended Income		Extended Income Plus		Impairment Income	
Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70	Before age 70
<i>Heart failure, where the symptoms progress to a stage where at rest there is tiredness, shortness of breath or heart palpitations (referred to as class IV New York Heart Association classification of heart failure).</i>						
Peripheral arterial disease						
Contractual definition: Peripheral arterial disease with moderate impairment, with abnormal Doppler readings, cold leg, rubor and pain on exercise. This must be confirmed by a vascular surgeon.	-	-	50	25	50	25
<i>Layman's explanation:</i> <i>This claim event covers peripheral arterial disease with moderate impairment, meeting the following criteria:</i>						
– Abnormal specialised test measuring blood flow in arteries (Doppler), and – Cold and discoloured and painful leg.						
<i>This must be confirmed by a specialist (vascular surgeon).</i>						
<i>Peripheral arterial disease is a problem with blood flow to the limbs due to narrowing of the arteries in the limbs.</i>						
Contractual definition: Peripheral arterial disease with severe impairment despite optimal treatment, meeting the following criteria: <ul style="list-style-type: none">• No palpable pulses, confirmed by absent Doppler readings, or• Severe vascular ulceration, or• Gangrene.	100	50	100	50	100	50
<i>Layman's explanation:</i> <i>This claim event covers peripheral arterial disease with severe impairment, meeting the following criteria:</i>						
– No palpable pulses confirmed by a specialised test measuring blood flow in arteries (Doppler), or – Severe ulcers due to poor blood flow, or – Death of tissue (gangrene).						
<i>This must be confirmed by a specialist (vascular surgeon).</i>						
<i>Peripheral arterial disease is a problem with blood flow to the limbs due to narrowing of the arteries in the limbs.</i>						
Peripheral venous disease						
Contractual definition: Peripheral venous disease with severe impairment despite optimal treatment, with severe deep and widespread vascular ulceration. This must be confirmed by a vascular surgeon.	-	-	50	25	50	25
<i>Layman's explanation:</i> <i>This claim event covers peripheral venous disease with severe impairment despite optimal treatment, with severe deep and widespread ulcers due to poor blood flow.</i>						

Impairment Claim event	Percentage of cover amount					
	Extended Income		Extended Income Plus		Impairment Income	
Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70	Before age 70
Peripheral venous disease						
<i>This must be confirmed by a specialist (vascular surgeon).</i>						
<i>Peripheral venous disease is a disease causing blockage of the blood vessels (veins) carrying blood from the arms and legs to the heart.</i>						
Primary pulmonary artery hypertension						
<i>Contractual definition:</i> Severe primary pulmonary artery hypertension despite optimal medical treatment, with mean pulmonary artery pressure 40-70 mmHg, and at least New York Heart Association (NYHA) class III classification of cardiac impairment. This must be confirmed by a physician.	-	-	50	25	50	25
<i>Layman's explanation:</i> <i>This claim event covers severe high blood pressure in the lung arteries despite optimal treatment, meeting the following criteria:</i>						
<ul style="list-style-type: none">- Specified artery pressure as in the contractual definition above, and- Symptoms have progressed to a stage where even with light activity there is tiredness, shortness of breath or heart palpitations (referred to as class III New York Heart Association classification of heart failure).						
<i>This must be confirmed by a specialist (physician).</i>						
Primary pulmonary artery hypertension						
<i>Contractual definition:</i> Severe primary pulmonary artery hypertension despite optimal medical treatment, with mean pulmonary artery pressure exceeding 70 mmHg, and at least New York Heart Association (NYHA) class IV classification of cardiac impairment. This must be confirmed by a physician.	100	50	100	50	100	50
<i>Layman's explanation:</i> <i>This claim event covers severe high blood pressure in the lung arteries despite optimal treatment, meeting the following criteria:</i>						
<ul style="list-style-type: none">- Specified artery pressure as in the contractual definition above, and- Symptoms have progressed to a stage where at rest there is tiredness, shortness of breath or heart palpitations (referred to as class IV New York Heart Association classification of heart failure).						
<i>This must be confirmed by a specialist (physician).</i>						
Blood system						
Anaemia						
<i>Contractual definition:</i> Severe treatment resistant anaemia despite optimal medical treatment, meeting the following criteria:	-	-	50	25	50	25
<ul style="list-style-type: none">• Hb less than 8 g/dL, and• Requiring 2 or more units of blood or blood products every 4 to 6 weeks.						
<i>This must be confirmed by a physician or haematologist.</i>						
<i>Layman's explanation:</i>						

Impairment Claim event	Percentage of cover amount					
	Extended Income		Extended Income Plus		Impairment Income	
Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70	Before age 70
<p>Impairment Claim event</p> <p>This claim event covers persistent low oxygen carrying capacity of red blood cell count despite optimal medical treatment (referred to as treatment resistant anaemia), meeting the following criteria:</p> <ul style="list-style-type: none"> – Low blood count meeting specific criteria for oxygen carrying capacity of red blood cells, and – Evidence of blood transfusions of 2 or more units every 4 to 6 weeks. <p>This must be confirmed by a specialist (physician or haematologist).</p>						
<p>Contractual definition: Life threatening, treatment resistant anaemia despite optimal treatment, meeting the following criteria:</p> <ul style="list-style-type: none"> • Hb less than 8 g/dL, and • Requiring 2 or more units of blood or blood products every 2 weeks. <p>This must be confirmed by a physician or haematologist.</p> <p>Layman's explanation: This claim event covers persistent low oxygen carrying capacity of red blood cell count despite optimal medical treatment (referred to as treatment resistant anaemia), meeting the following criteria:</p> <ul style="list-style-type: none"> – Low blood count meeting specific criteria for oxygen carrying capacity of red blood cells, and – Evidence of blood transfusions of 2 or more units every 2 weeks. <p>This must be confirmed by a specialist (physician or haematologist).</p>	100	50	100	50	100	50
White blood cell disorder						
<p>Contractual definition: Severe white blood cell disorder, meeting the following criteria:</p> <ul style="list-style-type: none"> • More than 1 hospitalisation per year for acute bacterial infection and an absolute neutrophil count of between 250 and 500, or • Lymphoma or leukaemia requiring 1 or 2 chemotherapy cycles per year. <p>This must be confirmed by a physician or haematologist.</p> <p>Layman's explanation: This claim event covers persistent low oxygen carrying capacity of red blood cell count despite optimal medical treatment (referred to as treatment resistant anaemia), meeting the following criteria:</p> <ul style="list-style-type: none"> – Low blood count meeting specific criteria for oxygen carrying capacity of red blood cells, and – Evidence of blood transfusions of 2 or more units every 2 weeks. <p>This must be confirmed by a specialist (physician or haematologist).</p>	-	-	50	25	50	25

Impairment Claim event	Percentage of cover amount					
	Extended Income		Extended Income Plus		Impairment Income	
Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70	
Contractual definition: Severe white blood cell disorder, meeting the following criteria: <ul style="list-style-type: none"> • Whole person impairment (WPI) of at least 35% despite optimal medical treatment, or • Lymphoma or leukaemia requiring 3 to 6 chemotherapy cycles per year. <p>This must be confirmed by a physician or haematologist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers severe white blood cell disorder, meeting the following criteria:</i> <ul style="list-style-type: none"> – Whole person impairment (WPI) of at least 35% despite optimal medical treatment, or – Cancer of infection-fighting cells of the immune system (lymphoma) or cancer of white blood cells (leukaemia), requiring 3 to 6 chemotherapy cycles per year. <p><i>This must be confirmed by a specialist (physician or haematologist).</i></p> </p>	100	50	100	50	100	50
Clotting disorder Contractual definition: Severe clotting disorder, meeting the following criteria: <ul style="list-style-type: none"> • Persistent despite optimal medical and surgical treatment, and • Resulting in end organ failure of one of the following, as described in this document for this benefit: <ul style="list-style-type: none"> • Respiratory failure • Cardiac failure end-stage • Kidney failure end-stage • Liver failure (which is not described in this document). <p>This must be confirmed by a specialist.</p> <p><i>Layman's explanation:</i> <i>This claim event covers severe clotting disorder, meeting the criteria in the contractual definition above. This must be confirmed by a specialist.</i></p> <p><i>Clotting disorder occurs when the body is unable to make components that are required by the body for blood to clot. When severe, this disorder can lead to severe bleeding from various sites, which can ultimately lead to multiple organ damage.</i></p>	100	50	100	50	100	50

Impairment Claim event	Percentage of cover amount					
	Extended Income		Income Plus		Impairment Income	
Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70	Before age 70
Respiratory system						
Respiratory failure						
Contractual definition: Severe respiratory failure, meeting the following criteria: Confirmed chronic respiratory disease despite optimal medical treatment, resulting in impaired airflow, meeting the following criteria: <ul style="list-style-type: none"> • Forced expiratory volume in one second (FEV1) of less than 50%, or • Forced vital capacity (FVC) of less than 50%, or • Impaired diffusion with diffusion capacity (DCO) of less than 50%, or • Impaired exercise tolerance with maximal effort test of 4 to 6 metabolic equivalents (METS). This must be confirmed by a pulmonologist or physician.	-	-	50	25	50	25
<i>Layman's explanation:</i> <i>This claim event covers severe chronic disease of the lungs, optimally treated but resulting in respiratory failure (lungs not being able to meet the oxygen requirements of the body), with impaired airflow. This must meet the criteria described in the contractual definition above and must be confirmed by a specialist (pulmonologist or physician).</i>						
Contractual definition: Severe respiratory failure, meeting the following criteria: Confirmed chronic respiratory disease despite optimal medical treatment, resulting in impaired airflow with <ul style="list-style-type: none"> • Forced expiratory volume in one second (FEV1) of less than 40%, or • Forced vital capacity (FVC) of less than 40%, or • Impaired diffusion with diffusion capacity (DCO) of less than 40%, or • Impaired exercise tolerance with maximal effort test of less than 4 metabolic equivalents (METS). This must be confirmed by a pulmonologist or physician.	100	50	100	50	100	50
<i>Layman's explanation:</i> <i>This claim event covers severe chronic disease of the lungs, resulting in respiratory failure (lungs not being able to meet the oxygen requirements of the body), with impaired airflow. This must meet the criteria described in the contractual definition above and must be confirmed by a specialist (pulmonologist or physician).</i>						
Lung transplant						
Contractual definition: <ul style="list-style-type: none"> • The undergoing of a complete lung transplant as a recipient, or • Confirmation of being on a recognised national South African transplant waiting list, awaiting a complete lung transplant. This must be confirmed by a specialist with supporting evidence.	100	50	100	50	100	50
<i>Layman's explanation:</i> <i>This claim event covers:</i>						

Impairment Claim event	Percentage of cover amount					
	Extended Income		Extended Income Plus		Impairment Income	
Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70	Before age 70
<ul style="list-style-type: none"> – The undergoing of a complete lung transplant as a recipient, to replace a diseased lung, or – Confirmation of being on a recognised national South African transplant waiting list, awaiting a complete lung transplant. <p><i>This must be confirmed by a specialist with supporting evidence.</i></p>						
Central nervous system						
Coma						
Contractual definition: A condition of unconsciousness not induced by sedation, where the life insured presents with a Glasgow Coma Scale reading of 8 or less for an uninterrupted period of at least 96 hours. This must be confirmed by a specialist.	100	50	100	50	100	50
<i>Layman's explanation:</i> <i>This claim event covers coma, where there is a state of unconsciousness not induced by medication causing a state of sleep. Specific criteria must be met, as described in the contractual definition above. This must be confirmed by a specialist.</i>						
Hemiplegia						
Contractual definition: 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. The following is required: <ul style="list-style-type: none"> • Radiological evidence such as a computed tomography (CT) scan or magnetic resonance imaging (MRI), and Must be confirmed by a neurologist or neurosurgeon.	100	50	100	50	100	50
Diplegia						
Contractual definition: The total and permanent loss of muscle function of both sides of the body due to disease of or injury to the spinal cord or brain. The following is required: <ul style="list-style-type: none"> • Radiological evidence, such as a computed tomography (CT) scan or magnetic resonance imaging (MRI), and • Must be confirmed by a neurologist or neurosurgeon. <i>Layman's explanation:</i> <i>This claim event covers diplegia, meeting the criteria in the contractual definition above. This must be confirmed by a specialist (neurologist or neurosurgeon).</i> <i>Diplegia is a total and permanent weakness of the same part on both sides of the body, which can be as a result of a disease or injury.</i>	100	50	100	50	100	50

Impairment Claim event	Percentage of cover amount					
	Extended Income		Extended Income Plus		Impairment Income	
Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70	
Paraplegia						
Contractual definition: The total and permanent loss of muscle function resulting in the loss of use of both legs due to disease or injury to the spinal cord or brain. The following is required: <ul style="list-style-type: none">• Radiological evidence such as a computed tomography (CT) scan or magnetic resonance imaging (MRI), and Must be confirmed by a neurologist or neurosurgeon.	100	50	100	50	100	50
Quadriplegia						
Contractual definition: The total and permanent loss of muscle function resulting in the loss of use of both arms and both legs due to disease or injury to the spinal cord or brain. The following is required: <ul style="list-style-type: none">• Radiological evidence such as a computed tomography (CT) scan or magnetic resonance imaging (MRI), and Must be confirmed by a neurologist or neurosurgeon.	100	50	100	50	100	50
Epilepsy						
Contractual definition: Uncontrolled epilepsy, meeting the following criteria: <ul style="list-style-type: none">• Documented epileptic attacks confirmed by an abnormal electro-encephalogram (EEG) reading, and• Attacks must be observed to be more than 3 per week, and be resistant to optimal therapy as confirmed by drug serum-level testing. This must be confirmed by a neurologist or physician. <i>Layman's explanation:</i> <i>This claim event covers uncontrolled convulsions or seizures, meeting the criteria in the contractual definition above. This must be confirmed by a specialist (neurologist or physician).</i>	-	-	50	25	50	25

Impairment Claim event	Percentage of cover amount					
	Extended Income		Extended Income Plus		Impairment Income	
Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70	Before age 70
Contractual definition: Frequent status epilepticus, meeting the following criteria: In spite of sustained optimal treatment and documented compliance of treatment, there must be <ul style="list-style-type: none"> at least 3 documented episodes of status epilepticus within the last 12 months, or 12 or more grand mal seizures per month, within the last 4 consecutive months. This will be assessed by all of the following evidence: <ul style="list-style-type: none"> Electro-encephalograms (EEGs), and Drug serum levels which must show compliance, and Documented evidence of epileptic attacks on clinical records, and Evidence of emergency treatment administered. This must be confirmed by a neurologist. Layman's explanation: <i>This claim event covers frequent status epilepticus, meeting the criteria in the contractual definition above. This must be confirmed by a specialist (neurologist).</i> <i>Status epilepticus is a single seizure lasting for more than 5 minutes, or 2 or more seizures within a 5-minute period without the person returning to normal between them.</i>	100	50	100	50	100	50
Parkinson's disease Contractual definition: Advanced Parkinson's disease confirmed by a neurologist, meeting the following criteria: <ul style="list-style-type: none"> Appropriate clinical signs and symptoms, and Permanent inability to perform independently at least 3 basic activities of daily living (ADLs). These ADLs are indicated in the table "Basic activities of daily living for impairment cover" later in this document. Permanence will be assessed after requirements for reasonable treatment has been met. Layman's explanation: <i>This claim event covers advanced Parkinson's disease, meeting the criteria in the contractual definition above. This must be confirmed by a specialist (neurologist).</i> <i>Parkinson's disease is a degenerative brain condition that leads to various symptoms, like tremor of the hands and head, a slow gait with shuffling feet, inability to show emotions, and a forward-falling posture.</i>	100	50	100	50	100	50

Impairment Claim event	Percentage of cover amount					
	Extended Income		Income Plus		Impairment Income	
Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70	From age 70
Cognitive dementia						
<p>Contractual definition: Early onset cognitive dementia due to organic brain disease (pre-senile dementia), meeting the following criteria: The diagnosis of cognitive dementia before age 65 (pre-senile dementia), confirmed by a neurologist or psychiatrist.</p> <p>There must be evidence of all of the following:</p> <ul style="list-style-type: none"> Typical findings in cognitive tests as per the latest Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria or 2 consecutive Global Clinical Dementia Rating (CDR) ratings of at least 1.0, and Supportive findings on neuro-imaging, and Permanent inability to perform independently at least 3 advanced activities of daily living (ADLs), or the need for assistance by a caregiver. These ADLs are indicated in the table "Advanced activities of daily living for impairment cover" later in this document. <p>Permanence will be established after 3 months.</p> <p><i>Layman's explanation:</i> <i>This claim event covers the early onset of a decline in thinking and memory function (cognitive function) not in keeping with what is normal for the age and occurring before age 65 (pre-senile dementia). This must be as a result of a disease of the brain, and not due to a psychological cause. This must be confirmed by a specialist (neurologist or psychiatrist).</i></p> <p>There must be evidence of all of the following:</p> <ul style="list-style-type: none"> Typical findings in specialised testing for memory and thinking called cognitive tests (as per the latest DSM criteria or 2 consecutive CDR ratings of at least 1.0), and Supportive findings on specialised radiological testing (neuro-imaging), and Permanent inability to perform independently at least 3 advanced activities of daily living, as indicated later in this document for this benefit, or the need for assistance by a caregiver. <p>Permanence will be established after 3 months.</p>	-	-	50	25	50	25

Impairment Claim event	Percentage of cover amount					
	Extended Income		Extended Income Plus		Impairment Income	
Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70	Before age 70
<p>Contractual definition: Early onset cognitive dementia due to organic brain disease (pre-senile dementia), meeting the following criteria: The diagnosis of cognitive dementia before age 65 (pre-senile dementia), with profound impairment, confirmed by a neurologist or psychiatrist.</p> <p>There must be evidence of all of the following:</p> <ul style="list-style-type: none"> Typical findings in cognitive tests as per the latest Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria or two consecutive Global Clinical Dementia Rating (CDR) ratings of at least 3.0, and Supportive findings on neuro-imaging, and Permanent inability to perform independently at least 3 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 impairment cover" later in this document. <p>Permanence will be established after 3 months.</p> <p>Layman's explanation: <i>This claim event covers the early onset of a decline in thinking and memory function (cognitive function), not in keeping with what is normal for the age and occurring before age 65 (pre-senile dementia). This must be as a result of a disease of the brain, and not due to a psychological cause. This must be confirmed by a specialist (neurologist or psychiatrist).</i></p> <p>There must be evidence of all of the following:</p> <ul style="list-style-type: none"> Typical findings in specialised testing for memory and thinking called cognitive tests (as per the latest DSM criteria or 2 consecutive CDR ratings of at least 3.0), and Supportive findings on specialised radiological testing (neuro-imaging), and Permanent inability to perform independently at least 3 basic activities of daily living, as indicated later in this document for this benefit, or the need for 24-hour supervision by a caregiver. <p>Permanence will be established after 3 months.</p>	100	50	100	50	100	50
<p>Cranial nerve V</p> <p>Contractual definition: Cranial nerve V pathology with severe trigeminal neuralgia, meeting the following criteria: The diagnosis of treatment resistant, severe unilateral or bilateral facial neuralgic pain by a neurologist, with evidence of treatment resistance as well as the need for decompression surgery.</p> <p>Layman's explanation: <i>The trigeminal nerve (the 5th cranial nerve) is a nerve responsible for sensation in the face and functions such as biting and chewing.</i></p> <p><i>This claim event covers severe chronic pain in this nerve area, meeting the following criteria: Diagnosis by a specialist (neurologist) of treatment resistant, severe one-sided or both-sided facial nerve pain, with evidence of treatment resistance as well as the need for decompression surgery.</i></p>	-	-	45	22.5	45	22.5

Impairment Claim event	Percentage of cover amount					
	Extended Income		Income Plus		Impairment Income	
Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70	Before age 70
Cranial nerve VII						
Contractual definition: Cranial nerve VII paralysis with severe unilateral upper motor neuron facial paralysis, involving more than 75% of the facial muscles, and inability to control eyelid closure. This must be confirmed by a neurologist.	-	-	50	25	50	25
<i>Layman's explanation:</i> <i>The facial nerve (the 7th cranial nerve) controls the muscles of facial expression, and functions in taste sensations of two-thirds of the tongue.</i>						
<i>This claim event covers paralysis of this nerve with upper motor neuron facial paralysis of more than 75% of the facial muscles and inability to close eyelids. This must be confirmed by a specialist (neurologist).</i>						
Cranial nerve VIII						
Contractual definition: Cranial nerve VIII paralysis or imbalance with moderately severe equilibrium impairment, with limitations of all activities of daily living (ADLs), and requiring permanent assistance with self-care. These ADLs are indicated in the tables "Basic activities of daily living for impairment cover" and "Advanced activities of daily living for impairment cover" later in this document. This must be confirmed by a neurologist or ear, nose and throat surgeon.	-	-	50	25	50	25
<i>Layman's explanation:</i> <i>The 8th cranial nerve transmits sound and balance information from the inner ear to the brain.</i>						
<i>This claim event covers paralysis of this nerve with moderate balance disturbance, with limitations in all activities of daily living (ADLs) and requiring permanent assistance with self-care. This must be confirmed by a specialist (neurologist or ear, nose and throat surgeon).</i>						
Contractual definition: Cranial nerve VIII paralysis or imbalance with severe equilibrium impairment, with limitations of all activities of daily living (ADLs), requiring permanent assistance with self-care and permanent confinement to a bed or wheelchair. These ADLs are indicated in the tables "Basic activities of daily living for impairment cover" and "Advanced activities of daily living for impairment cover" later in this document. This must be confirmed by a neurologist.	-	-	75	37.5	75	37.5
<i>Layman's explanation:</i> <i>The 8th cranial nerve transmits sound and balance information from the inner ear to the brain.</i>						
<i>This claim event covers paralysis of this nerve with severe balance disturbance, with limitations in all activities of daily living (ADLs) and requiring permanent assistance with self-care and permanent confinement to a bed or wheelchair. This must be confirmed by a specialist (neurologist).</i>						
Cranial nerves IX, X or XII						
Contractual definition:	-	-	25	12.5	25	12.5

Impairment Claim event	Percentage of cover amount					
	Extended Income		Income Plus		Impairment Income	
Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70	
Cranial nerves IX, X or XII paralysis or dysarthria or dysphagia, with moderately severe dysarthria or dysphagia with hoarseness, nasal regurgitation and aspiration of fluids. This must be confirmed by a neurologist.						
Layman's explanation: <i>This claim event covers paralysis of cranial nerves 9, 10 or 12, with moderate difficulty with swallowing, hoarseness, difficulty with speech, accidental inhalation of fluids into the lungs or airway or passage of food through the nasal passages. This must be confirmed by a specialist (neurologist).</i>						
Contractual definition: Cranial nerves IX, X or XII paralysis or dysarthria or dysphagia, with severe functional inability to swallow without choking and with the need for assistance and suctioning. This must be confirmed by a neurologist.	-	-	75	37.5	75	37.5
Layman's explanation: <i>This claim event covers paralysis of cranial nerves 9, 10 or 12, with severe inability to swallow without choking with the need for assistance and suctioning. This must be confirmed by a specialist (neurologist).</i>						
Neurologic impairment of respiration						
Contractual definition: Neurologic impairment of respiration, where the life insured is capable of spontaneous respiration, but is restricted to sitting, standing or limited ambulation. This must be confirmed by a neurologist.	-	-	50	25	50	25
Layman's explanation: <i>This claim event covers impairment of breathing due to neurological cause or reason, where the life insured is capable of spontaneous breathing, but is restricted to sitting or standing with limited ambulation. This must be confirmed by a specialist (neurologist).</i>						
Contractual definition: Neurologic impairment of respiration with severe functional impairment where the life insured is capable of spontaneous respiration, but to such a limited degree that he or she is permanently confined to a bed. This must be confirmed by a neurologist.	-	-	75	37.5	75	37.5
Layman's explanation: <i>This claim event covers impairment of breathing due to neurological cause or reason, where the life insured is capable of spontaneous breathing, but is limited to such a degree that he or she is permanently confined to a bed. This must be confirmed by a specialist (neurologist).</i>						
Contractual definition: Neurologic impairment of respiration to such an extent that there is no spontaneous respiration. This must be confirmed by a neurologist.	100	50	100	50	100	50
Layman's explanation: <i>This claim event covers impairment of breathing due to neurological cause or reason, where the life insured is incapable of spontaneous breathing. This must be confirmed by a specialist (neurologist).</i>						

Impairment Claim event	Percentage of cover amount					
	Extended Income		Income Plus		Impairment Income	
Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70	Before age 70
Gastro-intestinal system						
Gastro-intestinal tract disease						
Contractual definition: Gastro-intestinal tract disease, meeting the following criteria: Anatomic loss or alteration in gastro-intestinal tract, as a result of an organic cause, with any of the following: <ul style="list-style-type: none">• Symptoms uncontrolled by adequate treatment and 15% weight loss below accepted desirable weight for a period exceeding a year, or• Permanent stoma, or• Anatomic loss or alteration in gastro-intestinal tract, with persistent, irreducible and irreparable protrusion of a hernia after surgery, with bowel dysfunction and limitation in activities of daily living. This must be confirmed by a surgeon, physician or gastroenterologist. <i>Layman's explanation:</i> <i>The gastro-intestinal tract is an organ system within humans which takes in food, digests it to extract and absorb energy and nutrients, and expels the remaining waste as faeces. This claim event covers loss of a part of this system, or disease of this system, not due to a psychological cause.</i> <i>The following criteria must be met:</i> <ul style="list-style-type: none">– Loss due to trauma or surgery of a part of this system with evidence of disease and symptoms uncontrolled by adequate treatment with weight loss, as specified in the contractual definition above, despite optimal medical treatment, or– Permanent stoma (artificial opening in the gut), or– Persistent, irreducible and irreparable part of the bowel that protrudes through a weakness in the abdominal wall (hernia) after surgery, with bowel dysfunction and limitation in activities of daily living. <i>This must be confirmed by a specialist (surgeon, physician or gastroenterologist).</i>	-	-	50	25	50	25
Contractual definition: Gastro-intestinal tract disease, meeting the following criteria: Anatomic loss or alteration in gastro-intestinal tract, as a result of an organic cause, with symptoms uncontrolled by adequate treatment, and 25% weight loss below accepted desirable weight. This must be confirmed by a surgeon, physician or gastroenterologist. <i>Layman's explanation:</i> <i>The gastro-intestinal tract is an organ system within humans which takes in food, digests it to extract and absorb energy and nutrients, and expels the remaining waste as faeces. This claim event covers loss of a part of this system, or disease of this system, not due to a psychological cause.</i> <i>The following criteria must be met:</i> <i>Loss due to trauma or surgery of a part of this system with evidence of disease and symptoms uncontrolled by adequate treatment with weight loss, as specified in the contractual definition above, despite optimal medical treatment. This must be confirmed by a specialist (surgeon, physician or gastroenterologist).</i>	100	50	100	50	100	50
Loss of bowel function						

Impairment Claim event	Percentage of cover amount					
	Extended Income		Income Plus		Impairment Income	
Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70	Before age 70
Contractual definition: Permanent colostomy as a result of loss of bowel function, as a result of traumatic or medical conditions and confirmed by a specialist. <i>Layman's explanation:</i> <i>A surgical operation in which the colon is shortened to remove a damaged or diseased part and the cut end diverted to create a permanent opening in the abdominal wall. This must be confirmed by a specialist.</i>	-	-	50	25	50	25
Contractual definition: Complete and permanent faecal incontinence not amenable to medical treatment, as a result of an organic cause, confirmed by a specialist. <i>Layman's explanation:</i> <i>Faecal incontinence is the inability to control bowel movements, causing stool (faeces) to leak unexpectedly from the rectum.</i> <i>This claim event covers faecal incontinence when the condition is permanent with a total loss of control (thus complete). It must not be amenable to medical treatment and not due to a psychological cause. This must be confirmed by a specialist.</i>	100	50	100	50	100	50
Chronic liver disease Contractual definition: Severe chronic liver disease despite optimal medical treatment and confirmed by a gastroenterologist, with abnormal liver function tests, as evidenced by at least two of the following: <ul style="list-style-type: none">• Albumin 28-35 mg/L• INR 1.71-2.20• Bilirubin 34-50 umol/l• Ascites. <i>Layman's explanation:</i> <i>This claim event covers severe chronic liver disease despite optimal medical treatment, meeting the criteria as described in the contractual definition above. This must be confirmed by a specialist (gastroenterologist).</i> <i>Ascites is the abnormal accumulation of fluid in the abdominal cavity.</i>	-	-	50	25	50	25

Impairment Claim event	Percentage of cover amount					
	Extended Income		Extended Income Plus		Impairment Income	
Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70	
Contractual definition: Severe progressive chronic liver disease despite optimal medical treatment, confirmed by a gastroenterologist and meeting the following criteria: <ul style="list-style-type: none">• Objective evidence of jaundice, and• Ascites or bleeding oesophageal varices within the last year, and• 25% weight loss below accepted desirable weight.	100	50	100	50	100	50
Layman's explanation: <i>This claim event covers severe worsening chronic liver disease despite optimal medical treatment, meeting the following criteria:</i> <ul style="list-style-type: none">– Objective evidence of a medical condition with yellowing of the skin or whites of the eyes, arising from excess of the pigment bilirubin (jaundice), and– Abnormal accumulation of fluid in the abdominal cavity (ascites) or bleeding enlarged veins in the food pipe (oesophagus) within the last year, and– 25% weight loss below accepted desirable weight.						
<i>This must be confirmed by a specialist (gastroenterologist).</i>						
<i>The oesophagus (food pipe) is a muscular tube that moves food and liquids from the throat to the stomach.</i>						
Liver transplant						
Contractual definition: <ul style="list-style-type: none">• The undergoing of a complete liver transplant as a recipient, or• Confirmation of being on a recognised national South African transplant waiting list, awaiting a complete liver transplant.	100	50	100	50	100	50
<i>This must be confirmed by a specialist with supporting evidence.</i>						
Layman's explanation: <i>This claim event covers:</i> <ul style="list-style-type: none">– The undergoing of a complete liver transplant as a recipient, to replace a diseased liver, or– Confirmation of being on a recognised national South African transplant waiting list, awaiting a complete liver transplant.						
<i>This must be confirmed by a specialist with supporting evidence.</i>						
Biliary tract disease						
Contractual definition: Irreparable biliary tract obstruction with persistent jaundice despite optimal medical treatment, confirmed by a gastroenterologist.	100	50	100	50	100	50
Layman's explanation: <i>This claim event covers irreparable biliary tract obstruction with persistent jaundice. This must be confirmed by a specialist (gastroenterologist).</i>						
<i>Biliary obstruction is when one of the ducts that carry bile from the liver to the intestine via the gallbladder becomes blocked. Irreparable biliary tract obstruction with persistent</i>						

Impairment Claim event	Percentage of cover amount					
	Extended Income		Extended Income Plus		Impairment Income	
Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70	Before age 70
<i>jaundice is when the obstruction is irreparable and jaundice persists despite optimal medical treatment.</i>						
Pancreas transplant						
Contractual definition: <ul style="list-style-type: none"> • The undergoing of a complete pancreas transplant as a recipient, or • Confirmation of being on a recognised national South African transplant waiting list, awaiting a complete pancreas transplant. <i>This must be confirmed by a specialist with supporting evidence.</i>	100	50	100	50	100	50
<i>Layman's explanation:</i> <i>This claim event covers:</i> <ul style="list-style-type: none"> – <i>The undergoing of a complete pancreas transplant as a recipient, to replace a diseased pancreas, or</i> – <i>Confirmation of being on a recognised national South African transplant waiting list, awaiting a complete pancreas transplant.</i> <i>This must be confirmed by a specialist with supporting evidence.</i>						
Endocrine system						
Disorders of the hypothalamic pituitary axis						
Contractual definition: Disorders of the hypothalamic pituitary axis, with permanent whole person impairment (WPI) exceeding 26% despite optimal medical treatment. This must be confirmed by an endocrinologist.	-	-	50	25	50	25
<i>Layman's explanation:</i> <i>This claim event covers disorders of the hypothalamic pituitary axis, with permanent whole person impairment exceeding 26% despite optimal medical treatment. This must be confirmed by a specialist (endocrinologist).</i>						
<i>The hypothalamic pituitary axis plays key roles in controlling hormone secretion that has an effect on other organs in the body.</i>						
Hypoadrenalism						
Contractual definition: Hypoadrenalism, with permanent whole person impairment (WPI) exceeding 30% despite optimal medical treatment. This must be confirmed by an endocrinologist.	-	-	50	25	50	25
<i>Layman's explanation:</i> <i>This claim event covers hypoadrenalism, with permanent whole person impairment exceeding 30% despite optimal medical treatment. This must be confirmed by a specialist (endocrinologist).</i>						
<i>Hypoadrenalism is a condition in which the adrenal glands do not produce adequate amounts of steroid hormones. The adrenal glands are small glands located on the top end of the kidney that produce important hormones in the body.</i>						

Impairment Claim event	Percentage of cover amount					
	Extended Income		Income Plus		Impairment Income	
Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70	Before age 70
Hyperadrenocorticism						
Contractual definition: Hyperadrenocorticism, with permanent whole person impairment (WPI) exceeding 30% despite optimal medical treatment. This must be confirmed by an endocrinologist.	-	-	50	25	50	25
<i>Layman's explanation:</i> <i>This claim event covers hyperadrenocorticism, with permanent whole person impairment exceeding 30% despite optimal medical treatment. This must be confirmed by a specialist (endocrinologist).</i>						
<i>Hyperadrenocorticism, which is often called Cushing's syndrome, is an extremely complex condition that involves many areas of the body. It results from an excess of a hormone called cortisol and its effects on the human body.</i>						
Phaeochromocytoma						
Contractual definition: Phaeochromocytoma, with permanent whole person impairment (WPI) exceeding 30% despite optimal medical treatment. This must be confirmed by an endocrinologist.	-	-	50	25	50	25
<i>Layman's explanation:</i> <i>This claim event covers phaeochromocytoma, with permanent whole person impairment exceeding 30% despite optimal medical treatment. This must be confirmed by a specialist (endocrinologist).</i>						
<i>Pheochromocytoma is a rare tumour of adrenal gland tissue. It results in the release of too many of the hormones that control heart rate, metabolism, and blood pressure.</i>						
<i>The adrenal glands are small glands located on the top end of the kidney that produce important hormones in the body.</i>						
Diabetes mellitus: type I or II						
Contractual definition: Diabetes mellitus: type I or II with moderate to severe organ impairment, confirmed by a specialist and meeting the following criteria:	-	-	50	25	50	25
<ul style="list-style-type: none"> • Kidney functions impaired, which will be assessed under kidney failure events • Retinopathy with visual impairment, which will be assessed under visual impairment events • Ischaemic heart disease, which will be assessed under ischaemic heart disease with cardiac failure. 						
<i>Layman's explanation:</i> <i>Diabetes mellitus is a disorder in which blood sugar (glucose) levels are abnormally high because the body does not produce enough insulin to meet its needs.</i>						
<i>This claim event covers type I or II with moderate to severe organ impairment, meeting the criteria described in the contractual definition above. This must be confirmed by a specialist.</i>						
<i>Diabetic retinopathy is caused by damage to the blood vessels in the tissue at the back of the eye (retina). Poorly controlled blood sugar is a risk factor.</i>						

