Income protection

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 on 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.

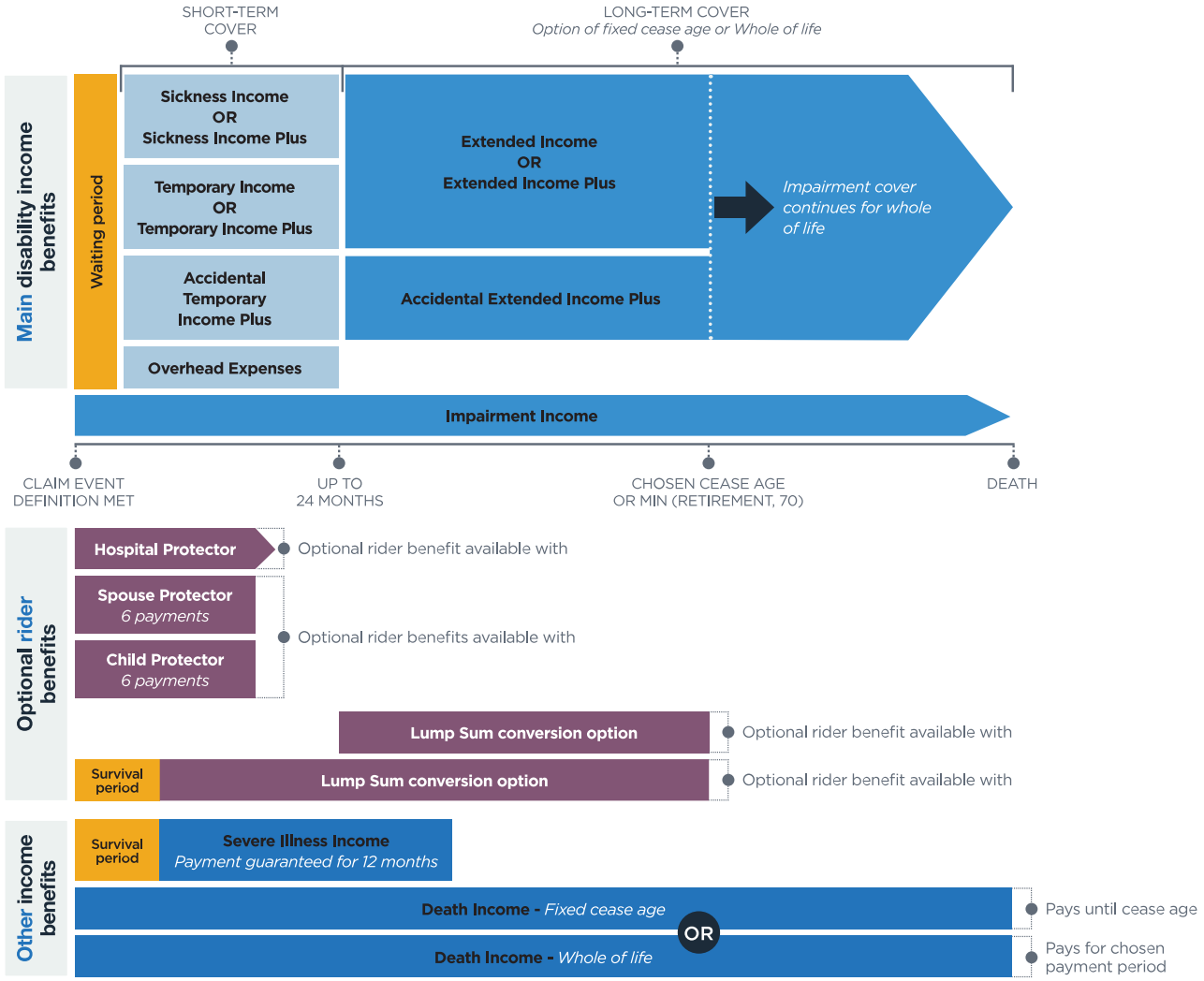
More than one instance of the same benefit, for example:

- 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 a 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 the 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	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. • 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	Available rider benefits: • Spouse protector • Child protector • Hospital protector * An additional payment will be charged for a rider benefit. * only available if the waiting period on the main benefit is 7 or 14 days
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 sick leave cover • 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, extended sick leave cover 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 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: R250 000 per month*, limited to the sliding scale percentage of the life insured's monthly gross professional income (GPI)**. *Subject to financial underwriting **Refer to the underwriting chapters for the sliding scales and the definitions of gross professional income.
Benefit payment period	Choice between the following, where any combination of benefit payment period and waiting period is allowed, subject to underwriting: • 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:

- 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:
- 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 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

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

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.

- 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

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
- 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, extended occupational disability cover and proof free additional cover is provided further in this section.

Type of benefit

Standalone

When will cover for this benefit end?

It 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: • 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: • 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: • 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: • 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* *Available to all disability classes.

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: • 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. This must be confirmed by a specialist with supporting evidence.	3 months
Amputation of a foot/loss of use of a foot	
Contractual definition: • 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: • 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: • History and clinical signs of compartment syndrome, and Nerve conduction studies.	3 weeks
Gunshot or penetrating stab wound resulting in theatre debridment	
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. 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.	Period of sick leave, limited to 3 months

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:	200 000 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: • 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: • 60 next birthday • 65 next birthday • 70 next birthday
Qualifying Lives	Lives who comply with the following may qualify, subject to age limits: • 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 availble for lives who do qualify for full cover.
Guarantee period	The initial guarantee period is 5 years.
Waiting period options	Choice between the following, subject to underwriting: • 7 days * • 14 days* • 1 month • 3 months * Only available to lives who qualify for disability classes A, B or C. The other waiting periods are available for all disability classes.

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 that 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: • 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. This must be confirmed by a specialist with supporting evidence.	3 months
Amputation of a foot/loss of use of a foot	
Contractual definition: • 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). This must be confirmed by a specialist with supporting evidence.	3 months
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: • 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: • History and clinical signs of compartment syndrome, and Nerve conduction studies.	
Gunshot or penetrating stab wound resulting in theatre debridment	
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. 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	Period of sick leave, limited to 3 months

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: • 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 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, 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: • 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. This must be confirmed by a specialist with supporting evidence.	3 months
Amputation of a foot/loss of use of a foot	
Contractual definition: • 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). This must be confirmed by a specialist with supporting evidence.	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: • 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

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

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.

- 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

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
- Proof free additional cover for qualifying standard lives
- Built-in future cover for young lives

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

More information on automatic waiver of payment, extended occupational disability cover and proof free additional cover is provided further in this section.

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.

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.**

	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.
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 • 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.
Guarantee period	The initial guarantee period is 5 years.
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.

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.

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 that 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*		
Contractual definition: Total surgical replacement of the hip joint with a prosthesis, confirmed by an orthopaedic surgeon. This must be supported by surgical reports. *Layman's explanation:* *Surgical total hip joint replacement with an artificial joint, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.*	50	4
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. *Layman's explanation:* *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.*	50	4
Total knee 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 knee joint with a prosthesis, confirmed by an orthopaedic surgeon. This must be supported by surgical reports. *Layman's explanation:* *Surgical total knee joint replacement with an artificial joint, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.*	50	4
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. *Layman's explanation:* *Surgical total shoulder joint replacement with an artificial joint, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.*	50	4
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. *Layman's explanation:* *Surgical total ankle joint replacement with artificial parts, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.*	50	4
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. *Layman's explanation:* *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).*	50	1
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. *Layman's explanation:* *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).*	50	2
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. *Layman's explanation:* *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).*	50	2

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 chest, resulting in a thoracotomy, with an operation report provided by a surgeon or trauma surgeon. *Layman's explanation:* *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).*	50	3
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. *Layman's explanation:* *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).*	50	2
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. *Layman's explanation:* *Penetration by a bullet or a sharp object through the neck, with damage to one or more of the following blood vessels or organs:* – *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).* *An operation report must be provided by a specialist (surgeon or trauma surgeon).*	50	2
Multiple rib fractures		
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. *Layman's explanation:* *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)*	50	2
Unstable pelvis fracture		

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: More than one fracture of the pelvic framework, resulting in instability, and requiring surgical intervention, confirmed by an orthopaedic specialist or surgeon. *Layman's explanation:* *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).*	50	3
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. *Layman's explanation:* *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).*	50	2
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. *Layman's explanation:* *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).*	50	2
Contractual definition: A fracture dislocation of the spine, with neurological deficit, confirmed with supporting evidence by a neurosurgeon or orthopaedic specialist. *Layman's explanation:* *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).*	50	3
Compression or avulsion 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: Compression or avulsion fractures without joint dislocation on two or more vertebrae, confirmed with supporting evidence by a neurosurgeon or orthopaedic specialist. *Layman's explanation:* *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).*	50	2
Liver rupture		
Contractual definition: Rupture of the liver, necessitating emergency laparotomy and surgical repair, with an operation report provided by a surgeon. *Layman's explanation:* *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).*	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. *Layman's explanation:* *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).*	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. *Layman's explanation:* *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).*	50	2
Compartment syndrome		

