Life Plan Guide.

Version 1.2

Dis-Chem Life.

GUARDRISK

Contents

1. Introduction

1.1 WELCOME TO DIS-CHEM LIFE

Welcome to Dis-Chem Life. We went on a mission to re-engineer, rebuild and redesign life insurance with the sole purpose to put customers first and enable them to better protect themselves and their families. We subsequently created a completely new type of life insurance, a revolutionary product that offers holistic coverage. Our Policy also no longer requires You to lock into a static long term contract but provides You with needs-matched cover that dynamically adjusts to ensure You are always optimally covered should You experience a Life Changing Event.

A Dis-Chem Life Policy enables You to protect Your most valuable assets, Your life, Your income and Your ability to obtain the most advanced treatments should You become severely ill or disabled. Our unique and (for many features) world-first products provide broad, comprehensive, efficient and dynamic long-term protection for You and Your family. You receive intelligent, tech-powered cover, unlimited risk cover for unrelated severe illnesses and complete transparency across our benefit structures. Our Life Cover, Lump-Sum Disability Cover, Income Protection, Education Legacy Protector, and Critical Illness Benefits are fully described in the rest of the Policy Guide.

This Policy Guide provides comprehensive information on all the Benefits offered by Dis-Chem Life. Details of the specific Benefits You have selected will appear on Your personal Policy Schedule accompanying this Policy Guide. It is important that You check Your Policy Schedule in conjunction with this Policy Guide carefully to ensure that the Benefits selected are correctly recorded on it.

This product is underwritten by Guardrisk Life Limited (FSP License Number 76) and administered by Dis-Chem Life. Guardrisk Life Limited is a licensed life insurer in terms of the Insurance Act.

The headings and subheadings in this Policy are for the purpose of convenience and reference only and shall not be used in the interpretation of, nor to modify nor amplify, the terms of this Policy. Please also note that throughout the Policy where figures are referred to in numerals and in words, if there is any conflict between the two, the words shall prevail. If there is ever a discrepancy between this document, the Policy Guide, and the Policy Schedule then the wording, terms and conditions in the Policy Guide will take precedence.

The Life Policy Guide has been written for Personal Assurance policies. All terms, conditions and Benefit workings in the Policy are exactly the same for Personal Assurance policies as well as Business Assurance policies, unless specified otherwise in the Policy.

1.2 DEFINITION OF TERMS

The definitions set forth below, unless inconsistent with the context in the Policy, shall bear the following meanings:

‘Absolute Cession’	:is a cession where the Cessionary takes ownership of the Policy and becomes liable for the payment of Premiums on the Policy.
‘Accident’	:means the sudden, unforeseen and uncertain event, which could not reasonably be expected to occur, which is caused by violent, external, physical and visible means at an identifiable time and place, resulting directly and independently of any other cause, in Bodily Injury. This does not include sickness or disease or any naturally occurring condition or degenerative process. Self-inflicted injury and suicide are excluded from this definition. “Accidental” has a corresponding meaning where the context so allows.
‘Accidental Death’	:means a Bodily Injury which results immediately or within 30 (thirty) Days as a direct consequence of the Bodily Injury in the death of the Insured Life and shall exclude Natural Death.
‘Accidental Disability’	:means a Bodily Injury which results immediately or within 30 (thirty) Days as a direct consequence of the Bodily Injury, in the Insured Life meeting one of the specified Disability Objective Medical Criteria, and shall exclude Natural Disability.
‘Activities of Daily Living’	:Activities of Daily Living (ADLs) is an internationally used scoring system that assesses the functional ability of a person including their physical, cognitive and interactive abilities. Dis-Chem Life uses the ADLs to assess functioning in the Illness Cover, Disability Cover, Education Legacy Protector and Permanent Income Protection Benefits when objective criteria of impairment are needed – for example when neurological and connective tissue diseases are assessed. Changes to the ADLs must be permanent, must have occurred after the Commencement Date of the Policy, and must be due to the condition, illness or event that is being Claimed for.
‘Administrator’	:means Dis-Chem Life (Pty) Ltd, with Registration Number 2019/389648/07 and FSP Number 50594.
‘Affiliates’	:means other companies or entities that are related to the Administrator through ownership, control, or a significant business relationship. These relationships may include ownership of a controlling interest, shared control by a common parent company, or formal agreements for collaboration or mutual support. Affiliates may include subsidiaries, joint venture partners, or other entities with which the company has a business relationship.

‘Anniversary Start Date’	:refers to the 1st (first) Day of the month in which the Commencement Date occurs. .
‘Annual Premium Increase’	:refers to the annual factor that will be applied to Your monthly Premium at Policy Anniversary. This is specified by the Administrator each year and takes into account either an inflationary increase or the Dynamic Premium Adjustment, as well as the age of the Life Insured at that point in time. This will be applied separately for each specific Benefit. The option between the inflationary increase and the Dynamic Premium Adjustment will be selected by the Policyholder.
‘Annual Benefit Increase’	:refers to the annual factor that will be applied to Your Benefit Sum Assured at Policy Anniversary. This will either be an inflationary increase or the Dynamic Benefit Adjustment. This will be applied separately for each specific Benefit. The option between the two will be selected by the Policyholder.
‘Applicable Laws’	:shall mean the Insurance Act 18 of 2017, the Long-term Insurance Act 52 of 1998, the Policyholder Protection Rules (Long-term Insurance), 2017, the Protection of Personal Information Act 4 of 2013, and any other legislation relating to or regulating the protection or processing of data or Personal Information, direct marketing or unsolicited electronic communications and which may be applicable in the Republic of South Africa from time-to-time.
‘Benefit Amount’	:means the amount of cover that the Life Insured is covered for, as specified in the Policy Schedule, and for which the appropriate Premium has been paid monthly and for which payment is up to date at the Claim Event Date. “Insured Amount" and “Cover Amount” shall have a corresponding meaning where the context so allows.
‘Benefit Expiry Age’	:means the age of the Life Insured when the respective Benefit ceases. The Benefit expires at the end of the month in which the Life Insured turns the specified age. This is defined for each Benefit in its respective section.
‘Blood Relative’	:means a relationship the Life Insured has with any Extended Family member by virtue of a blood line, which means there is a common ancestor, such as a parent, sibling, grandparent and a first cousin.
‘Bodily Injury’	:means physical bodily injury to an Insured Life caused solely directly and independently by an Accident. Bodily Injury shall be deemed to include death by starvation, thirst and/or exposure to the elements.
‘Business Day’	:means any Day excluding a Saturday, Sunday or recognised public holiday.

‘Business Assurance Policy’ :means a life insurance policy designed to provide financial security to a business in the event of the death, disability or critical illness of a key individual, such as an owner, partner, or key employee. It helps ensure the continuity and stability of the business by covering potential financial losses, facilitating buyouts, or repaying debts. It is defined in section 3.

‘Cedent’ :is the person who transfers the Policy during a cession.

‘Cessionary’ :is the person or entity to whom the Policy is transferred during a cession.

‘Child’ :means an unmarried person who is wholly dependent on the Principal Life Insured for financial support and maintenance, and who is:

(1) The Principal Life Insured’s Child who has not yet attained the age of 22 (twenty-two) years and shall include natural children, legally adopted children and step-children;

(2) This maximum age will be extended to 25 (twenty-five) years, in respect of an unmarried Child who is a full-time student wholly dependent on the Principal Life Insured for financial support and maintenance

(3) There will be no age restriction for Children who are either mentally or physically incapacitated from maintaining themselves, provided that the Child is wholly dependent on the Principal Life Insured for financial support and maintenance;

(4) Once a Child has become independent from the Principal Life Insured for financial support and maintenance, then that Child cannot resume dependence in terms of this definition unless the Child is still under the age of 22 (twenty-two) years and they again become wholly dependent on the Principal Life Insured for financial support and maintenance;

(5) A grandchild being a Child of the Principal Life Insured’s Children, where both the Child’s parents are deceased or the Child is wholly dependent on the Principal Life Insured for support and maintenance. Proof of dependency must be submitted to the Administrator or Insurer.

“Children” shall have a corresponding meaning where the context so allows.

A maximum of 5 (five) Children are allowed on a single Policy.

All Children must also be residing in South Africa in order to be eligible to be covered under this Policy.

‘Chronic Care Benefit Adjustments’ :means the adjustment multiplied to the Benefit Sum Assured on the Chronic Care Plan to give the new Sum Assured after the Life Insured goes for a new set of HealthChecks.