Impairment Claim event	Percentage of cover amount					
	Extended Income		Extended Income Plus		Impairment Income	
	Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70
Contractual definition: Diabetes mellitus: type I or II with severe organ impairment, confirmed by a specialist and meeting the following criteria: <ul style="list-style-type: none">• Kidney functions impaired, which will be assessed under kidney failure events• Retinopathy with visual impairment, which will be assessed under visual impairment events• Ischaemic heart disease, which will be assessed under ischaemic heart disease with cardiac failure.	100	50	100	50	100	50
<i>Layman's explanation:</i> <i>Diabetes mellitus is a disorder in which blood sugar (glucose) levels are abnormally high because the body does not produce enough insulin to meet its needs.</i>						
<i>This claim event covers type I or II with severe organ impairment, meeting the criteria in the contractual definition above. This must be confirmed by a specialist.</i>						
<i>Diabetic retinopathy is caused by damage to the blood vessels in the tissue at the back of the eye (retina). Poorly controlled blood sugar is a risk factor.</i>						
Catch-all for other disorders of the endocrine system						
Contractual definition: Any disorder of the endocrine system not specified in the other listed events for the endocrine system, that is confirmed by an endocrinologist, with permanent whole person impairment (WPI) exceeding 30% despite optimal medical treatment.	-	-	50	25	50	25
<i>Layman's explanation:</i> <i>The endocrine system has eight major glands, which make hormones. Hormones affect the functions of the entire body. Any disease of a gland can cause imbalances in the body which can be from mild to serious.</i>						
<i>This claim event covers any disorder of any of these glands not specified in the listed events that is confirmed by a specialist (endocrinologist), with permanent whole person impairment exceeding 30% despite optimal medical treatment.</i>						
Contractual definition: Any disorder of the endocrine system not specified in the listed events for the endocrine system, that is confirmed by an endocrinologist, with permanent whole person impairment (WPI) exceeding 40% despite optimal medical treatment.	100	50	100	50	100	50
<i>Layman's explanation:</i> <i>The endocrine system has eight major glands, which make hormones. Hormones affect the functions of the entire body. Any disease of a gland can cause imbalances in the body which can be from mild to serious.</i>						
<i>This claim event covers any disorder of any of these glands not specified in the listed events that is confirmed by a specialist (endocrinologist), with permanent whole person impairment exceeding 40% despite optimal medical treatment.</i>						
Renal system						

Impairment Claim event	Percentage of cover amount					
	Extended Income		Extended Income Plus		Impairment Income	
Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70	Before age 70
Kidney failure						
Contractual definition: Kidney failure with moderate impairment, meeting the following criteria: The diagnosis of permanent kidney failure by a nephrologist or urologist, with evidence of a creatinine clearance of 28 to 42 ml per minute despite adequate medical treatment.	-	-	50	25	50	25
<i>Layman's explanation:</i> <i>Kidney failure refers to failure of the kidneys to function properly.</i>						
<i>This claim event covers kidney failure with moderate impairment, meeting the criteria in the contractual definition above. This must be confirmed by a specialist (nephrologist or urologist).</i>						
Contractual definition: Kidney failure with severe impairment, meeting the following criteria: The diagnosis of permanent kidney failure by a nephrologist or urologist, with evidence of a creatinine clearance of less than 28 ml per minute, or the need for more than 8 hours of dialysis per week.	100	50	100	50	100	50
<i>Layman's explanation:</i> <i>Kidney failure refers to failure of the kidneys to function properly.</i>						
<i>This claim event covers kidney failure with severe impairment, meeting the criteria in the contractual definition above. This must be confirmed by a specialist (nephrologist or urologist).</i>						
Kidney transplant						
Contractual definition: <ul style="list-style-type: none">• 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.	100	50	100	50	100	50
<i>This must be confirmed by a specialist with supporting evidence.</i>						
<i>Layman's explanation:</i> <i>This claim event covers:</i> <ul style="list-style-type: none">– The undergoing of a complete kidney transplant as a recipient, to replace a diseased kidney, or– Confirmation of being on a recognised national South African transplant waiting list, awaiting a complete kidney transplant.						
<i>This must be confirmed by a specialist with supporting evidence.</i>						
Loss of bladder function						

Impairment Claim event	Percentage of cover amount					
	Extended Income		Income Plus		Impairment Income	
Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70	
Contractual definition: Loss of bladder function due to organic cause, which despite optimal medical treatment requires frequent catheterisation (at least weekly). This must be confirmed by a urologist.	-	-	45	22.5	45	22.5
Layman's explanation: <i>This claim event covers loss of bladder function, not due to a psychological cause. The life insured must require frequent catheterisation (at least weekly) despite optimal medical treatment. This must be confirmed by a specialist (urologist).</i>						
<i>Catheterisation is when a plastic tube (a catheter) is inserted into the bladder to provide urinary drainage.</i>						
Bladder or urethral disease						
Contractual definition: Bladder or urethral disease of organic cause resulting in complete urinary incontinence, which despite optimal medical treatment, requires indwelling catheterisation. This must be confirmed by a urologist.	100	50	100	50	100	50
Layman's explanation: <i>This claim event covers bladder or urethral disease, not due to a psychological cause. The following criteria must be met:</i>						
– <i>The disease must result in uncontrolled leakage of urine despite optimal medical treatment, and</i>						
– <i>It must require permanent catheterisation to provide continuous urinary drainage.</i>						
<i>This must be confirmed by a specialist (urologist).</i>						
<i>Catheterisation is when a plastic tube (a catheter) is inserted into the bladder to provide urinary drainage.</i>						
Surgical removal of the bladder						
Contractual definition: The surgical excision of the bladder by a surgeon, confirmed with a surgical report by an urologist or surgeon.	100	50	100	50	100	50
Layman's explanation: <i>This claim event covers the removal of the entire bladder by surgery. A surgical report from a specialist (urologist or surgeon) needs to confirm this.</i>						

Impairment Claim event	Percentage of cover amount					
	Before age 70	Extended Income From age 70	Before age 70	Extended Income Plus From age 70	Before age 70	Impairment Income From age 70
Musculoskeletal system						
Amputation of a thumb						
Contractual definition: The amputation of a thumb, at the interphalangeal level and proximal to the joint, by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	-	-	-	-	30*	15
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of a thumb at the first joint. This must be confirmed by a specialist with supporting evidence.</i>						
Amputation of three fingers other than the thumb						
Contractual definition: The amputation of 3 fingers other than the thumb on the same hand, at the proximal interphalangeal joint or more proximal than this joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	-	-	-	-	15*	7.5
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of 3 fingers, excluding the thumb on the same hand, at the level of the middle knuckles. This must be confirmed by a specialist with supporting evidence.</i>						
Amputation of three fingers, including the thumb						
Contractual definition: The amputation of 3 fingers, including the thumb, on the same hand, at the proximal interphalangeal joint or more proximal than this joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	-	-	-	-	45*	22.5
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of 3 fingers including the thumb on the same hand – the thumb at the first joint and the other fingers at the level of the middle knuckles. This must be confirmed by a specialist with supporting evidence.</i>						
Amputation of four fingers other than the thumb						
Contractual definition: The amputation of 4 fingers other than the thumb on the same hand, at the proximal interphalangeal joint or more proximal than this joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	-	-	-	-	45*	22.5
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of 4 fingers excluding the thumb on the same hand, at the level of the middle knuckles. This must be confirmed by a specialist with supporting evidence.</i>						
Amputation of a hand						

Impairment Claim event	Percentage of cover amount					
	Extended Income		Extended Income Plus		Impairment Income	
	Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70
Contractual definition: The amputation of a hand at the wrist by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	-	-	70	35	70	35
Layman's explanation: <i>The surgical or traumatic removal or severance of a hand at the wrist. This must be confirmed by a specialist with supporting evidence.</i>						
Loss of use of a hand						
Contractual definition:	-	-	70	35	70	35
• The permanent loss of function of an entire hand from the wrist (distal to the wrist), or • The permanent loss of function of an upper limb, with at least 60% impairment of the limb according to the latest American Medical Association (AMA) guidelines.						
This must be confirmed by a specialist with supporting evidence.						
Layman's explanation: <i>This claim event covers:</i>						
– The permanent loss of function of an entire hand from the wrist, or – The permanent loss of use of an arm (upper limb), meeting the criteria in the contractual definition above.						
<i>This must be confirmed by a specialist with supporting evidence.</i>						
Amputation of an arm below the elbow						
Contractual definition: The amputation of an arm distal to the elbow by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	-	-	75	37.5	75	37.5
Layman's explanation: <i>The surgical or traumatic removal or severance of an arm below the elbow. This must be confirmed by a specialist with supporting evidence.</i>						
Loss of use of an arm						
Contractual definition:	-	-	75	37.5	75	37.5
• The permanent loss of function of an entire arm from the shoulder (distal to the shoulder), or • The permanent loss of function of an upper limb, with at least 90% impairment of the limb according to the latest American Medical Association (AMA) guidelines.						
This must be confirmed by a specialist with supporting evidence.						
Layman's explanation: <i>This claim event covers:</i>						
– The permanent loss of use of an entire arm from the shoulder, or – The permanent loss of use of an arm (upper limb), meeting the criteria in the contractual definition above.						
<i>This must be confirmed by a specialist with supporting evidence.</i>						

Impairment Claim event	Percentage of cover amount					
	Extended Income		Extended Income Plus		Impairment Income	
Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70	
Amputation of an arm above the elbow						
Contractual definition: The amputation of an arm proximal to the elbow by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	-	-	80	40	80	40
Layman's explanation: <i>The surgical or traumatic removal or severance of an arm above the elbow. This must be confirmed by a specialist with supporting evidence.</i>						
Amputation of a foot						
Contractual definition: The amputation of a foot at the level of the ankle joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	-	-	30	15	30	15
Layman's explanation: <i>The surgical or traumatic removal or severance of a foot at the ankle joint. This must be confirmed by a specialist with supporting evidence.</i>						
Loss of use of a foot						
Contractual definition: The permanent loss of function of an entire foot from the ankle (distal to the ankle). This must be confirmed by a specialist with supporting evidence.	-	-	30	15	30	15
Layman's explanation: <i>The permanent loss of use of an entire foot from the ankle. This must be confirmed by a specialist with supporting evidence.</i>						
Amputation of a leg below the knee						
Contractual definition: The amputation of a leg distal to the knee joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	-	-	50	25	50	25
Layman's explanation: <i>The surgical or traumatic removal or severance of a leg below the knee. This must be confirmed by a specialist with supporting evidence.</i>						
Loss of use of a lower leg						
Contractual definition: <ul style="list-style-type: none"> • The permanent loss of function of an entire leg from below the knee (below and distal to the knee joint), or • The permanent loss of function of a lower limb, with at least 60% impairment of the limb according to the latest American Medical Association (AMA) guidelines. This must be confirmed by a specialist with supporting evidence.	-	-	50	25	50	25
Layman's explanation: <i>This claim event covers:</i>						

Impairment Claim event	Percentage of cover amount					
	Extended Income		Extended Income Plus		Impairment Income	
Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70	
<ul style="list-style-type: none"> – <i>The permanent loss of use of an entire leg from below the knee, or</i> – <i>The permanent loss of use of a leg (lower limb), meeting the criteria in the contractual definition above.</i> <p><i>This must be confirmed by a specialist with supporting evidence.</i></p>						
Loss of use of a leg						
Contractual definition:	-	-	75	37.5	75	37.5
<ul style="list-style-type: none"> • The permanent loss of function of an entire leg (proximal and distal to the knee joint), or • The permanent loss of function of a lower limb, with at least 90% impairment of the limb according to the latest American Medical Association (AMA) guidelines. <p><i>This must be confirmed by a specialist with supporting evidence.</i></p> <p><i>Layman's explanation:</i></p> <p><i>This claim event covers:</i></p> <ul style="list-style-type: none"> – <i>The permanent loss of use of an entire leg, or</i> – <i>The permanent loss of use of a leg (lower limb), meeting the criteria in the contractual definition above.</i> <p><i>This must be confirmed by a specialist with supporting evidence.</i></p>						
Amputation of a leg above the knee						
Contractual definition: The amputation of a leg proximal to the knee joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	-	-	75	37.5	75	37.5
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of a leg above the knee. This must be confirmed by a specialist with supporting evidence.</i>						
Amputation or loss of a combination of two limbs or an eye						
Contractual definition: The amputation or loss of any 2 of the following, due to the same cause, provided they are not part of the same limb:	100	50	100	50	100	50
<ul style="list-style-type: none"> • Amputation of a hand • Amputation of an arm below the elbow • Amputation of an arm above the elbow • Amputation of a foot • Amputation of a leg below the knee • Amputation of a leg above the knee • Loss of an eye. <p>Each amputation or loss must meet the definition of the individual claim event as described in this table and must be confirmed by a specialist with supporting evidence.</p>						

Impairment Claim event	Percentage of cover amount					
	Extended Income		Extended Income Plus		Impairment Income	
Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70	
Loss of use of a combination of two limbs or an eye						
Contractual definition: The permanent loss of function of any 2 of the following, due to the same cause, provided they are not part of the same limb:	100	50	100	50	100	50
<ul style="list-style-type: none"> • Loss of use of a hand • Loss of use of an arm • Loss of use of a foot • Loss of use of a lower leg • Loss of use of a leg • Total loss of vision of one eye or hemianopia of one eye. <p>Each loss must meet the definition of the individual claim event as described in this table and must be confirmed by a specialist with supporting evidence.</p>						
Chronic back and neck pain						
Contractual definition: Chronic back or neck pain, where the neck and back are both part of the spine. Only one claim for spinal pain will be allowed per spinal region.	-	-	25	12.5	25	12.5
<p>The spinal regions are the following:</p> <ul style="list-style-type: none"> • The cervical region (C1 to C7), and • The thoracic region (T1 to T12), and • The lumbosacral region (L1 to S1). <p>The C7 to T1 joint will be classified in the cervical region, and the T12 to L1 joint in the lumbosacral region.</p> <p>One of the following four diagnoses must be made as the cause of chronic pain:</p> <ul style="list-style-type: none"> • 50% compression of a vertebral body, or • Clinically significant radiculopathy, verified by an imaging study that confirms a herniated disc at the level and side as found clinically, and verified by electrodiagnostic testing, or • Alteration of motion segment integrity (instability), using flexion and extension radiographs, or • A back or cervical operation comprising laminectomy, discectomy or fusion, or a combination thereof. <p>In all four of the above diagnoses the clinical findings, pain distribution and findings on special examinations must make pathophysiological sense. The chronic pain will be evaluated by the following criteria:</p> <ul style="list-style-type: none"> • pain questionnaires, and • pain diagrams, and • analgesic medication usage. <p>This must be confirmed by an orthopaedic specialist or neurosurgeon with supporting evidence.</p> <p><i>Layman's explanation:</i> <i>Long-standing back and neck pain (where the neck and the back are both part of the spine). Only one claim for spinal pain will be allowed per spinal section.</i></p>						

Impairment Claim event	Percentage of cover amount					
	Before age 70	Extended Income	Before age 70	Extended Income Plus	Before age 70	Impairment Income
	From age 70		From age 70		From age 70	From age 70
The spinal sections are: <ul style="list-style-type: none"> - Cervical – holds up the head - Thoracic – ribs are attached - Lumbar – lower back. The pain must be due to one of the following causes: <ul style="list-style-type: none"> - A back bone (vertebra) having lost half of its height due to compression. <p>Compression of a vertebral body is when one or more back bones (vertebrae) collapse into itself and become squashed (compressed), or</p> <ul style="list-style-type: none"> - Significant signs of a pinched nerve, which is confirmed by specialised testing (MRI and electrodiagnostic testing), or - Proven instability of vertebrae on x-rays, or - A back or neck operation as stipulated in the contractual definition above. <p>This must be confirmed by a specialist (orthopaedic specialist or neurosurgeon), with the evidence provided as stipulated in the contractual definition above.</p>						
Cancer						
Malignant tumours of the spinal cord and vertebral column						
Contractual definition: The incontrovertible presence of uncontrolled growth and spread of malignant cells, the invasion of normal tissue, and the definite histological evidence of a malignant growth in the spinal cord and vertebral column. This must be confirmed by an oncologist, with supporting objective evidence.	-	-	50	25	50	25
Layman's explanation: Cancer of the spinal cord or vertebral column, confirmed by taking a sample of tissue of the area and confirming the presence of cancerous cells in these areas. A clinical report is required from a specialist (oncologist).						
Stage III cancer						
Contractual definition: Any stage III cancer, confirmed by an oncologist with supporting objective evidence, with the permanent inability to do 2 or more basic activities of daily living (ADLs) and 2 or more advanced activities of daily living (ADLs). These ADLs are indicated in the tables "Basic activities of daily living for impairment cover" and "Advanced activities of daily living for impairment cover" later in this document.	100	50	100	50	100	50
Layman's explanation: This claim event covers stage III cancer, meeting the criteria in the contractual definition above. A clinical report is required from a specialist (oncologist).						
Cancer prevents cells from dying when they should and causes new cells to form when the body does not need them. These cells are able to invade other tissues and spread to other parts of the body through the blood and lymph systems.						
Stage III cancer is cancer with regional spread - the cancer has spread within the general region in which it first began, and into the lymph nodes but not to other parts of the body.						

Impairment Claim event	Percentage of cover amount					
	Extended Income		Extended Income Plus		Impairment Income	
Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70	Before age 70
Stage IV cancer						
Contractual definition: Any stage IV cancer, confirmed by an oncologist with supporting objective evidence.	100	50	100	50	100	50
<i>Layman's explanation:</i> <i>Cancer prevents cells from dying when they should and causes new cells to form when the body does not need them. These cells are able to invade other tissues and spread to other parts of the body through the blood and lymph systems.</i>						
<i>This claim event covers stage IV cancer, which is cancer with distant spread (cancer that has spread to other parts of the body). A clinical report is required from a specialist (oncologist).</i>						
Visual system						
Total loss of vision of one eye or hemianopia of one eye						
Contractual definition: Total and permanent loss of vision of one eye or permanent hemianopia of one eye as a result of an organic cause, confirmed by an ophthalmologist with supporting evidence.	-	-	25	12.5	25	12.5
<i>Layman's explanation:</i> <i>This claim event covers the total and permanent loss of vision of one eye or permanent loss of either the left or right half of the visual field of one eye, not due to a psychological cause. This must be confirmed by a specialist (ophthalmologist) with supporting documents.</i>						
Loss of an eye						
Contractual definition: Complete enucleation of one eye due to injury or disease, confirmed by an ophthalmologist with supporting evidence.	-	-	50	25	50	25
<i>Layman's explanation:</i> <i>The complete removal of one eye from its socket as a result of trauma or surgery, confirmed by a specialist (ophthalmologist) with supporting documents.</i>						
Partial loss of vision of both eyes						
Contractual definition: Permanent bilateral visual impairment of 50% as a result of an organic cause, confirmed by an ophthalmologist with supporting evidence and meeting the following criteria:	-	-	50	25	50	25
<ul style="list-style-type: none"> • A reading of at least 20/125 (or equivalent measure) in each eye, or • Diabetic retinopathy grade III or grade III retinopathy as a result of a chronic disease in each eye, or • A visual field loss to a 20° radius of each eye. 						
<i>Layman's explanation:</i> <i>This claim event covers permanent decreased vision of 50%, not due to a psychological cause. It must meet the criteria described in the contractual definition above and must be confirmed by a specialist (ophthalmologist).</i>						

Impairment Claim event	Percentage of cover amount					
	Extended Income		Income Plus		Impairment Income	
Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70	Before age 70
Total loss of vision of both eyes or blindness of both eyes						
Contractual definition: Total and permanent loss of vision in both eyes or blindness of both eyes by visual acuity or retinal pathology or visual field measurements, as a result of an organic cause, confirmed by an ophthalmologist with supporting evidence and meeting the following criteria: Bilateral visual impairment of 70%, with evidence of 1 of the following: <ul style="list-style-type: none">• A reading of at least 20/200 (or equivalent measure) in each eye, or• Diabetic retinopathy grade IV or grade IV retinopathy as a result of a chronic disease of each eye, or• Permanent hemianopia of both eyes, or• A visual field loss to a 10° radius of each eye. <i>Layman's explanation:</i> <i>This claim event covers the total and permanent loss of vision of both eyes or blindness of both eyes, not due to a psychological cause. It must meet the criteria described in the contractual definition above, and must be confirmed by a specialist (ophthalmologist).</i>	100	50	100	50	100	50
Hearing						
Total loss of hearing in one ear						
Contractual definition: The total and permanent loss of hearing in one ear as confirmed by an ear, nose and throat surgeon, with objective audiology evidence, recording an average loss of at least 70dB across all measured frequencies.	-	-	25	12.5	25	12.5
Partial loss of hearing in both ears						
Contractual definition: The permanent loss of hearing of 60% or more in both ears as confirmed by an ear, nose and throat surgeon, with objective audiology evidence, recording an average loss of 70-87dB across all measured frequencies.	-	-	50	25	50	25
Total loss of hearing in both ears						
Contractual definition: The total and permanent loss of hearing in both ears as confirmed by an ear, nose and throat surgeon with objective audiology evidence, recording an average loss of greater than 87dB across all measured frequencies.	100	50	100	50	100	50
Speech						
Aphasia						
Contractual definition: Total and permanent loss of the ability to speak as a result of an organic brain disease, confirmed by a neurosurgeon or neurologist. <i>Layman's explanation:</i> <i>This claim event covers the total and permanent loss of the ability to speak, not due to a psychological cause. This must be confirmed by a specialist (neurosurgeon or neurologist).</i>	100	50	100	50	100	50

Impairment Claim event	Percentage of cover amount					
	Extended Income		Income Plus		Impairment Income	
	Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70
Partial loss of speech						
Contractual definition: Partial and permanent loss of the ability to speak as a result of organic ear, nose and throat (ENT) disease, affecting daily activity, confirmed by an ear, nose and throat specialist.	-	-	50	25	50	25
<i>Layman's explanation:</i> <i>This claim event covers the partial and permanent loss of the ability to speak as a result of confirmed disease of the ear, nose and throat organ, not due to a psychological cause. This must be confirmed by a specialist (ear, nose and throat specialist).</i>						
Total loss of speech						
Contractual definition: Total and permanent loss of the ability to speak as a result of organic ear, nose and throat (ENT) disease, confirmed by an ear, nose and throat specialist.	100	50	100	50	100	50
<i>Layman's explanation:</i> <i>This claim event covers the total and permanent loss of the ability to speak as a result of confirmed disease of the ear, nose and throat organ, not due to a psychological cause. This must be confirmed by a specialist (ear, nose and throat specialist).</i>						
Psychiatric conditions						
Psychiatric condition						
Contractual definition: Psychiatric condition with frequent, extended admissions, meeting the following criteria: <ul style="list-style-type: none"> • Institutionalised in a registered psychiatric facility at least 3 times during the last 12 months, with each admission lasting for longer than 6 weeks, and • Global Assessment Function (GAF) score of less than 40, and • Must be confirmed by a specialist. OR	-	-	50	25	50	25
Psychiatric condition with one prolonged admission: The diagnosis of a psychiatric disorder, as per the latest Diagnostic and Statistical Manual of Mental Disorders (DSM) classification, meeting the following criteria: <ul style="list-style-type: none"> • Institutionalised in a registered psychiatric facility for more than 6 consecutive months, and • Undergoing of constant supervision with a permanent caregiver, and • Global Assessment Function (GAF) score of 30 or less, and • Must be confirmed by at least 2 independent psychiatric reports by the relevant specialists. 						

Impairment Claim event	Percentage of cover amount					
	Extended Income		Extended Income Plus		Impairment Income	
	Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70
Contractual definition: Psychiatric condition with permanent institutionalisation: The diagnosis of a psychiatric disorder, as per the latest Diagnostic and Statistical Manual of Mental Disorders (DSM) classification, meeting the following criteria: <ul style="list-style-type: none"> • Permanent institutionalisation in a registered psychiatric facility, and • Undergoing of constant supervision with a permanent caregiver, and • Global Assessment Function (GAF) score of 30 or less, and • Must be confirmed by at least 2 independent psychiatric reports by the relevant specialists. 	100	50	100	50	100	50
Face and skin						
Facial disfigurement						
Contractual definition: Severe facial disfigurement despite more than two corrective facial surgical procedures by a registered plastic or maxillo facial surgeon, resulting in social withdrawal. The severity of the disfigurement and the social withdrawal must be confirmed by the relevant specialists.	-	-	50	25	50	25
Third-degree burns						
Contractual definition: Third-degree burns, full thickness of the skin, covering at least 20% of the total body surface, confirmed by a surgeon.	-	-	50	25	50	25
<i>Layman's explanation:</i> <i>Burn wounds to all three layers of the skin which affect at least 20% of the body's surface, as measured with a Lund and Browder chart, or a similar chart. This must be confirmed by a specialist (surgeon).</i>						
Contractual definition: Third-degree burns, full thickness of the skin, covering at least 30% of the total body surface, confirmed by a surgeon.	100	50	100	50	100	50
<i>Layman's explanation:</i> <i>Burn wounds to all three layers of the skin which affect at least 30% of the body's surface, as measured with a Lund and Browder chart, or a similar chart. This must be confirmed by a specialist (surgeon).</i>						
HIV						
Advanced HIV						
Contractual definition: <ul style="list-style-type: none"> • Advanced HIV despite optimal treatment by a relevant HIV medical practitioner and full adherence to prescribed antiretroviral therapy for more than 3 years, a permanent CD4 cell count of less than 50 measured 6 months apart and a positive PCR, or • Advanced HIV despite optimal treatment by a relevant HIV medical practitioner and full adherence to prescribed antiretroviral therapy for more than 3 years, a persistent 	100	50	100	50	100	50

Impairment Claim event	Percentage of cover amount			
	Before age 70	Extended Income	Before age 70	Extended Income Plus
	From age 70	From age 70	From age 70	Impairment Income
From age 70				
<p>CD4 cell count of less than 200 measured 6 months or more apart and a positive PCR;</p> <p>AND</p> <p>At least one of the following diseases must be diagnosed:</p> <ul style="list-style-type: none"> • Kaposi's sarcoma, or • Pneumocystis jirovecii pneumonia (PJP), or • Confirmed progressive multifocal leukoencephalopathy, or • Active extra-pulmonary tuberculosis, or • Cryptococcosis, or • Disseminated non-tuberculous mycobacteria infection, or • Confirmed diagnosis of any other condition as defined as stage 4 on the World Health Organisation (WHO) clinical criteria list. <p><i>Layman's explanation:</i></p> <ul style="list-style-type: none"> – Human immune virus (HIV) infection optimally treated by a doctor who manages patients with HIV. Despite the life insured's compliance to treatment for more than 3 years, the CD4 test (blood test for immune cells) remains below 50 continuously when measured every 6 months, and the PCR test (a specialised HIV detection blood test) remains positive, or – HIV infection optimally treated by a doctor who manages patients with HIV. Despite the life insured's compliance to treatment for more than 3 years, the CD4 test (blood test for immune cells) remains below 200 continuously when measured every 6 months, and the PCR test (a specialised HIV detection blood test) remains positive; <p>AND</p> <p>One of the following diseases must be diagnosed:</p> <ul style="list-style-type: none"> – Kaposi sarcoma (KS), which is a cancer that causes patches of abnormal tissue to grow under the skin, in the lining of the mouth, nose and throat, in lymph nodes, or in other organs, or – Pneumocystis jirovecii pneumonia (PJP), which is a type of pneumonia caused by a fungal infection, or – Progressive multiple leukoencephalopathy, which is a serious disease of the brain that causes progressive damage or inflammation of the white matter of the brain in many areas, or – Active extra-pulmonary tuberculosis, which is active tuberculosis in organs of the body other than the lungs, or – Cryptococcosis, which is a disease caused by fungus which is inhaled and spreads to the brain, or – Disseminated non-tuberculous mycobacteria infection, which is a widespread infection in the body by organisms which are related to the tuberculosis family, but which does not cause tuberculosis, or <p>Confirmed diagnosis of any other condition, with a World Health Organisation classification of severe stage of HIV infection (stage IV).</p>				

Impairment Claim event	Percentage of cover amount					
	Extended Income		Extended Income Plus		Impairment Income	
Before age 70	From age 70	Before age 70	From age 70	Before age 70	From age 70	Before age 70
Activities of daily living / Catch-all / Frail care						
Activities of daily living						
Contractual definition: The permanent inability to perform independently 2 or more basic activities of daily living (ADLs) and 2 or more advanced activities of daily living (ADLs). These ADLs are indicated in the tables "Basic activities of daily living for impairment cover" and "Advanced activities of daily living for impairment cover" later in this document. This must be confirmed by the treating health professional.	-	-	50	25	50	25
Contractual definition: The permanent inability to perform independently 3 or more basic activities of daily living (ADLs). These ADLs are indicated in the table "Basic activities of daily living for impairment cover" later in this document. This must be confirmed by the treating health professional.	100	50	100	50	100	50

*This claim event is payable for a period of 12 months only.

Basic activities of daily living for impairment cover

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

Advanced activities of daily living for impairment cover

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

Impairment Claim Events for Accidental Benefits

The impairment claim events with their contractual definitions, layman's explanations, where applicable, and percentages of the cover amount are indicated in the table below for the following benefits:

- Accidental Temporay Income Plus
- Accidental Extended Income Plus
- Impairment claim events from the early of retirement and age 70 can be found at the following link
[ImpairmentClaimEventsAccidentalBenefits](#)

The contractual definitions will apply when we consider a claim. The layman's explanations are provided for a better understanding of the claim events but will not be used in the legal interpretation of the claim events.

For multiple claims, we may pay a lower percentage than indicated in the table below.

Accidental Extended Income Plus with a fixed cease age:

Only the percentages in the column headed *before age 70* are applicable.

Whole life Accidental Extended Income Plus benefit:

At age 70, the percentages of the cover amount in the claim event table will reduce by 50%, as indicated in the column headed *from age 70*. For claims that we admit before age 70, the income payment will reduce by 50% at age 70, in line with the reduced percentages that apply from age 70. For claims that we admit from age 70, the reduced percentages will apply from the start. The payment for the benefit will however not be reduced.