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: 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: • History and clinical signs of compartment syndrome, and • Nerve conduction studies. *Layman's explanation:* *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.* *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.*	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. *Layman's explanation:* *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).* *2nd degree burns are burn wounds to the outer skin layer and the layer directly under this.* *3rd degree burns are burn wounds to all three layers of the skin.*	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:

- 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 availble 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 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 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 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

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 cilents, 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		
Contractual definition: Total surgical replacement of the hip joint with a prosthesis, confirmed by an orthopaedic surgeon. This must be supported by surgical reports. *Layman's explanation:* *Surgical total hip joint replacement with an artificial joint, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.*	50	4
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. *Layman's explanation:* *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.*	50	4
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. *Layman's explanation:* *Surgical total knee joint replacement with an artificial joint, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.*	50	4
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. *Layman's explanation:*	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
Surgical total shoulder joint replacement with an artificial joint, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.		
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. *Layman's explanation:* *Surgical total ankle joint replacement with artificial parts, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.*	50	4
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. *Layman's explanation:* *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).*	50	1
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. *Layman's explanation:* *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).*	50	2
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. *Layman's explanation:* *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).*	50	2
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. *Layman's explanation:* *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).*	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
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. *Layman's explanation:* *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).*	50	2
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. *Layman's explanation:* *Penetration by a bullet or a sharp object through the neck, with damage to one or more of the following blood vessels or organs:* – *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).* *An operation report must be provided by a specialist (surgeon or trauma surgeon).*	50	2
Multiple rib fractures		
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	3
Pelvis fracture		
Contractual definition: More than one fracture of different bones of the pelvic framework, confirmed by an orthopaedic specialist or surgeon. *Layman's explanation:* *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).*	50	2
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. *Layman's explanation:*	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
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).		
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. *Layman's explanation:* *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).*	50	2
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. *Layman's explanation:* *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).*	50	2
Contractual definition: A fracture dislocation of the spine, with neurological deficit, confirmed with supporting evidence by a neurosurgeon or orthopaedic specialist. *Layman's explanation:* *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).*	50	3
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. *Layman's explanation:* *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*	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
must be confirmed with supporting evidence by a specialist (neurosurgeon or orthopaedic specialist).		
Liver rupture		
Contractual definition: Rupture of the liver, necessitating emergency laparotomy and surgical repair, with an operation report provided by a surgeon. *Layman's explanation:* *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).*	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. *Layman's explanation:* *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).*	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. *Layman's explanation:* *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).*	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: • History and clinical signs of compartment syndrome, and • Nerve conduction studies. *Layman's explanation:* *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.* *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.*	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
Layman's explanation: *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).* *2nd degree burns are burn wounds to the outer skin layer and the layer directly under this.* *3rd degree burns are burn wounds to all three layers of the skin.*		

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	**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 • 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	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. *Layman's explanation:* *Surgical total hip joint replacement with an artificial joint, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.*	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. *Layman's explanation:* *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.*	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. *Layman's explanation:* *Surgical total knee joint replacement with an artificial joint, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.*	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. *Layman's explanation:* *Surgical total shoulder joint replacement with an artificial joint, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.*	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. *Layman's explanation:* *Surgical total ankle joint replacement with artificial parts, called a prosthesis. This must be confirmed by a specialist (orthopaedic surgeon) with supporting evidence.*	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. *Layman's explanation:* *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).*	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
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. *Layman's explanation:* *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).*	100	1 month	50	2 months
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. *Layman's explanation:* *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).*	100	1 month	50	2 months
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. *Layman's explanation:* *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).*	100	1 month	50	3 months
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. *Layman's explanation:* *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).*	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
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. *Layman's explanation:* *Penetration by a bullet or a sharp object through the neck, with damage to one or more of the following blood vessels or organs:* – *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).* *An operation report must be provided by a specialist (surgeon or trauma surgeon).*	100	1 month	50	2 months
Multiple rib fractures				
Contractual definition: Multiple rib fractures with ICU admission: Numerous rib fractures, requiring admission to an intensive care unit (ICU), confirmed by a specialist.	100	1 month and 2 weeks	50	2 months
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.	100	2 months	50	3 months
Pelvis fracture				
Contractual definition: More than one fracture of different bones of the pelvic framework, confirmed by an orthopaedic specialist or surgeon. *Layman's explanation:* *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).*	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. *Layman's explanation:* *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).*	100	3 months	50	3 months
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. *Layman's explanation:* *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).*	100	2 months	50	2 months
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. *Layman's explanation:* *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).*	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
Contractual definition: A fracture dislocation of the spine, with neurological deficit, confirmed with supporting evidence by a neurosurgeon or orthopaedic specialist. *Layman's explanation:* *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).*	100	2 months	50	3 months
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. *Layman's explanation:* *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).*	100	2 months	50	2 months
Liver rupture				
Contractual definition: Rupture of the liver, necessitating emergency laparotomy and surgical repair, with an operation report provided by a surgeon. *Layman's explanation:* *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).*	100	1 month and 2 weeks	50	2 months
Spleen rupture				
Contractual definition: Rupture of the spleen, necessitating emergency laparotomy and surgical repair or splenectomy, with an operation report provided by a surgeon. *Layman's explanation:*	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
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).				
ost-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. *Layman's explanation:* *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).*	100	1 month	50	2 months
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: • History and clinical signs of compartment syndrome, and • Nerve conduction studies. *Layman's explanation:* *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.* *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.*	100	3 weeks	50	1 month

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. *Layman's explanation:* *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).* *2nd degree burns are burn wounds to the outer skin layer and the layer directly under this.* *3rd degree burns are burn wounds to all three layers of the skin.*	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?	It 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.
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	**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. **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.
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 erythematosis 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	• 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	• 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	• 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	• 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 typeTroponientipe	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 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.

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 folowing 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?	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 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	**Benefit start age** A child will be covered from his/her 1st birthday. **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. 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. 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.
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 benfitbenefit 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 benefits 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: • 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
Pericardiectomy 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 thrombocytosis	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.

Pericardiectomy irrespective of technique

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

Arrhythmia having undergone pathway ablation

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

Arrhythmia having undergone a permanent pacemaker insertion

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

Arrhythmia having undergone a permanent defibrillator insertion

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

Peripheral arterial disease requiring angioplasty, stent or bypass graft of one peripheral artery

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

Peripheral arterial disease requiring angioplasty, stent or bypass graft of more than one peripheral artery

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

Loss of use of or loss of one foot due to peripheral arterial disease

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

Loss of use of or loss of one hand due to peripheral arterial disease

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

Angioplasty with or without stenting of one carotid artery

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

Angioplasty with or without stenting of bilateral carotid arteries

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

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

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

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

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

Surgical repair of an ileofemoral aneurysm or stenosis

Surgical repair, including bypass graft or keyhole surgery, of an ileofemoral aneurysm or ileofemoral stenosis by a specialist vascular surgeon. This must be supported with a detailed report by a surgeon, including copies of the operation reports.

Surgical repair of any aneurysm or stenosis of major arterial branches of the aorta

Surgical repair, including bypass graft or keyhole surgery, of any aneurysm or stenosis of the following branches of the aorta: subclavian, brachiocephalic, splenic, renal and iliac arteries. This must be supported with a detailed report by a surgeon, including copies of the operation reports.

Major surgery to dissect and surgically graft an aortic aneurysm

The undergoing of open chest or abdominal surgery to repair an aneurysm in the thoracic or abdominal aorta with a synthetic graft. This must be supported with a detailed report by a surgeon, including copies of the operation reports.

Primary pulmonary hypertension

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

Surgery for atrial septal defects or ventricular septal defects

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

Surgical repair of coarctation of the aorta

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

Left ventricular aneurysm repaired surgically

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

Surgery for atrial myxoma

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

Subarachnoid haemorrhage without neurological impairment

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

Arteriovenous malformation treated with radiological intervention

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

Arteriovenous malformation treated with open surgery craniotomy

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

Angioplasty with or without stenting of one or more coronary arteries

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

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

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

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

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

Mild heart attack

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

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

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

Mild heart attack of specified severity

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

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

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

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

- with ST segment elevation, are new or presumed new ST segment elevation at the J point in two or more contiguous leads with the cut-off points greater than or equal to 0.2 mV in leads V1, V2 or V3, and greater than or equal to 0.1 mV in other leads. Contiguity in the frontal plane is defined by the lead sequence AVL, I and II, AVF and III.
- without ST segment elevation, are ST segment depression of at least 0.1 mV, or T wave abnormalities only.