‘Chronic Care Health Level’	:means the level attained by the Life Insured (out of 5 (five) levels) based on Their HealthChecks and Their Script Score. Please see the General Benefits Limit Document for further information.
‘Chronic Care Matrix	:means the table with the relevant Chronic Care Benefit Adjustments, specific for the Life Insured. Please see the Schedule for further information.
‘Claim’	:means, unless the context indicates otherwise, a demand for Policy Benefits under this Policy by a Claimant, irrespective of whether or not the Claimant’s demand is valid, made by submitting a completed and signed claim form with supporting documentation to the Administrator.
‘Claim Anniversary’	:refers to the annual date which occurs after each 12 (twelve) (full calendar) month period of Benefit payments, starting from the date when the specified Benefit was first paid out. This anniversary date occurs annually until the end of the specified Benefit payment term. “Claim Anniversary Date” shall have a corresponding meaning where the context so allows.
‘Claim Event’	:means the risk insured (namely for death, disability, illness, disease and injury, as defined for each Benefit in different sections throughout this Policy) occurring during the currency of this Policy, and where the Premium has been paid up to date. “Life Changing Event” shall have a corresponding meaning where the context so allows.
‘Claim Event Date’	:means the date on which the Claim Event occurs giving rise to a Claim, and when all Claim and Policy criteria are met. For Life Cover: It is the date of the Life Insured’s death. For the Critical Illness Benefit, it is: • The date of diagnosis of the illness, medical condition, injury or trauma event; or • The date on which the injury occurred. For the Disability Cover Benefit, Temporary Income Protection Benefit and Permanent Income Protection Benefit: it is the Date of Disability. For the Education Legacy Protector, it will follow dates for the Education Legacy Protector Claim Events.

‘Claimant’ :means a person who makes a Claim in relation to this Policy. This will be the Beneficiaries or Cessionary for death Claim Events (or any other person who is due the payment) and the Policyholder for all the other Claim Events.

‘Collateral Cession’ :is a cession where the right to Life Cover, Critical Illness and Disability Benefits on the Policy are transferred to a third party as security for an unpaid debt or obligation (usually a bank).

‘Consumer Price Index’ :Consumer Price Index (CPI) is the inflationary increase which is determined by Statistics South Africa. This rate will differ from year to year as CPI fluctuates. The Administrator will use the CPI figure as released by Statistics South Africa three months before each Policy Anniversary in its relevant calculations.

‘Commencement Date’ :means the date when this Policy, and its cover, starts and is effective, being the date on which the first Premium is paid, unless otherwise specified in the Schedule.

“Date of Commencement” shall have a corresponding meaning where the context so allows.

‘Cooling-off Period’ :means the 31 (thirty-one) Day period, starting from the earliest of the following:

1. The date on which the Policyholder receives this Policy document; or
2. From a reasonable date on which it can be deemed that the Policyholder received this Policy document.

During this 31 (thirty-one) Day period, as defined above, the Policyholder may inform the Administrator In Writing of their requested cancellation. If no Benefit Amount has been paid or claimed as yet or the Claim Events insured against have not yet occurred, then any Premium paid up to the date of receipt of the cancellation request by the Administrator will be refunded to the Policyholder in full. In this scenario, the cancellation will be made immediately on the date of receipt of the cancellation request. No Benefit Amount for the Life Insured on the Policy will be payable on or after the date of receipt of the cancellation request.

‘Critical Illness Benefit’ :means the Benefit which provides a payment if the Life Insured suffers a severe illness, injury or disease. The payout is in the form of a single cash lump sum and it can be used to cover all unforeseen medical costs, lifestyle changes, assistive medical devices, rehabilitation programmes as well as assisting in accessing new breakthrough global treatments.

“Critical Illness Cover”, “Critical Illness Cover Benefit” shall have a corresponding meaning where the context so allows.

‘Date of Disability’ :For the Temporary Income Protection Benefit:
This is the first date where the client is partially or totally unable to perform the main duties of their Nominated Occupation due to experiencing an illness, injury, disease or condition which prevents them from working and earning an income, and where all Temporary Disability claims criteria are met. This date is to be confirmed by the Administrator/Insurer and must be based on objective, recognised and valid medical evidence received.

For the Disability Cover, Education Legacy Protector and Permanent Income Protection Benefits:
The Date of Disability is defined as follows:

- For Claims assessed under the Disability Objective Medical Criteria, this is the first date on which the Life Insured’s illness, injury, disease, impairment or condition satisfies the Disability Objective Medical Criteria, and where all Claims and Policy requirements have been met. The Date of Disability is to be confirmed by the Administrator/Insurer and must be based on objective, recognised and valid medical evidence received; or

- For Claims assessed under the Occupational Claims Criteria, this is the first date on which the Life Insured is totally unable to perform the material and substantial duties of their Nominated Occupation, due to illness, injury, disease or impairment, and prevents them from working and earning an income, and where all Claims and Policy requirements have been met. The Date of Disability is to be confirmed by the Administrator/Insurer and must be based on objective, recognised and valid medical evidence received.

“Disability Date” shall have a corresponding meaning where the context so allows.

‘Day’ :means a 24 (twenty-four) hour period and ‘Days’ has a corresponding meaning where the context so allows.

‘Debit Order’ :is when the Premium Payer gives the Administrator their banking details and the Administrator deducts the Premium directly from their bank account. In this case the Premium Payer is the person or entity from whom the Insurer/Administrator collects the Premium.

This also refers to all deductions made from a debit card or credit card if this was selected by the Premium Payer as their preferred payment method.

‘Disability Objective Medical

Criteria'	:is an objective, transparent and fair Claim system used to assess the severity of the Life Insured's disability Claim Event. The Disability Objective Medical Criteria are assessed based on the severity of the Life Insured's medical Impairment. By focusing on the effect that the Life Insured's medical impairment has on the Life Insured and Their lifestyle, Dis-Chem Life has developed an evaluation system that is objective. Please refer to the conditions covered as defined in Appendix 1 for a complete list of the conditions that the Life Insured is covered for. Please note that the Activities of Daily Living relating to these Objective Medical Criteria can be found in Appendix 4. "Objective Medical Criteria for disability" shall have a corresponding meaning where the context so allows.
'Dis-Chem Pharmacy"	:means a registered pharmacy that operates under the Dis-Chem brand and is part of the Dis-Chem group or a Dis-Chem retailer.
'Dynamic Benefit Adjustment'	:is the annual adjustment percentage suggested by the Dynamic Financial Needs Analysis, applied to each Benefit on the Policy at each Policy Anniversary. The Dynamic Benefit Adjustment (DBA) ensures that cover adjusts in line with the Life Insured's changing circumstances and is defined as $\frac{Proposed\ Sum\ Assured\ by\ DFNA}{Current\ Sum\ Assured} - 1$. Please see section 15 for further details.
'Dynamic Financial Needs Analysis'	:the Dynamic Financial Needs Analysis ("DFNA") is the algorithm that calculates the Life Insured's required cover, based on Their individual and unique circumstances. The algorithm dynamically adjusts to match the Life Insured's changing needs as Their life and financial needs change. Please see section 15 for further details. "DFNA" shall have a corresponding meaning where the context so allows.
'Dynamic Premium Adjustment'	:is the annual Premium adjustment percentage applied to each Benefit Premium on the Policy, at each Policy Anniversary. The Dynamic Premium Adjustment (DPA) is made up of the Dynamic Benefit Adjustment for that specific Benefit, as well as a factor to take into account the Life Insured's increasing age. Please see section 15 for further details.
'Education Legacy Protector'	:means the Benefit that providers cover for a Child's education on an Education Legacy Claim Event, as defined in section 12. 'Education Cover' and 'Education Legacy Cover' shall have a corresponding meaning where the context so allows.

‘Education Legacy Protector Claim Events’	:is defined as follows: The definition is based on the option selected by the Policyholder at Benefit start date. Under the Life Cover option, these events will include valid death Claims. Under the life, disability and illness option, these events will include valid death Claims, valid Disability Cover Claim Events (same definitions and workings as per the Disability Cover Benefit in section 7), and Severity A and B Critical Illness Claim Events (same definitions and workings as per the Critical Illness Benefit in section 6).
‘Exclusion’	:means the losses or risk events not covered under this Policy. Should a Claim Event arise from an Exclusion, no Benefit will be payable. ‘Exclusions’ shall have a corresponding meaning where the context so allows.
‘Family Member’	:means the Spouse, Child(ren), Parent(s) or Extended Family Member(s) of the Life Insured. A Spouse is defined as the person married to the Life Insured by law, tribal custom, or Tenets of any Religion; and shall include a common law husband/wife of the Life Insured or such person residing with the Life Insured, who is normally regarded by the community as the Life Insured’s husband/wife. A person of the same gender residing with the Life Insured who is regarded by themselves and the community as a common law couple shall also be regarded as a Spouse in terms of this Policy. A Parent is defined as the Principal Life Insured’s parent(s) and/or the Spouse’s parent(s) and this definition shall include natural parents, step parents and legally adoptive parents of the Principal Life Insured and/or their Spouse. An Extended Family Member is defined as a Blood Relative of the Life Insured. “Family Members” shall have a corresponding meaning where the context so allows.
‘General Benefit Limits Document’	:is the document which contains the maximum Benefit Sum Assureds for all Benefits on the Policy, at any given time. It also contains further material information, such as minimum and maximum entry ages, amongst others.