Impairment Claim Events Table

Impairment Claim event	Percentage of cover amount		
	Before age 70	From age 70	Accidental Extended Income Plus
Central nervous system			
Coma			
Contractual definition: A condition of unconsciousness not induced by sedation, where the life insured presents with a Glasgow Coma Scale reading of 8 or less for an uninterrupted period of at least 96 hours. This must be confirmed by a specialist.	100	100	50
Layman's explanation: <i>This claim event covers coma, where there is a state of unconsciousness not induced by medication causing a state of sleep. Specific criteria must be met, as described in the contractual definition above. This must be confirmed by a specialist.</i>			

	Impairment Claim event	Percentage of cover amount		
		Before age 70	Accidental Temporary Income Plus	Accidental Extended Income Plus
Hemiplegia				
Contractual definition: The total and permanent loss of muscle function of one side of the body due to injury to the spinal cord or brain.		100	100	50
The following is required:				
<ul style="list-style-type: none"> • Radiological evidence such as a computed tomography (CT) scan or magnetic resonance imaging (MRI), and • Must be confirmed by a neurologist or neurosurgeon. 				
Diplegia				
Contractual definition: The total and permanent loss of muscle function of both sides of the body due to injury to the spinal cord or brain.		100	100	50
The following is required:				
<ul style="list-style-type: none"> • Radiological evidence, such as a computed tomography (CT) scan or magnetic resonance imaging (MRI), and • Must be confirmed by a neurologist or neurosurgeon. 				
<i>Layman's explanation:</i> <i>This claim event covers diplegia, meeting the criteria in the contractual definition above. This must be confirmed by a specialist (neurologist or neurosurgeon).</i>				
<i>Diplegia is a total and permanent weakness of the same part on both sides of the body, which can be as a result of an injury.</i>				
Paraplegia				
Contractual definition: The total and permanent loss of muscle function resulting in the loss of use of both legs due to injury to the spinal cord or brain.		100	100	50
The following is required:				
<ul style="list-style-type: none"> • Radiological evidence such as a computed tomography (CT) scan or magnetic resonance imaging (MRI), and • Must be confirmed by a neurologist or neurosurgeon. 				
Quadriplegia				

	Impairment Claim event	Percentage of cover amount		
		Accidental Temporary Income Plus	Before age 70 Accidental Extended Income Plus	From age 70
Contractual definition: The total and permanent loss of muscle function resulting in the loss of use of both arms and both legs due to injury to the spinal cord or brain.		100	100	50
The following is required: <ul style="list-style-type: none"> • Radiological evidence such as a computed tomography (CT) scan or magnetic resonance imaging (MRI), and • Must be confirmed by a neurologist or neurosurgeon. 				
Cranial nerve V				
Contractual definition: Cranial nerve V pathology with severe trigeminal neuralgia, meeting the following criteria: The diagnosis of treatment resistant, severe unilateral or bilateral facial neuralgic pain by a neurologist, with evidence of treatment resistance as well as the need for decompression surgery.		45	45	22.5
<i>Layman's explanation:</i> <i>The trigeminal nerve (the 5th cranial nerve) is a nerve responsible for sensation in the face and functions such as biting and chewing.</i>				
<i>This claim event covers severe chronic pain in this nerve area, meeting the following criteria: Diagnosis by a specialist (neurologist) of treatment resistant, severe one-sided or both-sided facial nerve pain, with evidence of treatment resistance as well as the need for decompression surgery.</i>				
Cranial nerve VII				
Contractual definition: Cranial nerve VII paralysis with severe unilateral upper motor neuron facial paralysis, involving more than 75% of the facial muscles, and inability to control eyelid closure. This must be confirmed by a neurologist.		50	50	25
<i>Layman's explanation:</i> <i>The facial nerve (the 7th cranial nerve) controls the muscles of facial expression, and functions in taste sensations of two-thirds of the tongue.</i>				
<i>This claim event covers paralysis of this nerve with upper motor neuron facial paralysis of more than 75% of the facial muscles and inability to close eyelids. This must be confirmed by a specialist (neurologist).</i>				
Cranial nerve VIII				

	Impairment Claim event	Percentage of cover amount		
		Accidental Temporary Income Plus	Before age 70 Accidental Extended Income Plus	From age 70
Contractual definition: Cranial nerve VIII paralysis or imbalance with moderately severe equilibrium impairment, with limitations of all activities of daily living (ADLs), and requiring permanent assistance with self-care. These ADLs are indicated in the tables "Basic activities of daily living for impairment cover" and "Advanced activities of daily living for impairment cover" later in this document. This must be confirmed by a neurologist or ear, nose and throat surgeon.		50	50	25
<i>Layman's explanation:</i> <i>The 8th cranial nerve transmits sound and balance information from the inner ear to the brain.</i> <i>This claim event covers paralysis of this nerve with moderate balance disturbance, with limitations in all activities of daily living (ADLs) and requiring permanent assistance with self-care. This must be confirmed by a specialist (neurologist or ear, nose and throat surgeon).</i>				
Contractual definition: Cranial nerve VIII paralysis or imbalance with severe equilibrium impairment, with limitations of all activities of daily living (ADLs), requiring permanent assistance with self-care and permanent confinement to a bed or wheelchair. These ADLs are indicated in the tables "Basic activities of daily living for impairment cover" and "Advanced activities of daily living for impairment cover" later in this document. This must be confirmed by a neurologist.		75	75	37.5
<i>Layman's explanation:</i> <i>The 8th cranial nerve transmits sound and balance information from the inner ear to the brain.</i> <i>This claim event covers paralysis of this nerve with severe balance disturbance, with limitations in all activities of daily living (ADLs) and requiring permanent assistance with self-care and permanent confinement to a bed or wheelchair. This must be confirmed by a specialist (neurologist).</i>				
Cranial nerves IX, X or XII				

Impairment Claim event	Percentage of cover amount		
	Accidental Temporary Income Plus	Before age 70 Accidental Extended Income Plus	From age 70
Contractual definition: Cranial nerves IX, X or XII paralysis or dysarthria or dysphagia, with moderately severe dysarthria or dysphagia with hoarseness, nasal regurgitation and aspiration of fluids. This must be confirmed by a neurologist.	25	25	12.5
Contractual definition: Cranial nerves IX, X or XII paralysis or dysarthria or dysphagia, with moderately severe dysarthria or dysphagia with hoarseness, nasal regurgitation and aspiration of fluids. This must be confirmed by a neurologist.			
<i>Layman's explanation:</i> <i>This claim event covers paralysis of cranial nerves 9, 10 or 12, with moderate difficulty with swallowing, hoarseness, difficulty with speech, accidental inhalation of fluids into the lungs or airway or passage of food through the nasal passages. This must be confirmed by a specialist (neurologist).</i>			
Cranial nerves IX, X or XII paralysis or dysarthria or dysphagia, with severe functional inability to swallow without choking and with the need for assistance and suctioning. This must be confirmed by a neurologist.	75	75	37.5
<i>Layman's explanation:</i> <i>This claim event covers paralysis of cranial nerves 9, 10 or 12, with severe inability to swallow without choking with the need for assistance and suctioning. This must be confirmed by a specialist (neurologist).</i>			
Neurologic impairment of respiration			
Contractual definition: Neurologic impairment of respiration, where the life insured is capable of spontaneous respiration, but is restricted to sitting, standing or limited ambulation. This must be confirmed by a neurologist.	50	50	25
<i>Layman's explanation:</i> <i>This claim event covers impairment of breathing due to neurological cause or reason, where the life insured is capable of spontaneous breathing, but is restricted to sitting or standing with limited ambulation. This must be confirmed by a specialist (neurologist).</i>			

	Impairment Claim event	Percentage of cover amount		
		Accidental Temporary Income Plus	Before age 70	From age 70 Accidental Extended Income Plus
Contractual definition: Neurologic impairment of respiration with severe functional impairment where the life insured is capable of spontaneous respiration, but to such a limited degree that he or she is permanently confined to a bed. This must be confirmed by a <i>specialist</i> (neurologist).		75	75	37.5
<i>Layman's explanation:</i> <i>This claim event covers impairment of breathing due to neurological cause or reason, where the life insured is capable of spontaneous breathing, but is limited to such a degree that he or she is permanently confined to a bed. This must be confirmed by a specialist (neurologist).</i>				
Contractual definition: Neurologic impairment of respiration to such an extent that there is no spontaneous respiration. This must be confirmed by a neurologist.		100	100	50
<i>Layman's explanation:</i> <i>This claim event covers impairment of breathing due to neurological cause or reason, where the life insured is incapable of spontaneous breathing. This must be confirmed by a specialist (neurologist).</i>				
Renal system				
Surgical removal of the bladder				
Contractual definition: The surgical excision of the bladder by a surgeon, confirmed with a surgical report by an urologist or surgeon.		100	100	50
<i>Layman's explanation:</i> <i>This claim event covers the removal of the entire bladder by surgery. A surgical report from a specialist (urologist or surgeon) needs to confirm this.</i>				
Musculoskeletal system				
Amputation of a thumb				
Contractual definition: The amputation of a thumb, at the interphalangeal level and proximal to the joint, by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.		30*	-	-
<i>Layman's explanation:</i>				

Impairment Claim event	Percentage of cover amount		
	Accidental Temporary Income Plus	Accidental Extended Income Plus	From age 70
Before age 70	From age 70		
<i>The surgical or traumatic removal or severance of a thumb at the first joint. This must be confirmed by a specialist with supporting evidence.</i>			
Amputation of three fingers other than the thumb			
Contractual definition: The amputation of 3 fingers other than the thumb on the same hand, at the proximal interphalangeal joint or more proximal than this joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	15*	-	-
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of 3 fingers, excluding the thumb on the same hand, at the level of the middle knuckles. This must be confirmed by a specialist with supporting evidence.</i>			
Amputation of three fingers, including the thumb			
Contractual definition: The amputation of 3 fingers, including the thumb, on the same hand, at the proximal interphalangeal joint or more proximal than this joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	45*	-	-
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of 3 fingers including the thumb on the same hand – the thumb at the first joint and the other fingers at the level of the middle knuckles. This must be confirmed by a specialist with supporting evidence.</i>			
Amputation of four fingers other than the thumb			
Contractual definition: The amputation of 4 fingers other than the thumb on the same hand, at the proximal interphalangeal joint or more proximal than this joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	45*	-	-
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of 4 fingers excluding the thumb on the same hand, at the level of the middle knuckles. This must be confirmed by a specialist with supporting evidence.</i>			
Amputation of a hand			

Impairment Claim event	Percentage of cover amount		
	Accidental Temporary Income Plus	Before age 70 Accidental Extended Income Plus	From age 70
Contractual definition: The amputation of a hand at the wrist by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	70	70	35
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of a hand at the wrist. This must be confirmed by a specialist with supporting evidence.</i>			
Loss of use of a hand			
Contractual definition: <ul style="list-style-type: none"> • The permanent loss of function of an entire hand from the wrist (distal to the wrist), or • The permanent loss of function of an upper limb, with at least 60% impairment of the limb according to the latest American Medical Association (AMA) guidelines. This must be confirmed by a specialist with supporting evidence.	70	70	35
<i>Layman's explanation:</i> <i>This claim event covers:</i> <ul style="list-style-type: none"> – <i>The permanent loss of function of an entire hand from the wrist, or</i> – <i>The permanent loss of use of an arm (upper limb), meeting the criteria in the contractual definition above.</i> <i>This must be confirmed by a specialist with supporting evidence.</i>			
Amputation of an arm below the elbow			
Contractual definition: The amputation of an arm distal to the elbow by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	75	75	37.5
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of an arm below the elbow. This must be confirmed by a specialist with supporting evidence.</i>			
Loss of use of an arm			
Contractual definition: <ul style="list-style-type: none"> • The permanent loss of function of an entire arm from the shoulder (distal to the shoulder), or 	75	75	37.5

	Percentage of cover amount			
		Accidental Temporary Income Plus	Accidental Extended Income Plus	From age 70
Impairment Claim event		Before age 70	From age 70	
<ul style="list-style-type: none"> The permanent loss of function of an upper limb, with at least 90% impairment of the limb according to the latest American Medical Association (AMA) guidelines. <p>This must be confirmed by a specialist with supporting evidence.</p> <p><i>Layman's explanation:</i> <i>This claim event covers:</i> <ul style="list-style-type: none"> <i>The permanent loss of use of an entire arm from the shoulder, or</i> <i>The permanent loss of use of an arm (upper limb), meeting the criteria in the contractual definition above.</i> </p> <p><i>This must be confirmed by a specialist with supporting evidence.</i></p>				
Amputation of an arm above the elbow		80	80	40
Contractual definition: The amputation of an arm proximal to the elbow by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence. <p><i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of an arm above the elbow. This must be confirmed by a specialist with supporting evidence.</i></p>				
Amputation of a foot		30	30	15
Contractual definition: The amputation of a foot at the level of the ankle joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence. <p><i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of a foot at the ankle joint. This must be confirmed by a specialist with supporting evidence.</i></p>				
Loss of use of a foot		30	30	15
Contractual definition: The permanent loss of function of an entire foot from the ankle (distal to the ankle). This must be confirmed by a specialist with supporting evidence. <p><i>Layman's explanation:</i></p>				

	Impairment Claim event	Percentage of cover amount		
		Accidental Temporary Income Plus	Before age 70 Accidental Extended Income Plus	From age 70
<i>The permanent loss of use of an entire foot from the ankle. This must be confirmed by a specialist with supporting evidence.</i>				
Amputation of a leg below the knee				
Contractual definition: The amputation of a leg distal to the knee joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.		50	50	25
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of a leg below the knee. This must be confirmed by a specialist with supporting evidence.</i>				
Loss of use of a lower leg				
Contractual definition: <ul style="list-style-type: none">• The permanent loss of function of an entire leg from below the knee (below and distal to the knee joint), or• The permanent loss of function of a lower limb, with at least 60% impairment of the limb according to the latest American Medical Association (AMA) guidelines. This must be confirmed by a specialist with supporting evidence.		50	50	25
<i>Layman's explanation:</i> <i>This claim event covers:</i> <ul style="list-style-type: none">– <i>The permanent loss of use of an entire leg from below the knee, or</i>– <i>The permanent loss of use of a leg (lower limb), meeting the criteria in the contractual definition above.</i> <i>This must be confirmed by a specialist with supporting evidence.</i>				
Loss of use of a leg				
Contractual definition: <ul style="list-style-type: none">• The permanent loss of function of an entire leg (proximal and distal to the knee joint), or• The permanent loss of function of a lower limb, with at least 90% impairment of the limb according to the latest American Medical Association (AMA) guidelines. This must be confirmed by a specialist with supporting evidence.		75	75	37.5
<i>Layman's explanation:</i> <i>This claim event covers:</i>				

Impairment Claim event	Percentage of cover amount		
	Accidental Temporary Income Plus	Accidental Extended Income Plus	From age 70
Before age 70			
<ul style="list-style-type: none"> – <i>The permanent loss of use of an entire leg, or</i> – <i>The permanent loss of use of a leg (lower limb), meeting the criteria in the contractual definition above.</i> <p><i>This must be confirmed by a specialist with supporting evidence.</i></p>			
Amputation of a leg above the knee			
Contractual definition: The amputation of a leg proximal to the knee joint by traumatic or surgical means. This must be confirmed by a specialist with supporting evidence.	75	75	37.5
<i>Layman's explanation:</i> <i>The surgical or traumatic removal or severance of a leg above the knee. This must be confirmed by a specialist with supporting evidence.</i>			
Amputation or loss of a combination of two limbs or an eye			
Contractual definition: The amputation or loss of any 2 of the following, due to the same cause, provided they are not part of the same limb: <ul style="list-style-type: none"> • Amputation of a hand • Amputation of an arm below the elbow • Amputation of an arm above the elbow • Amputation of a foot • Amputation of a leg below the knee • Amputation of a leg above the knee • Loss of an eye. <p>Each amputation or loss must meet the definition of the individual claim event as described in this table and must be confirmed by a specialist with supporting evidence.</p>	100	100	50
Loss of use of a combination of two limbs or an eye			
Contractual definition: The permanent loss of function of any 2 of the following, due to the same cause, provided they are not part of the same limb: <ul style="list-style-type: none"> • Loss of use of a hand • Loss of use of an arm • Loss of use of a foot 	100	100	50

	Percentage of cover amount			
		Accidental Temporary Income Plus	Accidental Extended Income Plus	From age 70
Impairment Claim event				
<ul style="list-style-type: none"> Loss of use of a lower leg Loss of use of a leg Total loss of vision of one eye or hemianopia of one eye. <p>Each loss must meet the definition of the individual claim event as described in this table and must be confirmed by a specialist with supporting evidence.</p>				
Visual system				
Total loss of vision of one eye or hemianopia of one eye				
Contractual definition: Total and permanent loss of vision of one eye or permanent hemianopia of one eye, confirmed by an ophthalmologist with supporting evidence.	25	25	12.5	
<i>Layman's explanation:</i> <i>This claim event covers the total and permanent loss of vision of one eye or permanent loss of either the left or right half of the visual field of one eye. This must be confirmed by a specialist (ophthalmologist) with supporting documents.</i>				
Loss of an eye				
Contractual definition: Complete enucleation of one eye due to injury, confirmed by an ophthalmologist with supporting evidence.	50	50	25	
<i>Layman's explanation:</i> <i>The complete removal of one eye from its socket as a result of trauma or surgery, confirmed by a specialist (ophthalmologist) with supporting documents.</i>				
Partial loss of vision of both eyes				
Contractual definition: Permanent bilateral visual impairment of 50%, confirmed by an ophthalmologist with supporting evidence and meeting the following criteria: <ul style="list-style-type: none"> A reading of at least 20/125 (or equivalent measure) in each eye, or A visual field loss to a 20° radius of each eye. 	50	50	25	
<i>Layman's explanation:</i> <i>This claim event covers permanent decreased vision of 50% in each eye. It must meet the criteria described in the contractual definition above and must be confirmed by a specialist (ophthalmologist).</i>				

Impairment Claim event	Percentage of cover amount		
	Accidental Temporary Income Plus	Accidental Extended Income Plus	From age 70
Before age 70	From age 70		
Total loss of vision of both eyes or blindness of both eyes			
Contractual definition: Total and permanent loss of vision in both eyes or blindness of both eyes by visual acuity or retinal pathology or visual field measurements, confirmed by an ophthalmologist with supporting evidence and meeting the following criteria: Bilateral visual impairment of 70%, with evidence of 1 of the following: <ul style="list-style-type: none">• A reading of at least 20/200 (or equivalent measure) in each eye, or• Permanent hemianopia of both eyes, or• A visual field loss to a 10° radius of each eye. <i>Layman's explanation:</i> <i>This claim event covers the total and permanent loss of vision of both eyes or blindness of both eyes. It must meet the criteria described in the contractual definition above, and must be confirmed by a specialist (ophthalmologist).</i>	100	100	50
Hearing			
Total loss of hearing in one ear			
Contractual definition: The total and permanent loss of hearing in one ear as confirmed by an ear, nose and throat surgeon, with objective audiology evidence, recording an average loss of at least 70dB across all measured frequencies.	25	25	12.5
Partial loss of hearing in both ears			
Contractual definition: The permanent loss of hearing of 60% or more in both ears as confirmed by an ear, nose and throat surgeon, with objective audiology evidence, recording an average loss of 70-87dB across all measured frequencies.	50	50	25
Total loss of hearing in both ears			
Contractual definition: The total and permanent loss of hearing in both ears as confirmed by an ear, nose and throat surgeon with objective audiology evidence, recording an average loss of greater than 87dB across all measured frequencies	100	100	50
Face and skin			
Facial disfigurement			
Contractual definition:	50	50	25

	Impairment Claim event	Percentage of cover amount		
		Accidental Temporary Income Plus	Accidental Extended Income Plus	From age 70
Severe facial disfigurement despite more than two corrective facial surgical procedures by a registered plastic or maxillo facial surgeon, resulting in social withdrawal. The severity of the disfigurement and the social withdrawal must be confirmed by the relevant specialists.				
Third-degree burns				
Contractual definition: Third-degree burns, full thickness of the skin, covering at least 20% of the total body surface, confirmed by a surgeon.		50	50	25
<i>Layman's explanation:</i> <i>Burn wounds to all three layers of the skin which affect at least 20% of the body's surface, as measured with a Lund and Browder chart, or a similar chart. This must be confirmed by a specialist (surgeon).</i>				
Contractual definition: Third-degree burns, full thickness of the skin, covering at least 30% of the total body surface, confirmed by a surgeon.		100	100	50
<i>Layman's explanation:</i> <i>Burn wounds to all three layers of the skin which affect at least 30% of the body's surface, as measured with a Lund and Browder chart, or a similar chart. This must be confirmed by a specialist (surgeon).</i>				
Activities of daily living / Catch-all / Frail care				
Activities of daily living				
Contractual definition: The permanent inability to perform independently 2 or more basic activities of daily living (ADLs) and 2 or more advanced activities of daily living (ADLs). These ADLs are indicated in the tables "Basic activities of daily living for impairment cover" and "Advanced activities of daily living for impairment cover" later in this document. This must be confirmed by the treating health professional.		50	50	25
The permanent inability to perform independently 3 or more basic activities of daily living (ADLs). These ADLs are indicated in the table "Basic activities of daily living for impairment cover" later in this document. This must be confirmed by the treating health professional.		100	100	50

*This claim event is payable for a period of up to 12 months or up to the payment period, whichever is shorter.

Basic activities of daily living for impairment cover

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

Advanced activities of daily living for impairment cover

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

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Why A Student Package?

Despite their age, students are not immune to major life incidents like cancer, disability or death, and have a relatively greater risk of accidents, given their age and active lifestyles. The pay-out from a risk policy can help pay for various expenses, like adapting a car after a disability or paying off student debt. Getting cover at a young age is also more affordable and less likely to have medical loadings or exclusions.

A student package lays the foundation for a risk cover portfolio to further build on when the student starts working and helps students form the financial habits necessary for living a future life of financial confidence.

With the Graduate and Professional Student Package, qualifying students can now access benefits while they are studying which will remain suitable when they commence employment.

From an intermediary point of view, a student package enables intermediaries to attract future Graduate and Professional clients while they are still studying, partnering with them in their journey toward financial confidence, retaining them as clients for life.

Availability

The Student Packages are only available to graduate and professional students, as defined by the qualifying criteria of each package.

Graduate Student Package

The Graduate Student Package is a package specifically designed for students studying toward a 3-year degree or 4-year diploma. It is available under the Premier product option of our Matrix Topcover product.

Description	The Graduate Student Package is an offer which provides students with comprehensive cover. It is offered to students from their 2nd academic year, who are studying toward a National Qualifications Framework (NQF) level 7 or higher qualification. The benefits that form part of this package will remain suitable when they commence employment. There are 2 options available to provide for different levels of cover and affordability.
Product	Matrix Topcover (T02W)
Product Option	Premier
Guarantee Period	5 years
Payment Pattern	Age-related with CPI cover growth.
Qualifying lives	<p>In order to qualify for the Graduate Student Package the student must:</p> <ul style="list-style-type: none"> • Not yet have a Sanlam Student Package and • be younger than 30 and • Be a full-time student in at least their 2nd academic year, studying toward an NQF level 7 or higher qualification.* <p><small>*A National Qualifications Framework (NQF) Level 7 qualification is a 3-year university degree, a 4-year university of technology degree or a 4-year diploma. A student progresses to a next academic year when they successfully pass a tertiary study year.</small></p>

What benefits and cover amounts are included in the package?

The Graduate Student Package consists of 2 options and the plan holder will be able to choose either option A or option B. Each option will provide a pre-selected set of benefits with an initial recurring payment depending only on gender and smoker status.

The benefits that are included in the Graduate Student Package are all whole of life.

The table below illustrates the benefit and cover amounts for the 2 options:

Benefit	Cover amounts	
	Option A	Option B
Lump Sum Benefits		
Death (DS)	R300 000	R400 000
Comprehensive Disability Plus (Accelerator) (CAR4)	R300 000	R400 000
Comprehensive Severe Illness (Standalone) (TSW3)	R200 000	R300 000

Client roles

The following client roles apply to the plan:

- The plan-holder and the life insured must be the same person (the student).
- The payer of the plan need not be the plan-holder.
- The plan-holder may nominate beneficiaries for the Death benefit.

What cover is provided while the student is studying?

Comprehensive Disability Plus

Defined permanent impairment and accidental claim events

Apply from the start.

Temporary Incapacity Cover for Accidental and Non-Accidental Causes

This cover applies from the start.

Occupational disability cover

Occupational disability cover applies from the student's final academic year. The benefit will pay the cover amount if the student becomes totally and permanently disabled for a future occupation we may reasonably expect them to have practised, had they not become disabled and had they completed their studies.

Extended occupational disability cover

If the life insured successfully completes his or her studies, but does not yet start working, we will continue to cover him or her for occupational disability as if he or she is still a student, for up to 12 months from the date he or she stopped studying.

Death

Death cover applies from the start.

Comprehensive Severe Illness

Severe illness cover applies from the start.

For additional information on the benefits mentioned above please see the relevant chapters in this Technical Guide.

What cover is provided once the student starts working?

Once the life insured starts working, occupational disability cover will apply as for any other working client. Other cover provided by the above benefits will continue to apply as normal.

Application process

The following document must be provided to the student for information. It contains information similar to what is normally included in a quote:

- Sanlam Graduate Student Package Key Features and Disclosure document (AEB2152)

Then the following electronically fillable forms must be completed, signed by the student and submitted:

- Sanlam Graduate Student Package Application Cover Page (AEB2151)
- Sanlam Graduate Student Package Application Form (AEB2153)

A SanQuote quotation will not be required. The Key Features and Disclosure document together with the Application Cover Page above will form the product quotation.

Underwriting

The following will be required for underwriting :

- A short list of health questions and a Covid questionnaire.
- Cotinine tests for non-smoker applicants and HIV tests for all applicants.
- Further information or tests could be required based on the answers to the health or lifestyle questions.

Payments

The initial recurring payment for the package will depend only on smoker status, gender and the option selected.

Alterations

The following alterations will be available while the student is still studying:

- Changing from Option A to Option B. (Subject to underwriting)
- Adding of other benefits available to student lives, subject to normal underwriting rules for students.

For example:

- Adding the Funeral Expenses benefit for extended family
- Adding Cashback
- Adding the Wealth Bonus Early Access Option
- Adding the Cancer benefit

Other alterations normally available for students, like:

- Increasing cover*, subject to normal student limits, and
- Decreasing cover

**While the student is still studying the Comprehensive Disability Plus benefit cannot be increased other than changing from Option A to Option B.*

Once the student starts working full alteration capability will be possible, for example:

- Increasing the Comprehensive Disability Plus benefit and adding Income Protection benefits, in line with the life insured's starting salary.
- Increasing severe illness cover in line with increased affordability.

Upgrade Offer

Once the student starts working they will be able to make use of an upgrade offer, exclusively available to Graduate Student Package clients, to increase or add cover with a simplified medical underwriting process.

For more information on the upgrade offer please refer to the FlashFact on Sanport.

Wealth Bonus and Wealth Bonus Booster

The student packages includes Wealth Bonus, and once the student starts working they can qualify for Wealth Bonus Booster if they also take out a qualifying retirement annuity and meet the relevant minimum payment criteria.

Refer to the relevant Wealth Bonus and Wealth Bonus Booster chapter in this Technical Guide for more information.

Professional Student Package

The Professional Student Package is a package specifically designed for professional students. It is available under the Premier product option of our Topcover and Income Protector products.

Description	The Professional Student Package is a package which provides professional students with comprehensive cover. It is offered to students from their 2nd academic year, who are studying toward a National Qualifications Framework (NQF) level 8 or higher qualification. The benefits that form part of this package will remain suitable when they commence employment. There are 2 options available to provide for different levels of cover and affordability.
Products	Topcover for Professionals (T02W), and Income Protector for Professionals (T03W)
Product Option	Premier
Guarantee Period	5 years
Payment Pattern	Age-related with CPI cover growth.
Qualifying lives	In order to qualify for the Professional Student Package the student must: <ul style="list-style-type: none"> • not yet have a Sanlam Student Package and • be younger than 30 and • be a full-time student in at least their 2nd academic year, studying toward an NQF level 8 or higher qualification*, majoring in one of the qualifying fields of study.
<small>*A National Qualifications Framework (NQF) Level 8 qualification. A student progresses to a next academic year when they successfully pass a tertiary study year.</small>	
Qualifying Fields of Study	Students have to major in one of the following fields of study: <ul style="list-style-type: none"> • Accountancy • Actuarial Science • Architecture • Commerce • Dentistry • Economics • Engineering • Information/Computer Technology • Land Surveying • Law • Mathematics • Medicine • Occupational Therapy • Optometry • Pharmacy • Physiotherapy • Psychology • Statistics • Veterinary Science

Please note, the course or qualification cannot merely include subjects related to the above field. The above field of study should be what the student is majoring in.

What benefits and cover amounts are included in the package?

The Professional Student Package consists of 2 options and the student will be able to choose either option A or option B. For each option 2 plans will be issued, a Topcover for Professionals (T02W) plan and an Income Protector for Professionals (T03W) plan. Each option will provide a pre-selected set of benefits with an initial recurring payment depending only on gender and smoker status.

The following parameters will be applicable to the benefits:

- The Sickness Income Plus benefit will have a 7 day waiting period, and 24 month payment period.
- The Sickness Income Plus benefit and the Hospital Protector rider benefit will have a cease age of 70 age next birthday.
- The Extended Income Plus and lumpsum benefits will be whole of life.

The table below illustrates the benefits and cover amounts for the 2 options:

Benefit	Cover amounts	
	Option A	Option B
Income Benefits		
Sickness Income Plus (IS5)	R3 000 pm	R5 000 pm
Hospital Protector	R3 000 pm	R5 000 pm
Extended Income Plus (OIO6)	R3 000 pm	R5 000 pm
Lump Sum Benefits		
Death (DS)	R300 000	R400 000
Comprehensive Disability Plus (Accelerator) (CAR4)	R300 000	R400 000
Comprehensive Severe Illness (Standalone) (TSW3)	R200 000	R300 000

Client roles

The following will apply to both plans:

- The plan-holder and the life insured must be the same person (the student).
- The payer of the plan need not be the plan-holder.
- The plan-holder may nominate beneficiaries for the Death benefit.

What cover is provided while the student is studying?

Sickness Income Plus

Impairment cover

This cover applies from the start.

Hospital Protector

This cover applies from the start.

Sick leave cover

Sick leave cover applies from the 4th academic year. Sick leave is a medically recommended period of time during which the life insured, as a result of a bodily injury, illness or other cause or condition necessitating medical or dental treatment, is totally and continuously unable to engage in his or her studies, including during a holiday period while still enrolled in his or her studies.

Extended sick leave cover

If the life insured successfully completes his or her studies, but does not yet start working, we will continue to cover him or her for sick leave as if he or she is still a student, for up to 12 months from the date he or she stopped studying.

Extended Income Plus

Impairment Cover

This cover applies from the start.

Occupational disability cover

Occupational disability income cover applies from the 4th academic year. A benefit may be claimed if the life insured becomes disabled to the extent that he or she will be totally and permanently unable to fulfil the occupational demands of an occupation we may reasonably expect him or her to have practised, had they not become disabled and had they completed their studies.

Extended occupational disability cover

If the life insured successfully completes his or her studies, but does not yet start working, we will continue to cover him or her for occupational disability as if he or she is still a student, for up to 12 months from the date he or she stopped studying.

Built-in Future Cover for Young Lives

This will apply if the benefit was granted without medical loadings or exclusions.

Comprehensive Disability Plus**Defined permanent impairment and accidental claim events**

Apply from the start.

Temporary Incapacity Cover for Accidental and Non-Accidental Causes

This cover applies from the start.

Occupational disability cover

Occupational disability lump sum cover applies from the 3rd academic year. This covers disability to the extent that the life insured is totally and permanently unable to fulfil the occupational demands of an occupation we may reasonably expect him or her to have practised, had they not become disabled and had they completed their studies.

Extended occupational disability cover

If the life insured successfully completes his or her studies, but does not yet start working, we will continue to cover him or her for occupational disability as if he or she is still a student, for up to 12 months from the date he or she stopped studying.

Death

Death cover applies from the start.

Comprehensive Severe Illness

Severe illness cover applies from the start.

What cover is provided once the student starts working?

Once the life insured starts working, sick leave and occupational disability cover will apply as for any other working client. Other cover provided by the above benefits will continue to apply as normal.

For additional information on the all the benefits mentioned above please see the relevant chapters in this Technical Guide.

Application process

The following document must be provided to the student for information. It contains information similar to what is normally included in a quote:

- Sanlam Professional Student Package Key Features and Disclosure document (AEB2149)

Then the following electronically fillable forms must be completed, signed by the student and submitted:

- Sanlam Professional Student Package Application Cover Page (AEB2148)
- Sanlam Professional Student Package Application Form (AEB2150)

A SanQuote quotation will not be required. The Key Features and Disclosure document together with the Application Cover Page above will form the product quotation.

Underwriting

The following will be required for underwriting :

- A short list of health questions and a Covid questionnaire.
- Cotinine tests for non-smoker applicants and random HIV tests for all applicants.

Further information or tests could be required based on the answers to the health or lifestyle questions.

Payments

The initial recurring payment for the package will depend only on smoker status, gender and the option selected.

Alterations

The following alterations will be available while the student is still studying:

- Changing from Option A to Option B (Subject to underwriting)
- Adding of other benefits available to student lives, subject to normal underwriting rules for students.

For example:

- Adding the Funeral Expenses benefit for extended family
- Adding Cashback
- Adding the Wealth Bonus Early Access Option
- Adding accidental cover
- Adding additional layers of severe illness cover, like Comprehensive Severe Illness Plus benefit or the Cancer Benefit

Other alterations normally available for students, like increasing* or decreasing cover, subject to normal student limits.

**While the student is still studying the Sickness Income Plus and the Extended Income Plus benefits cannot be increased other than changing from Option A to Option B.*

Once the student starts working full alteration capability will be possible, for example:

- Increasing the Sickness Income Plus, Extended Income Plus and Comprehensive Disability Plus benefits in line with the client's starting salary.
- Increasing severe illness cover in line with increased affordability.

Upgrade Offer

Once the student starts working they will be able to make use of an upgrade offer, exclusively available to Graduate Student Package clients, to increase or add cover with a simplified medical underwriting process.

For more information on the upgrade offer please refer to the FlashFact on Sanport.

Wealth Bonus and Wealth Bonus Booster

The student packages includes Wealth Bonus, and once the student starts working they can qualify for Wealth Bonus Booster if they also take out a qualifying retirement annuity and meet the relevant minimum payment criteria.

Refer to the relevant Wealth Bonus and Wealth Bonus Booster chapter in this Technical Guide for more information.

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Why Cashback?

Cashback is an optional benefit that can be added per life insured, subject to new business requirements at the time. With the Cashback benefit we reward clients for their loyalty by providing the planholder with the opportunity to receive a benefit payment even if there is no claim on the plan.

The Cashback benefit can in fact continue after some claims. This can happen, for example:

- if a partial claim was admitted for a benefit, or
- if a claim was admitted under a benefit that allows more than one claim (like our standalone dread disease/severe illness benefits), or
- if a claim was admitted under a benefit and that claim did not affect other benefits of the life insured.

For a plan without cover growth and for which the cover amounts for all the benefits have remained the same for 15 years, the Cashback amount at the end of year 15 will be equal to all the payments that have been made for the lives insured with the Cashback benefit. This will include all the plan charges and the payments for the Cashback benefit, but exclude any collection payments for stop order payment methods. In addition, if the client does not want the Cashback amount at the end of year 15, he or she can benefit even more by getting a larger Cashback amount later. The Cashback amount will then continue to increase after year 15, while the payment for the Cashback benefit will fall away.

If cover is increased, either as a result of contractual cover growth or a cover increase requested by the planholder, a new cover layer is formed for each of these cover increases. The payments for each layer can be returned as a Cashback amount when that layer reaches a duration of at least 15 years.

Availability of benefit

The Cashback benefit is available for individual and business insurance.

Cashback (RS) (for Topcover products)

The Cashback benefit is an optional benefit that is available under the Express, Classic and Premier product options of our Topcover and the Premier product option of our Income protector products. Refer to "Cashback (RS) (for Income protector products)" for information about this benefit under our Income protector products.