Raised cardiac biomarkers, described as one of the following:

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

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

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

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

Conventional troponin markers		Value	
Assay	Troponin type	Unit (ng/l)	Unit (ng/ml)
Conventional TnT	TnT	> 500	> 0.5
Conventional AccuTnI or equivalent threshold with other Troponin I methods	TnI	> 250	> 0.25

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

Marker	Parameter
Cardiac troponin assay	Raised to the levels of either the sensitive troponin markers or conventional troponin markers listed in the table above

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

Marker	Parameter
Cardiac troponin assay	Raised to at least twice the levels of the sensitive troponin markers or conventional troponin markers listed in the table above

Moderate heart attack of specified severity

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

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

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

Raised cardiac biomarkers, described as one of the following:

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

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 l 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.

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

Chronic blood disorders requiring constant blood replacements

Any chronic disorder of the blood, where at least four units of blood or blood products has been transfused per month for at least 3 consecutive months. This must be confirmed by a specialist with all of the following: 1) Clinical records documenting the blood transfusions; 2) Blood counts.

Severe aplastic anaemia

The unequivocal diagnosis of bone marrow failure. This must be confirmed by a specialist, with all of the following: 1) Bone marrow biopsy; 2) Blood tests showing anaemia, neutropenia and thrombocytopenia; 3) Classified as severe aplastic anaemia according to the latest International Aplastic Anaemia Study Group; 4) Treated with at least one of the following: marrow stimulating agents, immunosuppressive agents, or bone marrow transplant. This claim event specifically excludes non-severe aplastic anaemia.

Bone marrow transplant

The undergoing of a bone marrow transplant after complete bone marrow ablation, as confirmed by a specialist. This must be supported with all of the following: 1) Bone marrow biopsy; 2) Laboratory tests.

Diffuse intravascular clotting

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

Idiopathic thrombocytopenic purpura with splenectomy

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

Chronic anaemia despite optimal treatment needing blood transfusion every second week

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

Autoimmune haemolytic anaemia with splenectomy

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

Essential thrombocytosis

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

Musculoskeletal system

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:

- 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?

Benefit 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.

Benefit with whole life cover

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

- 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

Benefit start age

Minimum:
- Premier: 18 next birthday
- Fixed compulsory growth: 30 next birthday

Maximum:
- Benefit with a fixed term: 10 years before the benefit cease age
- Benefit with whole life cover: 80 next birthday

Benefit cease age

- Benefit with a fixed term: Choice between 65 or 90 next birthday
- Benefit with whole life cover: At death

Income payment period

Benefit with a fixed term

- 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

A minimum income payment period of 5 years applies, even if the life insured dies shortly before the benefit cease age.

Benefit with whole life cover

Choice between the following: 1, 2, 5, 10, 15, 20 or 25 years.

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 %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
Cardiovascular system		
Valvular heart disease, cardiomyopathy		

Contractual definition:
Severe valvular heart disease or cardiomyopathy, meeting the following criteria:
• New York Heart Association (NYHA) class III on optimal treatment, and
• One of the following:
  • 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:
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).
 	
This claim event must meet the criteria as described in the contractual definition above, and must be confirmed by a specialist (cardiologist).
	-	50

Contractual definition: Severe valvular heart disease or cardiomyopathy, meeting the following criteria: • New York Heart Association (NYHA) class IV on optimal treatment, and • One of the following: • Maximal effort test of less than 4 metabolic equivalents (METS), or	100	100

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
• Ejection fraction (EF) of less than 40%, or • Valve gradient and/or valve area classified as severe. This must be confirmed by a cardiologist. *Layman's explanation:* *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).* *This claim event must meet the criteria as described in the contractual definition above, and must be confirmed by a specialist (cardiologist).*		
Ischaemic heart disease		

Contractual definition:
Ischaemic heart disease with cardiac failure, meeting the following criteria:
• 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:
  • 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.
This must be confirmed by a cardiologist.
 	
Layman's explanation:
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).
 	
This claim event must meet the criteria as described in the contractual definition above, and must be confirmed by a specialist (cardiologist).
	-	50

Contractual definition:
Ischaemic heart disease with cardiac failure, meeting the following criteria:
 	
• 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:
  • 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 %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
This must be confirmed by a cardiologist. *Layman's explanation:* *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).* *This claim event must meet the criteria as described in the contractual definition above, and must be confirmed by a specialist (cardiologist).*		
Heart transplant		
Contractual definition: • 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. This must be confirmed by a specialist with supporting evidence. *Layman's explanation:* *This claim event covers:* – *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.* *This must be confirmed by a specialist with supporting evidence.*	100	100

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
Pericardial disease		

Contractual definition:
Pericardial disease with cardiac failure, meeting the following criteria:
• Confirmed irreversible pericardial disease by a specialist, and
• New York Heart Association (NYHA) class III on optimal treatment, and
• One of the following:
  • 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.
 	
Layman's explanation:
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).
 	
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).
	-	50

Contractual definition:
Pericardial disease with cardiac failure, meeting the following criteria:
• Confirmed irreversible pericardial disease by a specialist, and
• New York Heart Association (NYHA) class IV on optimal treatment, and
• One of the following:
  • 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.
 	
Layman's explanation:
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).
 	
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).
	100	100

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
Arrhythmia		

Contractual definition:
Arrhythmia with moderate impairment, meeting the following criteria:
Arrhythmia on optimal treatment that results in
• New York Heart Association (NYHA) class III shortness of breath, and
• One of the following:
  • 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.
 	
This must be confirmed by a cardiologist, physician or electrophysiologist.
 	
Layman's explanation:
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).
 	
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:
– *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:*
– *Reduced exercise effort test meeting specified criteria, or*
Documented arrhythmia that fails to respond to optimal treatment, and leads to frequent fainting.
	-	50

Contractual definition: Arrhythmia with severe impairment, meeting the following criteria: Arrhythmia on optimal treatment that results in • New York Heart Association (NYHA) class IV shortness of breath, and • 2 or less metabolic equivalents (METS) with maximal effort test. This must be confirmed by a cardiologist, physician or electrophysiologist. *Layman's explanation:* *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).* *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:* – *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 %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
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. *Layman's explanation:* *This claim event covers high blood pressure with impaired kidney function, meeting the following criteria:* – *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.* *This must be confirmed by a specialist (physician, nephrologist or cardiologist).*	-	50
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. *Layman's explanation:* *This claim event covers high blood pressure with impaired kidney function, meeting the following criteria:* – *Persistent blood pressure reading of 160/100 up to179/109 despite optimal medical treatment, and* – *Specialised laboratory test measuring kidney function (creatinine clearance) of less than 20% of normal value for age.* *This must be confirmed by a specialist (physician, nephrologist or cardiologist).*	100	100
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. *Layman's explanation:* *This claim event covers disease of the main artery supplying oxygen rich blood to the body (called the aorta), meeting the following criteria:* – *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	100

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
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).		
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. *Layman's explanation:* *This claim event covers peripheral arterial disease with moderate impairment, meeting the following criteria:* – *Abnormal specialised test measuring blood flow in arteries (Doppler), and* – *Cold and discoloured and painful leg.* *This must be confirmed by a specialist (vascular surgeon).* *Peripheral arterial disease is a problem with blood flow to the limbs due to narrowing of the arteries in the limbs.*	-	50
Contractual definition: Peripheral arterial disease with severe impairment despite optimal treatment, meeting the following criteria: • No palpable pulses, confirmed by absent Doppler readings, or • Severe vascular ulceration, or • Gangrene. *Layman's explanation:* *This claim event covers peripheral arterial disease with severe impairment, meeting the following criteria:* – *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).* *This must be confirmed by a specialist (vascular surgeon).* *Peripheral arterial disease is a problem with blood flow to the limbs due to narrowing of the arteries in the limbs.*	100	100
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. *Layman's explanation:*	-	50