	"General Benefit Limits" shall have a corresponding meaning where the context so allows.
'Goodwill Payment'	:means a payment, whether in monetary form or in the form of a benefit or service, by or on behalf of the Insurer to a complainant as an expression of goodwill aimed at resolving a complaint, where the Insurer does not accept liability for any financial loss to the complainant as a result of the matter complained about.
'HealthCheck'	:means the clinical examination and health tests that measure specific health indicators, conducted at a Dis-Chem clinic. Please see the General Benefit Limits Document for further information.
'Illness Objective Medical Criteria'	:is an objective, transparent and fair Claim system used to assess the severity of the Life Insured's Critical Illness Claim. Our Critical Illness Benefit pays out an amount commensurate with the change in lifestyle following the Claim Event. The Illness Objective Medical Criteria are assessed based on the severity of the disease, illness, injury or Impairment. By focusing on the effect that the illness or impairment has on the Life Insured and Their lifestyle, Dis-Chem Life has developed an evaluation system that is objective and transparent and pays out commensurate with the change in the Life Insured's lifestyle. Please refer to the conditions covered as defined in Appendix 2 for a complete list of the conditions the Life Insured is covered for. Please note that the Activities of Daily Living relating to these Objective Medical Criteria can be found in Appendix 4. "Objective Medical Criteria for illness" shall have a corresponding meaning where the context so allows.
'In Writing'	:means a letter handed over from the Policyholder to the Administrator (or Insurer) or vice versa. It also includes a registered letter, post or other modern form of written or electronic communication (that is, any communication by any appropriate electronic medium that is accurately and readily reducible to written or printed form). "Written Notice", "Written/Electronic Communication" and "Written Request" shall have a corresponding meaning where the context so allows.
'In-Claim Escalation'	:means the annual increase factor applied to the in-claim Benefit payment. It is applied each year at the Claim Anniversary.

"In-Claim Escalation Factor" shall have a corresponding meaning where the context so allows.

'Income' :is defined as follows:

In the case of the Life Insured being a salaried employee, it shall be Their monthly cost-to-company less any PAYE tax, as per Their payslip.

- This includes any 13th (thirteenth) cheques. This 13th cheque is limited to 1 (one) month's additional net of tax salary, excluding any bonuses (this limit is the Life Insured's monthly cost-to-company less any PAYE tax, as per Their payslip).
- The following are, however, excluded from this definition:
    - Annual bonuses (except 13th cheques);
    - Ad hoc bonuses;
    - Leave pay;
    - Merit awards;
    - Share incentives; and
    - Bonuses/incentives paid to retain services.

In the case of the Life Insured being a sole proprietor, partner, member of a close corporation or director of a private company, it shall be the Life Insured's monthly share of fees for services rendered and gross profit from trading activities, less the Life Insured's monthly share of the business overhead expenses and tax.

- Gross profit from trading activities is defined as monthly sales less cost of sales.
- The tax is calculated using the South African tax tables and is based on the Life Insured's income not reduced by tax.
- Where it is difficult to determine the Life Insured's share of the income or expenses of the business, it shall be any income, dividends, loan account repayments and other benefits that the Life Insured derives from the business in Their personal capacity, less tax (as per the tax tables).

Income for the purposes of this definition shall exclude passive income from assets such as property or shares in a business acquired purely for investment purposes and where the Life Insured is not engaged in the management of this business. This includes any passive income that is not related to the income being generated for the occupation being insured for example, but not limited to, dividends, interest and rental income generated from a property that the Life Insured owns.

Please note that only income received from the Life Insured's Nominated Occupation may be covered under the above definition.

	Please note that the above Income definition will be reviewed from time to time and may be amended by the Insurer and/or Administrator, at either's sole discretion.
'Income Protection Benefit'	:is used to refer to both the Temporary Income Protection Benefit and Permanent Income Protection Benefit, unless otherwise specified.
'Insured Life'	:means the adult, who is at least 18 (eighteen) years of age but not yet 66 (sixty-six) years of age, who has applied for this Policy which has been accepted by the Insurer/Administrator. "Life Insured" shall have a corresponding meaning where the context so allows.
'Insurer'	:shall mean :the insurance company that underwrites this insurance, namely Guardrisk Life Limited (registration number 1999/013922/06 and FSP number 76), an authorised financial services provider and an insurer licensed to conduct life insurance business in terms of the Insurance Act 18 of 2017. See the disclosure notice for more details.
'Loss of Income Claims Criteria'	:is the claims criteria, under the Temporary Income Protection Benefit. You can claim under the Loss of Income Claims Criteria by providing proof that the Life Insured is partially or totally unable to perform Their Nominated Occupation due to Their injury, disease, impairment or illness, and as a result are unable to maintain Their Income level. You may only claim under the Loss of Income Claims Criteria if the Life Insured is unable to perform at least 25% of the material and substantial (main) duties of Their Nominated Occupation and is losing more than 25% of Their Pre-Claim Income. Please see section 8.1 for further details.
'Medical Practitioner'	:means a legally and duly qualified medical practitioner registered with the Health Professions Council of South Africa with a valid practice number.
'Mental and Behavioural Conditions'	:are mental or psychiatric disorders (including, but not limited to, adjustment disorders, post-traumatic stress disorders, cognitive impairments, communication disorders, dementia disorders, dissociative disorders, mood disorders, personality disorders, schizo-affective disorders and somatoform disorders, chronic fatigue syndrome and any other stress and anxiety related disorders). The Administrator defines mental or psychiatric disorders (Mental and Behavioural Conditions) in accordance

with the latest version of the Diagnostic and Statistical Manual of Mental Disorders Criteria (DSM criteria).

Please note that all depression and bipolar related claims, as well as psychosis, post-traumatic stress disorders and nervous breakdowns claims are included under the Mental and Behavioural Conditions definition.

‘Misrepresentation’ :the conscious decision to provide inaccurate or incorrect information in relation to any personal details or medical history or to change the true facts to mislead an interested party. This shall also mean the failure to disclose material information at the date of application, that had the Insurer been aware of would have resulted in the Policy not being issued or issued on different terms.

Misrepresentation also refers to situations where the Policyholder or Life Insured (or anyone acting on their behalf) fails to disclose any material information, or provides false information, or distorts information when applying for the Policy or at any point during the term of the Policy or at Claim stage.

“Misrepresent” shall also have a corresponding meaning where the context so allows.

‘Natural Death’ :shall refer to death that has not arisen from an Accident or Bodily Injury and is related to any illness, disease, infirmity or any other natural cause.

‘Natural Disability’ :shall refer to a disability that has not arisen from an Accident or Bodily Injury and is related to any illness, disease, infirmity or any other natural cause.

‘Nominated Beneficiary’ :means the person or persons nominated by the Policyholder as the person or persons in respect of whom the Insurer should meet the Policy Benefit, other than the Policyholder, on the Death of the Policyholder.

In order for an individual to be eligible to be a Nominated Beneficiary on the Policy, they must be at least 18 years of age as well as a South African Resident. A maximum of 5 (five) Nominated Beneficiaries may be allowed on the Dis-Chem Life Policy. Should no beneficiary be nominated, the Benefit will be payable to the deceased’s estate.

“Nominated Beneficiaries”, “Beneficiary” and “Beneficiaries” shall have a corresponding meaning where the context so allows.

‘Nominated Occupation’ :means the occupation that the Life Insured is performing for all or the majority of Their working hours and is as selected at the Commencement Date (You cannot select two occupations). It is the occupation that the Life

	Insured is trained for, knowledgeable of and from which the Life Insured derives all or the majority of Their income and will be the occupation against which the Life Insured is assessed under the Occupational Claims Criteria, if applicable to the Policy. Please see section 14.1 for further details.
'Occupational Claims Criteria'	:refers to the Claims criteria assessing Permanent Disability with respect to the Life Insured's occupation. The Occupational Claims Criteria relates to the Life Insured's inability to perform Their Nominated Occupation - namely that it is established, to the satisfaction of the Administrator/Insurer, that They are totally and permanently unable to perform the material and substantial duties of Their own Nominated Occupation (as indicated in the Policy Schedule) due to sickness, injury, disease, impairment or illness.
'Occupational In-Claim Escalation Option'	:means the In-Claim Escalation (ICE) option selected on the Policy. There are three group classification categories: Core, Standard, and Executive. Each year at the Claims Anniversary, the Benefit Sum Assured is increased by a certain factor based on CPI, age of the Claimant at that point in time and the Occupational In-Claim Escalation Option (if selected). The increases applied have been designed to replicate the actual increases that the Life Insured would have received from Their Nominated Occupation each year if They did not become disabled and were not losing Income. Please see section 8.3.4 for more details.
'Off Period'	:is defined as follows: For Temporary and Permanent Income Protection Benefit Claims: If the Life Insured recovers or is rehabilitated and claims again for the same cause which resulted in the Life Insured's original inability to perform Their Nominated Occupation within three months of recovery, the Waiting Period will be waived for the subsequent Claim. This time period is called the Off Period.
'Parent'	:means the Child's parent and this definition shall include natural parents, step parents and legally adoptive parents of the Child.
'Partial Disability'	:means the Life Insured is unable to perform some, but not necessarily all, of the main duties of Their Nominated Occupation due to disablement and as a result, suffer a partial loss of income.
'Period of Insurance'	:the period for which Premiums remain paid and the Policy remains in force.
'Permanent Disability'	:is the disability, relating to the Life Insured, in which the Life Insured is assessed to be totally and permanently disabled. In this scenario, the Life Insured meets one of the Permanent Disability Claims Criteria.