Benefit description	<p>We will pay the payments made for a life insured as a Cashback amount for specific events. For the purpose of calculating the Cashback amount, the cover amount of each benefit on the life of an insured is split into layers. The first layer is formed by the cover amount of a benefit on the later of the cover start date of that benefit and the cover start date of the Cashback benefit. Whenever the cover amount of a benefit is increased thereafter, whether due to benefit growth or a requested increase in the cover amount, a new layer is formed by the increased part of the cover amount. However, the Cashback benefit will not apply to a new layer with a remaining duration of less than 15 years. It will also not apply to a new layer that is formed from the plan anniversary before or on the life insured's 60th birthday.</p> <p>A separate Cashback amount is calculated for each layer. The Cashback amount for a layer is calculated as the total payments made for that layer. The payments for the Cashback benefit for that layer as well as any compulsory payment growth linked to that layer are included in the total payments for that layer.</p> <p>If we give a discount on the payments for some benefits because of a life insured's membership of Reality, we will use the discounted payments in the calculation of the Cashback amount.</p> <p>The total Cashback amount to be paid for a specific event is the sum of the Cashback amounts for all the layers with a duration of 15 years and longer.</p>
Type of benefit	Additional benefit
When will the Cashback benefit end?	<p>The Cashback benefit will end</p> <ul style="list-style-type: none"> • 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.
Age limits	<p>Benefit start age</p> <p>Minimum: 2 next birthday</p> <p>Maximum:</p> <ul style="list-style-type: none"> • At least 15 years before the benefit cease age of the benefit that ceases last, if the life insured has no whole life benefits • 60 next birthday, if the life insured has at least one whole life benefit. <p>Benefit cease age</p> <p>At the benefit cease age of the benefit that ceases last, or at death.</p>
Qualifying lives	<p>All lives qualify, subject to age limits. The Cashback benefit is selected per life insured and does not automatically apply to all the lives insured on a plan.</p> <p>Cashback is available for individual and business insurance.</p>
Payment pattern	<p>As selected for the plan, but NOT available under plans with the following payment patterns:</p> <ul style="list-style-type: none"> • Stepped • Yearly-rated.

What will be paid?

We will pay the payments made for a life insured as a Cashback amount for specific events. For the purpose of calculating the Cashback amount, the cover amount of each benefit on the life of an insured is split into layers. The first layer is formed by the cover amount of a benefit on the later of the cover start date of that benefit and the cover start date of the Cashback benefit. Whenever the cover amount of a benefit is increased thereafter, whether due to benefit growth or a requested increase in the cover amount, a new layer is formed by the increased part of the cover amount. However, the Cashback benefit will **not** apply to a new layer with a remaining duration of less than 15 years. It will also **not** apply to a new layer that is formed from the plan anniversary before or on the life insured's 60th birthday.

A separate Cashback amount is calculated for each layer. The Cashback amount for a layer is calculated as the total payments made for that layer. The payments for the Cashback benefit for that layer as well as any compulsory payment growth linked to that layer are included in the total payments for that layer.

If we give a discount on the payments for some benefits because of a life insured's membership of Reality, we will use the discounted payments in the calculation of the Cashback amount.

The total Cashback amount to be paid for a specific event is the sum of the Cashback amounts for all the layers with a duration of 15 years and longer.

If a plan charge is applicable to the plan, we will pay all the plan charges from the cover start date of the Cashback benefit up to the first event for which we will pay a Cashback amount. For every event thereafter, we will pay all the plan charges from the previous event up to the current event.

The payment charge, if applicable, as well as any payment for the plan that is waived due to a claim will not be used in the calculation of the Cashback amount.

The Cashback amount is illustrated in the quotation that forms part of the contract documents for the plan.

When we allow a benefit that previously existed on a plan and was linked to the Cashback benefit to be converted without an interruption in cover to another benefit on the same plan that is also linked to the Cashback benefit, we may give a credit for the payments made on the benefit before the conversion. For the type of conversions where medical underwriting is required, the cover amount of the benefit after the conversion must be equal to or greater than the cover amount of the benefit before the conversion to qualify for a possible credit. The credit will be added as a starting balance to the first layer of the benefit after the conversion. The first layer of the benefit after the conversion with a minimum duration of 15 years will start on its cover start date as described above.

Payment for Cashback benefit

A separate payment is calculated for each layer. When a layer reaches a duration of 15 years, **the payment for that layer will fall away**. The total payment for the Cashback benefit for a life insured is the sum of the payments for all the layers linked to that life insured.

If payment growth is applicable to the plan, the payment for the Cashback benefit for all the existing layers with a duration of less than 15 years will be increased.

When will the Cashback amount be paid?

We will pay the Cashback amount for the events described below.

Cashback amount paid on request

No Cashback amount is available on request within 15 years from the cover start date of the Cashback benefit.

If the planholder requests us to pay the Cashback amount for a life insured, we will pay the Cashback amounts for all the layers with a duration of 15 years and longer for all the benefits on the life of that insured linked to the Cashback benefit. The Cashback amounts for all the layers with a duration of less than 15 years will continue to increase for a possible payment later.

The Cashback benefit may be added again on request to the layers that have been paid out, subject to new business requirements at the time.

Benefit ends due to a claim

If a benefit on the plan ends due to a claim that has been admitted, we will pay the Cashback amounts for all the layers with a duration of 15 years and longer for that benefit. The Cashback amounts for all the layers with a duration of less than 15 years will be forfeited.

Benefit ends due to the death of a life insured

If a life insured dies, we will pay the Cashback amounts for all the layers with a duration of 15 years and longer linked to that life insured. The Cashback amounts for all the layers with a duration of less than 15 years will be forfeited.

Benefit reaches its cover end date

If a benefit on the plan reaches its cover end date, we will pay the Cashback amounts for all the layers for that benefit.

Plan lapses

If the plan lapses, we will pay the Cashback amounts for all the layers with a duration of 15 years and longer for all the benefits on the life of an insured linked to the Cashback benefit. The Cashback amounts for all the layers with a duration of less than 15 years will be forfeited.

Life insured removed from plan on request

If the planholder requests us to remove a life insured from the plan, we will pay the Cashback amounts for all the layers with a duration of 15 years and longer for all the benefits on the life of that insured linked to the Cashback benefit. The Cashback amounts for all the layers with a duration of less than 15 years will be forfeited.

Cashback benefit removed from plan on request

If the planholder requests us to remove the Cashback benefit from the plan for a life insured, we will pay the Cashback amounts for all the layers with a duration of 15 years and longer for all the benefits on the life of that insured linked to the Cashback benefit. The Cashback amounts for all the layers with a duration of less than 15 years will be forfeited.

Effect of reduction in cover amount of a benefit

If the cover amount of a benefit is reduced, the potential Cashback amount for that benefit will be less than before the reduction. For the purpose of calculating the Cashback amount, each layer for that benefit will be proportionally reduced. In addition, payments that have already been made for a layer with a duration of less than 15 years will be proportionally reduced. Payments that have already been made for a layer with a duration of 15 years and longer will not be reduced.

Cashback (RS) (for Income protector products)

The Cashback benefit is an optional benefit that is available under the Express, Classic and Premier product options of our Topcover and the Premier product option of our Income protector products. Refer to "Cashback (RS) (for Topcover products)" for information about this benefit under our Topcover products.

Benefit description	<p>We will pay the payments made for all the benefits linked to the Cashback benefit as a Cashback amount for specific events. For the purpose of calculating the Cashback amount, the cover amount of each benefit is split into layers. The first layer is formed by the cover amount of a benefit on the later of the cover start date of that benefit and the cover start date of the Cashback benefit. Whenever the cover amount of a benefit is increased thereafter, whether due to benefit growth or a requested increase in the cover amount, a new layer is formed by the increased part of the cover amount. However, the Cashback benefit will not apply to a new layer with a remaining duration of less than 15 years. It will also not apply to a new layer that is formed from the plan anniversary before or on the life insured's 60th birthday.</p> <p>A separate Cashback amount is calculated for each layer. The Cashback amount for a layer is calculated as the total payments made for that layer. The payments for the Cashback benefit for that layer as well as any compulsory payment growth linked to that layer are included in the total payments for that layer.</p> <p>If we give a discount on the payments for some benefits because of the life insured's membership of Reality, we will use the discounted payments in the calculation of the Cashback amount.</p> <p>The total Cashback amount to be paid for a specific event is the sum of the Cashback amounts for all the layers with a duration of 15 years and longer.</p>
Type of benefit	Additional benefit
When will the Cashback benefit end?	<p>The Cashback benefit will end</p> <ul style="list-style-type: none"> • 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.
Age limits	<p>Benefit start age</p> <ul style="list-style-type: none"> • Payment patterns other than fixed compulsory growth: <ul style="list-style-type: none"> • 19 next birthday for the Express product option • 18 next birthday otherwise • Fixed compulsory growth: 30 next birthday <p>Minimum:</p> <ul style="list-style-type: none"> • At least 15 years before the benefit cease age of the benefit that ceases last, if the life insured has no whole life benefits <p>Maximum:</p> <ul style="list-style-type: none"> • 60 next birthday, if the life insured has at least one whole life benefit. <p>Benefit cease age</p> <p>At the benefit cease age of the benefit that ceases last, or at death.</p>
Qualifying lives	<p>All lives qualify, subject to age limits.</p> <p>Cashback is available for individual and business insurance.</p>
Payment pattern	As selected for the plan.

What will be paid?

We will pay the payments made for all the benefits linked to the Cashback benefit as a Cashback amount for specific events. For the purpose of calculating the Cashback amount, the cover amount of each benefit is split into layers. The first layer is formed by the cover amount of a benefit on the later of the cover start date of that benefit and the cover start date of the Cashback benefit. Whenever the cover amount of a benefit is increased thereafter, whether due to benefit growth or a requested increase in the cover amount, a new layer is formed by the increased part of the cover amount. However, the Cashback benefit will **not** apply to a new layer with a remaining duration of less than 15 years. It will also **not** apply to a new layer that is formed from the plan anniversary before or on the life insured's 60th birthday.

A separate Cashback amount is calculated for each layer. The Cashback amount for a layer is calculated as the total payments made for that layer. The payments for the Cashback benefit for that layer as well as any compulsory payment growth linked to that layer are included in the total payments for that layer.

If we give a discount on the payments for some benefits because of the life insured's membership of Reality, we will use the discounted payments in the calculation of the Cashback amount.

The total Cashback amount to be paid for a specific event is the sum of the Cashback amounts for all the layers with a duration of 15 years and longer.

The payment charge, if applicable, as well as any payment for the plan that is waived due to a claim will not be used in the calculation of the Cashback amount.

The Cashback amount is illustrated in the quotation that forms part of the contract documents for the plan.

Payment for Cashback benefit

A separate payment is calculated for each layer. When a layer reaches a duration of 15 years, **the payment for that layer will fall away**. The total payment for the Cashback benefit is the sum of the payments for all the layers.

If payment growth is applicable to the plan, the payment for the Cashback benefit for all the existing layers with a duration of less than 15 years will be increased.

When will the Cashback amount be paid?

We will pay the Cashback amount for the events described below.

Cashback amount paid on request

No Cashback amount is available on request within 15 years from the cover start date of the Cashback benefit.

If the planholder requests us to pay the Cashback amount, we will pay the Cashback amounts for all the layers with a duration of 15 years and longer for all the benefits linked to the Cashback benefit. The Cashback amounts for all the layers with a duration of less than 15 years will continue to increase for a possible payment later.

The Cashback benefit may be added again on request to the layers that have been paid out, subject to new business requirements at the time.

Benefit ends due to a claim

If a benefit on the plan ends due to a claim that has been admitted, we will pay the Cashback amounts for all the layers with a duration of 15 years and longer for that benefit. The Cashback amounts for all the layers with a duration of less than 15 years will be forfeited.

Benefit ends due to the death of the life insured

If the life insured dies, we will pay the Cashback amounts for all the layers with a duration of 15 years and longer. The Cashback amounts for all the layers with a duration of less than 15 years will be forfeited.

Benefit reaches its cover end date

If a benefit on the plan reaches its cover end date, we will pay the Cashback amounts for all the layers for that benefit.

Plan lapses

If the plan lapses, we will pay the Cashback amounts for all the layers with a duration of 15 years and longer for all the benefits linked to the Cashback benefit. The Cashback amounts for all the layers with a duration of less than 15 years will be forfeited.

Cashback benefit removed from plan on request

If the planholder requests us to remove the Cashback benefit from the plan, we will pay the Cashback amounts for all the layers with a duration of 15 years and longer for all the benefits linked to the Cashback benefit. The Cashback amounts for all the layers with a duration of less than 15 years will be forfeited.

Effect of reduction in cover amount of a benefit

If the cover amount of a benefit is reduced, the potential Cashback amount for that benefit will be less than before the reduction. For the purpose of calculating the Cashback amount, each layer for that benefit will be proportionally reduced. In addition, payments that have already been made for a layer with a duration of less than 15 years will be proportionally reduced. Payments that have already been made for a layer with a duration of 15 years and longer will not be reduced.

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What is Wealth Bonus?

Wealth Bonus is the Sanlam Group's long term monetary benefit for clients. It rewards them by helping them to build meaningful, long-term wealth. Every time a client makes a payment on a participating Sanlam Group product, Sanlam will add to their Wealth Bonus at no additional cost.

The Matrix Premier product option is one of the Sanlam Group products which participates in giving clients Wealth Bonus.

For the remainder of the Wealth Bonus chapter, when we refer to rules governing Wealth Bonus, we are specifically referring to the portion of the Wealth Bonus contributed by the planholder's Matrix products (referred to as Matrix Wealth Bonus). Any Wealth Bonus contributed by the planholder's other Sanlam products are not specified here.

Matrix Wealth Bonus is automatically included for new business plans and the planholder does not pay extra for it. This means in addition to the cover the planholder receives for the premium, we will also match a percentage of the plan payment and contribute this amount to his or her Wealth Bonus. This Wealth Bonus continues to grow with these contributions and interest.

Clients with existing Matrix plans who do not have access to Wealth Bonus can opt in to the Wealth Bonus programme, subject to requirements at the time.

Every 5 years, 5% of the money in the Matrix Wealth Bonus becomes unlocked and available for the client to access. If the client maintains the plan until the Matrix Wealth Bonus cease date (specified below), all the money eventually becomes unlocked.

If this plan is cancelled or lapsed, if the planholder dies or if we admit a claim which causes the plan to end before the Matrix Wealth Bonus cease date, all the money in the Matrix Wealth Bonus that is locked will fall away. This plan will then make no further contributions to the planholder's Wealth Bonus.

What is Wealth Bonus Booster?

Wealth Bonus Booster Is an opportunity for Graduate and Professional clients to make the smart financial move to earn even more Wealth Bonus. Wealth Bonus Booster is an addition to the existing Wealth Bonus benefits clients have. As a graduate or professional life insured, clients have an exclusive opportunity to earn more Wealth Bonus through Wealth Bonus Booster if they have both a qualifying Matrix Premier risk plan with Wealth Bonus and a Cumulus Echo Retirement Plan.

This means that in addition to the current Wealth Bonus the client is accumulating, Sanlam Life will now also calculate an amount related to the payments made on the qualifying products where clients are graduates or professionals, which will accumulate over time to provide Wealth Bonus Booster.

At certain future dates, a portion of the accumulated Wealth Bonus Booster will become unlocked, provided certain qualifying criteria are being met. The full value of Wealth Bonus Booster becomes unlocked on the Wealth Bonus Booster final unlock date.

Availability

Matrix Wealth Bonus is available for individual and business insurance. The following products under the Premier product option will qualify to earn the Wealth Bonus

- Matrix Topcover (T02W)
- Matrix Termcover (T02)
- Matrix Income Protector (T03W)

The above is still subject to the planholder meeting certain qualifying criteria.

Wealth Bonus Booster is available for graduates and professionals who already have Matrix Wealth Bonus. The following combination of products will qualify to earn Wealth Bonus Booster:

- Matrix Topcover (T02W),
- Matrix Termcover (T02)
- Matrix Income Protector (T03W), and
- Cumulus Echo Retirement Plan for Graduates/Professionals (R39C)

The above is still subject to the planholder meeting certain qualifying criteria.

Matrix Wealth Bonus

Matrix Wealth Bonus is built into our Premier product option on our Matrix Topcover, Matrix Termcover and Matrix Income Protector.

Description	Wealth Bonus rewards the planholder for making regular payments towards his or her plan. The planholder does not pay anything extra in order to earn Wealth Bonus. They qualify by taking out a Matrix Topcover, Matrix Termcover or Matrix Income Protector plan. Every five years on the plan anniversary, 5% of the money in the Matrix Wealth Bonus becomes unlocked. If the planholder maintains the plan until the Wealth Bonus cease date, all the money eventually becomes unlocked.
Type	Built-in feature
What is the cease date for the Wealth Bonus?	The Wealth Bonus cease date will be on the plan anniversary before or on the "Wealth Bonus Linked Life's" * 70 th birthday. If the plan has no benefits with cover that could extend past the plan anniversary before or on the "Wealth Bonus Linked Life's" 70 th birthday, the Wealth Bonus cease date will be the cover end date of the benefit on the plan with the latest calendar date. * This refers to the planholder, or if the planholder is not a natural person (i.e. legal entity) this will reference the oldest life insured of the plan. Once we have determined the "Wealth Bonus Linked Life", it will not change for the remainder of the plan.
Qualifying products	<ul style="list-style-type: none"> • Matrix Topcover: All plans qualify • Matrix Termcover: Plan must have benefits that cease at or extend past the plan anniversary before or on the "Wealth Bonus Linked Life's" 70th birthday • Matrix Income Protector: All plans qualify <p>The qualification criteria is still subject to age limits set out below.</p>
Age limits	<p>Minimum: Same as for the Matrix Topcover, Matrix Termcover and Matrix Income Protector</p> <p>Maximum:</p> <ul style="list-style-type: none"> • at least 5 years before the cease date of the plan; if the plan has no whole life benefits • Wealth Bonus linked life age 65 next birthday; if the plan has at least one whole life benefit.
Qualifying lives	All planholders qualify, subject to the age limits and product qualifying criteria as set out above.
Additional option available	The Early Access Option is available to planholders who may want to accelerate the Matrix Wealth Bonus cease date to the "Wealth Bonus Linked Life's" 65 th birthday and access all the money in the Matrix Wealth Bonus at this earlier date. This option is available at an additional cost.
Premium patterns	Matrix Wealth Bonus is available across all premium patterns.

Contributions to the Matrix Wealth Bonus

The percentage that we will match, is based on the age of the "Wealth Bonus Linked Life", as indicated in the table below. The younger the "Wealth Bonus Linked Life" the higher the initial contribution percentage will be. If the plan has a Cashback payment, it will not be included in the payment that will be used to calculate the contribution to the Matrix Wealth Bonus. If we give a discount on the payments for some benefits because of a life insured's membership of Reality, we will use the discounted payments in the calculation of the contribution to the Matrix Wealth Bonus.

Plan year that starts on the plan anniversary before or on the "Wealth Bonus Linked Life's"	Contribution percentage to Matrix Wealth Bonus %
18th to 32nd birthday	100
33rd to 34th birthday	95
35th birthday	90
36th to 37th birthday	85
38th to 39th birthday	80
40th to 41st birthday	75
42nd to 43rd birthday	70
44th to 46th birthday	65
47th to 48th birthday	60
49th birthday	55
50th to 51st birthday	50
52nd to 53rd birthday	45
54th to 55th birthday	40
56th to 58th birthday	35
59th to 60th birthday	30
61st to 69th birthday	25
70th birthday	0

All formulas we use to determine the Matrix Wealth Bonus may change over time and are not guaranteed.

No payments will be contributed to the Matrix Wealth Bonus while we waive the payments of the plan due to a waiver of payment claim or an income protector claim.

How will the contributions to the Matrix Wealth Bonus grow?

The Matrix Wealth Bonus will earn interest. This interest rate will be market-related and will already allow for applicable life office tax.

We will aim to remove the effect of short-term market fluctuations to improve stability of interest rates over time.

When will the Matrix Wealth Bonus become unlocked?

Every five years on the plan anniversary, 5% of the money in the locked Matrix Wealth Bonus becomes unlocked. The planholder will then have the option to withdraw the unlocked money in the Matrix Wealth Bonus. If the planholder withdraws the unlocked money or a part of it, the Matrix Wealth Bonus will be decreased by the amount that is withdrawn. Otherwise the unlocked money will remain in the Matrix Wealth Bonus and will continue to grow. The planholder can withdraw his or her unlocked Matrix Wealth Bonus at any time. The amount of the unlocked Matrix Wealth Bonus can be viewed on Sanlam Secure Services.

All the money in the Matrix Wealth Bonus becomes unlocked on the Matrix Wealth Bonus cease date, provided that the plan is still active and payments are still being made. If the Matrix Wealth Bonus cease date is before the plan anniversary before or on the "Wealth Bonus Linked Life's" 70th birthday, the planholder has the option to withdraw all the money from the Matrix Wealth Bonus or to leave it to continue to grow until the plan anniversary before or on the "Wealth Bonus Linked Life's" 70th birthday. Any unlocked money that is not withdrawn by that plan anniversary will automatically be paid to the planholder.

After the Matrix Wealth Bonus cease date, no contributions will be made to the Matrix Wealth Bonus.

The effect of changes to the plan on the Matrix Wealth Bonus

If the planholder makes changes to the plan the Matrix Wealth Bonus cease date may change.

If a benefit is decreased or cancelled, and it results in the total payment of the plan being decreased the money in the locked Matrix Wealth Bonus will be decreased proportionally. However, we will allow a decrease of less than 20% of the payment of the plan once in the lifetime of the plan, without decreasing the money in the locked Matrix Wealth Bonus.

The money in the Matrix Wealth Bonus will, however, not be decreased if a benefit is reduced or cancelled, if

- the benefit reaches its cover end date, or
- a claim for a benefit is admitted, or
- a benefit is converted or upgraded.

If the plan is cancelled, only the unlocked money in the Matrix Wealth Bonus will be paid. The money in the Matrix Wealth Bonus that is not unlocked will fall away. This plan will then make no further contributions to the Matrix Wealth Bonus.

If the planholder cedes their rights to the plan, any locked money in the Matrix Wealth Bonus will fall away and the new planholder will not qualify for Sanlam Matrix Wealth Bonus.

The effect of claims on the Matrix Wealth Bonus

If the planholder is also the life insured on the plan with benefits that are payable at their death and they die, the unlocked money in your Sanlam Matrix Wealth Bonus will be paid together with the claim amount. The money in your Sanlam Matrix Wealth Bonus that is not unlocked at the time of the claim will fall away.

If the planholder is not a life insured on the plan and they die, the unlocked money in the Matrix Wealth Bonus will be paid to the planholder's estate. The money in the Matrix Wealth Bonus that is not unlocked at the time of the claim will fall away.

If the plan ends because of a claim, the unlocked money in the Matrix Wealth Bonus will be paid together with the claim amount. The money in the Matrix Wealth Bonus that is not unlocked at the time of the claim will fall away.

For any other claim, the unlocked money in the Matrix Wealth Bonus will remain there and continue to grow as long as the planholder still has other active benefits on the plan for which they are making payments.

When will contributions to the Matrix Wealth Bonus end?

They will end on the earlier of:

- the Matrix Wealth Bonus cease date, or
- the cover end date of the benefit that ends last, or
- the plan ending for any reason before the cover end date, or
- at the death of the planholder.

Additional option available

Early Access Option

The Early Access Option can be selected if the planholder wants to accelerate the Matrix Wealth Bonus cease date and access all the money in the Matrix Wealth Bonus at an earlier date.

Description

The client can choose the Early Access Option, at an additional cost, which accelerates the Matrix Wealth Bonus cease date and the unlocking of all the money in the Matrix Wealth Bonus. If this option is chosen then the cease date, will be the plan anniversary before or on the "Wealth Bonus Linked Life's" 65th birthday.

On the cease date the full Matrix Wealth Bonus will become unlocked, provided that the plan is still active and payments to the plan are still being made.

There will be no further contributions to the Matrix Wealth Bonus from this date onwards.

The client has the option to withdraw all the money from the Matrix Wealth Bonus or to leave it to continue to grow until the plan anniversary before or on the "Wealth Bonus Linked Life's" 70th birthday.

Availability

Available for products that already qualify for Matrix wealth Bonus. No underwriting applies.

Age Limits

- Wealth Bonus linked life age 50 next birthday; if the plan has at least one whole life benefit.
- Otherwise: at least 15 years before the cease date of the plan if the plan has no whole life benefits.

Option Cease age

- 65 age next birthday

What happens if this option is cancelled?

If this option is cancelled, the money in the Matrix Wealth Bonus will again become unlocked only after the original Matrix Wealth Bonus cease date, provided that the plan is still active and payments are still being made on the original Matrix Wealth Bonus cease date.

Wealth Bonus Booster

Description	The Wealth Bonus Booster is an additional tax-free cash amount that graduate and professional clients can earn. It does not impact the client's current Wealth Bonus of a participating product, but it is an opportunity for graduate and professional clients to earn even more Wealth Bonus.
Type	Additional feature available for qualifying graduate and professional clients.
What is the cease date for the Wealth Bonus Booster?	Clients earn Wealth Bonus Booster until 60 anb.
Qualifying products	<ul style="list-style-type: none"> • Matrix Premier: T02W, T03W and T02 with Wealth Bonus; and • Cumulus Echo Retirement Plan for Graduates/Professionals.
Qualifying lives	<p>In order to qualify for Wealth Bonus Booster clients must be:</p> <ul style="list-style-type: none"> • a graduate or professional • 50 anb or younger.

When do clients qualify for Wealth Bonus Booster?

To qualify for the Wealth Bonus Booster the following criteria will have to be met:

- The life insured must have at least a 3 year degree or a 4 year diploma
- The life insured must be 50 age next birthday or younger
- They need to have both qualifying products:
 - Matrix Premier risk plan with Wealth Bonus; and
 - Cumulus Echo Retirement Plan for Graduates/Professionals.
- Clients have to meet a minimum payment requirement on both participating products.

The required minimum monthly payments are detailed in the table below:

Age next birthday	Age 35 next birthday or younger		Age 36 to 50 next birthday	
Participating products	Cumulus Echo RA Plan	Matrix Premier with Wealth Bonus	Cumulus Echo RA Plan	Matrix Premier with Wealth Bonus
Minimum monthly payment requirement	R1 500 p.m. or R18 000 p.a.	R500 p.m.	R2 500 p.m. or R30 000 p.a.	R1 000 p.m.

Payments that earn Wealth Bonus Booster

The following payments will earn Wealth Bonus Booster, if the above qualifying criteria for Wealth Bonus Booster are met:

- On qualifying Matrix Premier plans, only the payments of risk benefits on which the client is the life insured will earn Wealth Bonus Booster. If the plan has Cashback benefits, the payments for the Cashback benefits will not earn Wealth Bonus Booster. Any Early Access Option payment, stop order fee or plan fee will only earn Wealth Bonus Booster if the client is also the planholder on the plan. Benefits that expire before 55 age next birthday will not earn Wealth Bonus Booster.
- On qualifying Cumulus Echo Retirement Plans, the total payment will earn Wealth Bonus Booster.

If a Sanlam Reality discount was applied, the payment before the discount will be used when assessing against the rand minimums, but the payment after the discount will be used when calculating the Wealth Bonus Booster. For any other discounts or loadings we will use the payment after the discount or loading when assessing against the rand minimums and when calculating the Wealth Bonus Booster.

If more than one Matrix Premier or Cumulus Echo Retirement plan qualifies, then the payments across all of these plans will be considered in the calculation of Wealth Bonus Booster.

If the payments of the qualifying plans are not being made due to a waiver of payment claim, an income protector claim, a payment holiday, or for any other reason, we will not include these payments when we calculate Wealth Bonus Booster.

Calculation of Wealth Bonus Booster

We will calculate the potential Wealth Bonus Booster by applying a percentage to each of the payments that earn Wealth Bonus Booster. This percentage is based on the client's age at the time that the payments on the qualifying plans are made as indicated in the table below.

Plan year that starts on the Wealth Bonus Booster anniversary on the planholder's	Percentage applied to the payments that earn Wealth Bonus Booster
29 th birthday or earlier	10%
30th to 39th birthday	8%
40th to 49th birthday	4%
50th to 59th birthday	2%

How will Wealth Bonus Booster grow?

When we calculate the Wealth Bonus Booster, we will grow each payment that earns Wealth Bonus Booster from the date the payment has been made, with market related interest net of tax.

We will aim to remove the effect of short-term market fluctuations to improve stability of interest rates over time.

When will Wealth Bonus Booster become unlocked and be available to withdraw?

Wealth Bonus Booster becomes unlocked at specific times depending on the client's age when they first qualified for Wealth Bonus Booster. The table below indicates when Wealth Bonus Booster will unlock, as well as the percentage of the accumulated Wealth Bonus Booster that will unlock.

Age next birthday when the planholder first qualified for Wealth Bonus Booster	Wealth Bonus Booster becomes unlocked on the last Wealth Bonus Booster anniversary before/on planholder's respective birthday below	Percentage Wealth Bonus Booster that becomes unlocked
30 years or younger	50 th	25%
	55 th	50%
	60 th	100%
31 to 40 years	55 th	50%
	60 th	100%
41 to 50 years	60 th	100%

When the Wealth Bonus Booster is unlocked, clients have the option to withdraw it. If the unlocked amount or a part of it is withdrawn, the Wealth Bonus Booster will be decreased by the withdrawn amount. Any unlocked Wealth Bonus Booster not withdrawn will remain and will continue to grow. Clients can withdraw their unlocked Wealth Bonus Booster at any time.

Wealth Bonus Booster becomes unlocked in full on the last Wealth Bonus Booster anniversary before or on the client's 60th birthday (the Wealth Bonus Booster final unlock date). Any unlocked amount that is not withdrawn by that date will automatically be paid to the client.

Wealth Bonus Booster cannot be earned after the final unlock date.

How will changes to the qualifying plans affect your Wealth Bonus Booster?

If payments that earn Wealth Bonus Booster are reduced or increased, the reduced or increased payments will be used in the calculation of further Wealth Bonus Booster.

If, at any time, any of the qualifying products no longer meet the minimum payment requirements due to any of the reasons below, the entire locked Wealth Bonus Booster will be forfeited and no further Wealth Bonus Booster will be earned:

- Requesting an alteration on a qualifying plan that results in its payment being reduced;

- Cancelling a qualifying plan or letting it lapse;
- Making a qualifying Cumulus Echo Retirement Plan paid-up or retiring before the Wealth Bonus Booster final unlock date, except when you retire before the age of 55 due to ill health as defined in the rules of the Central Retirement Annuity Fund.

If the Matrix Premier product no longer meets the minimum payment requirements due to a claim or due to a benefit reaching its contractual cease date, but payments that earn Wealth Bonus Booster are still being made, either on the Matrix Premier product or the Cumulus Echo product or on both, the client will not lose their locked Wealth Bonus Booster. However, if any subsequent alterations, cancellations or lapses result in the payments of the Matrix Premier product reducing further, the client will forfeit their entire locked Wealth Bonus Booster and not earn any further Wealth Bonus Booster.

If you die, you will forfeit your entire locked Wealth Bonus Booster. Any unlocked amount that has not yet been paid will be paid to your estate.

What restrictions apply to Wealth Bonus Booster?

Loans are not allowed against Wealth Bonus Booster.

No withdrawals are allowed before Wealth Bonus Booster becomes unlocked.

Clients may not cede Wealth Bonus Booster as security or cede or transfer the rights in Wealth Bonus Booster.

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Summary of underwriting for Express

A simplified underwriting process applies for Express, which streamlines the sales process for the intermediary as well as the client. Despite the manner in which the underwriting for Express has been simplified, our claims philosophy for Express is the same as for our other product options. Express clients can therefore enjoy the same peace of mind as under our other product options.

The following applies for Express:

- A shortened application form.
- The planholder's credit information from legally recognised resources or databases will be included in the risk assessment of the application. If this risk assessment does not meet Sanlam's minimum criteria, the application will be declined.
- Limited medical underwriting:
 - Only 13 health questions
 - Random Cotinine tests for lives insured who have indicated that they are non-smokers.
 - Random verification of height and weight.
 - Random verification of HIV status.
 - No other medical tests or examinations and there will be no requests for past medical reports.
- Lives insured with certain occupations or occupational duties do not qualify for the underwritten benefits* of Express, as indicated under "Occupational underwriting". Such lives can however apply for the Funeral Expenses benefit**.
- Lives insured who have participated in certain risky activities in the last 3 years before the quotation date or who are planning to do so in future do not qualify for the underwritten benefits of Express, as indicated under "Underwriting for risky activities". Such lives can however apply for the Funeral Expenses benefit**.
- Overseas underwriting applies to lives who are in certain countries at the time of application, or who are planning to travel to any of those countries during the next 12 months. Cover in certain countries is, however, always excluded for the Funeral Expenses benefit.
- Express is not available to foreigners who do not live in South Africa, and also not to foreigners who live in South Africa without valid travelling documents. Express is available to other foreigners but they will only have cover inside South Africa. Citizens of Lesotho and Namibia will however enjoy the same cover as South African citizens.
- It is compulsory for lives insured who apply for medically underwritten benefits to belong to a medical aid.

*Underwritten benefits are benefits other than the Funeral Expenses and Cashback benefits.

**An application for the Funeral Expenses benefit is subject to additional product rules, as indicated under "Insurable interest".

Deterioration of insurance risk

Before our obligations take effect

Lives insured must notify us in writing if any of the information we regard as relevant to the specific insurance risk, changes before our obligations for a plan take effect.

If we are not notified of such information which could influence our assessment of the risk and the acceptance of the application, or if information about the insurance risk is incomplete or incorrect, it could invalidate the acceptance of the application, or cause us to cancel the plan, in which event all payments made in terms of the plan will be forfeited.

Once our obligations have taken effect

We carry the risk of any changes in the personal circumstances of a life insured once our obligations for a plan have taken effect.

Once our obligations for a plan have taken effect, and while the plan continues without any lapses or changes, it is not necessary to notify us if the life insured does any of the following, **except** in the case where a specific clause was applied that requires that we be informed:

- changes his/her occupation, or starts working from home, or stops working*;
- starts a new part-time activity**;
- changes his/her smoker status from non-smoker to smoker;
- leaves South Africa to visit, work or stay in another country***.

Note the following:

- *Occupational disability cover, which is applicable to certain benefits and rider benefits, will no longer be provided if a life insured stops working. However, if the benefit also provides for other types of cover, that type of cover will still be provided.
- **Certain risky activities are excluded under Express, as indicated under "Underwriting for risky activities" in this chapter, and the applicable chapters where exclusions for specific benefits are discussed.
- ***Cover in certain countries is excluded for the Funeral Expenses benefit. Also note the conditions that apply to foreigners. Refer to "Territorial underwriting" in this chapter for more information.

Insurable interest

General

In South Africa the life insurance industry is controlled chiefly by contract law and the Long-term Insurance Act. To comply with this, we have to make sure that life insurance is not misused and we therefore must make certain that the insurable interest between a planholder (an applicant) and a life insured is acceptable, and that cover amounts are limited to acceptable levels.