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
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).* *Peripheral venous disease is a disease causing blockage of the blood vessels (veins) carrying blood from the arms and legs to the heart.*		
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. *Layman's explanation:* *This claim event covers severe high blood pressure in the lung arteries despite optimal treatment, meeting the following criteria:* – *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).* *This must be confirmed by a specialist (physician).*	-	50
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. *Layman's explanation:* *This claim event covers severe high blood pressure in the lung arteries despite optimal treatment, meeting the following criteria:* – *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).* *This must be confirmed by a specialist (physician).*	100	100
Blood system		
Anaemia		
Contractual definition: Severe treatment resistant anaemia despite optimal medical treatment, meeting the following criteria: • 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
This must be confirmed by a physician or haematologist. *Layman's explanation:* *This claim event covers persistent low oxygen carrying capacity of red blood cell count despite optimal medical treatment (referred to treatment resistant anaemia), meeting the following criteria:* – *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.* *This must be confirmed by a specialist (physician or haematologist).*		
Contractual definition: Life threatening, treatment resistant anaemia despite optimal treatment, meeting the following criteria: • Hb less than 8 g/dL, and • Requiring 2 or more units of blood or blood products every 2 weeks. This must be confirmed by a physician or haematologist. *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:* – *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.* *This must be confirmed by a specialist (physician or haematologist).*	100	100
White blood cell disorder		
Contractual definition: Severe white blood cell disorder, meeting the following criteria: • 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. This must be confirmed by a physician or haematologist. *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:* – *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.* *This must be confirmed by a specialist (physician or haematologist).*	-	50

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
Contractual definition: Severe white blood cell disorder, meeting the following criteria: • Whole person impairment (WPI) of at least 35% despite optimal medical treatment, or • Lymphoma or leukaemia requiring 3 to 6 chemotherapy cycles per year. This must be confirmed by a physician or haematologist. *Layman's explanation:* *This claim event covers severe white blood cell disorder, meeting the following criteria:* – 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.* *This must be confirmed by a specialist (physician or haematologist).*	100	100
Clotting disorder		

Contractual definition:
Severe clotting disorder, meeting the following criteria:
• 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:
  • 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.
 	
Layman's explanation:
This claim event covers severe clotting disorder, meeting the criteria in the contractual definition above. This must be confirmed by a specialist.
 	
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.
	100	100

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
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: • 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. *Layman's explanation:* *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).*	-	50
Contractual definition: Severe respiratory failure, meeting the following criteria: Confirmed chronic respiratory disease despite optimal medical treatment, resulting in impaired airflow with • 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. *Layman's explanation:* *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).*	100	100
Lung transplant		
Contractual definition: • 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. *Layman's explanation:*	100	100

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
This claim event covers: – *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.* *This must be confirmed by a specialist with supporting evidence.*		
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. *Layman's explanation:* *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.*	100	100
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: • 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
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: • Radiological evidence, such as a computed tomography (CT) scan or magnetic resonance imaging (MRI), and • Must be confirmed by a neurologist or neurosurgeon. *Layman's explanation:* *This claim event covers diplegia, meeting the criteria in the contractual definition above. This must be confirmed by a specialist (neurologist or neurosurgeon).* *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.*	100	100

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
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. The following is required: • 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
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. The following is required: • 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
Epilepsy		
Contractual definition: Uncontrolled epilepsy, meeting the following criteria: • 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. *Layman's explanation:* *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).*	-	50

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
Contractual definition: Frequent status epilepticus, meeting the following criteria: In spite of sustained optimal treatment and documented compliance of treatment, there must be • 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: • 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:* *This claim event covers frequent status epilepticus, meeting the criteria in the contractual definition above. This must be confirmed by a specialist (neurologist).* *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.*	100	100
Parkinson's disease		
Contractual definition: Advanced Parkinson's disease confirmed by a neurologist, meeting the following criteria: • 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:* *This claim event covers advanced Parkinson's disease, meeting the criteria in the contractual definition above. This must be confirmed by a specialist (neurologist).* *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.*	100	100

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
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: • 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. Permanence will be established after 3 months. *Layman's explanation:* *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).* *There must be evidence of all of the following:* – *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.* *Permanence will be established after 3 months.*	-	50

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
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. There must be evidence of all of the following: • 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. Permanence will be established after 3 months. *Layman's explanation:* *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).* *There must be evidence of all of the following:* – *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.* *Permanence will be established after 3 months.*	100	100
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. *Layman's explanation:* *The trigeminal nerve (the 5th cranial nerve) is a nerve responsible for sensation in the face and functions such as biting and chewing.* *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.*	-	45

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
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. *Layman's explanation:* *The facial nerve (the 7th cranial nerve) controls the muscles of facial expression, and functions in taste sensations of two-thirds of the tongue.* *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).*	-	50
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. *Layman's explanation:* *The 8th cranial nerve transmits sound and balance information from the inner ear to the brain.* *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).*	-	50
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. *Layman's explanation:* *The 8th cranial nerve transmits sound and balance information from the inner ear to the brain.* *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).*	-	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. *Layman's explanation:* *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).*	-	25
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. *Layman's explanation:* *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).*	-	75
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. *Layman's explanation:* *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).*	-	50
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. *Layman's explanation:* *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).*	-	75
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
Layman's explanation: *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).*		
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: • 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. *Layman's explanation:* *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.* *The following criteria must be met:* – *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.* *This must be confirmed by a specialist (surgeon, physician or gastroenterologist).*	-	50

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
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. *Layman's explanation:* *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.* *The following criteria must be met:* *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).*	100	100
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. *Layman's explanation:* *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.*	-	50
Contractual definition: Complete and permanent faecal incontinence not amenable to medical treatment, as a result of an organic cause, confirmed by a specialist. *Layman's explanation:* *Faecal incontinence is the inability to control bowel movements, causing stool (faeces) to leak unexpectedly from the rectum.* *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.*	100	100
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: • 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
• Ascites. *Layman's explanation:* *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).* *Ascites is the abnormal accumulation of fluid in the abdominal cavity.*		
Contractual definition: Severe progressive chronic liver disease despite optimal medical treatment, confirmed by a gastroenterologist and meeting the following criteria: • Objective evidence of jaundice, and • Ascites or bleeding oesophageal varices within the last year, and • 25% weight loss below accepted desirable weight. *Layman's explanation:* *This claim event covers severe worsening chronic liver disease despite optimal medical treatment, meeting the following criteria:* – *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.* *This must be confirmed by a specialist (gastroenterologist).* *The oesophagus (food pipe) is a muscular tube that moves food and liquids from the throat to the stomach.*	100	100
Liver transplant		
Contractual definition: • 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. This must be confirmed by a specialist with supporting evidence. *Layman's explanation:* *This claim event covers:* – *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.* *This must be confirmed by a specialist with supporting evidence.*	100	100
Biliary tract disease		

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
Contractual definition: Irreparable biliary tract obstruction with persistent jaundice despite optimal medical treatment, confirmed by a gastroenterologist. *Layman's explanation:* *This claim event covers irreparable biliary tract obstruction with persistent jaundice. This must be confirmed by a specialist (gastroenterologist).* *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.*	100	100
Pancreas transplant		
Contractual definition: • 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. This must be confirmed by a specialist with supporting evidence. *Layman's explanation:* *This claim event covers:* – *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.* *This must be confirmed by a specialist with supporting evidence.*	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. *Layman's explanation:* *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).* *The hypothalamic pituitary axis plays key roles in controlling hormone secretion that has an effect on other organs in the body.*	-	50
Hypoadrenalism		
Contractual definition:	-	50

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
Hypoadrenalism, with permanent whole person impairment (WPI) exceeding 30% despite optimal medical treatment. This must be confirmed by an endocrinologist. *Layman's explanation:* *This claim event covers hypoadrenalism, with permanent whole person impairment exceeding 30% despite optimal medical treatment. This must be confirmed by a specialist (endocrinologist).* *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.*		
Hyperadrenocorticism		
Contractual definition: Hyperadrenocorticism, with permanent whole person impairment (WPI) exceeding 30% despite optimal medical treatment. This must be confirmed by an endocrinologist. *Layman's explanation:* *This claim event covers hyperadrenocorticism, with permanent whole person impairment exceeding 30% despite optimal medical treatment. This must be confirmed by a specialist (endocrinologist).* *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.*	-	50
Phaeochromocytoma		
Contractual definition: Phaeochromocytoma, with permanent whole person impairment (WPI) exceeding 30% despite optimal medical treatment. This must be confirmed by an endocrinologist. *Layman's explanation:* *This claim event covers phaeochromocytoma, with permanent whole person impairment exceeding 30% despite optimal medical treatment. This must be confirmed by a specialist (endocrinologist).* *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 the kidney that produce important hormones in the body.*	-	50
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: • 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
• 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. *Layman's explanation:* *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.* *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.* *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.*		
Contractual definition: Diabetes mellitus: type I or II with severe organ impairment, confirmed by a specialist and meeting the following criteria: • 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. *Layman's explanation:* *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.* *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.* *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.*	100	100

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
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. *Layman's explanation:* *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 (endocrinologist), with permanent whole person impairment exceeding 30% despite optimal medical treatment.*	-	50
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. *Layman's explanation:* *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 (endocrinologist), with permanent whole person impairment exceeding 40% despite optimal medical treatment.*	100	100
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. *Layman's explanation:* *Kidney failure refers to failure of the kidneys to function properly.* *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).*	-	50
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