	‘Permanently Disabled’ shall have a corresponding meaning where the context so allows.
‘Permanent Disability Claims Criteria’	:are Claim Events where the Life Insured is assessed to be Permanently Disabled, namely that it is established, in the opinion and to the satisfaction of the Administrator/Insurer, that the Life Insured either meets one of the Disability Objective Medical Criteria (found in Appendix 1) or the Life Insured qualifies for a Claim under the Occupational Claims Criteria. Please see sections 7 and 8.2 for more details. Please note that these are the Permanent Disability Claims Criteria, for both the Permanent Income Protection Benefit and the Disability Cover Benefit. ‘Permanent Disability Claims’ and ‘Permanent Disability Claim Events’ shall have a corresponding meaning where the context so allows.
‘Personal Assurance’	:means individual-focused coverage tailored to protect the personal financial security of the Insured Life and their loved ones
‘Personal Information’	:means personal information as defined in the Protection of Personal Information Act 4 of 2013, as amended from time to time.
‘Policyholder’	:means the policy owner. It also refers to the Premium Payer. This can be either a natural person or a juristic person.
‘Policy’	:refers to the Policy Schedule, the terms and conditions contained in this document, the General Benefit Limits Document and any endorsements thereto. This a legal document that binds the Policyholder and the Insurer. This also includes any declarations made or information provided by the Policyholder, or Life Insured, at application (and underwriting) stage.
‘Policy Anniversary’	:refers to the annual anniversary which occurs on the same day and month as that of the Anniversary Start Date. “Policy Anniversary Date” shall have a corresponding meaning where the context so allows.
‘Policy Benefits’	:means the benefits specified on the Policy Schedule payable in the event of a valid Claim. “Policy Benefit”, “Benefit” and “Benefits” have a corresponding meaning where the context so allows.

‘Progressive Claim’ :refers to conditions where a worsening of symptoms or stages of the disease can be expected, for example the progression of cancer, connective tissue disease or respiratory disease. A relapse of a previous cancer will be assessed as a progressive illness. Please see section 16.3 for further details.

“Progressive Claims” shall have a corresponding meaning where the context so allows.

‘Pre-Claim Income’ :means the Life Insured’s average monthly Income from Their Nominated Occupation for the 12 (twelve) month period prior to the Their Claim Event. The following points relate to the Pre-Claim Income definition:

- The Administrator/Insurer will not take into account a Sabbatical in the calculation of average Income.
- If the Life Insured’s Income is of a variable nature, the Administrator/Insurer, at either’s sole discretion, may determine a period other than 12 (twelve) months to calculate average monthly Income.
- Any Claim made within 12 (twelve) months of returning to work following a period of retrenchment will exclude the period of retrenchment for the purposes of calculating the Life Insured’s Pre-Claim Income.
- A certified copy of the official proof of the Life Insured’s net Income for the past 12 (twelve) months (or other requested period, if required) before the date on which the Claim Event occurred is required.
    - This may include salary advices, salary payslips, tax returns, bank statements and audited statements (if applicable).
- Please note that only Income received from the Life Insured’s Nominated Occupation may be covered.
- Please note the income used here is that of the Income definition.

The above definition, the period over which it is determined and the method of calculation will be reviewed from time to time and may be amended by the Insurer and/or Administrator from time to time, at either’s sole discretion.

‘Pre-Existing Condition’ :shall mean any illness, infirmity, physical or mental defect, disease, disability or Bodily Injury sustained or contracted by the Life Insured or a condition arising directly or indirectly or contributed or traceable to or resultant from any medical condition (including any physical or mental defect, disease, illness, infirmity, disability or Bodily Injury) which he or she has been aware of, or should reasonably have been aware of, or received medical treatment, tests or advice, referral or recommendation for from a Medical Practitioner prior to the initial Commencement Date or reinstatement date of the Policy (whichever occurred last) .

	"Pre-Existing Medical Condition'" shall have a corresponding meaning where the context so allows.
'Premium'	:the monthly amount payable as stated in the Policy Schedule or any endorsement issued in terms of this Policy. "Premiums" shall have a corresponding meaning where the context so allows.
'Premium Payer'	:means the person or entity from whose bank account the Insurer/Administrator deducts the Premiums if the Premium payment method is by Debit Order. This also means the person or entity from whose debit or credit card the Insurer/Administrator deducts the Premiums if the Premium payment method selected is by debit or credit card. The owner of this Policy must be the Premium Payer.
'Repudiate'	:means, in relation to a Claim, any action by which the Insurer rejects or refuses to pay a Claim or any part of a Claim, for any reason, and includes instances where a Claimant lodges a Claim- (i) in respect of a loss event or risk not covered under this Policy; (ii) in respect of a loss event or risk covered under this Policy but the Premium or Premium(s) payable in respect of this Policy has/have not been paid up to date; and (iii) in respect of Policy terms and conditions not being met. and 'Repudiation' shall have a corresponding meaning where the context so allows.
'Regulatory Authority/Body'	:refers to the Information Regulator, the Financial Sector Conduct Authority (FSCA) and the Prudential Authority (PA).
'Related Claim'	:is a Claim Event where there is a link to a previous Claim, for example, complications or consequences of a disease or injury previously Claimed for. This would be where the later Claim Event would not have arisen if it was not for the initial condition or illness. It also includes side effects or complications of treatment of the previously claimed for condition. Progressive Claims are not included in this definition. Please see section 16.3 for further details. "Related Claims" shall have a corresponding meaning where the context so allows.
'Sabbatical'	:is a period of leave from employment which does not fall within the employee's employment contract.

	The Administrator/Insurer will allow the Life Insured a maximum Sabbatical term of 6 (six) months every three years on the Policy.
‘Schedule’	:the document specifying the scope of cover with information relating to the significant Exclusions, name and characteristics of the Life Insured, Benefit features, Cover Amounts, Premiums and any other material Policy terms and conditions, as attached to this Policy. “Policy Schedule” and “Key Information Document” shall have a corresponding meaning where the context so allows.
‘Script Score’	:a score that looks at the script usage and adherence of the Life Insured. Please see the General Benefit Limits Document for further details.
‘Specialist’	:is a Medical Practitioner registered as such with the Health Professionals Council of South Africa, with a valid practice number, who has completed advanced education and clinical training in a specific area of medicine (their specialty area) (that is, this person must be registered with the Health Professions Council of South Africa in a relevant specialty).
‘Sum Assured’	:means the equivalent of the Benefit Amount as stated in the Schedule. ‘Benefit Sum Assured’ shall have a corresponding meaning where the context so allows.
‘Survival Period’	:means the period which the Life Insured must survive (not die), without the assistance of any life support, in order to be eligible to receive Policy Benefits/in order for a valid Claim to be made. During this period, the Policyholder is not entitled to Policy Benefits, that is, during this period no Benefit Amount will be paid out.
‘Temporary Disability’	:is the disability, relating to the Life Insured, in which the Life Insured is assessed to be either partially or totally disabled. In this scenario, the Life Insured does not meet the Permanent Disability Claims Criteria but is still unable to perform some or all of the main duties of their Nominated Occupation (after workplace modifications or assistance) due to sickness, injury, disease, impairment or illness (disablement). Here, the Life Insured must also satisfy the Loss of Income Claims Criteria.
‘Their, Them, They, Themself’	:refers to the Life Insured.

‘Total Disability’	:means the Life Insured’s is unable to perform all of the main duties of Their Nominated Occupation, due to illness, disease, impairment or injury or any other disablement.
‘Unclaimed Benefit’	:means a benefit in terms of an approved Claim where the Benefit can’t be paid to the Nominated Beneficiary within 3 (three) months of the Claim having been approved because the Nominated Beneficiary is not contactable. In other words, the Nominated Beneficiary cannot be located, his/her emails are undelivered, his/her post is returned to the Administrator and/or his/her contact number is no longer in use. “Unclaimed Benefits” shall have a corresponding meaning where the context so allows.
‘Unrelated Claim’	:is a Claim Event which is not related or due to the original Claim. It is also a Claim where the Claim Event did not progress from a previous Claim Event and/or previous condition which gave rise to the Claim Event. Please see section 16.3 for further details. “Unrelated Claims” shall have a corresponding meaning where the context so allows.
‘Variation’	:means any act that results in a change to: (i) the Premium; (ii) any terms; (iii) any condition; (iv) any Policy Benefit(s); (v) any Exclusion; or (vi) the duration/term of this Policy/Benefits, and “Vary” and “Variations” shall have a corresponding meaning where the context so allows.
‘Waiting Period’	:means a period during which a Policyholder is not entitled to Policy Benefits, that is, a period in which no Claim amount will be paid out.
‘We, Us, Our’	:means the Insurer.
‘You, Your’	:the person named as the Policyholder in the Policy Schedule.

2. Eligibility

The Life Insured qualifies for this Policy if:

- At the Commencement Date of the Policy, the Life Insured is at least 18 (eighteen) years old but not older than 65 (sixty-five) years of age.
- The Policyholder has a South African bank account.

Cover may only be taken out for the Life Insured. Separate policies, can, however, be taken out for the Life Insured's spouse or children, if they qualify. The Policyholder will be the policy owner as well as the Premium Payer.

2.1 MINIMUM AND MAXIMUM ENTRY AGES

Please refer to the General Benefit Limits Document for the minimum and maximum entry ages on the Policy.

3. Business Assurance Policy

Business owners may take out cover on a Business Assurance Policy to cover Business Assurance needs.

We understand that business owners have worked hard to build a sustainable business. The risks they have undertaken to guide their business in the direction of their vision is the reason they need to protect it.