The applicant may only take out life insurance on the life of a person in whom he or she has an insurable interest. The insurable interest between an applicant and a life insured must be as follows:

- the applicant must have a legally recognised relationship with the life insured, and
- the applicant must suffer a financial loss if the insured event occurs to the life insured.

In addition, the rules of a particular product option may further limit the allowable insurable interests for that option.

For benefits other than Funeral Expenses, with or without Cashback, the relationship between the applicant and life insured can be any of the following:

- applicant and life insured the same person
- applicant and spouse.

For the Funeral Expenses benefit, with or without Cashback, the relation to the applicant can be any of the following:

- own life
- spouse
- child
- parent, including parent-in-law
- grandparent
- other family
- fiancé.

The following additional product rules apply for the Funeral Expenses benefit on an Express plan:

- Immediate Expenses (DSF3) and/or Funeral Expenses (FSC3), with or without Cashback, may not be the only benefits on a plan.
- The planholder can have the Funeral Expenses benefit, with or without Cashback, only in combination with other benefits on his/her own life.
- The spouse can have the Funeral Expenses benefit on its own, or in combination with any of the other available benefits.
- The planholder's child, parent, grandparent, other family members and/or fiancé can only have the Funeral Expenses benefit, with or without the Cashback benefit - no other benefits are allowed for them.
- For the planholder and spouse the Immediate Expenses and Funeral Expenses benefits may be taken together on the same plan for the same life insured.

Explanations

Spouse

A person to whom the planholder is legally married on the date of inclusion as a life insured, or with whom the planholder has concluded an agreement recognised as a marriage in accordance with any law or custom, provided that in the case of a marriage by law or custom, he or she lives with that person as if legally married.

Child

A biological, legally adopted or step child.

Parent

An adult who was a guardian of the planholder or spouse, including a biological, foster or step-parent, who was responsible for the upbringing of the planholder or spouse.

Grandparent

The parent of the "Parent" as described **in this section**.

Other family

A relative that is not a spouse, child, parent or grandparent, for example, a brother, sister, nephew, niece, cousin, uncle, aunt.

Fiancé

A person to whom the planholder is engaged to be married.

Ensure that underwriting progresses smoothly

To limit the need to request more information and to ensure that underwriting progresses smoothly, the intermediary can do the following:

- Make sure a valid insurable interest exists between the planholder and the life insured, according to the insurable interest rules for the Express product option.
- Make sure all the required information is complete and correct at application stage, for example, make sure the following is provided:
 - accurate income, according to our definitions;
 - accurate occupation category selected;
 - accurate information about existing insurance.
- Make sure the following is done:
 - all yes/no boxes are filled in, where required;
 - all questions relevant to a benefit are answered.
- Make sure that the medical questions, if applicable, are answered in full, e.g., provide all the detail requested if a health question has a "yes" answer. Provide as much information as possible to assist the underwriters to offer the best possible terms to the client.
- Provide the required documentation for replacements, as indicated on the application form.

Occupational underwriting

Occupations/occupational duties that do not qualify

Lives insured with any of the following occupations or occupational duties **do not qualify** for the underwritten* benefits of Express. Such lives can however apply for the Funeral Expenses benefit, with or without Cashback, under Express:

- Working underground for more than 10 hours per week
- Working at heights of more than 15 meters
- Working with voltages of more than 10000V
- Working on an oil rig, or with asbestos, or with explosives
- Cash in transit industry, debt collecting (excluding per telephone) or micro-lending
- Security guard, body guard, escort, bouncer or private investigator
- Driving or owning a minibus taxi
- Helicopter flying, flying at low altitudes, or flying fighter aeroplanes
- Diving, stuntwork or hunting big game
- Professional sportsman or -woman
- Unemployed (excl., housewives, students or pensioners).

*Underwritten benefits are benefits other than the Funeral Expenses and Cashback benefits..

The above lives may however be able to obtain cover on the Classic and Premier product options, subject to full underwriting.

Other occupations

Other occupations may qualify, and will be classified into one of the following occupational categories. The category that applies to a life insured will be the category that best describes the life insured's work.

Professional

Those with a post-graduate qualification who perform a professional occupation (e.g. doctor, lawyer, accountant, engineer, scientist). Typically registered with a professional body. Also include IT professionals, university lecturers and school principals.

Administrative or Clerical work

Clerical, administrative, information technology or managerial occupations involving mostly office duties, with on average less than 1 hour a day travel or light physical duties.

Combination of Administrative duties and Travel

Travelling sales representatives or other administrative and sales occupations involving, on average, more than 1 hour of travel per day. (May include on average light physical duties of less than 1 hour).

Combination of Light work and Travel

Business owners or workers performing light physical duties in non-hazardous environments (e.g. coffee shop owners), claims assessors or light-physical skilled workers (e.g. electric appliance or other technicians), farmers.

Student, Housewife, Pensioner

Teacher, Educator

Entertainment and Performing Arts

Nurse or Physiotherapist

Qualified Tradesperson doing skilled work

Qualified tradespeople involved in non-hazardous environments doing light physical work (e.g. hair dressers, qualified plumbers, cabinet makers, workshop owners or business owners supervising and performing light physical duties in a workshop or factory environment, electricians (low voltage), game rangers).

Mostly Travel or Delivery

Manual work (no unusual risk)

Manual workers, who are not subject to unusual accident or health risks (e.g. cleaners, fencing contractors, mechanics).

Pilot or Air Traffic Controller

Higher rank Armed Forces, Correctional Services or Police

Army, Air force (excluding Pilot), Navy, Correctional Services or Police with ranks of Warrant Officer and higher or Correctional Officer I and higher, excluding persons with administrative duties only.

Lower rank Armed Forces, Correctional Services or Police, and other risky occupations

- Army, Air force (excluding Pilot), Navy, Correctional Services or Police with ranks of Sergeant/Staff Sergeant/Flight Sergeant/Chief Petty Officer and lower, excluding persons with administrative duties only
- Paramedics, Firefighters, Ambulance workers, Traffic officers
- Working with voltages from 1000V to 10000V
- Working underground (but not more than 10 hours per week)
- Working in a dry cleaner or with pesticides
- Street vendors
- Construction workers and builders (not working at heights of more than 15 meters).

Underwriting decision

The occupational underwriting decision for the underwritten* benefits may be any of the following:

- Accept cover on standard terms with no occupational loadings or occupational exclusions.
- Decline disability cover for certain occupational categories.

*Underwritten benefits are benefits other than the Funeral Expenses and Cashback benefits.

Rate group

Each underwritten life insured* is classified into one of five rate groups (1 to 5). Lives insured in certain occupational categories **and** with a 4-year degree or equivalent or higher may qualify for rate group 5. If a life insured does not qualify for rate group 5, only the income and qualification is used to determine the rate group.

*Underwritten lives insured are lives insured with at least one underwritten benefit. Underwritten benefits are benefits other than the Funeral Expenses and Cashback benefits.

To determine the rate group, a life insured is underwritten according to:

- his/her own occupational category, and
- his/her own qualifications, except for a student, where the qualifications of the parent/legal guardian will be used, and
- income, as described in the "Income" section.

Rate group 5

An underwritten life insured* may qualify for rate group 5 if his/her occupational category is one of the following:

- Professional
- Administrative or Clerical work
- Combination of Administrative duties and Travel
- Combination of Light work and Travel
- Student, Housewife, Pensioner
- Teacher, Educator
- Nurse or Physiotherapist.

In addition to this, the life insured must also have one of the following (or equivalent or higher) qualifications:

- M-Tech Degree (B-Tech plus additional year)
- D-Tech Degree (M-Tech plus additional year)
- Two 3-year Bachelor's Degrees (university)
- 4-year Bachelor's Degree (university)
- Honours Degree (university)
- Master's Degree (university)
- Doctorate (university)
- Certified Financial Planner (CFP)
- Actuarial qualification: FASSA/FIA/FFA.

*Underwritten lives insured are lives insured with at least one underwritten benefit. Underwritten benefits are benefits other than the Funeral Expenses and Cashback benefits.

Rate groups 1, 2, 3 and 4

The requirements for rate groups 1 to 4 are indicated in the table below.

Qualification category	Requirements for rate groups 1, 2, 3 and 4						
	Income						
	≤ R7 499	R7 500 - R13 999	R14 000 - R15 999	R16 000 – R22 499	R22 500 – R29 999	R30 000 – R39 999	≥ R40 000
Rate group							
No matric	1	1	1	2	2	3	4
Matric / Grade 12	1	2	2	3	3	4	4
3-year diploma	2	2	3	3	4	4	4
3-year degree / Btech / 4-year diploma	2	3	4	4	4	4	4
4-year degree	4	4	4	4	4	4	4

Examples of qualifications to determine rate groups 1 to 4

Qualifications are grouped into 5 different categories in order to determine rate groups 1 to 4.

Examples of qualifications in the different categories::

- No matric category:
 - Grade 10 (Standard 8) and lower
 - Grade 11 (Standard 9)
 - National Certificate (N1 or N2).
- Matric / Grade 12 category:
 - Matric / Grade 12 (*also referred to as Standard 10*)
 - Post matric course, certificate or diploma of less than 3 years:
 - National Certificate (N3, N4, N5 or N6).
- 3-year diploma category:
 - 3-year Teacher's/ Nursing Diploma
 - 3-year Technikon Diploma (T3/S4/ND).
- 3-year degree / Btech / 4-year diploma category:
 - 3-year Bachelor's Degree (university)
 - B-Tech Degree (Technikon Degree)
 - 4-year Teacher's/ Nursing Diploma
 - 4-year Technikon Diploma (T4/T5/T6/NHD)
 - Any qualification in the rate group 5 section above (*only if the client does not qualify for rate group 5*).

Income

Income is defined according to the various definitions provided in this section, whichever is applicable to the life insured.

Average monthly income

“Average monthly income” is the taxable monthly income from the life insured’s regular occupation, averaged over the 12 months before application. However, if the life insured has a fluctuating income, we will calculate the average monthly income over the 36 months before application. For self-employed clients, we will always consider their average monthly income rather than their most recent income.

Bonuses may be included in the calculation of the income, subject to a maximum of 10% of the life insured’s guaranteed yearly package.

In determining the total income, any form of income from the following is excluded: overtime pay, non-taxable fringe benefits, interest, dividends and rental income.

In addition to the above, the following applies to the monthly income when the **rate group** is determined:

- For an unmarried person, his/her own income is normally used, but exceptions may apply, as listed below.
- For a spouse* the greater of his/her own income and the income of his/her spouse is used.
- For a student the monthly income is the greater of the monthly income of the two parents/legal guardians.
- See “Income for pensioners” for more information about the monthly income for pensioners.

When the **financial limit requirements** are determined for a life insured, only his/her own income is used. However, for a housewife/house husband the greater of his/her own income and the income of his/her spouse is used, while for a student the greater of the income of the two parents/legal guardians is used.

*A spouse is a person to whom the planholder is legally married on the date of inclusion as a life insured, or with whom the planholder has concluded an agreement recognised as a marriage in accordance with any law or custom, provided that in the case of a marriage by law or custom, he or she lives with that person as if legally married.

Definitions of gross income

These definitions of gross income are used when rate groups are determined, as well as for financial underwriting.

Gross income for lives insured in formal employment of an employer

This is the cost-to-company income which consists of gross taxable income of the life insured including the employer’s contributions to a medical scheme, provident fund or pension fund on behalf of the life insured, and the cost of any other benefits paid for by the life insured’s employer that form part of the life insured’s remuneration package and are reflected in the employer’s financial statements.

Examples of lives insured in employment of an employer: administrative worker, teacher, policeman, mine worker, labourer, factory worker, domestic worker, etc..

Gross income for professionals in practice

The income for a professional who charges a fee for services is equal to the sum of professional fees and net income from trading activities, less business overhead expenses.

Examples of professionals in practice: pharmacist, doctor or architect with own business, etc.

Gross income for other self-employed lives insured

This is the salary withdrawn from the business, if applicable, plus the life insured's share of profit in the business.

Examples of other self-employed lives insured: business owners, shop owners, self-employed electricians or plumbers, street vendors, etc. This includes businesses with more than one owner.

Gross income for pensioners

For a pensioner the income is as follows:

- income benefits from pension and retirement annuity funds, plus
- any regular interest and dividend income from fixed investments, plus
- income from rent.

Business overhead expenses

The life insured's share of the overhead expenses is a proportion of the total overhead expenses of the affected business*. The proportion is calculated as the business income the life insured generates in the affected business, averaged over the 12 months before the application, divided by the total business income of the affected business.

*This is the business where the life insured fulfilled his or her duties immediately before the application.

Overhead expenses include the following:

- rent for the business premises;
- water, electricity, telephone;
- regular maintenance services;
- property taxes and mortgage interest for the business premises;
- equipment leasing costs;
- insurance premiums;
- accounting fees;
- salaries of employees;
- other normal and necessary expenses that we agree to include.

Overhead expenses exclude the following:

- depreciation;
- cost of goods or merchandise or additions to inventory;
- cost of furniture or equipment;
- capital payments on outstanding debt;
- expenditure on assets;
- fees on current accounts;
- business rationalisation costs, for example, retrenchment;
- any remuneration or other consideration to the life insured, the planholder, associates in the affected business, and any other person who shares directly or indirectly in the profit of the affected business.

Accident and disability classes

Each underwritten life insured* is classified into one of five accident or disability classes (A - E), according to his/her occupational category (as described in the section "Other occupations" earlier in this chapter). The accident and disability classes may differ.

*Underwritten lives insured are lives insured with at least one underwritten benefit. Underwritten benefits are benefits other than the Funeral Expenses and Cashback benefits.

Underwriting for risky activities

Applying for the underwritten benefits of Express

The underwritten benefits* of Express are not available to lives who have participated in any of the following risky activities in the last 3 years before the quotation date or who are planning to do so in future. Such lives can however apply for the Funeral Expenses benefit, with or without Cashback:

- scuba diving at depths greater than 40 m, free diving at depths greater than 25 m, unaccompanied scuba diving or cliff diving;
- drag powerboat racing, competitive jet-skiing or competitive water skiing;
- helicopter or gyrocopter flying (other than as a passenger for sightseeing purposes);
- risky aviation activities with a fixed-wing aeroplane or flights as a student pilot;
- expedition style mountaineering, solo climbing mountaineering or expedition caving;
- recurrent (more than once) hang-gliding, paragliding, parasailing, sky-diving, parachuting, sky-surfing or microlight flights.

*Underwritten benefits are benefits other than the Funeral Expenses and Cashback benefits.

The above lives may however be able to obtain cover on the Classic and Premier product options, subject to full underwriting.

Exclusions for risky activities

We will not admit a claim if the claim event resulted directly or indirectly from any of the following risky activities:

- recurrent (more than once) hang-gliding, paragliding, parasailing, sky-diving, parachuting, sky-surfing or microlight flights.

The above exclusions for risky activities **do not apply** to the following benefits:

- Death
- Immediate Expenses
- Funeral Expenses
- Death cover on Credit Life
- Death income.

We will also not admit a claim if the claim event resulted directly or indirectly from any of the following risky activities indicated below. These exclusions **do not apply** to the Funeral Expenses benefit.

- acrobatic flights or BASE jumping;
- cave diving, commercial diving, or the exploration of underwater wrecks for financial gain;
- motorised racing or speed contests;
- professional boxing, professional kick-boxing or professional wrestling.

Financial underwriting

When the financial limit requirements are determined for a life insured, only his/her own income is used. However, for a housewife/house husband the greater of his/her own income and the income of his/her spouse is used, while for a student the greater of the income of the two parents/legal guardians is used.

We underwrite the total cover amount applied for with us and other insurers, including incomplete applications.

Maximum cover that can be applied for under Express (service model 4)

The calculation of maximum cover described in this technical guide must only be seen as a guideline. Sanlam reserves the right to question any of the values provided and will consider the acceptance of the application according to ruling guidelines and policies.

Absolute maximums

Lives not in the “Student, Housewife, Pensioner” occupational category

Benefit	Absolute maximums (subject to financial underwriting)
Lump sum benefits	
Death-related cover	
Death	R5 000 000
Estate Expenses	R5 000 000
Immediate Expenses	R150 000
Funeral Expenses	<ul style="list-style-type: none"> • R15 000 before a life insured's 6th birthday • R30 000 on or after a life insured's 6th birthday, but before that life insured's 14th birthday • R60 000 on or after a life insured's 14th birthday
Accidental death	R2 500 000
Accidental injury-related cover	
Accidental injury	R5 000 000
Disability- and impairment-related cover	
<ul style="list-style-type: none"> • Comprehensive Disability-/Plus • Comprehensive Impairment • Accidental Comprehensive Disability-/Plus • Accidental Comprehensive Impairment 	R5 000 000
Severe illness/dread disease-related cover	
<ul style="list-style-type: none"> • Cancer-/Plus • Cardiovascular-/Plus • Core dread disease (including Whole life) 	R5 000 000
Credit Life cover	
Credit Life	R5 000 000

Lives in the “Student, Housewife, Pensioner” occupational category

Benefits offering cover for occupational disability (lump sum or income), the Credit life and severe illness income benefits are not available to any of these lives. The absolute maximums for the available benefits are as follows, subject to financial underwriting:

- Immediate Expenses and Funeral Expenses: Same as above.
- Other lump sum benefits: R2 000 000.

Maximum available cover

When the maximum available cover for a selected benefit for a specific life insured is determined, the sum of certain types of cover will be calculated (aggregated), and then tested against the applicable financial limits. Lump sum, waiver of payment and income type benefits will be taken into account. Income and waiver of payment benefit amounts will be converted to lump sums for the calculations.

- **New cover applied for as well as existing cover at all businesses in the Sanlam group and other insurers may be taken into account.** Group cover and incomplete applications for cover will also be included, but replacements will be excluded. Also refer to the section “Existing cover and incomplete applications for cover” for more information.

Note that no information about existing cover or other incomplete applications for cover is required when a quotation is done. Therefore, at quotation stage, only other benefits applied for on the same quotation will be taken into account to determine the maximums. Information about existing insurance and other incomplete applications are only required during the application process. The benefits granted on a quotation may therefore be limited or declined if such other cover leads to over-insurance.

- Absolute maximums as indicated in the previous section in this chapter will be taken into account.
- Additional financial underwriting limits may also be applied. For example, the sum of lump sum disability- and impairment-related cover may not be more than R5 million for a life insured under the Express product option.
- The age of a life insured and the monthly income (before tax) is used for financial underwriting – refer to the “Income” section earlier in this chapter. The following formulas will be used (but not for housewives/house husbands, children/scholars, students, pensioners or unemployed persons), where the relevant factors and percentages are indicated in the tables below:
 - **Death, accidental injury, impairment, severe illness/dread disease:** Monthly income x Multiple factor
 - **Disability cover:** [Monthly income x Conversion factor x (Sliding scale percentage, limited to a maximum of 75%)] + [24 x Monthly income].

Age next birthday of life insured	Multiple factor
≤ 25	240
26 – 30	288
31 – 35	276
36 – 40	264
41 – 50	216
51 – 55	180
56 – 60	144
61 – 65	96
≥ 66	72

Age next birthday	Conversion factor
up to 25	320
26 - 30	320
31 - 35	320
36 - 40	280
41 - 45	240
46 - 50	200
51 - 55	160
56	150
57	140
58	130
59	120
60	110
61	100
62	90
63	80
64	70
65	60
66	60
67	60
68	60
69	60
70	60

Existing cover and incomplete applications for cover

Existing cover and incomplete applications for cover, including group cover, will be taken into account when determining the maximum amount of cover available for a life insured, but replacements will be excluded.

Information required on the application form

Certain information about existing insurance must be provided on the application forms. Incomplete applications for insurance must be included, but replacements must be excluded.

When applying for benefits other than the Funeral Expenses benefit, with or without Cashback:

- Provide cover amounts for insurance with other insurers (including group cover).
- Cover with MiMay Life, Sanlam Indie and Sanlam Group Risk must also be included, but other Sanlam insurance must be excluded.

Information about the following types of cover must be provided:

- Life cover
- Disability cover
- Disability plus impairment
- Dread disease (Trauma) / Severe illness
- Temporary disability income
- Disability income (less than 24 month waiting period)
- Disability income (24 month waiting period)
- Death income.

When applying for the Funeral Expenses benefit, with or without Cashback:

- For children before their 14th birthday: Information about **life and funeral cover** must be provided. MiWay Life, Sanlam Indie, Sanlam Group Risk and Sanlam Sky cover must be included but other Sanlam insurance must be excluded. Cover with other insurers must be included (including group cover).
- For lives insured on or after their 14th birthday: **Only** information about **funeral cover** must be provided. Only MiWay Life, Sanlam Indie and Sanlam Group Risk funeral cover must be included.

Cover at Sanlam Life

The existing benefits/types of cover at Sanlam Life that will be taken into account when applying for a specific benefit are indicated below.

Benefit applied for	Sanlam Life cover
Lump sum benefits	
Death-related cover	
Death (DS)	<ul style="list-style-type: none"> • DS, DS80, DSF1, DSF3, ASC, DSC, DI3, and • All other death-related benefits, excluding funeral benefits
Estate Expenses (DEC)	<ul style="list-style-type: none"> • DEC
Immediate Expenses (DSF3)	<ul style="list-style-type: none"> • DSF1, DSF3
Funeral Expenses (FSC3) – for children before their 14th birthday	<ul style="list-style-type: none"> • FSC2, FSC3, and • All other death-related benefits, including funeral benefits
Funeral Expenses (FSC3) – for lives insured on or after their 14th birthday	<ul style="list-style-type: none"> • FSC2, FSC3, and • All other funeral-related benefits (except DSF1)
Accidental death (ASC)	<ul style="list-style-type: none"> • DS, DS80, DSF1, DSF3, ASC, DSC, DI3, and • OLV, DU, T84, and • All other death-related benefits, excluding funeral benefits
Accidental injury-related cover	
Accidental injury (ASW)	<ul style="list-style-type: none"> • ASW

Benefit applied for	Sanlam Life cover
Lump sum benefits	
Disability- and impairment-related cover	
Comprehensive Disability (CAR3, CSR3)	<ul style="list-style-type: none"> OAR, OSR, OAR2, OSR2, OAS, OSS, CAR, CSR, CAR3, CSR3, CAR4, CSR4, CAR5, CSR5, CAS, CSS, ASO, ASO3, ASO4, ASO5, OAF, OSF, OAI, OSI, ASI, OAP, OSP, OAP2, OSP2, OAP3, OSP3, LAP, LSP, DSC, OGG, OGG1, OPG, OPG1, OIO, OIO3, OIR, and T48
Comprehensive Disability Plus (CAR4, CSR4)	
Comprehensive Impairment (OAI, OSI)	
Accidental Comprehensive Disability (ASO3)	<ul style="list-style-type: none"> ASO, ASO3, ASO4, ASO5, ASI
Accidental Comprehensive Disability Plus (ASO4)	
Accidental Comprehensive Impairment (ASI)	
Severe illness/dread disease-related cover	
Cancer (TAT3, TST3)	<ul style="list-style-type: none"> TAT3, TST3, TAT4, TST4, TAW3, TSW3, TAW4, TSW4, TAC, TSC, TAC2, TSC2, TAW, TSW, TAW2, TSW2, dread disease cover on LAP and LSP, and KTV, TV, T16
Cancer Plus (TAT4, TST4)	
Cardiovascular (TAH3, TSH3)	<ul style="list-style-type: none"> TAH3, TSH3, TAH4, TSH4, TAW3, TSW3, TAW4, TSW4, TAC, TSC, TAC2, TSC2, TAW, TSW, TAW2, TSW2, dread disease cover on LAP and LSP, and KTV, TV, T16
Cardiovascular Plus (TAH4, TSH4)	
Core dread disease (TAC, TSC)*	<ul style="list-style-type: none"> TAT3, TST3, TAT4, TST4, TAH3, TSH3, TAH4, TSH4, TAW3, TSW3, TAW4, TSW4, TAC, TSC, TAC2, TSC2, TAW, TSW, TAW2, TSW2, dread disease cover on LAP and LSP, and KTV, TV, T16
Whole life core dread disease(TAC2, TSC2)*	
Credit Life cover	
Credit Life (DSC)	<ul style="list-style-type: none"> DS, DS80, DSF1, DSF3, ASC, DSC, DI3, and All other death-related benefits, excluding funeral benefits

*When applying for this benefit: For financial underwriting the total cover amount of benefits that provide only cancer cover will be determined, as well as the total cover amount of benefits that provide only cardiovascular cover. The maximum of these two amounts will then be added to the cover amounts of all the other benefits in this group. The benefits that provide only cancer cover are the Cancer (TAT3, TST3) and Cancer Plus (TAT4, TST4) benefits, while the benefits that provide only cardiovascular cover are the Cardiovascular (TAH3, TSH3) and Cardiovascular Plus (TAH4, TSH4) benefits.

Medical underwriting

General

Medical underwriting is done, but **not** if a life insured takes only the Funeral Expenses or accidental benefits, with or without Cashback.

The following applies:

- Only 13 health questions.
- Random Cotinine tests for lives insured who have indicated that they are non-smokers. If the test result is positive, the application will be declined and future applications made for Express within the next 12 months thereafter will also be declined.
- Random verification of height and weight (also referred to as "Body mass index assessment" or "BMI assessment").
- Random verification of HIV status. Express is not available for lives who have ever tested positive for HIV. Refer to the chapter *Overview of Classic and Premier* for information about the benefits available for HIV positive lives under the Classic and Premier product options.
- No other medical tests or examinations will apply and there will be no requests for past medical reports.

The medical underwriting decision may be any of the following:

- accept the cover on standard terms with no medical loadings or medical exclusions;
- accept the cover and add a medical loading;
- accept the cover and apply a medical exclusion;
- decline all or a part of the cover;
- accept the cover with any combination of the decisions above.

In accordance with the HIV testing protocol of the Association for Savings and Investment South Africa (ASISA), no samples may be processed by any service provider without documentary proof that:

- in the case of an HIV test, the client has received the required pre-testing information, and
- a photographic identity check has been carried out by the person taking blood or urine samples, and
- the life insured has signed informed consent for an HIV test.

If these prescriptions are not complied with, we reserve the right to withhold payment for the services by a service provider.

Before a random Cotinine or HIV test or BMI assessment may be done, the applicant or life insured must have

- requested and authorised us to obtain information from the service provider, and
- agreed that we share information with other life offices directly or through ASISA for purposes of underwriting and/or claims assessment.

In terms of ASISA protocol the applicant/life insured may enquire about information held by ASISA and such information will be made available to him/her by his/her nominated medical practitioner.

Identification policy for random Cotinine and HIV tests and BMI assessments

ASISA requires that lives insured must identify themselves before undergoing medical examinations and tests for the insurance industry.

One of the following is required for proof of identity for random Cotinine or HIV tests or BMI assessments:

- a valid RSA identity document;
- a valid temporary RSA identity document issued by the Department of Home Affairs;
- a valid card-type driver's licence issued by the Department of Transport in the RSA;
- a valid passport.

We reserve the right to request additional proof of identification.

Validity period of medical reports for random Cotinine tests, HIV tests and BMI assessments

Enquire at local underwriting office for detail about validity periods.

Requirements for completing medical reports and doing tests

Medical reports and tests for random Cotinine tests and BMI assessments will be accepted only if completed/done according to the requirements below.

Body mass index (BMI) assessment

A Body mass index (BMI) assessment form (form AE4027) may be completed by a registered nurse or enrolled nurse, registered with the South African Nursing Council (SANC), and who is bona fide in the service of a medical practitioner, pathologist or third party service provider with whom Sanlam New Business has a valid contract.

Blood and urine samples for random Cotinine and HIV tests

Only test results of ASISA-accredited pathology laboratories will be accepted.

Blood and urine samples* to do random Cotinine and/or HIV tests may be taken by any of the following:

- a practising medical practitioner registered with the Health Professions Council of South Africa (HPCSA);
- a registered nurse or enrolled nurse, registered with the South African Nursing Council (SANC), and who is bona fide in the service of a medical practitioner, pathologist or third party service provider with whom Sanlam New Business has a valid contract;
- a registered person who has been authorised by the HPCSA to draw blood and who is bona fide in the service of an accredited pathology laboratory.

*Note that not all service providers do urine tests for Cotinine. Therefore, if a planholder wants to have urine instead of blood tests done for Cotinine, he/she must first check if urine tests are done by the service provider that he/she is planning to use.

Territorial underwriting

Overseas underwriting

Overseas underwriting applies to lives insured who are in a foreign country at the time of application, or who are planning to travel to a foreign country during the next 12 months. For the purpose of this, the following countries/regions can be ignored: SADC countries (excluding Angola, the DRC, Mozambique and Zimbabwe), United Kingdom, Europe, United States of America, Canada, Australia and New Zealand.

The territorial underwriting decision may be any of the following:

- accept the cover on standard terms, with no territorial exclusions;
- accept the cover, but limit the rate group and cover amount;
- decline all or a part of the cover.

Also refer to the sections below for additional information about the Funeral Expenses benefit and cover for foreigners.

Countries where cover for the Funeral Expenses benefit is excluded

We will not admit a claim for the Funeral Expenses benefit if a life insured dies in one of the following countries:

Afghanistan, Angola: Cabinda Province, Burundi, Central African Republic, Chad, Democratic Republic of the Congo, Iran (Islamic Republic of Iran), Iraq, Lebanon, Libya (Lybian Arab Jamahiriya), Mali, Nigeria: Niger Delta, North Korea, Pakistan, Somalia, South Sudan, Sudan, the Syrian Arab Republic and Yemen. If a life insured lives or plans to live in one of these countries, it is the planholder's responsibility to request us in writing to end the Funeral Expenses benefit for that life insured. We will not refund any payments because of cover being excluded in these countries.

This list of countries may change in future and if another benefit version was applicable to a life insured in the past, this list of countries may differ from the countries in those list(s). If the cover amount of the Funeral Expenses benefit is increased, other than through benefit growth, the latest list of countries will apply to the increased part of the cover amount of the Funeral Expenses benefit. The list(s) of countries that applied to the cover amount before the increase will continue to apply to that part of the cover amount after the increase. Different lists of countries could therefore apply to different parts of the cover amount at the time of a claim.

Foreigners

We will only consider cover for a foreigner who is in South Africa at the time of application, and who has the required documentation for identification.

Foreigners with citizenship in Lesotho or Namibia

Express is available to these foreigners, regardless of whether they live in South Africa or not. For these foreigners the benefits on the plan will cover claim events both inside and outside South Africa, excluding those countries where cover is excluded, if applicable.

Other foreigners

Express is not available to these foreigners if they do not live in South Africa or if they live in South Africa without valid travelling documents.

Cover is available to these foreigners if they live in South Africa with valid travelling documents, but is restricted to claim events in South Africa only. However, if a foreigner life insured at any stage obtains a permanent residence permit, or South African citizenship, the benefits on the plan for that life insured will cover claim events both inside and outside South Africa, excluding those countries where cover is excluded, if applicable.

If a foreigner life insured as described in this section no longer lives in South Africa, it is the planholder's responsibility to request us in writing to end the benefits on the plan for that life insured. We will not refund any payments because of cover being restricted to claim events in South Africa only.

Territorial questionnaires

Not applicable to the Funeral Expenses benefit.

The *Residence/travelling outside the Republic of South Africa* (form AEVL07) must be completed for lives insured who are in a foreign country at the time of application, or who are planning to travel to a foreign country during the next 12 months. For the purpose of this, the following countries/regions can be ignored: SADC countries (excluding Angola, the DRC, Mozambique and Zimbabwe), United Kingdom, Europe, United States of America, Canada, Australia and New Zealand.

The territorial questionnaires are available on the Sanlam intranet and SanPort.

Rates differentiation

Rates depend on the age of a life insured, the guarantee period and the chosen cover amount for a benefit. For the Funeral Expenses benefit the insurable interest is also taken into account.

A body mass index (BMI) assessment may be done for purposes of product pricing. Currently an additional BMI payment may be charged for the Death, Immediate Expenses and Death income benefits, but **not** for smokers, rate group 5 lives insured or lives insured with a post-matric/post-grade 12 qualification.

In addition to this, where a benefit offers a choice with regards to the following, the rate for a life insured may differ depending on the choices made:

- payment pattern and cover growth*
- with or without optional rider benefits
- benefit cease age
- benefit waiting period
- benefit payment period.

*This choice is made for a plan, but will apply to all the benefits of the plan.

Our other criteria for rates differentiation are indicated below with a √.

Rates differentiation					
Benefit	Gender	Smoker status	Rate group	Accident class (occupation)	Disability class (occupation)
Life cover					
Death (DS)	√	√	√		
Immediate Expenses (DSF3)	√	√	√		
Estate Expenses (DEC)	√	√	√		
Funeral Expenses (FSC3)	√				
Accidental death (ASC)	√			√	
Disability and impairment benefits					
Comprehensive Disability (CAR3, CSR3)	√	√			√
Comprehensive Disability Plus (CAR4, CSR4)	√	√			√
Comprehensive Impairment (OAI, OSI)	√	√			√
Accidental Comprehensive Disability (ASO3)	√			√	
Accidental Comprehensive Disability Plus (ASO4)	√			√	

Rates differentiation					
Benefit	Gender	Smoker status	Rate group	Accident class (occupation)	Disability class (occupation)
Disability and impairment benefits					
Accidental Comprehensive Impairment (ASI)	✓			✓	
Severe illness benefits					
Cancer (TAT3, TST3)	✓	✓	✓		
Cancer Plus (TAT4, TST4)	✓	✓	✓		
Cardiovascular (TAH3, TSH3)	✓	✓	✓		
Cardiovascular Plus (TAH4, TSH4)	✓	✓	✓		
Dread disease and injury benefits					
Core dread disease (TAC, TSC)	✓	✓	✓		
Whole life core dread disease (TAC2, TSC2)	✓	✓	✓		
Accidental injury (ASW)	✓			✓	
Credit Life cover					
Credit Life (DSC)	✓	✓	✓		✓
Cashback					
Cashback (RS)	The payment for this benefit is a fixed percentage of the total payment for all the other applicable benefits of a life insured with the Cashback benefit.				