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
Layman's explanation: *Kidney failure refers to failure of the kidneys to function properly.* *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).*		
Kidney transplant		
Contractual definition: • 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. *Layman's explanation:* *This claim event covers:* – *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.* *This must be confirmed by a specialist with supporting evidence.*	100	100
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 a urologist. *Layman's explanation:* *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).* *Catheterisation is when a plastic tube (a catheter) is inserted into the bladder to provide urinary drainage.*	-	45
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. *Layman's explanation:* *This claim event covers bladder or urethral disease, not due to a psychological cause.* *The following criteria must be met:*	100	100

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
– *The disease must result in uncontrolled leakage of urine despite optimal medical treatment, and* – *It must require permanent catheterisation to provide continuous urinary drainage.* *This must be confirmed by a specialist (urologist).* *Catheterisation is when a plastic tube (a catheter) is inserted into the bladder to provide urinary drainage.*		
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. *Layman's explanation:* *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.*	100	100
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. *Layman's explanation:* *The surgical or traumatic removal or severance of a thumb at the first joint. This must be confirmed by a specialist with supporting evidence.*	-	30*
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. *Layman's explanation:* *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.*	-	15*
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 %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
surgical means. This must be confirmed by a specialist with supporting evidence. *Layman's explanation:* *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.*		
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. *Layman's explanation:* *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.*	-	45*
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. *Layman's explanation:* *The surgical or traumatic removal or severance of a hand at the wrist. This must be confirmed by a specialist with supporting evidence.*	-	70
Loss of use of a hand		
Contractual definition: • 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:* *This claim event covers:* – *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.* *This must be confirmed by a specialist with supporting evidence.*	-	70
Amputation of an arm below the elbow		

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
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. *Layman's explanation:* *The surgical or traumatic removal or severance of an arm below the elbow. This must be confirmed by a specialist with supporting evidence.*	-	75
Loss of use of an arm		
Contractual definition: • 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:* *This claim event covers:* – *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.* *This must be confirmed by a specialist with supporting evidence.*	-	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. *Layman's explanation:* *The surgical or traumatic removal or severance of an arm above the elbow. This must be confirmed by a specialist with supporting evidence.*	-	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. *Layman's explanation:* *The surgical or traumatic removal or severance of a foot at the ankle joint. This must be confirmed by a specialist with supporting evidence.*	-	30

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
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. *Layman's explanation:* *The permanent loss of use of an entire foot from the ankle. This must be confirmed by a specialist with supporting evidence.*	-	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. *Layman's explanation:* *The surgical or traumatic removal or severance of a leg below the knee. This must be confirmed by a specialist with supporting evidence.*	-	50
Loss of use of a lower leg		
Contractual definition: • 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. *Layman's explanation:* *This claim event covers:* – *The permanent loss of use of an entire leg from below the knee, or* – *The permanent loss of use of a leg (lower limb), meeting the criteria in the contractual definition above.* *This must be confirmed by a specialist with supporting evidence.*	-	50
Loss of use of a leg		
Contractual definition: • 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. *Layman's explanation:* *This claim event covers:* – *The permanent loss of use of an entire leg, or*	-	75

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
– *The permanent loss of use of a leg (lower limb), meeting the criteria in the contractual definition above.* *This must be confirmed by a specialist with supporting evidence.*		
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. *Layman's explanation:* *The surgical or traumatic removal or severance of a leg above the knee. This must be confirmed by a specialist with supporting evidence.*	-	75
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: • 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. 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.	100	100
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: • 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. 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.	100	100
Chronic back and neck pain		
Contractual definition:	-	25

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
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. The spinal regions are the following: • 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: • 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: • pain questionnaires, and • pain diagrams, and • analgesic medication usage. This must be confirmed by an orthopaedic specialist or neurosurgeon with supporting evidence. *Layman's explanation:* *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.* *The spinal sections are:* – *Cervical – holds up the head* – *Thoracic – ribs are attached* – *Lumbar – lower back.* *The pain must be due to one of the following causes:* – *A back bone (vertebra) having lost half of its height due to compression. Compression of a vertebral body is when one or more back bones (vertebrae) collapse into itself and become squashed (compressed), or* – *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.*		

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
This must be confirmed by a specialist (orthopaedic specialist or neurosurgeon), with the evidence provided as stipulated in the contractual definition above.		
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. *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).*	-	50
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. *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.*	100	100
Stage IV cancer		
Contractual definition: Any stage IV cancer, confirmed by an oncologist with supporting objective evidence. *Layman's explanation:* *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.* *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).*	100	100

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		
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. *Layman's explanation:* *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.*	-	25
Loss of an eye		
Contractual definition: Complete enucleation of one eye due to injury or disease, confirmed by an ophthalmologist with supporting evidence. *Layman's explanation:* *The complete removal of one eye from its socket as a result of trauma or surgery, confirmed by a specialist (ophthalmologist) with supporting documents.*	-	50
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: • 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. *Layman's explanation:* *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).*	-	50

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
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: • 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. *Layman's explanation:* *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).*	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 audiometry evidence, recording an average loss of at least 70dB across all measured frequencies.	-	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 audiometry evidence, recording an average loss of 70-87dB across all measured frequencies.	-	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 audiometry evidence, recording an average loss of greater than 87dB across all measured frequencies.	100	100
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. *Layman's explanation:*	100	100

Impairment Claim event	Percentage of cover amount %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
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).		
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. *Layman's explanation:* *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).*	-	50
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. *Layman's explanation:* *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).*	100	100
Psychiatric conditions		
Psychiatric condition		
Contractual definition: Psychiatric condition with frequent, extended admissions, meeting the following criteria: • 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: • 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
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: • 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		
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
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. *Layman's explanation:* *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).*	-	50
Contractual definition: Third-degree burns, full thickness of the skin, covering at least 30% of the total body surface, confirmed by a surgeon. *Layman's explanation:* *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).*	100	100
HIV		
Advanced HIV		
Contractual definition: • 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
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: • 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. *Layman's explanation:* – *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;* *AND* *One of the following diseases must be diagnosed:* – *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 %	
	Sickness Income / Temporary Income	Sickness Income Plus / Temporary Income Plus
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
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 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 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
Cardiovascular system						
Valvular heart disease, cardiomyopathy						

Contractual definition:
Severe valvular heart disease or cardiomyopathy, meeting the following criteria:
• New York Heart Association (NYHA) class III on optimal treatment, and
• One of the following:
  • 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:
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).
	-	-	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
This claim event must meet the criteria as described in the contractual definition above, and must be confirmed by a specialist (cardiologist).						

Contractual definition:
Severe valvular heart disease or cardiomyopathy, meeting the following criteria:
• New York Heart Association (NYHA) class IV on optimal treatment, and
• One of the following:
  • 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.
 	
This must be confirmed by a cardiologist.
 	
Layman's explanation:
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).
 	
This claim event must meet the criteria as described in the contractual definition above, and must be confirmed by a specialist (cardiologist).
	100	50	100	50	100	50

Ischaemic heart disease						

Contractual definition:
Ischaemic heart disease with cardiac failure, meeting the following criteria:
• 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:
  • 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.
This must be confirmed by a cardiologist.
 	
Layman's explanation:
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).
 	
This claim event must meet the criteria as described in the contractual definition above, and must be confirmed by a specialist (cardiologist).
	-	-	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:
 	
• 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:
  • 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.
 	
This must be confirmed by a cardiologist.
 	
Layman's explanation:
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).
 	
This claim event must meet the criteria as described in the contractual definition above, and must be confirmed by a specialist (cardiologist).
	100	50	100	50	100	50

Heart transplant						
Contractual definition: • 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. This must be confirmed by a specialist with supporting evidence. *Layman's explanation:* *This claim event covers:* – *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.* *This must be confirmed by a specialist with supporting evidence.*	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
Pericardial disease						

Contractual definition:
Pericardial disease with cardiac failure, meeting the following criteria:
• Confirmed irreversible pericardial disease by a specialist, and
• New York Heart Association (NYHA) class III on optimal treatment, and
• One of the following:
  • 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.
 	
Layman's explanation:
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).
 	
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).
	-	-	50	25	50	25

Contractual definition:
Pericardial disease with cardiac failure, meeting the following criteria:
• Confirmed irreversible pericardial disease by a specialist, and
• New York Heart Association (NYHA) class IV on optimal treatment, and
• One of the following:
  • 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.
 	
Layman's explanation:
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).
 	
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).
	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
Arrhythmia						

Contractual definition:
Arrhythmia with moderate impairment, meeting the following criteria:
Arrhythmia on optimal treatment that results in
• New York Heart Association (NYHA) class III shortness of breath, and
• One of the following:
  • 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.
 	
This must be confirmed by a cardiologist, physician or electrophysiologist.
 	