We offer comprehensive, personalised, whole-of-life protection for Your business assurance needs to help maintain the business if the Life Insured experiences a Life Changing Event such as death, critical illness or disability.

Our Benefits are designed to address business assurance needs such as contingent liability insurance and key person cover.

- Contingent liability insurance protects a business owner's family from the creditors of the business. Very often a business owner is required to stand surety in their personal capacity for the obligations of the business. If the creditors of the business for any reason call the business owner to perform under the surety (pay the debt on behalf of the business), their family may suffer. It is for this reason that the business will take out a life insurance policy on the life of the business owner to pay the proceeds to the creditors if the business owner suffers a Life Changing Event and the creditors decide to call up the surety. The proceeds of this Policy will be paid to the business unless this Policy has been ceded to creditors of the business. Through this insurance, the business owner's family is protected.

- Key person cover is a life insurance policy taken out by the business on the life of the business owner or a person who is very important to the business (a key person). This is to ensure that on the key person suffering a Life Changing Event, the cash flow is available to minimise the effects of the loss of the key person and replace the deceased/disabled key person.

Only the following benefits will be allowed on a Business Assurance policy:

- Life Cover
- Critical Illness Benefit
- Disability Cover

The main differences between the Personal Assurance policy and a Business Assurance policy are:

- On the Business Assurance policy, the Cover Amounts increase each year at Policy Anniversary with CPI only.
- The Dynamic Financial Needs Analysis doesn't apply to Business Assurance policies.
- More than 1 (one) Business Assurance policy can be taken out on a single Life Insured.
- The conversion of Life Cover and Disability Cover to Critical Illness Cover does not apply to Business Assurance policies.
- The Disability Cover Benefit and Critical Illness Benefit are accelerated, meaning that a Claim on either the Disability Cover Benefit or Critical Illness Benefit will result in a reduction of the Life Cover Benefit amount. This holds throughout the Policy, irrespective of the wording used in sections 6 and 7.

4. Operative Clause for the Dis-Chem Life Policy Guide

In return for the timeous and prior payment of the required monthly Premium by You, the Policyholder, and receipt thereof by the Insurer and subject to the terms of cover, a Benefit Amount will be paid, for a valid Claim, on receipt of the necessary Claim documentation based on the following:

- The Claim Event occurs within the Period of Insurance;
- The event giving rise to a Claim is covered in terms of the Exclusions and/or the terms and conditions of this Policy;
- The truth and accuracy of the information given at the time of application;
- The Claim Event arises outside any applicable Waiting Period(s), where applicable;
- The Claimant provides the Insurer/Administrator with all the relevant documents that We may require; and
- The Claim Event is reported within the prescribed periods.

This means that Benefit Amounts under this Policy will only be considered or made if both the Insured Life and Policyholder (if different) on this Policy have complied with all the terms and conditions of this Policy, and if the Insured Life/Policyholder or the Life Insured's/Policyholder's representative(s) has complied with all the requirements of the Claims process.

5. Life Cover

5.1 WHAT IS THE PURPOSE OF THE BENEFIT?

The Life Cover Benefit provides a Benefit payment to the Beneficiaries should the Life Insured die. It can be used to cover all the expected future expenses incurred by the Life Insured's family. These can be used to pay for such costs as education, healthcare, food, housing, transport and for any other expenses incurred by the Life Insured's family. A portion can also be used to pay off the Life Insured's outstanding debts, as well as transfer wealth to the Life Insured's family members.

5.2 BENEFIT WORKINGS

This Benefit will pay out 100% of the Life Cover Sum Assured on a valid Claim. Please note that an amount equal to, but not exceeding, the Life Cover Benefit Amount (as specified in Your Policy Schedule) will be paid if the Life Insured passes away, provided all the required Claims criteria specified throughout this Policy are met.

5.2.1 Recurring Payment Option

The Policyholder may also select a portion of the Life Cover Benefit to be paid out in recurring payments on a valid Claim payout. The maximum total recurring payment amount that may be selected is equal to 50% (fifty percent) of the total Life Cover Benefit. These recurring payouts will be made in 5 (five) equal annual payments, starting one year after the Claim Event Date. The payments will be made at the end of the month in which the Claims Anniversary falls. Please refer to the Schedule to see if this option was selected and if so, what percentage was selected.

The recurring payouts will remain level at each payout date (this means the amount calculated for a single payout at the time of the Claim Event will be consistently paid at every scheduled interval) and will accrue no interest over time. All policy terms, conditions and rules applying to the lump sum Life Cover payout (as described in section 5) will be applied to the Life Cover recurring payouts.

Example

Suppose a Policyholder selects 30% (thirty percent) of the total Life Cover Benefit to be paid out as recurring payments. The Life Insured has a Life Cover Benefit Sum Assured of R1 000 000. The Life Insured unfortunately dies in a car accident on 3 March 2025.

In this scenario, the Insurer will pay out R700 000 (R1 000 000 x (1-30%)) as a lump sum on the Life Insured's death, and then the remaining R300 000 (R1 000 000 x 30%) will be paid out in five equal recurring payments of R60 000 (R300 000 ÷ 5), starting 1 (one) year from the Claim Event Date (at the end of the month).

This means that R60 000 will be paid on 31st March 2026, 31st March 2027, 31st March 2028, 31st March 2029 and 31st March 2030.

5.2.2 Immediate Expense Benefit

To support your Nominated Beneficiaries with costs that may be incurred with your death, the Life Cover Benefit automatically includes an Immediate Expense Benefit. With this Benefit, a nominal amount of the minimum of R50 000 (Fifty Thousand Rand and Zero cents), or 5% of the Life Cover Benefit Amount (whichever is the lessor) at the time of the Life Insured's death will be paid within 48 (forty-eight) hours of submitting a valid death certificate, claims form and associated documentation, in the case of a valid death Claim. In order to qualify for this Benefit, Your Policy must have been in force for at least 2 (two) years and the cause of death of the Life Insured must be known. After paying out the Immediate Expense Benefit Claim, the remainder of the Life Cover Benefit Amount will be paid out when a normal Life Cover Claim would have been paid out, as specified in section 5.4.

In the case of an Accidental Death, the Immediate Expense Benefit will be at Our discretion where there is a criminal investigation in connection with the death of the Life Insured, or any of the Beneficiaries is a suspect in connection with the death of the Life Insured, or where we suspect any forms of fraudulent activities in relation to the Claim.

If, after the Immediate Expense Benefit is made by Us, We repudiate the Claim, or if the any of the Beneficiaries is found guilty of a criminal charge in connection with the death of the Life Insured, We will claim back any Immediate Expense Benefit payout made.

Example

Example details:

- You take out a Policy with R500 000 Life Cover on 1 July 2020.
- You are both the Policyholder and Life Insured on the Policy.
- For simplicity, assume the Sum Assured remains level and does not grow in this example.
- Ten years later, on 1 July 2030, You unfortunately pass away from a heart attack.

In this scenario, within 48 (forty-eight) hours after submitting a valid death certificate, Your Beneficiaries will be paid R25 000 (calculated as the minimum of R50 000 or R500 000 x 5% = R25 000). After processing the Immediate Expense Benefit Claim, Your Beneficiaries will be paid the remaining amount of the Life Cover Sum Assured, which will be R 475 000 (R500 000 – R25 000).

5.3 HOW DOES THE BENEFIT CHANGE?

For Personal Assurance policies, the Benefit Sum Assured will change each year, at Policy Anniversary, by CPI.

The Policyholder may also select for the Sum Assured to change by the Dynamic Benefit Adjustment, specified by the Dynamic Financial Needs Analysis. The Dynamic Financial Needs Analysis is the smart algorithm that calculates required cover on an ongoing basis, based on the Life Insured's individual and unique circumstances. The algorithm automatically and dynamically adjusts cover to match the Life Insured's changing needs as the Life Insured's life and financial needs change.

For Business Assurance policies, the Benefit Sum Assured will change each year with CPI.

5.4 CLAIMS

The full Life Cover Sum Assured will be paid out for a valid Claim.

All death Claim Events will be covered, except death Claims for any specific Exclusions as specified in section 14.2 or any other Exclusions specified throughout this Policy.

There is a Waiting Period of 60 (sixty) full calendar months for suicide Claims. The Waiting Period applies to cover taken out at the Commencement Date, additional cover taken out through a voluntary servicing change (for example, but not limited to, a voluntary increase of cover or a voluntary change of salary which increases the applicable DFNA suggested Cover Amounts) during the term of Your Policy and from the reinstatement date of the Policy. The Waiting Period will apply from the date that the cover is successfully added onto the Policy (from the date on which the Insurer accepts the liability). Payouts will only be made for a suicide Claim Event which occurs after the Waiting Period.

Each time You make a voluntary servicing change and increase Your Life Cover Benefit, a new 60 (sixty) month Waiting Period will apply to the additional portion of cover added. The portion of Life Cover Sum Assured that You had before You increased Your cover will be paid out if the Claim is past the original 60 (sixty) month Waiting Period.

Example

Example details:

- You take out a Policy with R5 000 000 Life Cover on 1 July 2020.
- You are both the Policyholder and Life Insured on the Policy.
- For simplicity, assume the Sum Assured remains level and does not grow in this example.