New business service offerings

Medical support services

To make medical underwriting easier, walk-in services as well as Nurses on wheels (NOW) are available to clients, once underwriting terms have been set.

Walk-in services at doctors, pathologists, MediCross and Intercare facilities

Walk-in services to draw blood/ take urine samples for Cotinine tests and for BMI assessments are offered at pathologists, MediCross and Intercare facilities. Note, however, that not all service providers do urine tests for Cotinine. Therefore, if a planholder wants to have urine instead of blood tests done for Cotinine, he/she must first check if urine tests are done by the service provider that he/she is planning to use.

Nurses on wheels (NOW)

If the payment for a new plan is R300 or more, and the final underwriting terms have been set, clients can make use of Nurses on wheels (NOW). These nurses are available, by appointment only, to visit clients at their place of work to draw blood/ take urine samples for Cotinine or HIV tests and for BMI assessments.

No minimum payment applies to the clients below, and these clients automatically qualify for NOW services once the final underwriting terms have been set:

- clients of VIP brokers;
- clients of bank brokers;
- rate group 5 clients;
- clients of a select group of about 200 brokers, as determined by regional general managers, who are frequent writers of risk business.

Once the final underwriting terms have been set, contact NOW@sanlam.co.za or call (021) 916 3600 (option 4) for further assistance.

Tele-underwriting

A client in rate groups 2 to 5 can choose to be called by a tele-underwriter at any time between 08:00 and 20:00 (Monday to Friday). Tele-underwriting is not currently available to rate group 1 clients.

If tele-underwriting is selected:

- the client will do medical declarations telephonically via a tele-interview;
- no completion of medical questionnaires by the intermediary is required.

The benefits to an intermediary of making use of tele-underwriting are the following:

- shorter client visits;
- less administration;
- no accountability for inaccurate answers to medical questions;
- some clients prefer the privacy of a telephone conversation;
- some clients may prefer not to disclose personal information to an intermediary;
- all calls are recorded for future reference.

All tele-underwriting calls by Sanlam Life will be made from 087 350 9073. As clients are often reluctant to answer numbers that they may not be familiar with, they may find it useful to save this number. This number can also be called to, for example, leave a message for an alternative interview time.

Contact details

To make use of the new business service offerings, call (021) 916-3600.

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Deterioration of insurance risk

Before our obligations take effect

Lives insured must notify us in writing if any of the information we regard as relevant to the specific insurance risk, changes before our obligations for a plan take effect.

If we are not notified of such information which could influence our assessment of the risk and the acceptance of the application, or if information about the insurance risk is incomplete or incorrect, it could invalidate the acceptance of the application, or cause us to cancel the plan, in which event all payments made in terms of the plan will be forfeited.

Once our obligations have taken effect

We carry the risk of any changes in the personal circumstances of a life insured once our obligations for a plan have taken effect.

Once our obligations for a plan have taken effect, and while the plan continues without any lapses or changes, it is not necessary to notify us if the life insured does any of the following, **except** in the case where a specific clause was applied that requires that we be informed:

- changes his/her occupation, or starts working from home, or stops working*;
- starts a new part-time activity**;
- changes his/her smoker status from non-smoker to smoker;
- leaves South Africa to visit, work or stay in another country***.

Once our obligations for a plan have taken effect, we may, however, reconsider our underwriting decisions on request if the life insured:

- changes his/her risky occupation, for which an additional payment is charged, to an occupation that is less risky in his/her opinion;
- stops taking part in a risky part-time activity.

Note the following:

- *Occupational disability cover, which is applicable to certain benefits and rider benefits, will no longer be provided if a life insured stops working. However, if the benefit also provides for other types of cover, that type of cover will still be provided.
- **Certain risky activities are excluded under Classic and Premier, as indicated under "General exclusions" in the *Overview of Classic and Premier* chapter, and the applicable chapters where exclusions for specific benefits are discussed.
- ***Cover in certain countries is excluded for the Funeral Expenses benefit, as indicated under "Territorial underwriting" in this chapter.

Insurable interest

General

In South Africa the life insurance industry is controlled chiefly by contract law and the Long-term Insurance Act. To comply with this, we have to make sure that life insurance is not misused and we therefore must make certain that the insurable interest between an applicant and a life insured is acceptable, and that cover amounts are limited to acceptable levels.

The applicant may only take out life insurance on the life of a person in whom he or she has an insurable interest. The insurable interest between an applicant and a life insured must be as follows:

- the applicant must have a legally recognised relationship with the life insured, and
- the applicant must suffer a financial loss if the insured event occurs to the life insured.

For benefits other than the Funeral Expenses benefit the relationship between the applicant and life insured can be any of the following:

- applicant and life insured the same person
- applicant and spouse
- parent and child, where the child is financially dependent on the parent or the parent is financially dependent on the child
- company and employee.

For the Funeral Expenses benefit the relation to the applicant can be any of the following:

- own life
- spouse
- child
- parent, including parent-in-law
- grandparent
- other family
- fiancé.

Explanations

Spouse

A person to whom the planholder is legally married on the date of inclusion as a life insured, or with whom the planholder has concluded an agreement recognised as a marriage in accordance with any law or custom, provided that in the case of a marriage by law or custom, he or she lives with that person as if legally married.

Child

A biological, legally adopted or step child.

Parent

An adult who was a guardian of the planholder or spouse, including a biological, foster or step-parent, who was responsible for the upbringing of the planholder or spouse.

Grandparent

The parent of the "Parent" as described **in this section**.

Other family

A relative that is not a spouse, child, parent or grandparent, for example, a brother, sister, nephew, niece, cousin, uncle, aunt.

Fiancé

A person to whom the planholder is engaged to be married.

Ensure that underwriting progresses smoothly

To limit the need to request more information and to ensure that underwriting progresses smoothly, the intermediary can do the following:

- Make sure a valid insurable interest exists between the planholder and the life insured.
- Make sure all the required information is complete and correct at application stage, e.g., make sure the following is provided:
 - correct occupation;
 - accurate income according to our definition;
 - full details about part-time activities;
 - details of travelling outside RSA borders;
 - accurate net worth of the client or net profit of the business.
- Make sure the following is done:
 - all yes/no boxes are filled in, where required;
 - all questions relevant to a benefit are answered.
- Make sure that the medical requirements requested by the underwriters are correctly provided, e.g., if a medical report by a family doctor with attention to a certain impairment is requested, do not arrange for a medical report by a medical doctor who does not know the client.
- Provide as much information as possible to assist the underwriters to offer the best possible terms to the client.

Financial underwriting for large applications

Financial underwriting for large cases is dependent on the information that intermediaries supply in support of the cases. If all of the information does not reach the underwriters at application stage, the underwriter needs to call for supportive documents or question the financial reason for application. This process often leads to delays.

Owing to the impact of financial fraud, the underwriters must adhere to basic guidelines and be able to negotiate terms with reinsurers based on supporting documentation. Their decision to accept or decline cover depends on the information provided.

To limit the need to request more information and to ensure that financial underwriting for large applications progresses smoothly, the intermediary can do the following:

- Make sure the same income is provided on the quotation, application form and financial questionnaire.
- Make sure information about existing insurance is complete and correct, because this information is required to determine the maximum cover allowed for the new application.
- Make sure the reason for insurance is clearly motivated in the application documents.
- Provide a needs analysis and any additional background like insurable interest, structure of company, shareholding, etc., at application stage.
- Make use of the pre-underwriting facility for applications by calling our senior underwriters. They will be able to assist in determining upfront financial requirements on personal and business insurance.
- Complete only the relevant sections of the financial questionnaire.
- For individual insurance provide the following:
 - A needs analysis with a total insurance portfolio, and
 - The required documentation for replacements.
- For buy and sell insurance provide financial statements as supportive documentation, as well as the following information:
 - How was the value of the business determined?
 - Net profit of business.
 - What is each partner's shareholding?
- For key person insurance provide the following information:
 - Why is the life insured viewed as a key person?
 - What is his/her expertise?
 - What method was used to determine the value to be insured?
- If a legal consultant (e.g. a market specialist with a legal qualification) was used, give details or provide the proposal from the legal consultant.

Occupational underwriting

The occupational underwriting decision may be any of the following:

- accept the cover on standard terms with no occupational loadings or occupational exclusions;
- accept the cover and add an occupational loading;
- accept the cover and apply an occupational exclusion;
- decline all or a part of the cover.

Rate group

Each life insured is classified into one of five rate groups (1 to 5). A rate group is determined according to occupation, qualifications and income, and may be limited as a result of a specific occupation. We reserve the right to verify the life insured's income and qualification before accepting the application.

To determine the rate group, a life insured is underwritten according to:

- his/her own occupation, and
- his/her own qualifications, except for a child, scholar or student, where the qualifications of the parent/legal guardian will be used, and
- income, as described in the "Income" section.

Rate group 5

The life insured may qualify for rate group 5 if he or she practises a qualifying occupation, as determined by us.

In addition to this, the life insured must also have one of the following (or equivalent or higher) qualifications:

- M-Tech Degree (B-Tech plus additional year)
- D-Tech Degree (M-Tech plus additional year)
- Two 3-year Bachelor's Degrees (university)
- 4-year Bachelor's Degree (university)
- Honours Degree (university)
- Master's Degree (university)
- Doctorate (university)
- Certified Financial Planner (CFP)
- Actuarial qualification: FASSA/FIA/FFA
- Professional accountants, fully registered with SAIPA
- Accountants and auditors with at least a 3-year Bachelor's degree at a university and who have successfully completed either their Professional Evaluation or Institute of Internal Auditors qualification.

Students

A full-time student at a university, in at least his/her fourth academic year, following a 4-year or longer course, or Honours degree or higher qualification in one of the following study fields, may qualify for rate group 5:

- Medicine
- Law
- Dentistry
- Accountancy
- Actuarial
- Architectural
- Engineering
- Pharmaceutical
- Optometry
- Physiotherapy
- Surveying
- Veterinary Science
- Information/computer technology
- Commerce
- Occupational therapy.

Rate groups 1, 2, 3 and 4

The requirements for rate groups 1, 2, 3 and 4 are indicated in the table below.

Qualification category	Requirements for rate groups 1, 2, 3 and 4						
	Income						
	≤ R7 499	R7 500 - R13 999	R14 000 - R15 999	R16 000 – R22 499	R22 500 – R29 999	R30 000 – R39 999	≥ R40 000
Rate group							
No matric	1	1	1	2	2	3	4
Matric / Grade 12	1	2	2	3	3	4	4
3-year diploma	2	2	3	3	4	4	4
3-year degree / Btech / 4-year diploma	2	3	4	4	4	4	4
4-year degree	4	4	4	4	4	4	4

Examples of qualifications to determine rate groups 1 to 4

Qualifications are grouped into 5 different categories in order to determine rate groups 1 to 4.

Examples of qualifications in the different categories:

- No matric category:
 - Grade 10 (Standard 8) and lower
 - Grade 11 (Standard 9)
 - National Certificate (N1 or N2)
- Matric / Grade 12 category:
 - Matric / Grade 12 (*also referred to as Standard 10*)
 - Post matric course, certificate or diploma of less than 3 years:
 - National Certificate (N3, N4, N5 or N6)
- 3-year diploma category:
 - 3-year Teacher's/ Nursing Diploma
 - 3-year Technikon Diploma (T3/S4/ND)
- 3-year degree / Btech / 4-year diploma category:
 - 3-year Bachelor's Degree (university)
 - B-Tech Degree (Technikon Degree)
 - 4-year Teacher's/ Nursing Diploma
 - 4-year Technikon Diploma (T4/T5/T6/NHD)
 - Any qualification in the rate group 5 section above (*only if the client does not qualify for rate group 5*).

Income

Income is defined according to the various definitions provided in this section, whichever is applicable to the life insured

Average monthly income

"Average monthly income" is the taxable monthly income from the life insured's regular occupation, averaged over the 12 months before application. However, if the life insured has a fluctuating income we will calculate the average monthly income over the 36 months before application. For self-employed clients, we will always consider their average monthly income rather than their most recent income.

Bonuses may be included in the calculation of the income, but subject to a maximum of 10% of the life insured's guaranteed yearly package.

In determining the total income, any form of income from the following is excluded: overtime pay, non-taxable fringe benefits, interest, dividends and rental income.

In addition to the above, the following applies when the **rate group** is determined:

- For an unmarried person, his/her own income is normally used, but exceptions may apply, as listed below.
- For a spouse* the greater of his/her own income and the income of his/her spouse is used;
- For a child, scholar or student the monthly income is the greater of the monthly income of the two parents/legal guardians.
- See "Income for pensioners" in this section for more information about the monthly income for pensioners.
- An unemployed person will automatically be limited to rate group 1, and the given income is not taken into consideration.

When the **financial limit requirements** are determined for a life insured, only his/her own income is used. However, for a housewife/house husband the greater of his/her own income and the income of his/her spouse is used, while for a student the greater of the income of the two parents/legal guardians is used.

*A spouse is a person to whom the planholder is legally married on the date of inclusion as a life insured, or with whom the planholder has concluded an agreement recognised as a marriage in accordance with any law or custom, provided that in the case of a marriage by law or custom, he or she lives with that person as if legally married.

Definitions of gross income

These definitions of gross income are used when rate groups are determined, as well as for financial underwriting. However, when the financial limits are determined for the Sickness Income and Sickness Income Plus benefit, the gross professional income (GPI) is used. (Note that GPI includes business overhead expenses, while gross income excludes it.)

Gross income for lives insured in formal employment of an employer

This is the cost-to-company income which consists of gross taxable income of the life insured including the employer's contributions to a medical scheme, provident fund or pension fund on behalf of the life insured, and the cost of any other benefits paid for by the life insured's employer that form part of the life insured's remuneration package and are reflected in the employer's financial statements.

Examples of lives insured in employment of an employer: administrative worker, teacher, policeman, mine worker, labourer, factory worker, domestic worker, etc.

Gross income for professionals in practice

The income for a professional who charges a fee for services is equal to the sum of professional fees and net income from trading activities, less business overhead expenses.

Examples of professionals in practice: pharmacist, doctor or architect with own business, etc.

Gross income for other self-employed lives insured

This is the salary withdrawn from the business, if applicable, plus the life insured's share of profit in the business.

Examples of other self-employed lives insured: business owners, shop owners, self-employed electricians or plumbers, street vendors, etc. This includes businesses with more than one owner.

Gross income for pensioners

For a pensioner the income is as follows:

- income benefits from pension and retirement annuity funds, plus
- any regular interest and dividend income from fixed investments, plus
- income from rent.

Definitions of gross professional income (GPI)

The gross professional income (GPI) is only used when determining the financial limits for the Sickness Income and Sickness Income Plus benefit. (Note that GPI includes business overheads expenses.)

GPI for lives insured in formal employment of an employer

This is the cost-to-company income which consists of gross taxable income of the life insured including the employer's contributions to a medical scheme, provident fund or pension fund on behalf of the life insured, and the cost of any other benefits paid for by the life insured's employer that form part of the life insured's remuneration package and are reflected in the employer's financial statements.

GPI for professionals in practice

The GPI for professionals who charge a fee for services is equal to the sum of professional fees and net income from trading activities, i.e. the total income of the business, after cost of sales is subtracted, but before business overhead expenses are subtracted.

GPI for other self-employed lives insured

This is the income or benefits receivable for the life insured's employment, or any services rendered by the life insured, plus the life insured's share of profit in the business.

Business overhead expenses

The life insured's share of the overhead expenses is a proportion of the total overhead expenses of the affected business*. The proportion is calculated as the business income the life insured generates in the affected business, averaged over the 12 months before the application, divided by the total business income of the affected business.

*This is the business where the life insured fulfilled his or her duties immediately before the application.

Overhead expenses include the following:

- rent for the business premises;

- water, electricity, telephone;
- regular maintenance services;
- property taxes and mortgage interest for the business premises;
- equipment leasing costs;
- insurance premiums;
- accounting fees;
- salaries of employees;
- other normal and necessary expenses that we agree to include.

Overhead expenses exclude the following:

- depreciation;
- cost of goods or merchandise or additions to inventory;
- cost of furniture or equipment;
- capital payments on outstanding debt;
- expenditure on assets;
- fees on current accounts;
- business rationalisation costs, for example, retrenchment;
- any remuneration or other consideration to the life insured, the planholder, associates in the affected business, and any other person who shares directly or indirectly in the profit of the affected business.

Accident and disability classes

Each life insured is classified into one of five accident or disability classes (A - E). The accident and disability classes may differ.

The following are used to determine the accident and disability classes of a life insured:

- occupation;
- the average number of hours per work day that the life insured spends in the performance of his/her occupation on each of the following:
 - administrative work;
 - travelling;
 - light physical work;
 - heavy physical work.

If a function/task is not done on a daily basis, the total number of hours for that function/task over a one month period is calculated, and then converted to an average number of hours per day by dividing the monthly total by the number of working days in the month. For example, if 44 hours in a month is spent on administrative work, and the month has 22 working days, then an average of 2 hours per day is spent on administrative work (i.e. $44/22 = 2$).

Definitions of types of work

Administrative work

This is the average number of hours per work day spent in an office or education environment busy with any of the following duties:

- personnel management;
- reading and writing;
- working at a computer;
- telephone conversations;
- attending meetings;
- client services: no selling
- education, lecturing or training.

If, for example, the life insured works in an office environment, his or her occupation is seen as administrative and then only the average number of hours per day spent travelling needs to be determined. The same applies to, for example, a teacher or lecturer.

Travelling

This is the average number of hours per work day spent travelling for work purposes*, but excluding time travelled:

- between a life insured's residence and workplace, and
- as a passenger on a scheduled flight on a registered airline.

*See "Heavy Physical Work" below if travelling is done for transport purposes. Note that travelling for this purpose does not include air travel on regular, scheduled airline flights.

To calculate the average number of hours per day, we assume that it takes 1 hour to travel 100 kilometres. The formulae below are then used to calculate the average number of hours per day.

Total hours travelled in month = Total kilometres travelled in month/100

Average number of hours per day = Total hours travelled in month/Number of work days in month

If, for example the life insured travels an average of 6 600 km in a month with 22 work days in the performance of his/her occupation, then:

Total hours travelled in month = 6 600/100 = 66

Average number of hours per day = 66/22 = 3

Light physical work

This is the average number of hours per work day spent on light physical work. Light physical work is any of the following activities, **excluding for administrative duties***:

- standing and walking;
- climbing up and down stairs occasionally, usually not more than two flights of stairs per day;
- using your arms and hands to grasp, hold and turn objects;
- carrying, lifting, moving of objects not exceeding 15kg in weight.

*If the intermediary has established that the life insured has an administrative occupation and any of the activities under "Light physical work" are also included in his or her day, activities will not be seen as light physical work. For example, using stairs or carrying files for purposes of administrative duties are not classified as light physical work.

Heavy physical work

This is the average number of hours per work day spent on heavy physical work. Heavy physical work is any of the following activities:

- climbing up and down stairs frequently, usually more than two flights of stairs per day, with no alternative to stairs available;
- climbing up and down ladders, installations;
- carrying, lifting, moving objects weighing more than 15kg;
- working with machinery, tools;
- working with or driving motorised machinery;
- travelling for transport purposes*.

*Note that travelling for this purpose does not include air travel on regular, scheduled airline flights.

Risky activities underwriting

No underwriting for risky activities will apply for the Funeral Expenses and Child: Illness and injury benefits.

Current participation

The underwriting decision may be any of the following:

- accept the cover on standard terms with no loadings or exclusions for risky activities;
- accept the cover with a loading for risky activities;
- accept the cover and apply an exclusion for risky activities;
- decline all or a part of the cover.

No current participation, but participation during last three years, or intended future participation

The plan will be accepted with an "A-clause". Refer to "A-clause" below for more information.

Questionnaires for part-time activities

The following questionnaires are available on the Sanlam intranet and SanPort:

- *Supplementary information in respect of motorsport* (form AE96)
- *Supplementary information in respect of flying activities* (form AE97)
- *Supplementary information in respect of diving* (form AE98).

If information about other part-time activities is required, it will be requested by our underwriters.

Clauses

Clauses are sometimes applied for certain occupations or part-time activities.

A-clause

An "A-clause" is placed when a life insured is not participating in an activity when cover is applied for, but has participated during the last 3 years or is intending to do so in future.

An example of an "A-clause" follows:

The planholder must immediately notify us in writing if the life insured starts or resumes participation in diving. We may then increase the payment for this benefit, or exclude cover for this benefit, or cancel this benefit.

B-clause

A "B-clause" is placed when a loading is applied for a specific activity.

An example of a "B-clause" follows.

Because the life insured participates in diving, the payment for this benefit includes a loading. If the life insured stops participating in diving, we may reconsider the loading on request.

The loading for this benefit is R5.00 per month. It is included in the total payment for the life insured.

The loading in the above example is illustrative and is not an indication of the actual loading that may apply.

U-clause

A "U-clause" is placed when cover for a specific activity is excluded.

An example of a "U-clause" follows.

Despite anything to the contrary in the plan, we will not admit a claim if the claim event is caused directly or indirectly by, or is related to, participation in, or training with the intention of participating in, diving.

Financial underwriting

When the financial limit requirements are determined for a life insured, only his/her own income is used. However, for a housewife/house husband the greater of his/her own income and the income of his/her spouse is used, while for a student the greater of the income of the two parents/legal guardians is used.

We underwrite the total cover amount applied for with us and other insurers, including incomplete applications.

Financial questionnaires

The *Financial questionnaire for individual insurance* (form AE4023) is required under the following conditions for death-related cover:

- for rate groups 1, 2, 3 and 4:
 - if the total death-related cover applied for is less than or equal to R7 million, but more than the Multiple factor* x Gross monthly income, or
 - if the total death-related cover applied for is more than R7 million.
- for rate group 5:
 - if the total death-related cover applied for is less than or equal to R10 million, but more than the Multiple factor* x Gross monthly income, or
 - if the total death-related cover applied for is more than R10 million.

*Refer to the Multiple factor table in the "Maximum available cover" section.

Financial questionnaires are available on the Sanlam intranet and SanPort.

Maximum cover that can be applied for under Classic and Premier

The calculation of maximum available cover described in this technical guide must only be seen as a guideline. Sanlam reserves the right to question any of the values provided and will consider the acceptance of the application according to ruling guidelines and policies.

Absolute maximums

Lives other than housewives/house husbands, children/scholars, students, pensioners, unemployed

Benefit	Absolute maximums (subject to financial underwriting)
Lump sum benefits	
Death-related cover	
• Death	None
• First death	
• Estate Expenses	
Immediate Expenses	R150 000
Funeral Expenses	<ul style="list-style-type: none"> • R15 000 before a life insured's 6th birthday • R30 000 on or after a life insured's 6th birthday, but before that life insured's 14th birthday • R60 000 on or after a life insured's 14th birthday
Accidental death	R2 500 000
Accidental injury-related cover	
Accidental injury	R10 000 000
Disability- and impairment-related cover	
• Comprehensive Disability-/Plus	R35 000 000
• Elite Disability	
• Comprehensive Impairment	
• Accidental Comprehensive Disability-/Plus	R10 000 000
• Accidental Elite Disability	
• Accidental Comprehensive Impairment	
Severe illness/dread disease-related cover	
• Cancer-/Plus	R6 000 000
• Cardiovascular-/Plus	
• Comprehensive Severe Illness-/Plus	
• Core dread disease (including Whole life)	
Child illness and injury cover	
Child: Illness and injury	<ul style="list-style-type: none"> • R500 000 for rate groups 1 or 2 • R1 000 000 for rate groups 3 or 4
Credit Life cover	
Credit Life	R16 000 000
Future cover group	
FutureCover (Death or Comprehensive)	R10 000 000
Income benefits	
Death-related cover	
Death income	None
Disability- and impairment-related cover	
Sickness Income and Sickness Income Plus*	R250 000 per month, limited to the sliding scale percentage** of the life insured's monthly gross professional income (GPI)
• Temporary Income and Temporary Income Plus	R200 000 per month, limited to the sliding scale percentage** of the life insured's gross monthly income
• Extended income	
• Accidental Extended Income Plus	
• Accidental Extended Income Plus	
• Impairment Income	

Overhead expenses	R150 000 per month, limited to 100% of the life insured's share of the overhead expenses of the business
Severe illness/dread disease-related cover	
Severe Illness Income	R50 000 per month, limited to 25% of the life insured's gross monthly income

*Note that business overhead expenses can be insured as part of the Sickness Income and Sickness Income Plus benefit: therefore, we will use gross professional income (GPI) (which includes business overheads) for financial underwriting. When a Temporary Income and Temporary Income Plus benefit is taken instead of the Sickness Income and Sickness Income Plus benefit, business overheads must however be insured with a separate Overheads expenses protector benefit.

**The sliding scale percentages are indicated in the applicable table in the "Maximum available cover" section.

Housewives/house husbands, children/scholars, students, pensioners, unemployed

The absolute maximums for the Immediate Expenses, Funeral Expenses and Child: Illness and injury benefits are the same as above. For other benefits the calculated amounts in the table below will be **further limited to the absolute maximums above**. All maximums are **subject to financial underwriting**.

Note that the Credit Life and income benefits (excluding the Death income benefit) are not available for housewives/house husbands, children/scholars, students, pensioners or unemployed persons.

Benefit	Absolute maximums (<i>subject to financial underwriting</i>)				
	Housewife/ house husband	Minor (child/scholar)	Student	Retired (pensioner)	Unemployed (up to age 54 next birthday, thereafter same rules as for pensioner)
Lump sum benefits					
Death-related cover					
• Death • First death • Estate Expenses	Larger of: • R2 500 000, or • 3 x Gross annual income of spouse	R1 000 000	R2 000 000	Larger of: • R2 000 000, or • Cover allowed using the highest of insured's and spouse's gross monthly income	R250 000
Accidental death	Larger of: • R2 500 000, or • 3 x Gross annual income of spouse	R1 000 000	R2 000 000	Larger of: • R2 000 000, or • Cover allowed using the highest of insured's and spouse's gross monthly income	R250 000

Benefit	Absolute maximums (subject to financial underwriting)				
	Housewife/ house husband	Minor (child/scholar)	Student	Retired (pensioner)	Unemployed (up to age 54 next birthday, thereafter same rules as for pensioner)
Lump sum benefits					
Accidental injury-related cover					
Accidental injury	Larger of: <ul style="list-style-type: none"> • R2 500 000, or • 3 x Gross annual income of spouse 	R1 000 000	R2 000 000	R2 000 000	R250 000
Disability- and impairment-related cover					
<ul style="list-style-type: none"> • Comprehensive Disability/-Plus • Elite Disability • Accidental Comprehensive Disability/-Plus • Accidental Elite Disability 	Benefits not available	Benefits not available	R2 000 000 (only available to students in at least their fourth year of study for a professional occupation)	Benefits not available	Benefits not available
<ul style="list-style-type: none"> • Comprehensive Impairment • Accidental Comprehensive Impairment 	Larger of: <ul style="list-style-type: none"> • R2 500 000, or • 3 x Gross annual income of spouse 	R2 000 000	R2 000 000	R2 000 000	R250 000
Severe illness/dread disease-related cover					
<ul style="list-style-type: none"> • Cancer/-Plus • Cardiovascular/-Plus • Comprehensive Severe Illness/-Plus • Core dread disease (including Whole life) 	Larger of: <ul style="list-style-type: none"> • R2 500 000, or • 3 x Gross annual income of spouse 	R2 000 000	R2 000 000	R2 000 000	R250 000
Future cover group					
FutureCover (Death or Comprehensive)	Benefits not available	R1 000 000	R5 000 000	Benefits not available	Benefits not available
Income benefits					
Death-related cover					
Death income	The amount for the lump sum Death benefit in this table, divided by the applicable factor* for the Death income benefit.				
Disability- and impairment-related cover					
Impairment Income	Smallest of: <ul style="list-style-type: none"> • R50 000 or • 50% x gross monthly income** 	Benefits not available	Benefits not available	Smallest of: <ul style="list-style-type: none"> • R50 000 or • 50% x gross monthly income** 	Benefits not available

*The applicable factor for the Death income benefit is equal to the following:

- For a benefit with a fixed term it is the Multiple factor for death in the next section.
- For a benefit with whole life cover it is the smaller of the selected Income payment period in months, and the Multiple factor in the next section.

** Where 'gross monthly income' for housewife/husband and pensioner is the maximum of own income or spouse's income.

Maximum available cover

When the maximum available cover for a selected benefit for a specific life insured is determined, the sum of certain types of cover will be calculated (aggregated), and then tested against the applicable financial limits. Lump sum, waiver of payment and income type benefits will be taken into account. Income and waiver of payment benefit amounts will be converted to lump sums for the calculations.

- New cover applied for as well as existing cover at all businesses in the Sanlam group and other insurers may be taken into account.** Group cover and incomplete applications for cover will also be included, but replacements will be excluded. Also refer to the section "Existing cover and incomplete applications for cover" for more information.

Note that no information about existing cover or other incomplete applications for cover is required when a quotation is done. Therefore, at quotation stage, only other benefits applied for on the same quotation will be taken into account to determine the allowed maximums. Information about existing insurance and other incomplete applications are only required during the application process. The benefits granted on a quotation may therefore be limited or declined if such other cover leads to over-insurance.

- Absolute maximums as indicated in the previous section in this chapter will be taken into account.
- Additional financial underwriting limits may also be applied. For example, the sum of lump sum disability- and impairment-related cover may not be more than R35 million for a life insured.
- The age of a life insured and the monthly income (before tax) is used for financial underwriting – refer to the "Income" section earlier in this chapter. The following formulas will be used (but not for housewives/house husbands, children/scholars, students, pensioners or unemployed persons), where the relevant factors and percentages are indicated in the tables below:
 - Death, accidental injury, impairment, severe illness/dread disease:** Monthly income x Multiple factor
 - Future cover:** 1.5 x Monthly income x Multiple factor
 - Disability cover:** [Monthly income x Conversion factor x Sliding scale percentage] + [24 x Monthly income].

The electronic *Calculating Disability and Sickness maximums* calculator on SanPort can be used to determine the maximums for disability- and impairment-related cover under the Classic and Premier product options. The calculator will take lump sum, waiver of payment and income cover into account, including existing insurance and incomplete applications for cover at Sanlam and other insurers, if such information is provided. The calculator can however not be used for housewives/house husbands, children/scholars, students, pensioners or unemployed persons.

Age next birthday of life insured	Multiple factor
≤ 25	240
26 – 30	288
31 – 35	276
36 – 40	264
41 – 50	216
51 – 55	180
56 – 60	144
61 – 65	96
≥ 66	72

Age next birthday	Conversion factor
up to 25	320
26 – 30	320
31 – 35	320
36 – 40	280
41 – 45	240
46 – 50	200
51 – 55	160
56	150
57	140
58	130
59	120
60	110
61	100
62	90
63	80
64	70
65	60
66	60
67	60
68	60
69	60
70	60

Annual Gross Income * (Annual GI)	Sliding scale %
GI ≤ R150 000	100%
R150 000 < GI ≤ R300 000	90%
R300 000 < GI ≤ R550 000	85%
R550 000 < GI ≤ R850 000	80%
R850 000 < GI ≤ R1 500 000	75%
R1 500 000 < GI ≤ R3 000 000	70%
R3 000 000 < GI	65%

*For the Sickness Income and Sickness Income Plus benefit the gross professional income (GPI) is used to look up the sliding scale percentage. For all other benefits the gross income is used. (Note that GPI includes business overhead expenses, while gross income excludes it.)

Existing cover and incomplete applications for cover

Existing cover and incomplete applications for cover, including group cover, will be taken into account when determining the maximum amount of cover available for a life insured, but replacements will be excluded.

Information required on the application forms

Certain information about existing insurance must be provided on the application forms. Incomplete applications for insurance must be included, but replacements must be excluded.

When applying for benefits other than the Funeral Expenses benefit, with or without Cashback:

- Provide cover amounts for insurance with other insurers (including group cover).
- Cover with MiMay Life, Sanlam Indie and Sanlam Group Risk must also be included, but other Sanlam insurance must be excluded.

Information about the following types of cover must be provided:

- Life cover
- Disability cover
- Disability plus impairment
- Dread disease (Trauma) / Severe illness
- Sickness Income
- Temporary Income
- Overhead expenses
- Disability income (less than 24 month waiting period)
- Disability income (24 month waiting period)
- Impairment Income
- Death income.

When applying for the Funeral Expenses benefit, with or without Cashback:

- For children before their 14th birthday: Information about **life and funeral cover** must be provided. MiWay Life, Sanlam Indie, Sanlam Group Risk and Sanlam Sky cover must be included but other Sanlam insurance must be excluded. Cover with other insurers must be included (including group cover).
- For lives insured on or after their 14th birthday: **Only** information about **funeral cover** must be provided. Only MiWay Life, Sanlam Indie and Sanlam Group Risk funeral cover must be included.

Cover at Sanlam Life

The existing benefits/types of cover at Sanlam Life that will be taken into account when applying for a specific benefit are indicated below.