Layman's explanation:
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).
 	
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:
– 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:
– Reduced exercise effort test meeting specified criteria, or
Documented arrhythmia that fails to respond to optimal treatment, and leads to frequent fainting.
	-	-	50	25	50	25

Contractual definition: Arrhythmia with severe impairment, meeting the following criteria: Arrhythmia on optimal treatment that results in • New York Heart Association (NYHA) class IV shortness of breath, and • 2 or less metabolic equivalents (METS) with maximal effort test. This must be confirmed by a cardiologist, physician or electrophysiologist. *Layman's explanation:* *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).* *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:* *– 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	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
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. *Layman's explanation:* *This claim event covers high blood pressure with impaired kidney function, meeting the following criteria:* – *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.* *This must be confirmed by a specialist (physician, nephrologist or cardiologist).*	-	-	50	25	50	25
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. *Layman's explanation:* *This claim event covers high blood pressure with impaired kidney function, meeting the following criteria:* – *Persistent blood pressure reading of 160/100 up to179/109 despite optimal medical treatment, and* – *Specialised laboratory test measuring kidney function (creatinine clearance) of less than 20% of normal value for age.* *This must be confirmed by a specialist (physician, nephrologist or cardiologist).*	100	50	100	50	100	50
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. *Layman's explanation:* *This claim event covers disease of the main artery supplying oxygen rich blood to the body (called the aorta), meeting the following criteria:* – *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
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).						
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. *Layman's explanation:* *This claim event covers peripheral arterial disease with moderate impairment, meeting the following criteria:* – *Abnormal specialised test measuring blood flow in arteries (Doppler), and* – *Cold and discoloured and painful leg.* *This must be confirmed by a specialist (vascular surgeon).* *Peripheral arterial disease is a problem with blood flow to the limbs due to narrowing of the arteries in the limbs.*	-	-	50	25	50	25
Contractual definition: Peripheral arterial disease with severe impairment despite optimal treatment, meeting the following criteria: • No palpable pulses, confirmed by absent Doppler readings, or • Severe vascular ulceration, or • Gangrene. *Layman's explanation:* *This claim event covers peripheral arterial disease with severe impairment, meeting the following criteria:* – *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).* *This must be confirmed by a specialist (vascular surgeon).* *Peripheral arterial disease is a problem with blood flow to the limbs due to narrowing of the arteries in the limbs.*	100	50	100	50	100	50
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. *Layman's explanation:* *This claim event covers peripheral venous disease with severe impairment despite optimal treatment, with severe deep and widespread ulcers due to poor blood flow.*	-	-	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
This must be confirmed by a specialist (vascular surgeon). *Peripheral venous disease is a disease causing blockage of the blood vessels (veins) carrying blood from the arms and legs to the heart.*						
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. *Layman's explanation:* *This claim event covers severe high blood pressure in the lung arteries despite optimal treatment, meeting the following criteria:* – *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).* *This must be confirmed by a specialist (physician).*	-	-	50	25	50	25
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. *Layman's explanation:* *This claim event covers severe high blood pressure in the lung arteries despite optimal treatment, meeting the following criteria:* – *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).* *This must be confirmed by a specialist (physician).*	100	50	100	50	100	50
Blood system						
Anaemia						
Contractual definition: Severe treatment resistant anaemia despite optimal medical treatment, meeting the following criteria: • 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. *Layman's explanation:*	-	-	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
This claim event covers persistent low oxygen carrying capacity of red blood cell count despite optimal medical treatment (referred to treatment resistant anaemia), meeting the following criteria: – *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.* *This must be confirmed by a specialist (physician or haematologist).*						
Contractual definition: Life threatening, treatment resistant anaemia despite optimal treatment, meeting the following criteria: • Hb less than 8 g/dL, and • Requiring 2 or more units of blood or blood products every 2 weeks. This must be confirmed by a physician or haematologist. *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:* – *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.* *This must be confirmed by a specialist (physician or haematologist).*	100	50	100	50	100	50
White blood cell disorder						
Contractual definition: Severe white blood cell disorder, meeting the following criteria: • 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. This must be confirmed by a physician or haematologist. *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:* – *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.* *This must be confirmed by a specialist (physician or haematologist).*	-	-	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: • Whole person impairment (WPI) of at least 35% despite optimal medical treatment, or • Lymphoma or leukaemia requiring 3 to 6 chemotherapy cycles per year. This must be confirmed by a physician or haematologist. *Layman's explanation:* *This claim event covers severe white blood cell disorder, meeting the following criteria:* – 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.* *This must be confirmed by a specialist (physician or haematologist).*	100	50	100	50	100	50
Clotting disorder						

Contractual definition:
Severe clotting disorder, meeting the following criteria:
• 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:
  • 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.
 	
Layman's explanation:
This claim event covers severe clotting disorder, meeting the criteria in the contractual definition above. This must be confirmed by a specialist.
 	
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.
	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
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: • 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. *Layman's explanation:* *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).*	-	-	50	25	50	25
Contractual definition: Severe respiratory failure, meeting the following criteria: Confirmed chronic respiratory disease despite optimal medical treatment, resulting in impaired airflow with • 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. *Layman's explanation:* *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).*	100	50	100	50	100	50
Lung transplant						
Contractual definition: • 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. *Layman's explanation:* *This claim event covers:*	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
– *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.* *This must be confirmed by a specialist with supporting evidence.*						
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. *Layman's explanation:* *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.*	100	50	100	50	100	50
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: • 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: • Radiological evidence, such as a computed tomography (CT) scan or magnetic resonance imaging (MRI), and • Must be confirmed by a neurologist or neurosurgeon. *Layman's explanation:* *This claim event covers diplegia, meeting the criteria in the contractual definition above. This must be confirmed by a specialist (neurologist or neurosurgeon).* *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.*	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 of or injury to the spinal cord or brain. The following is required: • 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 of or injury to the spinal cord or brain. The following is required: • 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: • 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. *Layman's explanation:* *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).*	-	-	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: Frequent status epilepticus, meeting the following criteria: In spite of sustained optimal treatment and documented compliance of treatment, there must be • 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: • 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:* *This claim event covers frequent status epilepticus, meeting the criteria in the contractual definition above. This must be confirmed by a specialist (neurologist).* *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.*	100	50	100	50	100	50
Parkinson's disease						
Contractual definition: Advanced Parkinson's disease confirmed by a neurologist, meeting the following criteria: • 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:* *This claim event covers advanced Parkinson's disease, meeting the criteria in the contractual definition above. This must be confirmed by a specialist (neurologist).* *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.*	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
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: • 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. Permanence will be established after 3 months. *Layman's explanation:* *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).* *There must be evidence of all of the following:* – *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.* *Permanence will be established after 3 months.*	-	-	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: 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. There must be evidence of all of the following: • 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. Permanence will be established after 3 months. *Layman's explanation:* *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).* *There must be evidence of all of the following:* – *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.* *Permanence will be established after 3 months.*	100	50	100	50	100	50
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. *Layman's explanation:* *The trigeminal nerve (the 5th cranial nerve) is a nerve responsible for sensation in the face and functions such as biting and chewing.* *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.*	-	-	45	22.5	45	22.5

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
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. *Layman's explanation:* *The facial nerve (the 7th cranial nerve) controls the muscles of facial expression, and functions in taste sensations of two-thirds of the tongue.* *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).*	-	-	50	25	50	25
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. *Layman's explanation:* *The 8th cranial nerve transmits sound and balance information from the inner ear to the brain.* *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).*	-	-	50	25	50	25
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. *Layman's explanation:* *The 8th cranial nerve transmits sound and balance information from the inner ear to the brain.* *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).*	-	-	75	37.5	75	37.5
Cranial nerves IX, X or XII						
Contractual definition:	-	-	25	12.5	25	12.5

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
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:* *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).*						
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. *Layman's explanation:* *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).*	-	-	75	37.5	75	37.5
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. *Layman's explanation:* *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).*	-	-	50	25	50	25
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. *Layman's explanation:* *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).*	-	-	75	37.5	75	37.5
Contractual definition: Neurologic impairment of respiration to such an extent that there is no spontaneous respiration. This must be confirmed by a neurologist. *Layman's explanation:* *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).*	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
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: • 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. *Layman's explanation:* *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.* *The following criteria must be met:* – *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.* *This must be confirmed by a specialist (surgeon, physician or gastroenterologist).*	-	-	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. *Layman's explanation:* *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.* *The following criteria must be met:* *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).*	100	50	100	50	100	50
Loss of bowel function						