- 6 (six) years later, on 1 July 2026, You add an additional R2 000 000 Life Cover, meaning Your total Life Cover is now R7 000 000.
- Unfortunately, one year later, on 1 July 2027, You pass away and the Claim Event was due to suicide.

In this scenario, Your Beneficiaries will be paid R5 000 000, since the Claim Event is past the 60 (sixty) months (or five year) Waiting Period for the original Life Cover Sum Assured. However, the R2 000 000 Life Cover added on 1 July 2026 will not be paid out as this portion of Your Life Cover is still in its 60 (sixty) month Waiting Period for suicide Claims.

Please note that increases to the Life Cover amount suggested by the Dynamic Financial Needs Analysis will only attract a new 60 (sixty) months Waiting Period for suicide Claim Events if the increase in cover is above the maximum allowed servicing limits, at the time of change in cover. Please note that these maximums will be reviewed from time to time and may be amended by the Insurer and/or Administrator, at either's sole discretion.

Payouts will be made only when the Administrator/Insurer are satisfied that all the Policy and Claims requirements are met. There is no specified timeframe for this.

Please note that the Death Claim Events covered under this Benefit, as described in this section, must have occurred after the commencement of this Benefit in order for the Claimant to be eligible for a Claim pay-out.

Should the Administrator/Insurer exclude or decline cover for any previous or Pre-Existing Medical Condition, We will not pay out for any Claims that arise under any body system that is directly related to or is a consequence of the conditions or body system that was declined or excluded.

5.5 WHEN DOES THE BENEFIT END?

There is no Benefit Expiry Age for the Life Cover Benefit, meaning that the Life Cover Benefit will be provided for the Life Insured's whole life, as long as the Life Insured still needs Life Cover. Where selected, the Dynamic Financial Needs Analysis will re-assess the amount of Life Cover required every year to ensure the Life Insured is always optimally protected.

The Benefit will cease on a death Claim, as well as any instances where the Policy has been terminated by the Policyholder or by the Insurer, for whatever reason. All termination events defined in section 19.2 apply here as well.

5.6 THINGS TO NOTE

Please note that:

- Life Cover Claims will be subject to an overall maximum Claim amount. . Please refer to the General Benefit Limits Document or Your Schedule for this maximum amount. The maximum amount will be reviewed annually and may be amended by the Insurer and/or Administrator, at either's sole discretion.
- All rules, terms, conditions, calculations and Benefit formulas and workings and rules stated throughout section 5 above will be reviewed from time to time by the Administrator/Insurer and may be changed or amended, from time to time, at the Administrator/Insurer's sole discretion.
- Occupations affect the Premiums charged – if the Life Insured's occupation changes, the Administrator/Insurer requests that You inform Us. We reserve the right to amend Your Premiums and/or Benefits should You alter the Life Insured's occupation to one considered to be of a higher risk than Their previous occupation. The classification of whether the new occupation is deemed to be a higher risk occupation will be made at the sole discretion of the Administrator/Insurer.

6. Critical Illness Benefit

6.1 WHAT IS THE PURPOSE OF THE BENEFIT?

The Critical Illness Benefit provides a payment if the Life Insured suffers a severe illness, injury or disease. The payout is in the form of a single cash lump sum and it can be used to cover all unforeseen medical costs, lifestyle changes, assistive medical devices, rehabilitation programmes as well as assisting in accessing new breakthrough global treatments.

The Benefit was designed to ensure that the payout matches the severity of the Claim Event, ensuring the Life Insured has adequate cover for the impact that the illness or injury is expected to have on Their lifestyle.

6.2 BENEFIT WORKINGS

The Insurer will pay out an amount commensurate with the change in lifestyle following the Claim Event. The payout amount will equal the Sum Assured multiplied by a severity percentage.

Please note that an amount equal to, but not exceeding, the Critical Illness Benefit Amount (as specified in Your Policy Schedule) will be paid if the Life Insured suffers a valid Claim, under the Illness Objective Medical Criteria in Appendix 2, provided the Life Insured meets all the required Policy and Claims criteria specified throughout this Policy. In certain circumstances where the Severity percentage is above 100%, We will pay more than the Critical Illness Sum Assured at the time of Claim. The definitions found in Appendix 2 may also refer to the Activities of Daily Living definitions and metrics, which can be found in Appendix 4.

The Critical Illness Benefit is a standalone Benefit. This means that Claim payouts from this Benefit will not reduce the Life Cover Sum Assured or any other Benefits on Policy, and that the Benefit can be taken out as a standalone Benefit without the need to have Life Cover on the Policy.

The Critical Illness Cover Benefit has three Benefit options that the Policyholder may select: the Critical Illness 200 Benefit, the Critical Illness 250 Plus Benefit and the Critical Illness 500 Max Plus Benefit. This will be detailed below.

6.2.1 Critical Illness 200 Benefit

Under the Critical Illness 200 Benefit, the Insurer will pay out an amount commensurate with the change in lifestyle following the Claim Event. This means that the Critical Illness Benefit offers a tiered payout with four severity levels, as follows:

Our Critical Illness Benefit pays out an amount commensurate with the change in lifestyle following the Claim Event. This means that the Critical Illness Benefit offers a tiered payout with four severity levels, as follows:

- Severity A: 120% - 200%
- Severity B: 100%
- Severity C: 75%
- Severity D: 50%

Example

Example Details:

- You have a Critical Illness 200 Benefit Sum Assured of R1 000 000.
- You are both the Policyholder and the Life Insured on the Policy.
- You Claim for a Stage IV cancer which qualifies for a Severity B claim (100% payout).

In this scenario, You will receive R1 000 000 = R 1 000 000 x 100%.

6.2.2 Critical Illness 250 Plus Benefit

The Critical Illness 250 Plus Benefit will work exactly the same as under the Critical Illness 200 Benefit.

Additionally, the Insurer will pay out up to 250% on certain Claim Events, as well as offering coverage for more conditions under Severity D and E as can be seen below:

- Severity A: 120% - 250%
- Severity B: 100%
- Severity C: 75%
- Severity D: 50%
- Severity E: 25%

The definitions and payouts can be found in Appendix 2.

6.2.3 Critical Illness 500 Plus Benefit

The Critical Illness 500 Max Plus Benefit works the same as the Critical Illness 250 Plus Benefit in all respects.

Additionally, it has the following unique and powerful Benefit enhancements:

- A Cancer Relapse Benefit
- A Cancer Plus Benefit
- A Rare Disease Benefit
- A Rare Disease Global Booster
- A Dis-Chem LifeTech Benefit

- A Dis-Chem 100% extraRewards Discount Protector

6.2.3.1 Cancer Relapse Benefit

On recurrence of a valid cancer Claim Event after at least a five-year remission period, the Life Insured will receive an additional payment. The full Benefit payment will be made on the recurrence of the cancer (for cancers in Severities A to E). The Life Insured will get paid the full Sum Assured at the time of Claim multiplied by the applicable severity percentage.

The remission period is based on the most recent cancer Claim. If a Progressive Claim (cancer related) occurs within 5 (five) years of the previous cancer Claim, the remission period will reset, and a new remission period will begin from the latest cancer Claim Event Date. This ensures that the remission period always reflects the most recent progression of the cancer.

Normal Progression rules do not apply to the Cancer Relapse Benefit. The Cancer Relapse Benefit will be paid out in addition to normal cancer Claim payout, and at the full applicable severity level. Each individual payout, however, will be capped at 100% of the Sum Assured at the Claim Event Date, meaning some Severity A payouts will be paid out at 100%.

We will allow up to a maximum of 3 (three) payouts under the Cancer Relapse Benefit over the lifetime of the Benefit. This means a Life Insured can claim a maximum of 3 (three) times on the Cancer Relapse Benefit.

The Cancer Relapse Benefit will be paid on the development of local, regional and distant recurrence of a cancer with same histology as previously claimed for after a 5 (five) year period of documented remission, irrespective of the stage of the recurrent cancer.

Additionally, both the previous and recurrent cancer Claims must qualify for at least a Severity E claim in order for a payment to be made.

> *Definition: Remission is defined as being cancer free after completion of chemotherapy, radiotherapy, surgical treatment and biological therapy (if indicated) and confirmed by subsequent absence of radiological or biochemical (including molecular) evidence of disease. Hormone treatment is not regarded as active treatment for purposes of the remission definition.*
>
> *The relevant Specialist (oncologist) must confirm the remission period meets the definitions above..*

The Cancer Relapse Benefit payment is calculated on the full Critical Illness Benefit sum assured before any progressive claims were deducted from it. This payment will be made in addition to the normal progressive cancer claims. If the Life Insured's recurrent cancer is at a higher stage, the Life Insured may additionally qualify for a payment under the normal cancer progression rules.

EXAMPLE

A Life Insured takes out a Policy on 15th January 2025 with the Critical Illness 500 Max Plus Benefit and a Sum Assured of R1 000 000. Please ignore any Annual Benefit Increases in this example.

Claim 1: The first Claim is for a Severity E cancer which pays out at 25%. The amount paid out is R250 000 (R1 000 000 x 25%).

Claim 2: The Life Insured remains in remission for 6 (six) years and then suffers a second progressive cancer Claim. The second Claim is diagnosed as a Severity B claim at 100%.