Benefit applied for	Sanlam Life cover
Lump sum benefits	
Death-related cover	
Death (DS)	<ul style="list-style-type: none"> • DS, DS80, DSF1, DSF3, ASC, DSC, DI3, DEC and • All other death-related benefits, excluding funeral benefits
First death (DS80)	
Estate Expenses (DEC)	
Immediate Expenses (DSF3)	<ul style="list-style-type: none"> • DSF1, DSF3
Funeral Expenses (FSC3) – for children before their 14th birthday	<ul style="list-style-type: none"> • FSC2, FSC3, and • All other death-related benefits, including funeral benefits
Funeral Expenses (FSC3) – for lives insured on or after their 14th birthday	<ul style="list-style-type: none"> • FSC2, FSC3, and • All other funeral-related benefits (except DSF1)
Accidental death (ASC) - excluding housewives/house husbands, children/scholars, students, pensioners, unemployed	<ul style="list-style-type: none"> • ASC, and • OLV, DU, T84
Accidental death (ASC) - housewives/house husbands, children/scholars, students, pensioners, unemployed	<ul style="list-style-type: none"> • DS, DS80, DSF1, DSF3, ASC, DSC, DI3, and • OLV, DU, T84, and • All other death-related benefits, excluding funeral benefits

Accidental injury-related cover	
Accidental injury (ASW)	• ASW
Benefit applied for	Sanlam Life cover
Lump sum benefits	
Disability- and impairment-related cover	
Comprehensive Disability (CAR3, CSR3)	• OAR, OSR, OAR2, OSR2, OAS, OSS, CAR, CSR, CAR3, CSR3, CAR4, CSR4, CAR5, CSR5, CAS, CSS, ASO, ASO3, ASO4, ASO5, AIO, OAF, OSF, OAI, OSI, OAP, OSP, OAP2, OSP2, OAP3, OSP3, LAP, LSP, DSC, OGG, OGG1, OPG, OPG1, OIO, OIO3, OIO4, OIO6, OIR, and
Comprehensive Disability Plus (CAR4, CSR4)	• OA, OB, OC, OD, OE, OF, OG, OGG, OP, OPG, M-OP, T46, T47, T48
Elite Disability (CAR5, CSR5)	
Comprehensive Impairment (OAI, OSI)	
Accidental Comprehensive Disability (ASO3)	• ASO, ASO3, ASO4, ASO5, AIO
Accidental Comprehensive Disability Plus (ASO4)	
Accidental Elite Disability (ASO5)	
Accidental Comprehensive Impairment (ASI)	
Severe illness/dread disease-related cover	
Cancer (TAT3, TST3)	• TAT3, TST3, TAT4, TST4, TAW3, TSW3, TAW4, TSW4, TAC, TSC, TAC2, TSC2, TAW, TSW, TAW2, TSW2, dread disease cover on LAP and LSP, and
Cancer Plus (TAT4, TST4)	• KTV, TV, T16
Cardiovascular (TAH3, TSH3)	• TAH3, TSH3, TAH4, TSH4, TAW3, TSW3, TAW4, TSW4, TAC, TSC, TAC2, TSC2, TAW, TSW, TAW2, TSW2, dread disease cover on LAP and LSP, and
Cardiovascular Plus (TAH4, TSH4)	• KTV, TV, T16
Severe illness/dread disease-related cover	
Comprehensive Severe Illness (TAW3, TSW3)*	• TAT3, TST3, TAT4, TST4, TAH3, TSH3, TAH4, TSH4, TAW3, TSW3, TAW4, TSW4, TAC, TSC, TAC2, TSC2, TAW, TSW, TAW2, TSW2, dread disease cover on LAP and LSP, and
Comprehensive Severe Illness Plus (TAW4, TSW4)*	• KTV, TV, T16
Core dread disease (TAC, TSC)*	
Whole life core dread disease(TAC2, TSC2)*	
Child illness and injury cover	
Child: Illness and injury (TSK)	• TSK
Credit Life cover	
Credit Life (DSC)	• DS, DS80, DEC, DSF1, DSF3, ASC, DSC, DI3, and • All other death-related benefits, excluding funeral benefits
Future cover group	
FutureCover: Death (FS1)	• DS, DS80, DEC, DSF1, DSF3, ASC, DSC, DI3, FS1, FS2, TD, and
FutureCover: Comprehensive (FS2)	• All other death-related benefits, excluding funeral benefits
Waiver of payment benefits	
Waiver of payment with future growth at death (DG)	No fixed maximums; subject to financial underwriting
Waiver of payment without future growth at death (DP)	
Waiver of payment with future growth at disability (OGG1)	
Waiver of payment without future growth at disability (OPG1)	

Benefit applied for	Sanlam cover
Income benefits	
Death-related cover	
Death income (DI3)	<ul style="list-style-type: none"> • DS, DS80, DSF1, DSF3, ASC, DSC, DI3, DEC and • All other death-related benefits, excluding funeral benefits
Disability- and impairment-related cover	
Sickness Income (IS4) and Sickness Income Plus (IS5)	<ul style="list-style-type: none"> • DSC, IS1, IS2, IS3, IS4, IS5, OIT, OIT3, OIT4, OIT5, OIB, OIB4, OIO (less than 24 months waiting periods only), and • T46, T47, T48
Temporary Income (OIT4) and Temporary Income Plus (OIT5)	
Overhead expenses (OIB4)	
Impairment Income	<ul style="list-style-type: none"> • OIO3, OIO4, OIO6, OIR, OIT3, OIT4, OIT6, AIO
Extended Income (OIO4) and Extended Income Plus (OIO6)	<ul style="list-style-type: none"> • OAR, OSR, OAS, OSS, OAR2, OSR2, CAR, CSR, CAR3, CSR3, CAR4, CSR4, CAR5, CSR5, CAS, CSS, LAP, LSP, DSC, OIO (all waiting periods), OIO3, OIO4, OIO6 OIR, and • T46, T47, T48
Accidental Temporary Income Plus	<ul style="list-style-type: none"> • OIO3, OIO4, OIO6, OIR, OIT3, OIT4, OIT6
Accidental Extended Income Plus	<ul style="list-style-type: none"> • OIO3, OIO4, OIO6, OIR
Severe illness/dread disease-related cover	
Severe Illness income (TIW3)	<ul style="list-style-type: none"> • TIW3

*When applying for this benefit: For financial underwriting the total cover amount of benefits that provide only cancer cover will be determined, as well as the total cover amount of benefits that provide only cardiovascular cover. The maximum of these two amounts will then be added to the cover amounts of all the other benefits in this group. The benefits that provide only cancer cover are the Cancer (TAT3, TST3) and Cancer Plus (TAT4, TST4) benefits, while the benefits that provide only cardiovascular cover are the Cardiovascular (TAH3, TSH3) and Cardiovascular Plus (TAH4, TSH4) benefits.

Medical underwriting and non-medical limit requirements

General

Medical underwriting is done, but **not** for the following:

- If a life insured takes only the Funeral Expenses or accidental benefits, with or without Cashback.
- If a life insured exercises a proof-free option to take out cover.

The medical underwriting decision may be any of the following:

- accept the cover on standard terms with no medical loadings or medical exclusions;
- accept the cover and add a medical loading;
- accept the cover and apply a medical exclusion;
- decline all or a part of the cover;
- accept the cover with any combination of the decisions above..

In accordance with the HIV testing protocol of the Association for Savings and Investment South Africa (ASISA), no samples may be processed by any service provider without documentary proof that:

- in the case of an HIV test, the client has received the required pre-testing information, and
- a photographic identity check has been carried out by the person taking blood or urine samples, and
- the life insured has signed informed consent for an HIV test.

If these prescriptions are not complied with, we reserve the right to withhold payment for the services by a service provider.

Before any test may be done, the applicant or life insured must have

- requested and authorised us to obtain information from the service provider, and
- agreed that we share information with other life offices directly or through ASISA for purposes of underwriting and/or claims assessment.

In terms of ASISA protocol the applicant/life insured may enquire about information held by ASISA and such information will be made available to him/her by his/her nominated medical practitioner.

Identification policy for medical examinations and tests

ASISA requires that lives insured must identify themselves before undergoing certain medical examinations and tests for the insurance industry.

One of the following is required for proof of identity for medical examinations and tests:

- a valid RSA identity document;
- a valid temporary RSA identity document issued by the Department of Home Affairs;
- a valid card-type driver's licence issued by the Department of Transport in the RSA;
- a valid passport.

We reserve the right to request additional proof of identification.

Validity period of medical reports

Enquire at local underwriting office for detail about validity periods.

Requirements for completing medical reports and doing tests

Medical reports and tests will be accepted only if completed/done according to the requirements below.

Confidential short medical report

The *Confidential short medical report* (form AE2681) may be completed by any of the following:

- the life insured's family doctor;
- a general practitioner registered with the Health Professions Council of South Africa (HPCSA);
- a registered nurse or enrolled nurse, registered with the South African Nursing Council (SANC), and who is bona fide in the service of a medical practitioner, pathologist or third party service provider with whom Sanlam New Business has a valid contract.

Confidential medical report

The *Confidential medical report* (form AE2230) may be completed by any of the following:

- the life insured's family doctor;
- a general practitioner registered with the Health Professions Council of South Africa (HPCSA).

Body mass index (BMI) assessment

A BMI assessment may be completed by a registered nurse or enrolled nurse, registered with the South African Nursing Council (SANC), and who is bona fide in the service of a medical practitioner, pathologist or third party service provider with whom Sanlam New Business has a valid contract.

Personal medical adviser's report

To obtain a *Personal medical adviser's report* (form AE1762), the sales office sends the family doctor a letter with a request to complete a form AE1762 from the medical records of the life insured. It will never be necessary for a life insured to visit his/her doctor for this purpose.

X-rays

X-rays done by any of the following will be accepted:

- a radiologist;
- a general practitioner, if he/she has the necessary apparatus;
- a hospital.

Blood and urine samples

Only test results of ASISA-accredited pathology laboratories will be accepted.

Blood and urine samples* may be taken by any of the following:

- a practising medical practitioner registered with the Health Professions Council of South Africa (HPCSA);
- a registered nurse or enrolled nurse, registered with the South African Nursing Council (SANC), and who is bona fide in the service of a medical practitioner, pathologist or third party service provider with whom Sanlam New Business has a valid contract;
- a registered person who has been authorised by the HPCSA to draw blood and who is bona fide in the service of an accredited pathology laboratory.

*Note that not all service providers do urine tests for Cotinine. Therefore, if a planholder wants to have urine instead of blood tests done for Cotinine, he/she must first check if urine tests are done by the service provider that he/she is planning to use.

Availability of medical questionnaires

Medical questionnaires are available on the Sanlam intranet and SanPort.

Non-medical limit requirements

Not applicable to the Child: Illness and injury benefit.

The following rules will apply when non-medical limit requirements are determined:

- Only cover accepted by us within the last 12 months will be accumulated to determine the effective cover amount.
- Determine the category that must be used as follows:
 - Where benefits fall into both categories 3 and 4, the total of the cover amounts of the benefits in categories 3 and 4 must be used;
 - For all other benefits, the total cover amount of all the benefits in that category and the non-medical limit requirements for that category must be used.

The non-medical limit requirements are indicated in the tables below, where:

- A = *Confidential short medical report** (form AE2681)
- B = *Confidential medical report** (form AE2230)
- C = Effort ECG by general practitioner or family practitioner
- IC = Individual consideration.

*Refer to "Requirements for completing medical reports and doing tests" in this chapter.

The following applies **in addition to** the non-medical limit requirements indicated in the tables below:

- A fully completed application form, with "Statement of health by life insured" included, is always required for all benefit types.
- A cotinine test is always required for a non-smoker.
- Depending on the body mass index (BMI) of a life insured as per application form, we may require verification of height and weight for purposes of product pricing.
- An HIV test is sometimes required, and is dependent on the age and rate group of a life insured and the effective cover amount applied for. Refer to "HIV limit requirements" for more information.

Effective cover amount	Non-medical limit requirements for rate groups 1, 2 and 3		
	Age next birthday		
	≤ 45	46 - 59	≥ 60
Category 1: DS, DS80, DEC, DSF1, DSF3, DSC, DG*, DP*, FS1, DI3*			
Category 2: OAR, OSR, OAR2, OSR2, OAS, OSS, CAR, CSR, CAR3, CSR3, CAR4, CSR4, CAR5, CSR5, CAS, CSS, OAF, OSF, OAI, OSI, OAP, OSP, OAP2, OSP2, OAP3, OSP3, Permanent disability cover on DSC, FS2, and disability and physical impairment cover on LAP and LSP			
≤ R2.5m	-	-	-
R2 500 001 – R5m	-	A	B, C
R5 000 001 – R12m	-	B, C	B, C
> R12m	IC	B, C, IC	B, C, IC
Category 3: Temporary disability cover on DSC**, IS1, IS2, IS3, IS4, IS5 Income benefits with waiting period < 12 months (OIT, OIT3, OIT4, OIT5, OIB, OIB4 OIO), OGG, OGG1, OPG, OPG1			
Category 4: Income benefits with waiting period ≥ 12 months (OIT3, OIO, OIO3, OIO4, OIO6), OIR			
≤ R15 000 per month	-	-	-
R15 001 – R30 000 per month	-	A	B, C
R30 001 – R60 000 per month	-	B, C	B, C
> R60 000 per month	IC	B, C, IC	B, C, IC
Category 5: TAT3, TST3, TAT4, TST4, TAH3, TSH3, TAH4, TSH4, TAW3, TSW3, TAW4, TSW4, TAC, TSC, TAC2, TSC2, TAW, TSW, TAW2, TSW2, dread disease cover on LAP and LSP, TIW3***			
≤ R500 000	-	-	A
R500 001 – R2m	-	A	B, C****
R2 000 001 – R4m	-	B, C****	B, C****
> R4m	A	B, C****, IC	B, C****, IC

*Category 1: For DG, DP and DI3 the monthly cover amounts will be converted to lump sums.

**Category 3: For DSC the lump sum cover amount will be converted to income.

***Category 5: For TIW3 the monthly cover amount x 12 will be used.

****Category 5: Requirement C will not apply for TAT3, TST3, TAT4 and TST4.

Effective cover amount	Non-medical limit requirements for rate groups 4 and 5		
	Age next birthday	≤ 45	46 - 59
Category 1: DS, DS80, DEC, DSF1, DSF3, DSC, DG*, DP*, FS1, DI3*			
Category 2: OAR, OSR, OAR2, OSR2, OAS, OSS, CAR, CSR, CAR3, CSR3, CAR4, CSR4, CAR5, CSR5, CAS, CSS, OAF, OSF, OAI, OSI, OAP, OSP, OAP2, OSP2, OAP3, OSP3, Permanent disability cover on DSC, FS2, and disability and physical impairment cover on LAP and LSP			
≤ R4m	-	-	-
R4 000 001 – R8m	-	A	B, C
R8 000 001 – R20m	-	B, C	B, C
> R20m	IC	B, C, IC	B, C, IC
Category 3: Temporary disability cover on DSC**, IS1, IS2, IS3, IS4, IS5 Income benefits with waiting period < 12 months (OIT, OIT3, OIT4, OIT5 OIB, OIB4, OIO), OGG, OGG1, OPG, OPG1			
Category 4: Income benefits with waiting period ≥ 12 months (OIT3, OIO, OIO3, OIO4, OIO6), OIR			
≤ R25 000 per month	-	-	-
R25 001 – R50 000 per month	-	A	B, C
R50 001 – R100 000 per month	-	B, C	B, C
> R100 000 per month	IC	B, C, IC	B, C, IC
Category 5: TAT3, TST3, TAT4, TST4, TAH3, TSH3, TAH4, TSH4, TAW3, TSW3, TAW4, TSW4, TAC, TSC, TAC2, TSC2, TAW, TSW, TAW2, TSW2, dread disease cover on LAP and LSP, TIW3***			
≤ R2m	-	-	A
R2 000 001 – R5m	-	B, C****	B, C****
> R5m	A	B, C****, IC	B, C****, IC

*Category 1: For DG, DP and DI3 the monthly cover amounts will be converted to lump sums.

**Category 3: For DSC the lump sum cover amount will be converted to income.

***Category 5: For TIW3 the monthly cover amount x 12 will be used.

****Category 5: Requirement C will not apply for TAT3, TST3, TAT4 and TST4.

HIV limit requirements

Not applicable to the Child: Illness and injury benefit.

The following rules will apply when HIV limit requirements are determined:

- Only cover which has been accepted by us within the last 12 months will be accumulated to determine the effective cover amount;
- The monthly cover amounts of waiver of payment and death income benefits will be converted to lump sums to determine the effective cover amount for Category 1, while the lump sum cover amounts of Credit Life benefits will be converted to income for Category 3.

The effective cover amount in a category that must be used to determine the HIV limit requirements, is the total of the cover amounts of all the benefits in the category:

- Category 1: DS, DS80, DEC, DSF1, DSF3, DSC, DG, DP, FS1, DI3
- Category 2: OAR, OSR, OAR2, OSR2, OAS, OSS, CAR, CSR, CAR3, CSR3, CAR4, CSR4, CAR5, CSR5, CAS, CSS, OAF, OSF, OAI, OSI, OAP, OSP, OAP2, OSP2, OAP3, OSP3, Permanent disability cover on DSC, FS2, and disability and physical impairment cover on LAP and LSP
- Category 3: Temporary disability cover on DSC, IS1, IS2, IS3, IS4, IS5, Income benefits with waiting period < 12 months (OIT, OIT3, OIT4, OIT5, OIB, OIB4, OIO), OGG, OGG1, OPG, OPG1
- Category 4: Income benefits with waiting period ≥ 12 months (OIT3, OIO, OIO3, OIO4, OIO6), OIR
- Category 5: TAT3, TST3, TAT4, TST4, TAH3, TSH3, TAH4, TSH4, TAW3, TSW3, TAW4, TSW4, TAC, TSC, TAC2, TSC2, TAW, TSW, TAW2, TSW2, dread disease cover on LAP and LSP, TIW3*.

*For TIW3 the monthly cover amount x 12 will be used..

An HIV test is always required for rate group 1. For rate groups 2, 3 and 4, an HIV test is required if the effective cover amount in any of the five categories above exceeds the "Effective cover amount" indicated in the table below. The lives insured in rate group 5 who must undergo an HIV test will be randomly selected.

Age next birthday	HIV limit requirements			
	Effective cover amount			
	Rate group 2	Rate group 3	Rate group 4	Rate group 5
≤ 45	≥ R10 000	≥ R10 000	≥ R10 000	
46 – 60	≥ R25 000	≥ R50 000	≥ R75 000	
≥ 61	≥ R25 000	≥ R50 000	≥ R200 000	Randomly selected

Territorial underwriting

Overseas underwriting

Overseas underwriting applies to lives insured who are in a foreign country at the time of application, or who are planning to travel to a foreign country during the next 12 months. For the purpose of this, the following countries/regions can be ignored: SADC countries (excluding Angola, the DRC, Mozambique and Zimbabwe), United Kingdom, Europe, United States of America, Canada, Australia and New Zealand.

The territorial underwriting decision may be any of the following:

- accept the cover on standard terms, with no territorial exclusions;
- accept the cover, but limit the rate group and cover amount;
- decline all or a part of the cover.

Also refer to the "Funeral Expenses benefit (FSC3)" section below for additional information.

Foreigner underwriting for foreigner in South Africa

Foreigner underwriting applies to a foreigner in South Africa. We will only consider cover for a foreigner who is in South Africa at the time of application, and who has the required documentation for identification.

The territorial underwriting decision may be any of the following, but also see "Funeral Expenses benefit (FSC3)" below for additional information for this benefit:

- accept the cover on standard terms, with no territorial exclusions;
- accept the cover and apply a foreigner's clause*;
- decline the cover.

*A foreigner clause will **never** be applied for foreigners with citizenship in **Lesotho or Namibia**.

Funeral Expenses benefit (FSC3)

Countries where cover for the Funeral Expenses benefit is excluded

We will not admit a claim for the Funeral Expenses benefit if a life insured dies in one of the following countries: Afghanistan, Angola: Cabinda Province, Burundi, Central African Republic, Chad, Democratic Republic of the Congo, Iran (Islamic Republic of Iran), Iraq, Lebanon, Libya (Lybian Arab Jamahiriya), Mali, Nigeria: Niger Delta, North Korea, Pakistan, Somalia, South Sudan, Sudan, the Syrian Arab Republic and Yemen. If a life insured lives or plans to live in one of these countries, it is the planholder's responsibility to request us in writing to end the Funeral Expenses benefit for that life insured. We will not refund any payments because of cover being excluded in these countries.

This list of countries may change in future and if another benefit version was applicable to a life insured in the past, this list of countries may differ from the countries in those list(s). If the cover amount of the Funeral Expenses benefit is increased, other than through benefit growth, the latest list of countries will apply to the increased part of the cover amount of the Funeral Expenses benefit. The list(s) of countries that applied to the cover amount before the increase will continue to apply to that part of the cover amount after the increase. Different lists of countries could therefore apply to different parts of the cover amount at the time of a claim.

The Funeral Expenses benefit (FSC3) for foreigners

Foreigners with citizenship in Lesotho or Namibia

The Funeral Expenses benefit is available to these foreigners, regardless of whether they live in South Africa or not. For these foreigners the Funeral Expenses benefit will cover claim events both inside and outside South Africa, excluding those countries where cover for the Funeral Expenses benefit is excluded.

Other foreigners

The Funeral Expenses benefit is not available to these foreigners if they do not live in South Africa or if they live in South Africa without valid travelling documents.

The Funeral Expenses benefit is available to these foreigners if they live in South Africa with valid travelling documents, but is restricted to claim events in South Africa only. However, if a foreigner life insured at any stage obtains a permanent residence permit, or South African citizenship, the Funeral Expenses benefit for that life insured will cover claim events both inside and outside South Africa, excluding those countries where cover for the Funeral Expenses benefit is excluded.

If a foreigner life insured as described in this section no longer lives in South Africa, it is the planholder's responsibility to request us in writing to end the Funeral Expenses benefit for that life insured. We will not refund any payments because of cover being restricted to claim events in South Africa only.

Territorial questionnaires

Not applicable to the Funeral Expenses benefit.

The *Residence/travelling outside the Republic of South Africa* (form AEVL07) must be completed for lives insured who are in a foreign country at the time of application, or who are planning to travel to a foreign country during the next 12 months. For the purpose of this, the following countries/regions can be ignored: SADC countries (excluding Angola, the DRC, Mozambique and Zimbabwe), United Kingdom, Europe, United States of America, Canada, Australia and New Zealand.

The *Foreign clients' questionnaire* (form AE4006) must be completed for:

- a foreigner who does not have a valid RSA identity document;
- a foreigner who is a refugee, regardless of whether the refugee has a valid RSA identity document or not.

The territorial questionnaires are available on the Sanlam intranet and SanPort.

Rates differentiation

Rates differentiation depends on the inception age of a life insured and the chosen cover amount for a benefit. For the Funeral Expenses benefit the insurable interest is also taken into account.

A body mass index (BMI) assessment may be done for purposes of product pricing. Currently an additional BMI payment may be charged for the Death, First death, Immediate Expenses and Death income benefits, but **not** for smokers, rate group 5 lives insured or lives insured with a post-matric/post-grade 12 qualification.

In addition to this, where a benefit offers a choice with regards to the following, the rate for a life insured may differ depending on the choices made:

- payment pattern and cover growth*
- guarantee period*
- with or without optional rider benefits
- benefit cease age
- benefit waiting period
- benefit payment period.

*This choice is made for a plan, but will apply to all the benefits of the plan.

Our other criteria for rates differentiation are indicated in the tables below.

Rates differentiation					
Benefit	Gender	Smoker status	Rate group	Accident class (occupation)	Disability class (occupation)
Life cover					
Death (DS)	✓	✓	✓		
First death (DS80)	✓	✓	✓		
Estate Expenses (DEC)	✓	✓	✓		

Immediate Expenses (DSF3)	✓	✓	✓		
Funeral Expenses (FSC3)	✓				
Accidental death (ASC)	✓			✓	
Disability and impairment benefits					
Comprehensive Disability (CAR3, CSR3)	✓	✓			✓
Comprehensive Disability Plus (CAR4, CSR4)	✓	✓			✓
Elite Disability (CAR5, CSR5)	✓	✓			✓
Comprehensive Impairment (OAI, OSI)	✓	✓			✓
Accidental Comprehensive Disability (ASO3)	✓			✓	
Accidental Comprehensive Disability Plus (ASO4)	✓			✓	
Accidental Elite Disability (ASO5)	✓			✓	
Accidental Comprehensive Impairment (ASI)	✓			✓	
Severe illness benefits					
Cancer (TAT3, TST3)	✓	✓	✓		
Cancer Plus (TAT4, TST4)	✓	✓	✓		
Cardiovascular (TAH3, TSH3)	✓	✓	✓		
Cardiovascular Plus (TAH4, TSH4)	✓	✓	✓		
Comprehensive Severe Illness (TAW3, TAW3)	✓	✓	✓		
Comprehensive Severe Illness Plus (TAW4, TSW4)	✓	✓	✓		

Rates differentiation for Risk products					
Benefit	Gender	Smoker status	Rate group	Accident class (occupation)	Disability class (occupation)
Dread disease and injury benefits					
Core dread disease (TAC, TSC)	✓	✓	✓		
Whole life core dread disease (TAC2, TSC2)	✓	✓	✓		
Child: Illness and injury (TSK)	✓		✓ (of the parent/legal guardian)		
Accidental injury (ASW)	✓			✓	
Credit Life cover					
Credit Life (DSC)	✓	✓	✓		✓
Waiver of payment and Future cover					
Waiver of payment with future growth at death (DG)	No rates differentiation for gender, smoker status, rate group, disability class and accident class.				
Waiver of payment without future growth at death (DP)					
Waiver of payment with future growth at disability (OGG1)					✓
Waiver of payment without future growth at disability (OPG1)					✓
FutureCover: Death (FS1)	✓	✓	✓		
FutureCover: Comprehensive (FS2)	✓	✓	✓		✓
Income protection					
Sickness Income (IS4) and Sickness Income Plus (IS5) <i>(with or without the optional Spouse protector and Child protector rider benefits)</i>	✓	✓			✓
Temporary Income (OIT4) and Temporary Income Plus (OIT5) <i>(with or without the optional Spouse protector and Child protector rider benefits)</i>	✓	✓			✓
Overhead expenses (OIB4)	✓	✓			✓
Extended Income (OIO4) and Extended Income Plus (OIO6)	✓	✓			✓
Impairment Income (OII)	✓	✓			✓
Accidental Temporary Income Plus (AIT)	✓	✓		✓	
Accidental Extended Income Plus (AIO)	✓	✓		✓	
Severe illness income (TIW3)	✓	✓	✓		
Death income (DI3)	✓	✓	✓		
Cashback					
Cashback (RS)	The payment for this benefit is a fixed percentage of the total payment for all the other applicable benefits of a life insured with the Cashback benefit.				

New business service offerings

Medical support services

To make medical underwriting easier, walk-in services as well as Nurses on wheels (NOW) are available to clients, once underwriting terms have been set.

Walk-in services at doctors, pathologists, MediCross and Intercare facilities

The walk-in services offered at pathologists, MediCross and Intercare facilities are:

- drawing of blood;
- completion of the *Confidential short medical report* (form AE2681);
- completion of ad hoc medical questionnaires.

Nurses on wheels (NOW)

If the payment for a new plan is R300 or more, and the final underwriting terms have been set, clients can make use of Nurses on wheels (NOW). These nurses are available, by appointment only, to visit clients at their place of work for the following:

- drawing of blood;
- completion of the *Confidential short medical report* (form AE2681);
- completion of ad hoc medical questionnaires.

No minimum payment applies to the clients below, and these clients automatically qualify for NOW services once the final underwriting terms have been set:

- clients of VIP brokers;
- clients of bank brokers;
- rate group 5 clients;
- clients of Cobalt for Professionals;
- clients of a select group of about 200 brokers, as determined by regional general managers, who are frequent writers of risk business.

Once the final underwriting terms have been set, contact NOW@sanlam.co.za or call (021) 916 3600 (option 4) for further assistance.

Tele-underwriting

A client in rate groups 2 to 5 can choose to be called by a tele-underwriter at any time between 08:00 and 20:00 (Monday to Friday). Tele-underwriting is not currently available to rate group 1 clients.

If tele-underwriting is selected:

- the client will do medical declarations telephonically via a tele-interview;
- no completion of medical questionnaires by the intermediary is required.

The benefits to an intermediary of making use of tele-underwriting are the following:

- shorter client visits;
- less administration;
- no accountability for inaccurate answers to medical questions;
- some clients prefer the privacy of a telephone conversation;
- some clients may prefer not to disclose personal information to an intermediary;
- all calls are recorded for future reference.

All tele-underwriting calls by Sanlam Life will be made from 087 350 9073. As clients are often reluctant to answer numbers that they may not be familiar with, they may find it useful to save this number. This number can also be called to, for example, leave a message for an alternative interview time.

Contact details

To make use of the new business service offerings, call (021) 916-3600.

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Payment of plan benefits

Benefits will be paid in South Africa in South African currency.

To whom will the benefits be paid?

Benefits where the planholder is not the life insured

Benefits where the planholder is not the life insured will be paid to the planholder.

Benefits payable at the planholder's death

Benefits payable at the planholder's death will be paid to his or her estate.

However, the planholder on a Topcover or Termcover plan may appoint one or more beneficiaries to receive the benefits (including funeral benefits) at his or her death. The appointed beneficiary or beneficiaries can however only accept the appointment after the planholder's death. We will only pay the benefits to a beneficiary if the beneficiary accepts the appointment.

The planholder may cancel or change the appointment of a beneficiary at any time. The appointment, cancellation or change must be in writing and signed by the planholder, and must reach our head office before the planholder's death.

Other benefits on the planholder's life

Benefits where the planholder is the life insured and the benefit is payable on an event other than the planholder's death will be paid to the planholder.

However, if we determine from the medical and other applicable evidence we received for the claim that the planholder has lost his or her legal capacity to act, we will by law not be able to make the payment directly to the planholder. We will need to withhold the payment, until an Administrator is duly appointed by the Master of the High Court, or a Curator Bonis is duly appointed by the High Court, as the case may be. This appointment can be costly and significantly delay a benefit payment.

Losing the planholder's legal capacity to act refers to the planholder being wholly incapable of making rational financial decisions or understanding the nature, purpose and consequences of these decisions, for example, as a result of suffering from dementia.

Sanlam Protector Umbrella Trust

However, if the planholder has given consent for the Sanlam Protector Umbrella Trust (the Trust), we will, in the above circumstances, be able to pay the benefits to the mentioned Trust instead. Any Cashback amounts that are payable at the time of a claim will also be payable to the Trust.

The Trust will then administer the funds for the planholder's benefit until the funds are depleted or until the planholder's death. However, should the planholder to the satisfaction of the trustees, fully recover and regain his or her legal capacity to act, the planholder may, in this instance, provide instructions to the trustees as to how he or she wants the benefits to be administered. The administration of the Trust will be subject to fees as determined by Sanlam Trust. The Trust Deed and information on the Trust administration is available on the Sanlam Trust website at www.sanlamtrust.co.za.

If the planholder has given consent, this consent will apply across all his or her plans with us, to benefits where he or she is both the planholder and the life insured and the benefit is payable on an event other than the planholder's death. Consent can only be provided, and be legally valid, while the planholder still has the legal capacity to act.

If, at the time when a claim amount is payable, the planholder has the legal capacity to act, the money will be paid to the him or her directly and not to the Trust.

Can the appointment of beneficiaries lapse?

Yes, it will lapse if the planholder cedes the plan outright. If the planholder cedes the plan as collateral security, the appointment will not lapse, but the rights of the cessionary will take preference over any rights of a beneficiary.

Role players and cessions

Number of role players

Each plan has **one planholder**. The minimum and maximum for other role players are indicated in the table below.

Number of role players			
Product	Product code	Minimum	Maximum
Life insured			
Topcover and Termcover products, excluding Matrix Express Topcover	T02, T02W	1	10
Matrix Express Topcover	T02W	1 underwritten life insured*	10 (1 underwritten life insured and 9 lives insured with Funeral (FSC2) / Funeral Expenses (FSC3) only, OR 2 underwritten lives insured and 8 lives insured with Funeral (FSC2) / Funeral Expenses (FSC3) only)*
Income protector products	T03W	1	1

*For **Matrix Express Topcover** an “underwritten life insured” is a life insured with benefits other than Funeral (FSC2) or Funeral Expenses (FSC3), with or without the Cashback benefit. An underwritten life insured for this product may only be the planholder and/or spouse of the planholder. (Note that the Funeral (FSC2) benefit is no longer available for new business.)

A spouse is a person to whom the planholder is legally married on the date of inclusion as a life insured, or with whom the planholder has concluded an agreement recognised as a marriage in accordance with any law or custom, provided that in the case of a marriage by law or custom, he or she lives with that person as if legally married.

Number of role players			
Product	Product code	Minimum	Maximum
Beneficiary (to receive death benefits on planholder's own life, at planholder's death)			
Topcover and Termcover products	T02, T02W	0	<ul style="list-style-type: none"> 1 (and only one) for the Funeral (FSC2)* or Funeral Expenses (FSC3) benefit 10 otherwise <p>*Note that the Funeral (FSC2) benefit is no longer available for new business.</p>
Income protector products	T03W	<ul style="list-style-type: none"> 1 compulsory for the Death income benefit Not allowed otherwise 	<ul style="list-style-type: none"> 10 for the Death income benefit Not allowed otherwise
Nominee to become new planholder			
Topcover and Termcover products	T02, T02W	0	1
Income protector products	T03W	Not allowed	
Cessionary for cession as security (collateral cession)			
Topcover and Termcover products	T02, T02W	<ul style="list-style-type: none"> 1 compulsory for the Credit Life benefit Not compulsory otherwise 	1
Income protector products	T03W	Not allowed	

Number of role players			
Product	Product code	Minimum	Maximum
Cessionary for change of planholder (outright cession)			
Topcover and Termcover products	T02, T02W	0	<ul style="list-style-type: none"> • Not allowed for a plan with a Credit Life benefit • 1 otherwise
Income protector products, excluding Matrix Express Income Protector	T03W	0	1
Matrix Express Income Protector	T03W	Not allowed	

Planholder

- The planholder specifies which lives insured and benefits must be on a plan, and is also responsible for the payments of the plan. Another party may make the payments, but the planholder remains responsible.
- The planholder can deal with the plan without the consent of the lives insured on the plan.
- The rights of the planholder can be transferred to another party (the cessionary) by means of a cession, subject to conditions as indicated under "Cession as security (collateral cession)" and "Change of planholder (outright cession)" later in this chapter.
- The plan is not terminated at the death of the planholder in cases where the planholder was not a life insured on the plan, or where the planholder was not the only life insured. If the planholder was the party who made the payments, another party will have to continue with the payments for the plan in order to keep the cover for the remaining lives insured in place. (Note that the plan will not lapse if we are waiving the payments under a waiver of payment benefit claim.).
- Where a trust is the planholder, the tax status of a plan is determined by the status of the trust beneficiaries, for example a natural person or an entity that is taxable or not, in terms of section 29A(4) of the Income Tax Act.