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: Permanent colostomy as a result of loss of bowel function, as a result of traumatic or medical conditions and confirmed by a specialist. *Layman's explanation:* *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.*	-	-	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. *Layman's explanation:* *Faecal incontinence is the inability to control bowel movements, causing stool (faeces) to leak unexpectedly from the rectum.* *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.*	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: • Albumin 28-35 mg/L • INR 1.71-2.20 • Bilirubin 34-50 umol/l • Ascites. *Layman's explanation:* *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).* *Ascites is the abnormal accumulation of fluid in the abdominal cavity.*	-	-	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: • Objective evidence of jaundice, and • Ascites or bleeding oesophageal varices within the last year, and • 25% weight loss below accepted desirable weight. *Layman's explanation:* *This claim event covers severe worsening chronic liver disease despite optimal medical treatment, meeting the following criteria:* – *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.* *This must be confirmed by a specialist (gastroenterologist).* *The oesophagus (food pipe) is a muscular tube that moves food and liquids from the throat to the stomach.*	100	50	100	50	100	50
Liver transplant						
Contractual definition: • 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. This must be confirmed by a specialist with supporting evidence. *Layman's explanation:* *This claim event covers:* – *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.* *This must be confirmed by a specialist with supporting evidence.*	100	50	100	50	100	50
Biliary tract disease						
Contractual definition: Irreparable biliary tract obstruction with persistent jaundice despite optimal medical treatment, confirmed by a gastroenterologist. *Layman's explanation:* *This claim event covers irreparable biliary tract obstruction with persistent jaundice. This must be confirmed by a specialist (gastroenterologist).* *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*	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
jaundice is when the obstruction is irreparable and jaundice persists despite optimal medical treatment.						
Pancreas transplant						
Contractual definition: • 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. This must be confirmed by a specialist with supporting evidence. *Layman's explanation:* *This claim event covers:* – *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.* *This must be confirmed by a specialist with supporting evidence.*	100	50	100	50	100	50
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. *Layman's explanation:* *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).* *The hypothalamic pituitary axis plays key roles in controlling hormone secretion that has an effect on other organs in the body.*	-	-	50	25	50	25
Hypoadrenalism						
Contractual definition: Hypoadrenalism, with permanent whole person impairment (WPI) exceeding 30% despite optimal medical treatment. This must be confirmed by an endocrinologist. *Layman's explanation:* *This claim event covers hypoadrenalism, with permanent whole person impairment exceeding 30% despite optimal medical treatment. This must be confirmed by a specialist (endocrinologist).* *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.*	-	-	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
Hyperadrenocorticism						
Contractual definition: Hyperadrenocorticism, with permanent whole person impairment (WPI) exceeding 30% despite optimal medical treatment. This must be confirmed by an endocrinologist. *Layman's explanation:* *This claim event covers hyperadrenocorticism, with permanent whole person impairment exceeding 30% despite optimal medical treatment. This must be confirmed by a specialist (endocrinologist).* *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.*	-	-	50	25	50	25
Phaeochromocytoma						
Contractual definition: Phaeochromocytoma, with permanent whole person impairment (WPI) exceeding 30% despite optimal medical treatment. This must be confirmed by an endocrinologist. *Layman's explanation:* *This claim event covers phaeochromocytoma, with permanent whole person impairment exceeding 30% despite optimal medical treatment. This must be confirmed by a specialist (endocrinologist).* *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 the kidney that produce important hormones in the body.*	-	-	50	25	50	25
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: • 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. *Layman's explanation:* *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.* *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.* *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.*	-	-	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: Diabetes mellitus: type I or II with severe organ impairment, confirmed by a specialist and meeting the following criteria: • 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. *Layman's explanation:* *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.* *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.* *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.*	100	50	100	50	100	50
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. *Layman's explanation:* *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 (endocrinologist), with permanent whole person impairment exceeding 30% despite optimal medical treatment.*	-	-	50	25	50	25
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. *Layman's explanation:* *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 (endocrinologist), with permanent whole person impairment exceeding 40% despite optimal medical treatment.*	100	50	100	50	100	50
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
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. *Layman's explanation:* *Kidney failure refers to failure of the kidneys to function properly.* *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).*	-	-	50	25	50	25
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. *Layman's explanation:* *Kidney failure refers to failure of the kidneys to function properly.* *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).*	100	50	100	50	100	50
Kidney transplant						
Contractual definition: • 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. *Layman's explanation:* *This claim event covers:* – *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.* *This must be confirmed by a specialist with supporting evidence.*	100	50	100	50	100	50
Loss of bladder function						

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: 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. *Layman's explanation:* *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).* *Catheterisation is when a plastic tube (a catheter) is inserted into the bladder to provide urinary drainage.*	-	-	45	22.5	45	22.5
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. *Layman's explanation:* *This claim event covers bladder or urethral disease, not due to a psychological cause. The following criteria must be met:* – *The disease must result in uncontrolled leakage of urine despite optimal medical treatment, and* – *It must require permanent catheterisation to provide continuous urinary drainage.* *This must be confirmed by a specialist (urologist).* *Catheterisation is when a plastic tube (a catheter) is inserted into the bladder to provide urinary drainage.*	100	50	100	50	100	50
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. *Layman's explanation:* *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.*	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
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. *Layman's explanation:* *The surgical or traumatic removal or severance of a thumb at the first joint. This must be confirmed by a specialist with supporting evidence.*	-	-	-	-	30*	15
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. *Layman's explanation:* *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.*	-	-	-	-	15*	7.5
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. *Layman's explanation:* *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.*	-	-	-	-	45*	22.5
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. *Layman's explanation:* *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.*	-	-	-	-	45*	22.5
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. *Layman's explanation:* *The surgical or traumatic removal or severance of a hand at the wrist. This must be confirmed by a specialist with supporting evidence.*	-	-	70	35	70	35
Loss of use of a hand						
Contractual definition: • 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:* *This claim event covers:* – *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.* *This must be confirmed by a specialist with supporting evidence.*	-	-	70	35	70	35
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. *Layman's explanation:* *The surgical or traumatic removal or severance of an arm below the elbow. This must be confirmed by a specialist with supporting evidence.*	-	-	75	37.5	75	37.5
Loss of use of an arm						
Contractual definition: • 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:* *This claim event covers:* – *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.* *This must be confirmed by a specialist with supporting evidence.*	-	-	75	37.5	75	37.5

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. *Layman's explanation:* *The surgical or traumatic removal or severance of an arm above the elbow. This must be confirmed by a specialist with supporting evidence.*	-	-	80	40	80	40
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. *Layman's explanation:* *The surgical or traumatic removal or severance of a foot at the ankle joint. This must be confirmed by a specialist with supporting evidence.*	-	-	30	15	30	15
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. *Layman's explanation:* *The permanent loss of use of an entire foot from the ankle. This must be confirmed by a specialist with supporting evidence.*	-	-	30	15	30	15
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. *Layman's explanation:* *The surgical or traumatic removal or severance of a leg below the knee. This must be confirmed by a specialist with supporting evidence.*	-	-	50	25	50	25
Loss of use of a lower leg						
Contractual definition: • 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. *Layman's explanation:* *This claim event covers:*	-	-	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
– *The permanent loss of use of an entire leg from below the knee, or* – *The permanent loss of use of a leg (lower limb), meeting the criteria in the contractual definition above.* *This must be confirmed by a specialist with supporting evidence.*						
Loss of use of a leg						
Contractual definition: • 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. *Layman's explanation:* *This claim event covers:* – *The permanent loss of use of an entire leg, or* – *The permanent loss of use of a leg (lower limb), meeting the criteria in the contractual definition above.* *This must be confirmed by a specialist with supporting evidence.*	-	-	75	37.5	75	37.5
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. *Layman's explanation:* *The surgical or traumatic removal or severance of a leg above the knee. This must be confirmed by a specialist with supporting evidence.*	-	-	75	37.5	75	37.5
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: • 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. 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.	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
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: • 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. 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.	100	50	100	50	100	50
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. The spinal regions are the following: • 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: • 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: • pain questionnaires, and • pain diagrams, and • analgesic medication usage. This must be confirmed by an orthopaedic specialist or neurosurgeon with supporting evidence. *Layman's explanation:* *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.*	-	-	25	12.5	25	12.5