Since the Claim is a progressive cancer claim, the Life Insured is paid out R750 000 = R1 000 00 x 75% (100% - 25%)

Additionally, since the Life Insured remained in remission for at least 5 (five) years, we will make an additional payment of 100% under the Cancer Relapse Benefit. This will be R1 000 000 (R1 000 000 x 100%).

Claim 3 The Life Insured remains in remission for another 6 (six) years and then suffers a third related cancer Claim at severity level D (50%). No pay out will be made under the normal cancer claim rules. However, under the Cancer Relapse Benefit, an amount of R500 000 would be paid out here.

In total, the Life Insured would have received R2 500 000 in claims payouts, for an original Sum Assured of R1 000 000.

Please note that:

- Multifocal or more than 1 (one) invasive solid cancer lesion within the same organ that occurs at the same time is seen as a single life event.
- To ensure that the Cancer Relapse Benefit is in line with rapidly advancing medical technology, the Administrator/Insurer may review the remission period, benefit workings, terms and conditions at detailed in section 6.2.3.1 from time to time, after consultation with medical specialists and make changes at either's sole discretion.
- The cancers described under the Rare Disease Benefit, as defined in Appendix 3, will not be eligible for any Benefit Claim or payout under the Cancer Relapse Benefit.

6.2.3.2 Cancer Plus Benefit

For a valid Severity A or B Critical Illness cancer Claim, there will be an additional Claim payout. This will be made in addition to the original Claim payment, which is defined in section 6.2. The second, additional payment will be made 10 (ten) years later after the original (first) cancer Claim Event Date.

The second payment is equal to 50% of the Critical Illness Sum Assured at the Claim Event Date. This payment will be made at the end of the month marking the tenth year from the Claim Event Date. The

amount paid will reflect the Sum Assured as of the cancer Claim Event Date, without any adjustments for inflation or other benefit adjustment occurring after the original Severity A or B Claim Event Date.

The Cancer Plus Benefit will cease on the death of the Life Insured, and no further payments will be made. The Life Insured does not necessarily need to have an active Dis-Chem Life Policy at the tenth year to receive the Benefit payment.

Example

The Policyholder took out the Critical Illness 500 Max Plus Option. The Life Insured has a Sum Assured of R2,000,000

Initial Diagnosis and Claim:
At Year 5 (five), the Life Insured is diagnosed with a Severity A cancer. The Claim is valid and a payout is made, as detailed in section 6.2.

At 10 (ten) years after diagnosis, the Cancer Plus Benefit provides an additional payout of 50% of the original Sum Assured, where the Policyholder receives an additional R1,000,000.

6.2.3.3 Rare Disease Benefit

The Insurer will pay out 300% for a specified list of rare diseases on a valid Claim Event. This will be 300% multiplied by the Sum Assured at the Claim Event Date. These rare diseases include 2 (two) groups: Cancer related diseases and non-Cancer related diseases. Please refer to Appendix 3 for more details on the Claim Events under this Benefit.

You can only Claim once over the Policy term under this Benefit.

6.2.3.4 Rare Disease Global Booster

Upon suffering one of the defined conditions in Appendix 3 and where the Life Insured decides to receive care overseas, We will boost the payout by an additional 200% on a valid Claim Event.

These funds can be used to fund the travel, accommodation and food related costs that the Life Insured may experience. It may also be used to fund the costs of a family member to travel with the Life Insured for support.

This Benefit may only be Claimed for once over the course of the Policy term. The overseas medical treatment must occur within 6 (six) months of a valid Claim in order for a Claim payment to be made. This means that the Life Insured has 6 (six) months to exercise this option and receive overseas treatment, else it falls away forever.

The full payout will be made once the Life Insured returns to South Africa, after the treatment overseas.

The Administrator/Insurer does not accept any responsibility or liability for the quality of medical procedures, treatment or medical facilities overseas treatment or advice provided to the Life Insured.

The extra 200% will be paid out only if all of the following conditions are met:

- Pre-Approval for Overseas Treatment:
    - Prior approval is required before the Life Insured goes overseas.
    - The Insurer's medical panel will verify that the treatment is necessary and unavailable in South Africa.
- The Administrator/Insurer must be notified of the trip within the required period;
- It must be an approved medical facility in the United States of America.
    - The Administrator/Insurer has specified a list of approved hospitals, clinics, and treatment centres overseas. These can be found on the Dis-Chem website at www.dischemlife.co.za.
- Time Limits and Deadlines for Claim Submission:
    - Claim Submission Deadlines: The Life Insured must within, 90 (ninety) Days from the end of the trip, submit all documents to the Administrator.
- The treatment for the rare disease is not available in South Africa;
- The Life Insured must receive a second medical opinion from a qualified professional (selected at the Administrator/Insurer's sole discretion) before proceeding with overseas treatment;
- The procedure is not experimental in nature;
- If follow up treatment is required, this is available in South Africa.

6.2.3.5 Dis-Chem LifeTech Benefit

We will pay out an additional R20 000 every 3 (three) years for up to 15 (fifteen) years to fund new medical devices and assistive devices from Dis-Chem (total of 5 (five) payouts). This payment will be made when the Life Insured suffers a severity A or B Claim Event.

The first payment will be paid out 3 (three) years after the Claim Event Date. The total Benefit payable will be capped at 2.5% of the Benefit Sum Assured at the Claim Event Date. No inflationary increases will be made on the payouts. This means that the aggregated pay-out will never exceed 2.5% of the Critical Illness Sum Assured at the Claim Event Date.

Example

A Policyholder purchases the Critical Illness 500 Max Plus Option on 1 January 2025 for a cover amount of R2 000 000. The Policyholder is the Life Insured in this example. With this selected cover option, they are also eligible for the Life Tech benefit, which will pay up to R50,000 (2.5% of R2 000 000) upon a Severity A or B claim. This benefit is paid in instalments of R20,000 every 3 (three) years over a period of 15 (fifteen) years.

On 1 May 2025, the individual is diagnosed with a Severity B Stage IV Cancer, triggering a payout of R1 000 000 (100% x R1 000 000).

After 3 (three) years on 1 May 2028, they will receive an additional R20,000 from the LifeTech benefit. 3 (three) years later (year 6 (six)) on 1 May 2031, they receive an additional R20,000 under the Life Tech benefit. 3 (three) years later (year 9 (nine)) on 1 May 2034, they receive an additional R10,000 under the Life Tech benefit (R50 000 – R40 000).

Since the full 2.5% of the cover amount has been paid, no further payments will be made in years 12, or 15.

These payouts will be made as Dis-Chem vouchers to be spent within a Dis-Chem store. The method of payment may be changed from time to time, at the sole discretion of the Administrator/Insurer.

Please note that payments and this Benefit will stop on the death of the Life Insured.

6.2.3.6 100% extraRewards Discount Protector

When the Life Insured suffers a Severity A or B Critical Illness condition, the Life Insured will be eligible to receive 100% extraRewards in store discounts for 2 (two) years. This will be a monthly benefit, starting from the month where a valid Critical Illness Benefit Payment is made.

The Benefit works as follows:

1. The Life Insured will continue to receive the in store extraRewards discount percentage that They were eligible for at the Claim Event Date.
2. The difference between 100% and the above percentage will be paid out in Dis-Chem vouchers to the Claimant.
3. All Benefit rules, including caps and limits, will apply to the above calculation.

The benefit will be capped at 2.5% of the Benefit Sum Assured at Claims Event Date. This means that the aggregated pay-out will never exceed 2.5% of the Critical Illness Sum Assured at the Claim Event Date. The overall monthly cap that the Administrator/Insurer will pay out will be subject to a maximum limit, as defined in the General Benefit Limits Document.

6.3 HOW DOES THE BENEFIT CHANGE?

For Personal Assurance policies, the Benefit Sum Assured will change each year, at Your Policy Anniversary, by CPI.

The Policyholder may also select for the Sum Assured to change by the Dynamic Benefit Adjustment, specified by the Dynamic Financial Needs Analysis. The Dynamic Financial Needs Analysis is the smart algorithm that calculates required cover on an ongoing basis, based on the Life Insured's individual and

unique circumstances. The algorithm automatically and dynamically adjusts cover to match the Life Insured's changing needs as the Life Insured's life and financial needs change.

For Business Assurance policies, the Benefit Sum Assured will change each year with CPI.

6.4 CLAIMS

The payout for the Critical Illness Benefit will be equal to the Sum Assured at the Claim Event Date multiplied by the severity percentage.

The Critical Illness Benefit will have a 1 (one) month Survival Period from the Claim Event Date. This will be 1 (one) full calendar month from the Claim Event Date.

Additionally, there will be a 1 (one) month Waiting Period from the Claim Event Date before the payment may be made to You. This is to give the Administrator/Insurer time to assess the validity and permanence of the Claim Event. This means that Claims will only be paid out at a minimum 1 (one) full calendar month after the Claim Event Date. If further time is required to assess the permanence of a Claim, then the Claim will only be paid out once the medical team of the Administrator/Insurer are satisfied that the condition meets the Illness Objective Medical Criteria. The maximum period for permanence to be established will be 12 (twelve) months from the Claim Event Date. Please refer to the definitions in the Illness Objective Medical Criteria (in Appendix 2) to see which conditions specifically require Waiting Periods longer than 1 (one) month to assess the permanence of the illness, injury, disease or condition.