Conditions for the planholder

- Topcover products:
 - For Express plans the planholder must be a natural person, and he or she does not have to be a life insured on the plan. The minimum age of the planholder at the start of a plan is 19 next birthday for Express plans.
 - For Classic and Premier plans, excluding a Topcover plan with Funeral (FSC2)* or Funeral Expenses (FSC3), the planholder may be a natural person, trust or institution and he or she does not have to be a life insured on the plan. For a plan with Funeral (FSC2)* or Funeral Expenses (FSC3) the planholder must be a natural person, and he or she must also be a life insured on the plan. No minimum age applies to the planholder for Classic and Premier plans.

*Note that the Funeral (FSC2) benefit is no longer available for new business.

- Termcover products (Premier plans): The planholder may be a natural person, trust or institution and he or she does not have to be a life insured on the plan.
- Income protector products:
 - For Express plans the planholder must be a natural person and the same person as the life insured.
 - For Premier plans the planholder may be a natural person or institution, subject to the following:
 - If the planholder is a natural person, the planholder and life insured must be the same person.
 - If the planholder is an institution, the planholder must also be the employer of the life insured.

Life insured

A life insured must be a natural person. A valid insurable interest must exist between the planholder and a life insured on the plan. Refer to "Insurable interest" in the underwriting chapters for more information.

Lives insured can be added to, or removed from a plan. An additional life insured can only be added if more than one life insured is allowed for the plan. The adding of a life insured is subject to underwriting.

Beneficiaries for Topcover and Termcover products

Conditions for appointment of beneficiaries for Topcover and Term cover products

We recommend that beneficiaries are appointed, although doing so is not compulsory. If beneficiaries are appointed, the following applies:

- Beneficiaries are allowed on Death, First death, Funeral and other immediate expenses, Immediate Expenses, Funeral, Funeral Expenses, Accidental death and Credit Life benefits, but only if the **planholder is the life insured on the benefit**.
- A beneficiary can be a natural person, trust or institution;
- The beneficiaries may differ for each benefit;
- For benefits other than the Funeral or Funeral Expenses benefit:
 - The planholder may appoint one or more beneficiaries per benefit (on the planholder's own life), up to a maximum of 10 per benefit.
 - A percentage, between 0% and 100%, allocated to each beneficiary, must be specified separately for each benefit.
 - The total percentage allocated to beneficiaries for a benefit may not be more than 100%. If the total percentage allocated for a benefit is less than 100%, the remaining part of that benefit will be paid to the planholder's estate.
- For the Funeral or Funeral Expenses benefit (on the planholder's own life): Only one beneficiary may be appointed per benefit and the percentage allocated will always be 100%.

Note that the Funeral and other immediate expenses (DSF1) and Funeral (FSC2) benefits are no longer available for new business.

Beneficiaries for Income protector products: Death income benefit

Appointment of a beneficiary is compulsory

The appointment of one or more beneficiaries to receive the income payments is compulsory for this benefit. After the death of the life insured an appointed beneficiary will have to accept the appointment as beneficiary before we can start making the income payments.

The planholder may cancel or change the appointment of a beneficiary at any time. The appointment, cancellation or change must be in writing and signed by the planholder, and must reach our head office before the death of the life insured.

What will happen if an appointed beneficiary dies?

Benefit with a fixed term

If we admit a claim and an appointed beneficiary is no longer alive, the life insured's estate will have the option to appoint another beneficiary or to take a lump sum. The lump sum will be equal to the present value of the income payments that would have been made until the cover end date, discounted at a rate in line with long-term interest rates at the time of the calculation.

If an appointed beneficiary dies after we have already started making the income payments, we will pay the remaining income payments as a lump sum to the beneficiary's estate. The lump sum will be equal to the present value of the remaining income payments that would have been made until the cover end date, discounted at a rate in line with long-term interest rates at the time of the calculation.

Benefit with whole life cover

If we admit a claim and an appointed beneficiary is no longer alive, the life insured's estate will have the option to appoint another beneficiary or to take a lump sum. The lump sum will be equal to the present value of the income payments that would have been made until the end of the chosen income payment period, discounted at a rate in line with long-term interest rates at the time of the calculation.

If an appointed beneficiary dies after we have already started making the income payments, we will pay the remaining income payments as a lump sum to the beneficiary's estate. The lump sum will be equal to the present value of the remaining income payments that would have been made until the end of the chosen income payment period, discounted at a rate in line with long-term interest rates at the time of the calculation.

Conditions for appointment of beneficiaries for the Death income benefit

The following applies:

- The planholder must be a natural person and the life insured on the benefit;
- The beneficiary can be a natural person, trust or institution;
- The planholder may appoint one or more beneficiaries, up to a maximum of 10. It is compulsory to appoint at least one beneficiary.
- A percentage, between 0% and 100%, allocated to each beneficiary, must be specified separately.
- The total percentage allocated to beneficiaries for a Death income benefit must be 100%.

Nominee to become new planholder (nomination for plan-ownership)

The planholder on a Topcover or Termcover plan may nominate one other party to become the new planholder at his or her death. **We recommend such a nomination, although a nomination is not compulsory.**

The nominee must accept the nomination to become the new planholder. The nominee, as the new planholder, must then make the payments. However, the nominee can only accept the nomination after the planholder's death. **If the nominee does not accept the nomination, or if nobody has been nominated, the plan will be an asset in the planholder's estate (for executor's purposes) until a new planholder can be appointed, or until the plan lapses due to payments not made.** The plan will not lapse while we are waiving the payments under a waiver of payment benefit claim.

The planholder may cancel or change a nomination at any time. The nomination, cancellation or change must be in writing and signed by the planholder, and must reach our head office before the planholder's death.

Can the nomination lapse?

Yes, it will lapse if the planholder cedes the plan, whether outright or as collateral security.

Conditions for nomination

If a nominee is appointed for a Topcover or Termcover product, the following applies:

- The existing planholder must be a natural person, and the plan will not cease once this planholder dies.
- The planholder may only nominate one nominee.
- The existing planholder must not be a life insured on the plan, or, if he or she is a life insured on the plan, he or she may not be the only life insured.
- There must not be a collateral cession on the plan.
- For the Express product option the nominee must be a natural person.
- For the Classic and Premier product options:
 - Plan without Funeral (FSC2)* or Funeral Expenses (FSC3): The nominee can be a natural person, trust or institution.
 - Plan with Funeral (FSC2)* or Funeral Expenses (FSC3): The nominee must be a natural person.

*The Funeral (FSC2) benefit is no longer available for new business.

Cession as security (collateral cession)

With a collateral cession the planholder may cede the plan as security to one other party, where this party may be a natural person, trust or institution. The planholder must notify us of the cession in writing. The notice will take effect when we receive it.

A collateral cession is allowed for Topcover and Termcover products, but is not compulsory. It is, however, compulsory for a plan with a Credit Life benefit to be ceded as security to the financial institution who provides the loan.

If the plan has been ceded as security, the cessionary must consent, in writing, to every alteration, before we can do it. It is the planholder's responsibility to obtain this consent.

The following benefits will not be included in the cession:

- Funeral and other immediate expenses (DSF1)*
- Immediate Expenses (DSF3)
- Funeral (FSC2)*
- Funeral Expenses (FSC3).

*The Funeral and other immediate expenses (DSF1) and Funeral (FSC2) benefits are no longer available for new business.

After the plan has been ceded, our assumptions for lapses, for example, may change. As a result we may then increase the payment at the end of a guarantee period.

An appointment of a beneficiary to receive the benefits payable at the planholder's death will not be cancelled when the plan is ceded as security, but the cessionary will have the first right to benefits when they become payable.

If planholder has given consent for the Sanlam Protector Umbrella Trust this consent will not be cancelled, but the cessionary will have the first right to benefits when they become payable.

A nomination of a natural person or entity to become the planholder at the planholder's death, will be cancelled when the plan is ceded.

Change of planholder (outright cession)

The planholder may cede his or her rights as planholder to one other party. The cessionary will then replace him or her as planholder and will be shown as the planholder in the plan overview. The planholder must notify us of the cession in writing. The notice will take effect when we receive it.

If Cashback is applicable to the plan and the cessionary is not a life insured on the plan, Cashback has to be removed from the plan.

After the plan has been ceded, our assumptions for lapses, for example, may change. As a result we may then increase the payment at the end of a guarantee period.

An appointment of a beneficiary to receive the benefits payable at the planholder's death, and a nomination of a natural person or an entity to become the planholder at the planholder's death, will be cancelled when the plan is ceded.

If the planholder has given consent for the Sanlam Protector Umbrella Trust the consent for a plan will be cancelled when the plan is ceded to a new planholder. The consent will however remain in place for any other plans the planholder may have.

Conditions for change of planholder (outright cession)

- Topcover products:
 - Plan with a Credit Life benefit: Not allowed.
 - For Express plans the cessionary must be the existing planholder's spouse and a life insured on the plan.
 - For Classic and Premier plans, excluding a Topcover plan with Funeral (FSC2)* or Funeral Expenses (FSC3), the cessionary may be a natural person, trust or institution. For a plan with Funeral (FSC2)* or Funeral Expenses (FSC3) the cessionary must be a natural person.
- *The Funeral (FSC2) benefit is no longer available for new business.
- Termcover products (Premier plans):
 - Plan with a Credit Life benefit: Not allowed
 - The cessionary may be a natural person, trust or institution.
- Income protector products
 - Express plans: Not allowed
 - Premier plans: An outright cession is only possible if the planholder is a company (the life insured's employer) and the plan is ceded to another company (the life insured's new employer) or to the life insured him/herself. This is only allowed after the plan has been issued.

Identification policy

Identification for a plan is required for each of the following:

- planholder
- life insured
- nominee for plan-ownership
- beneficiary for death benefit
- payer
- cessionary.

One of the following is required for proof of identity:

- a valid RSA identity document
- a valid temporary RSA identity document issued by the Department of Home Affairs
- a valid passport.

Refer to "Identification policy for medical examinations and tests" and "Territorial underwriting" in the underwriting chapters for further requirements.

We reserve the right to request additional proof of identification.

RSA citizen outside South Africa or Namibia

Territorial underwriting applies to an RSA citizen who is currently in a foreign country, or who plans to travel to a foreign country during the next 12 months. Refer to the underwriting chapters for more information.

Foreigner in South Africa

Territorial underwriting applies to a foreigner in South Africa. We will only consider cover for a foreigner who is in South Africa at the time of application. Refer to the underwriting chapters for more information.

Application forms

Application forms for risk products		
Product	Product code	Form number
Buy and Sell (Enhanced Matrix Method)		
Buy and Sell (Enhanced Matrix Method) • New business: Application form		AEB2116
Business insurance (excluding Buy and Sell (Enhanced Matrix Method))		
Business insurance • New business: Application form		AEB2076, or (AEB2059 with AEB2068)
Legacy Life Plan		
Legacy Life Plan • New business: Application form (PGH) (<i>Rate book process</i>) • Full version • Condensed version • New business: Legacy Life Plan (PHI) Smart Application form (<i>Electronic process</i>) • New business: Legacy Life Plan (PHI) application form (<i>This form must be submitted together with a Legacy Life Plan mobile app PDF quote.</i>)	T02W	AEB2127 AEB2130 - AEB2134
Matrix		
Matrix Express Topcover (Sanquote process) • New business: Application form • Alterations: • Application form • Quotation form	T02W	AEB2126 AEB2019 AEB2017
Matrix Topcover • New business: Application form • Alterations: • Application form • Quotation form	T02W T02W/ T15W	AEB2059 AEB2022 / AEB2107 AEB2055
Matrix Termcover • New business: Application form • Alterations: • Application form • Quotation form	T02	AEB2059 AEB2022 / AEB2107 AEB2055
Matrix Express Income Protector • New business: Application form • Alterations: • Application form • Quotation form	T03W	AEB2126 AEB2019 AEB2017
Matrix Income Protector • New business: Application form • Alterations: • Application form • Quotation form	T03W	AEB2059 AEB2022 / AEB2107 AEB2035

Application forms for risk products		
Product	Product code	Form number
Professionals		
Express Topcover for Professionals	T02W	AEB2126
<ul style="list-style-type: none"> • New business: Application form • Alterations: <ul style="list-style-type: none"> • Application form • Quotation form 		AEB2019 AEB2017
Express Income Protector for Professionals	T03W	AEB2126
<ul style="list-style-type: none"> • New business: Application form • Alterations: <ul style="list-style-type: none"> • Application form • Quotation form 		AEB2019 AEB2017
Topcover for Professionals and Income Protector for Professionals		
<ul style="list-style-type: none"> • New business: Application form • Alterations: <ul style="list-style-type: none"> • Quotation form (Income Protector) • Quotation form (Other) • Application form 	T02W/ T03W	AEB2059
	T03W	AEB2035
	M01W/ T02/ T02W	AEB2055
	M01W/ T02W/ T02/ T03W	AEB2022 / AEB2107
Graduates		
Express Topcover for Graduates	T02W	AEB2126
<ul style="list-style-type: none"> • New business: Application form • Alterations: <ul style="list-style-type: none"> • Application form • Quotation form 		AEB2019 AEB2017
Topcover for Graduates	T02W	AEB2059
<ul style="list-style-type: none"> • New business: Application form • Alterations: <ul style="list-style-type: none"> • Application form • Quotation form 		AEB2022 / AEB2107 AEB2055
Express Income Protector for Graduates	T02W	AEB2126
<ul style="list-style-type: none"> • New business: Application form • Alterations: <ul style="list-style-type: none"> • Application form • Quotation form 		AEB2019 AEB2017
Income Protector for Graduates	T03W	AEB2059
<ul style="list-style-type: none"> • New business: Application form • Alterations: <ul style="list-style-type: none"> • Application form • Quotation form 		AEB2022 / AEB2107 AEB2035
Funeral TopCover		
Funeral TopCover	69	AEB2
Alterations: Application form		

Declarations	
Declaration for Express cover electronic applications/alterations submitted on SanQuote	AEB2078
Declaration for other electronic applications/alterations submitted on SanQuote (for products other than Legacy Life Plan)	AEB2007
Declaration for Legacy Life Plan (PHI) applications submitted electronically via the smart application form	AEB2101

All forms are available electronically on the Sanlam intranet and SanPort, while some forms can also be ordered from Supply Services at Drake & Scull.

Claims

What must be done in the event of a claim?

We must be informed of the claim as soon as possible. To obtain the necessary claim forms, and to ensure that all the required information is given to us, contact the Sanlam Life Claims Call Centre at telephone (021) 916-1710.

Admittance of a claim

We will admit a claim only if we are satisfied that all of the following conditions are met:

- The claim meets the description and requirements of the claim event.
- We receive all information we reasonably may require.
- The life insured obtained and followed medical advice immediately after the bodily injury took place or the illness had started. This condition does not apply to the following benefits:
 - Death
 - First death
 - Death cover on Credit Life
 - Funeral and other immediate expenses*
 - Immediate Expenses
 - Funeral*
 - Funeral Expenses
 - Waiver of payment at death
 - Death income.

*The Funeral and other immediate expenses (DSF1) and Funeral (FSC2) benefits are no longer available for new business.

- All aspects of the claim are proved by medical and other evidence we reasonably may require. The planholder will be responsible for the cost of this evidence.
- The payments of the plan have been made in full.

We will also admit a claim only if the bodily injury took place, or the cause of the claim was diagnosed for the first time, or the symptoms of the cause of the claim first presented, while the cover for the benefit was in force.

Conditions for the admittance of claims that only apply to specific benefits, are set out in the chapters for that benefits.

If a future cover option is exercised

For a benefit taken out when a future cover option has been exercised, we will admit a claim only if the claim event occurred, or the description and requirements of a claim event were first met, while the cover for the new benefit was in force.

If a group risk or conversion option is exercised

The following applies for a benefit taken out when a group risk or conversion option has been exercised:

- We will admit a claim only if the claim event occurred, or the description and requirements of a claim event were first met, while the cover for the new benefit was in force.
- To be able to claim for any claim event that was not part of the group risk plan or the benefit before conversion, the bodily injury must have taken place, or the cause of such claim must have been diagnosed for the first time, or the symptoms of the cause of such claim must have first presented, while the cover for the new benefit was in force.

Furthermore, for a benefit taken out when a group risk option has been exercised the following applies:

- Any conditions or claim events that were excluded for the life insured individually for the group risk plan, will remain excluded for the plan.
- Any pre-existing conditions that the life insured suffered from at inception of the group risk plan that were excluded for the group risk plan, will remain excluded for the plan.

False information supplied or fraudulent claim

The approval of plan benefits and cover amounts will be based on the medical, financial, lifestyle and occupational information provided by the planholder and a life insured. We will use this information in our decision to provide cover, to determine the payments we charge for this cover, and whether or not to add exclusions and/or loadings. It is therefore the responsibility of the planholder and a life insured to ensure that the information provided is correct and complete. If we later determine that there is any information the planholder and a life insured have not provided that might have affected our decision, it may result in exclusions and/or loadings being added to the benefits, or even the benefits being cancelled. The plan benefits may also be reduced or even refused if a claim is submitted in future.

If a fraudulent claim for a benefit is submitted, the plan with all its benefits will be cancelled, and any payments made will be forfeited.

How payment of a claim affects the plan benefits and payments

Not applicable to Income Protector products.

If we admit a claim for a standalone benefit, we will reduce the cover amount of that standalone benefit only. We will not reduce the cover amount of any other benefit.

If we admit a claim for an accelerator benefit, we will reduce the cover amount of that accelerator benefit as well as the cover amount of Death or First death, whichever is applicable to the life insured, by the claim amount. Where the cover amount of another accelerator benefit for the life insured exceeds the reduced cover amount of Death or First death for the life insured, we will reduce the cover amount of that accelerator benefit so that it is equal to the reduced cover amount of Death or First death.

We will reduce the payment for a benefit to reflect any reduction in the cover amount of that benefit.

Conditions that apply to First death only are set out in the *Life cover* chapter under "Admittance of a claim" and "How a claim for an accelerator benefit affects this benefit".

Simultaneous claims

Not applicable to Income Protector products.

Simultaneous claims for a life insured will be treated as consecutive claims. We will consider the claims according to the size of the potential claim amount, starting with the claim that will result in the largest claim amount if we admit it.

Due to the effect of a claim on an accelerator benefit as described above under "How payment of a claim affects the plan benefits and payments", the total claim amount that we will pay for all the accelerator benefits for a life insured will not be more than the cover amount of Death or First death, whichever is applicable to the life insured.

Different conditions may, however, apply for simultaneous claims for Living protector. Conditions that apply to the Living protector benefit only are set out in the *Living protector* chapter.

Documents required when submitting a death claim

The documents required when submitting a death claim are indicated in the tables below. If the beneficiary on a plan is a minor, we also require the birth certificate and the name of the guardian or trust. We reserve the right to request additional information.

Any reference to "claimant" refers to the recipient(s) of the claim payment, i.e. the planholder, beneficiaries, nominees or estate, as applicable.

Product name	Documents required for death claims
	Products available for new business
Final expenses (DSF1) / Funeral and other immediate expenses (DSF1) / Immediate Expenses (DSF3) Matrix / Glacier / Cobalt for Professionals Topcover / Topcover for Professionals / Topcover for Graduates (T02W/ T15W/ M02W) Matrix Termcover (T02)	<p>We aim to pay this benefit within 48 hours after the following requirements have been received at our head office:</p> <ul style="list-style-type: none"> • a certified copy of the death certificate of the deceased life insured, issued by the Department of Home Affairs; • form BI1663, issued by the doctor who certified the death, that is held on record by the Department of Home Affairs, or any other form that may replace it in future; • a certified copy of the identity document or passport of the deceased life insured; • the death claim form, fully completed; • a declaration by the South African Police Service (SAPS), if the cause of death is unnatural or unknown; • a certified copy of the identity document or passport of the claimant requesting the payment . <p>In certain cases we may also require the following:</p> <ul style="list-style-type: none"> • a letter of executorship, if the planholder is deceased and no beneficiary has been appointed; • the name of the guardian or trust and birth certificate of the beneficiary, if the planholder is deceased and the beneficiary is a minor; • a medical certificate. <p>If the name, identity number or date of birth of a life insured contained in the above-mentioned requirements differs from the particulars as indicated in the plan overview for that life insured, we may refuse to pay the cover amount.</p>
Funeral (FSC2) / Funeral Expenses (FSC3) Matrix / Glacier / Cobalt for Professionals Topcover / Topcover for Professionals / Topcover for Graduates (T02W/ T15W/ M02W)	<p>We aim to pay this benefit within 48 hours after the following requirements have been received at our head office:</p> <ul style="list-style-type: none"> • a certified copy of the death certificate of the deceased life insured, issued by the Department of Home Affairs; • form BI1663, issued by the doctor who certified the death, that is held on record by the Department of Home Affairs, or any other form that may replace it in future; • a certified copy of the identity document or passport of the deceased life insured; • the death claim form, fully completed; • a declaration by the South African Police Service (SAPS), if the cause of death is unnatural or unknown; • a certified copy of the identity document or passport of the claimant requesting the payment. <p>In certain cases we may also require the following:</p> <ul style="list-style-type: none"> • a letter of executorship, if the planholder is deceased and no beneficiary has been appointed; • the name of the guardian or trust and birth certificate of the beneficiary, if the planholder is deceased and the beneficiary is a minor; • proof of replaced funeral cover, if this benefit has been taken or the cover amount of this benefit has been increased to replace funeral cover that the planholder previously had on the life of the insured. This proof must meet our requirements and be verified by the product provider of the replaced funeral cover. <p>If the name, identity number or date of birth of a life insured contained in the above-mentioned requirements differs from the particulars as indicated in the plan overview for that life insured, we may refuse to pay the cover amount.</p>

Product name	Documents required for death claims
Products available for new business	
<p><i>Not applicable to Final expenses (DSF1) / Funeral and other immediate expenses (DSF1) / Immediate Expenses (DSF3) / Funeral (FSC2) / Funeral Expenses (FSC3)</i></p> <p>Matrix / Glacier / Cobalt for Professionals Topcover / Topcover for Professionals / Topcover for Graduates (T02W/ T15W/ M02W)</p> <p>Matrix Termcover (T02)</p>	<ul style="list-style-type: none"> • Death claim form (form SLDC001E) • Death certificate • Medical certificate (if applicable) • Letter of executorship (if payable to estate) • Identity documents of claimant and deceased • Name of guardian or trust and birth certificate (if beneficiary a minor) • Road traffic accident report (if life insured was passenger in car accident) • SAPS declaration (if cause of death unnatural or unknown) • Judicial inquiry and post mortem report (if cause of death unnatural or unknown) • Blood alcohol test (if done) • Proof of bank account (claimant)
<p>Matrix / Glacier / Cobalt for Professionals Income Protector / Income Protector for Professionals / Income Protector for Graduates (T03W)</p>	<ul style="list-style-type: none"> • Death certificate
Products withdrawn for new business	
<p>Funeral TopCover (TAB 69)</p>	<ul style="list-style-type: none"> • Funeral claim form (form SLFC001E) • Death certificate • BI1663 issued by the doctor who certified the death • Medical certificate (if applicable) • Notice of stillborn baby from doctor (proof of number of weeks pregnant) and identity document of mother of stillborn baby • Letter from funeral director who confirmed the body • Identity documents of claimant and deceased • Birth certificate (for uninsured children, death within 6 months of birth) • SAPS declaration (if cause of death unnatural or unknown) • Proof of bank account (claimant)
<p>The One FamilySupporter (TAB 67/ 68/ 367/ 368/ 467/ 468/ 567/ 568)</p> <p>The Funeral Help Plans A, B and C (TAB 65 (PLAN A)/ TAB 65 (PLAN B)/ TAB 69 (PLAN C))</p>	<ul style="list-style-type: none"> • Funeral claim form (form SLFC001E) • Death certificate • BI1663 issued by the doctor who certified the death • Medical certificate (if applicable) • Notice of stillborn baby from doctor (proof of number of weeks pregnant) and identity document of mother of stillborn baby • Letter from funeral director who confirmed the body • Identity documents of claimant and deceased • Birth certificate (for uninsured children, death within 6 months of birth) • SAPS declaration (if cause of death unnatural or unknown) • Proof of bank account (claimant)

Product name	Documents required for death claims
Products withdrawn for new business	
Optional Group Scheme for Individual Life (TAB 63A/ 63B/ 63C/ 64A/ 64B/ 64C)	<ul style="list-style-type: none"> • Funeral claim form (form SLFC001E) • Death certificate • BI1663 issued by the doctor who certified the death • Medical certificate (if applicable) • Notice of stillborn baby from doctor (proof of number of weeks pregnant) and identity document of mother of stillborn baby • Written proof that the child was a full-time student (for uninsured child or insured child older than 21 but younger than 25) – only for tables 63B and 64B • Written proof that the child was disabled (for uninsured/insured child older than 21 and fully dependant on the principal life insured) – only for tables 63B and 64B • Letter from funeral director who confirmed the body • Identity documents of claimant and deceased • Birth certificate (for uninsured children, death within 6 months of birth) • SAPS declaration (if cause of death unnatural or unknown) • Proof of bank account (claimant)
The One Policy for Special risks (T303)	<ul style="list-style-type: none"> • Death claim form (form SLDC001E) • Death certificate • Letter of executorship (if payable to estate) • SAPS declaration (if cause of death unnatural or unknown) • Proof of bank account (claimant)
Waiver of Premium Benefit (Indicated by a "P")	<ul style="list-style-type: none"> • Death claim form (form SLDC001E) • Death certificate • Medical certificate (if applicable) • SAPS declaration (if cause of death unnatural or unknown) • Judicial inquiry and post mortem report (if cause of death unnatural or unknown)
Topaz Immediate Expense Provider (T86D)	<ul style="list-style-type: none"> • Death claim form (form SLDC001E) • Death certificate • BI1663 issued by the doctor who certified the death • Letter of executorship (if payable to estate) • Identity document of claimant • SAPS declaration (if cause of death unnatural or unknown) • Proof of bank account (claimant)
One Step Cover (T86R)	<ul style="list-style-type: none"> • Death claim form (form SLDC001E) • Death certificate • BI1663 issued by the doctor who certified the death
One Step Term Cover (T86M)	<ul style="list-style-type: none"> • Letter of executorship (if payable to estate) • SAPS declaration (if cause of death unnatural or unknown) • Proof of bank account (claimant)
Funeral Benefit (BGF benefit TAB 301 / 303)	<ul style="list-style-type: none"> • Death claim form (form SLDC001E) • Death certificate • Identity document of deceased • Proof that person requesting payment is one of the following: <ul style="list-style-type: none"> • appointed beneficiary (identity document is required), or • institution to whom plan was ceded • Proof of bank account (claimant)
Death Income Benefit (TAB 2EB/ 2JRB/ 45GRB/ 145GRB)	Documents required are determined per plan

Product name	Documents required for death claims
Products withdrawn for new business	
Optional Group Scheme for Individual Life (TAB 63A/ 63B/ 63C/ 64A/ 64B/ 64C)	<ul style="list-style-type: none"> • Funeral claim form (form SLFC001E) • Death certificate • BI1663 issued by the doctor who certified the death • Medical certificate (if applicable) • Notice of stillborn baby from doctor (proof of number of weeks pregnant) and identity document of mother of stillborn baby • Written proof that the child was a full-time student (for uninsured child or insured child older than 21 but younger than 25) – only for tables 63B and 64B • Written proof that the child was disabled (for uninsured/insured child older than 21 and fully dependant on the principal life insured) – only for tables 63B and 64B • Letter from funeral director who confirmed the body • Identity documents of claimant and deceased • Birth certificate (for uninsured children, death within 6 months of birth) • SAPS declaration (if cause of death unnatural or unknown) • Proof of bank account (claimant)
The One Medical Plan (TAB 371/ 471/ 571/ 372/ 472/ 572/ 373/ 473/ 573/ 382/ 482/ 582)	<ul style="list-style-type: none"> • Death claim form (form SLDC001E) • Death certificate • Letter of executorship (if payable to estate) • Proof of bank account (claimant)
The One Medical Benefit Fund	<ul style="list-style-type: none"> • Death claim form (form SLDC001E) • Death certificate • Letter of executorship (if payable to estate) • Notice of cession (if principal member passed away, and if no nominee for plan ownership, and if ceded) • Proof of bank account (claimant)
Hospital Policy (TAB 70I/ 70N)	<ul style="list-style-type: none"> • Death claim form (form SLDC001E) • Death certificate • Proof of bank account (claimant)
The Income Protector (TAB 46/ 47/ 48)	<ul style="list-style-type: none"> • Death certificate
Accident Cover (TAB 84N)	<ul style="list-style-type: none"> • Death claim form (form SLDC001E) • Death certificate • Letter of executorship (if payable to estate) • Identification of deceased • Road traffic accident report (if life insured was passenger in car accident) • SAPS declaration (if cause of death unnatural or unknown) • Judicial inquiry and post mortem report (if cause of death unnatural or unknown) • Blood alcohol test (if done) • Proof of bank account (claimant)

Enquiries

The contact details for claims are indicated below.

Type of claim	Contact details
Death claims, including claims under Final expenses (DSF1) / Funeral and other immediate expenses (DSF1) / Immediate Expenses (DSF3) / Funeral (FSC2) / Funeral Expenses (FSC3)	<ul style="list-style-type: none">• Telephone: (021) 916 3456• Fax: (021) 947 3989• e-mail: deathclaims@sanlam.co.za• Web: www.sanlam.co.za/claims
Funeral and Family Supporter claims	<ul style="list-style-type: none">• Telephone: 0861 106 180• Fax: (021) 947 4487• e-mail: deathclaimsfamily@sanlam.co.za• Web: www.sanlam.co.za/claims
Living benefit claims	<ul style="list-style-type: none">• Telephone: (021) 916 3455• Fax: (021) 947 5804• e-mail for all Living benefits (except Sickness benefits): livingbenefits@sanlam.co.za• e-mail for Sickness benefits: sickness@sanlam.co.za• Web: www.sanlam.co.za/claims
One Medical Plan claims	<ul style="list-style-type: none">• Telephone: (021) 916 3457• Fax: (021) 947 6035• e-mail: onemedicalplan@sanlam.co.za• Web: www.sanlam.co.za/claims

Tax

Income tax for 2023/2024 tax year for individuals and trusts

The tax rate for individuals and trusts for the 2023/2024 tax year of assessment ending 29 February 2024 are indicated below.

Tax table for individuals, deceased estates, insolvent estates and special trusts*

Tax table for individuals, deceased estates, insolvent estates and special trusts*	
Taxable income (R)	Rate of tax (R)
1 – 237 100	18% of taxable income
237 101 – 370 500	42 678 + 26% of taxable income above 237 100
370 501 – 512 800	77 362 + 31% of taxable income above 370 500
512 801 – 673 000	121 475 + 36% of taxable income above 512 800
673 001 – 857 900	179 147 + 39% of taxable income above 673 000
857 901 – 1 817 000	251 258 + 41% of taxable income above 857 900
1 817 001 and above	644 489 + 45% of taxable income above 1 817 000

*A special trust is a trust created solely for the benefit of a person with a disability, or a trust created under the will of a person for his or her relatives.

Tax rebate for individuals

Tax rebate for individuals	
Primary	R17 235
Secondary (persons 65 and older)*	R9 444
Tertiary (persons 75 and older)**	R3 145

*A person is "65 and older" as soon as he turns 65. If he reaches the age of 65 on the last day of the year of assessment, he will qualify for the additional rebate.

**A person is "75 and older" as soon as he turns 75. If he reaches the age of 75 on the last day of the year of assessment, he will qualify for the additional rebate.

Tax threshold for individuals

Tax threshold for individuals	
Below age 65	R95 750
Age 65 to below 75	R148 217
Age 75 and over	R165 689

Rate of tax for inter vivos trust or testamentary trust

Rate of tax is 45%.

Tax for risk products

The policyholder can be an individual, a trust, tax-paying institution or tax-exempt institution.

Where a trust is the policyholder, the tax status of a policy is currently determined by the status of the trust beneficiaries, for example an individual or an entity that is taxable or not, in terms of section 29A(4) of the Income Tax Act.

Individual insurance

Lump sum, sickness and death income benefits

According to current legislation policyholders cannot consider the premiums for lump sum, sickness and death income benefits as deductions from their taxable income for income tax purposes.

The policy benefits are not taxable for income tax purposes in the hands of the policyholder, a beneficiary, if any, or the estate of the policyholder, if applicable. However, the policy benefits are currently subject to estate duty in the estate of the policyholder.

Disability income and temporary disability income benefits

Before 1 March 2015

Individual policyholders could consider the premiums for disability income and temporary disability income benefits as deductions from their taxable income for income tax purposes. These premiums could be deducted from their taxable income in terms of section 11(a), read with section 23(m) of the Income Tax Act, over and above any contributions towards retirement annuities in terms of section 11(n) of the Income Tax Act. The income payments received by the policyholder in terms of a claim were fully taxable in the hands of the policyholder until 28 February 2015.

For employer-owned policies, premiums for disability income and temporary disability income benefits are tax-deductible to the employer in terms of section 11(w)(i) of the Income Tax Act. The employee (life insured) was taxed on the employer premiums. However, the employee could deduct these premiums from tax in terms of section 11(a), read with section 23(m) of the Income Tax Act. The income payments received by the employee in terms of a claim were fully taxable in the hands of the employee until 28 February 2015.

Income payments in terms of a claim are always made to the policyholder. Until 28 February 2015 the South African Revenue Service would regard such income payments as taxable income, regardless of whether the premiums were deducted from taxable income or not.

From 1 March 2015

According to legislation from 1 March 2015 onwards policyholders cannot consider the premiums for disability income and temporary disability income benefits as deductions from their taxable income for income tax purposes.

For employer-owned policies, premiums for disability income and temporary disability income benefits are still tax-deductible to the employer in terms of section 11(w)(i) of the Income Tax Act. The employee (life insured) is still taxed on the employer premiums. Unlike the situation before 1 March 2015, the employee can no longer deduct these premiums from tax as from 1 March 2015. The income payments received by the employee in terms of a claim were fully taxable in the hands of the employee until 28 February 2015, but are exempt from 1 March 2015.

Income payments in terms of a claim are always made to the policyholder. The policy benefits are not taxable for income tax purposes in the hands of the policyholder, regardless of whether the premiums were deducted from taxable income (before 1 March 2015) or not.

Business insurance

Refer to the *Business insurance* chapter for information about income tax, estate duty and capital gains tax for business insurance.