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
The spinal sections are: – *Cervical – holds up the head* – *Thoracic – ribs are attached* – *Lumbar – lower back.* *The pain must be due to one of the following causes:* – *A back bone (vertebra) having lost half of its height due to compression. Compression of a vertebral body is when one or more back bones (vertebrae) collapse into itself and become squashed (compressed), or* – *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.* *This must be confirmed by a specialist (orthopaedic specialist or neurosurgeon), with the evidence provided as stipulated in the contractual definition above.*						
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. *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).*	-	-	50	25	50	25
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. *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.*	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
Stage IV cancer						
Contractual definition: Any stage IV cancer, confirmed by an oncologist with supporting objective evidence. *Layman's explanation:* *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.* *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).*	100	50	100	50	100	50
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. *Layman's explanation:* *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.*	-	-	25	12.5	25	12.5
Loss of an eye						
Contractual definition: Complete enucleation of one eye due to injury or disease, confirmed by an ophthalmologist with supporting evidence. *Layman's explanation:* *The complete removal of one eye from its socket as a result of trauma or surgery, confirmed by a specialist (ophthalmologist) with supporting documents.*	-	-	50	25	50	25
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: • 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. *Layman's explanation:* *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).*	-	-	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
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: • 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. *Layman's explanation:* *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).*	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 audiometry 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 audiometry 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 audiometry 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. *Layman's explanation:* *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).*	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
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. *Layman's explanation:* *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).*	-	-	50	25	50	25
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. *Layman's explanation:* *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).*	100	50	100	50	100	50
Psychiatric conditions						
Psychiatric condition						
Contractual definition: Psychiatric condition with frequent, extended admissions, meeting the following criteria: • 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: • 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	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: 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: • 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. *Layman's explanation:* *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).*	-	-	50	25	50	25
Contractual definition: Third-degree burns, full thickness of the skin, covering at least 30% of the total body surface, confirmed by a surgeon. *Layman's explanation:* *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).*	100	50	100	50	100	50
HIV						
Advanced HIV						
Contractual definition: • 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					
	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
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: • 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. *Layman's explanation:* – *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;* *AND* *One of the following diseases must be diagnosed:* – *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					
	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
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 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 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		
	Accidental Temporary Income Plus	Accidental Extended Income Plus	
		Before age 70	From age 70
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. *Layman's explanation:* *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.*	100	100	50

Impairment Claim event	Percentage of cover amount		
	Accidental Temporary Income Plus	Accidental Extended Income Plus	
		Before age 70	From age 70
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. The following is required: • 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	50
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: • Radiological evidence, such as a computed tomography (CT) scan or magnetic resonance imaging (MRI), and • Must be confirmed by a neurologist or neurosurgeon. *Layman's explanation:* *This claim event covers diplegia, meeting the criteria in the contractual definition above. This must be confirmed by a specialist (neurologist or neurosurgeon).* *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.*	100	100	50
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: • 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	50
Quadriplegia			

Impairment Claim event	Percentage of cover amount		
	Accidental Temporary Income Plus	Accidental Extended Income Plus	
		Before age 70	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. The following is required: • 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	50
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. *Layman's explanation:* *The trigeminal nerve (the 5th cranial nerve) is a nerve responsible for sensation in the face and functions such as biting and chewing.* *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.*	45	45	22.5
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. *Layman's explanation:* *The facial nerve (the 7th cranial nerve) controls the muscles of facial expression, and functions in taste sensations of two-thirds of the tongue.* *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).*	50	50	25
Cranial nerve VIII			

Impairment Claim event	Percentage of cover amount		
	Accidental Temporary Income Plus	Accidental Extended Income Plus	
		Before age 70	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. *Layman’s explanation:* *The 8th cranial nerve transmits sound and balance information from the inner ear to the brain.* *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).*	50	50	25
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. *Layman’s explanation:* *The 8th cranial nerve transmits sound and balance information from the inner ear to the brain.* *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).*	75	75	37.5
Cranial nerves IX, X or XII			

Impairment Claim event	Percentage of cover amount		
	Accidental Temporary Income Plus	Accidental Extended Income Plus	
		Before age 70	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. 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. *Layman's explanation:* *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).*	25	25	12.5
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. *Layman's explanation:* *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).*	75	75	37.5
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. *Layman's explanation:* *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).*	50	50	25

Impairment Claim event	Percentage of cover amount		
	Accidental Temporary Income Plus	Accidental Extended Income Plus	
		Before age 70	From age 70
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 *specialist* (neurologist). *Layman's explanation:* *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).*	75	75	37.5
Contractual definition: Neurologic impairment of respiration to such an extent that there is no spontaneous respiration. This must be confirmed by a neurologist. *Layman's explanation:* *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).*	100	100	50
Renal system			
Surgical removal of the bladder			
Contractual definition: The surgical excision of the bladder by a surgeon, confirmed with a surgical report by ana urologist or surgeon. *Layman's explanation:* *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.*	100	100	50
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. *Layman's explanation:*	30*	-	-

Impairment Claim event	Percentage of cover amount		
	Accidental Temporary Income Plus	Accidental Extended Income Plus	
		Before age 70	From age 70
The surgical or traumatic removal or severance of a thumb at the first joint. This must be confirmed by a specialist with supporting evidence.			
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. *Layman's explanation:* *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.*	15*	-	-
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. *Layman's explanation:* *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.*	45*	-	-
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. *Layman's explanation:* *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.*	45*	-	-
Amputation of a hand			

Impairment Claim event	Percentage of cover amount		
	Accidental Temporary Income Plus	Accidental Extended Income Plus	
		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. *Layman's explanation:* *The surgical or traumatic removal or severance of a hand at the wrist. This must be confirmed by a specialist with supporting evidence.*	70	70	35
Loss of use of a hand			
Contractual definition: • 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:* *This claim event covers:* – *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.* *This must be confirmed by a specialist with supporting evidence.*	70	70	35
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. *Layman's explanation:* *The surgical or traumatic removal or severance of an arm below the elbow. This must be confirmed by a specialist with supporting evidence.*	75	75	37.5
Loss of use of an arm			
Contractual definition: • The permanent loss of function of an entire arm from the shoulder (distal to the shoulder), or	75	75	37.5

Impairment Claim event	Percentage of cover amount		
	Accidental Temporary Income Plus	Accidental Extended Income Plus	
		Before age 70	From age 70
• 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:* *This claim event covers:* – *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.* *This must be confirmed by a specialist with supporting evidence.*			
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. *Layman's explanation:* *The surgical or traumatic removal or severance of an arm above the elbow. This must be confirmed by a specialist with supporting evidence.*	80	80	40
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. *Layman's explanation:* *The surgical or traumatic removal or severance of a foot at the ankle joint. This must be confirmed by a specialist with supporting evidence.*	30	30	15
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. *Layman's explanation:*	30	30	15

Impairment Claim event	Percentage of cover amount		
	Accidental Temporary Income Plus	Accidental Extended Income Plus	
		Before age 70	From age 70
The permanent loss of use of an entire foot from the ankle. This must be confirmed by a specialist with supporting evidence.			
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. *Layman's explanation:* *The surgical or traumatic removal or severance of a leg below the knee. This must be confirmed by a specialist with supporting evidence.*	50	50	25
Loss of use of a lower leg			
Contractual definition: • 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. *Layman's explanation:* *This claim event covers:* – *The permanent loss of use of an entire leg from below the knee, or* – *The permanent loss of use of a leg (lower limb), meeting the criteria in the contractual definition above.* *This must be confirmed by a specialist with supporting evidence.*	50	50	25
Loss of use of a leg			
Contractual definition: • 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. *Layman's explanation:* *This claim event covers:*	75	75	37.5

Impairment Claim event	Percentage of cover amount		
	Accidental Temporary Income Plus	Accidental Extended Income Plus	
		Before age 70	From age 70
– *The permanent loss of use of an entire leg, or* – *The permanent loss of use of a leg (lower limb), meeting the criteria in the contractual definition above.* *This must be confirmed by a specialist with supporting evidence.*			
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. *Layman's explanation:* *The surgical or traumatic removal or severance of a leg above the knee. This must be confirmed by a specialist with supporting evidence.*	75	75	37.5
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: • 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. 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.	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: • Loss of use of a hand • Loss of use of an arm • Loss of use of a foot	100	100	50

Impairment Claim event	Percentage of cover amount		
	Accidental Temporary Income Plus	Accidental Extended Income Plus	
		Before age 70	From age 70
• 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. 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.			
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. *Layman's explanation:* *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.*	25	25	12.5
Loss of an eye			
Contractual definition: Complete enucleation of one eye due to injury, confirmed by an ophthalmologist with supporting evidence. *Layman's explanation:* *The complete removal of one eye from its socket as a result of trauma or surgery, confirmed by a specialist (ophthalmologist) with supporting documents.*	50	50	25
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: • 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. *Layman's explanation:* *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).*	50	50	25

Impairment Claim event	Percentage of cover amount		
	Accidental Temporary Income Plus	Accidental Extended Income Plus	
		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: • 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. *Layman's explanation:* *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).*	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 audiometry 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 audiometry 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 audiometry 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	
		Before age 70	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. *Layman's explanation:* *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).*	50	50	25
Contractual definition: Third-degree burns, full thickness of the skin, covering at least 30% of the total body surface, confirmed by a surgeon. *Layman's explanation:* *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).*	100	100	50
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