Please note that Premiums must continue to be paid during both the Waiting and Survival Periods, and whilst the Claim is being assessed (up until permanence of the illness, condition or injury is established, that is, up until the date on which the Claim is deemed valid).

Please note that if the Life Insured survives the 1 (one) month Survival Period from the Claim Event Date, then the cover will reinstate to the full amount before the Claim Event. Future Unrelated Claims will be paid from this fully reinstated amount, whilst Related and Progressive Claims will only be paid for higher severities using the difference in severity percentages between the latest (current) Claim and the highest of all previous Claims, multiplied by the full Sum Assured. Please see section 16 for more details on multiple claim rules.

Example

Example Details:

- You take out R1 000 000 Illness Cover.
- You are both the Policyholder and Life Insured on the Policy.
- Unfortunately, 2 (two) years later, You Claim for a stage III cancer.
- You qualify for a 100% pay out.

This means We will pay out R1 000 000 x 100% = R1 000 000.

If You survive the 1 (one) month Survival Period, then the Sum Assured will increase back to the full R1 000 000. This is because You will still have full coverage for all future Unrelated Claims – that is, You will receive a payout based on the full Sum Assured and the relevant severity for all for all future Unrelated Claims.

As mentioned above, if the Life Insured survives the 1 (one) month Survival Period, then cover will reinstate to the full amount before the Claim Event Date. Critical Illness Premiums will also continue to be paid in full thereafter – that is, the Premium payable will be for 100% of the full reinstated Critical Illness Sum Assured.

If a Critical Illness Claim is Repudiated (for whatever reason), then the Critical Illness Premium will continue to be paid thereafter. This is done so that the Life Insured continues to be protected, should They experience a Claim Event in the future.

Should the Administrator/Insurer exclude or decline cover for any previous or Pre-Existing Medical Condition, We will not pay out for any Claim Events that arise under any body system that is directly related to or is a consequence of the conditions or body system that was declined or excluded. Please refer to Your Schedule to see if any Exclusions apply to Your Policy.

Exclusions for the Critical Illness Benefit can be found in section 14.2. Certain condition specific/category specific Exclusions can also be found in Appendix 2.

6.5 WHEN DOES THE BENEFIT END?

The Critical Illness Benefit provides whole-of-life coverage and changes every year with the Life Insured's changing circumstances, ensuring that cover remains relevant to the Life Insured's evolving needs. This means that there is no explicit expiry age for the Critical Illness Benefit.

The Benefit will cease when:

- The Life Insured dies; or

- The Policy has been terminated by any party, for whatever reason.

All termination events defined in section 19.2 apply here as well.

6.6 THINGS TO NOTE

Please note that:

- Critical Illness Claims will be subject to an overall maximum Claim amount. Please refer to the General Benefit Limits Document for this maximum amount. The maximum amount will be reviewed annually and may be amended by the Administrator and/or Insurer, at either's sole discretion.
- Occupations affect the Premiums charged – if the Life Insured's occupation changes, the Administrator/Insurer requests that You inform Us. We reserve the right to amend Your Premiums and/or Benefits should You alter the Life Insured's occupation to one considered to be of a higher risk than Their previous occupation. The classification of whether the new occupation is deemed to be a higher risk occupation will be made at the sole discretion of the Administrator/Insurer.
- The Dis-Chem Life Policy is a living, dynamic Policy which changes as the Life Insured and the world around the Life Insured changes. This means it evolves and updates with the changing medical landscape. Therefore, the Administrator and/or Insurer reserves the right, at their sole discretion, to review and amend the specified list of Illness Objective Medical Criteria conditions as well as Activities of Daily Living (found in Appendix 2 and Appendix 4) from time to time, after consultation with medical experts. Amendments may be due to, but are not limited to, changes in the relevance, prognosis, occurrence, recovery rates, survival rates, mortality rates (following the onset of the condition) and lifestyle impacts of each condition. This means that the Administrator and/or Insurer may add or remove conditions from the Illness Objective Medical Criteria Claim Events, from time to time at their sole discretion. The Administrator and/or Insurer reserves the right to review and adjust the Critical Illness Benefit Premium, at their sole discretion, in light of any amendments to the Illness Objective Medical Criteria categories covered and the definitions contained therein.

7. Disability Cover Benefit

7.1 WHAT IS THE PURPOSE OF THE BENEFIT?

The Disability Cover Benefit provides a payment if the Life Insured becomes Permanently Disabled. The payout is made as a single cash lump sum and it can be used to cover the Life Insured's expected future lost income and/or all the expected future expenses incurred by the Life Insured and Their family. These can be used to pay for such costs as education, healthcare, food, housing, transport and for any other expenses incurred by the Life Insured and Their family. This payment is made as a single lump sum payment to You. The lump sum, or a portion thereof, can also be used to pay off any outstanding debts, if so required.

7.2 BENEFIT WORKINGS

This Benefit will pay out 100% of the Disability Cover Benefit Sum Assured on a valid Claim. An amount equal to, but not exceeding, the Disability Cover Benefit Sum Assured (as specified in Your Policy Schedule) will be paid if the Life Insured suffers a valid Claim, under the Disability Objective Medical Criteria or the Occupational Claims Criteria and provided that the Life Insured meets all other Policy requirements.

This Benefit is a standalone Benefit. This means that any Claim amount from this Benefit will not reduce the Life Cover Sum Assured or any other Benefits on the Policy.

7.3 HOW DOES THE BENEFIT CHANGE?

For Personal Assurance policies, the Benefit Sum Assured will change each year, at Your Policy Anniversary, by CPI.

The Policyholder may also select for the Sum Assured to change by the Dynamic Benefit Adjustment, specified by the Dynamic Financial Needs Analysis. The Dynamic Financial Needs Analysis is the smart algorithm that calculates the required cover on an ongoing basis, based on the Life Insured's individual and unique circumstances. The algorithm automatically and dynamically adjusts cover to match the Life Insured's changing needs as Their life and financial needs change.

For Business Assurance policies, the Benefit Sum Assured will change each year with CPI.

7.4 CLAIMS

The full Disability Cover Benefit Sum Assured will be paid out for a valid Claim. This means that 100% of the Benefit Sum Assured will be paid out on a valid Claim.

This Benefit will pay out on 2 (two) different claims criterion, namely the Permanent Disability Claim Events:

- The Disability Objective Medical Criteria
- The Occupational Claims Criteria

Disability Objective Medical Criteria

The Disability Objective Medical Criteria is an objective, transparent and fair Claim system used to assess the severity of the Life Insured's disability. The disability is assessed based on the severity of the Life Insured's medical impairment.

Occupational Claims Criteria

The Benefit will pay out if the Life Insured's disability meets the Occupational Claims Criteria definition.

Please note that the Occupational Claims Criteria is not available for certain occupations. Please refer to Your Policy Schedule to see if the Life Insured's occupation qualifies for the Occupational Claim Criteria.

Please note that chronic fatigue syndrome (and any manifestations thereof), fibromyalgia (or conditions similar thereto), chronic pain disorders, any Mental and Behavioural Conditions (including post traumatic stress disorder) and any lower back conditions are excluded under the Occupational Claims Criteria. The lower back Exclusion is defined as follows: *No amount or Sum Assured under this Benefit shall be payable for a disability which is caused wholly or partly, directly or indirectly, by an injury to, or a disorder of Lumbar Sacral spine or any complications thereof*.

Please note that the Life Insured will still be able to claim for Mental and Behavioural or lower back conditions if They meet one of the Disability Objective Medical Criteria definitions.

Please note that the maximum specified timeframe for the Claims assessment under the Disability Objective Medical Criteria or Occupational Claims Criteria is 12 (twelve) months from the Claim Event Date (longer periods will be allowed if specifically specified in any of the individual Disability Objective Medical Criteria definitions). A Claim decision, and payment, will only be made when the Administrator/Insurer are comfortable that the Claim meets the Permanent Disability claims criteria.

Please note that there is a 1 (one) month Waiting and Survival Period from the Claim Event Date:

- The 1 (one) month Survival Period means that the Life Insured will need to survive 1 (one) full calendar month from the Claim Event Date in order for a Claim to be made.
- In order to give the Insurer time to assess the validity and permanence of the Claim Event, there will be a 1 (one) month Waiting Period from the Claim Event. This means that Claims will only be paid out at a minimum of 1 (one) month after the Claim Event Date. Further time may be required to assess the permanence of a Claim Event and the Claim will only be paid out once the Administrator/Insurer are satisfied that the Claim condition meets the Permanent Disability Claims definition. Please also refer to the definitions in Appendix 1 to see which conditions specifically require Waiting Periods longer than 1 (one) month to assess the permanence of the illness, injury, disease or condition. No other Policy changes will be allowed in the time period from the Date of Disability until the end of the Waiting Period or until permanence is established, whichever comes later.

Premiums must continue to be paid during the Survival and Waiting Periods, as well as during the time when the Claim is being assessed. They must continue to be paid up to the date at which permanence is established.

If the Claim is repudiated, then the Disability Cover Benefit and Premiums will both continue to ensure the Life Insured remains protected if They were to experience a Claim Event going forward.

Please note that no Claim payout will be made if the Claim Event condition is due to an Exclusion, as defined in section 14.2. Certain condition specific/category specific Exclusions can also be found in Appendix 1.

Please also note that no multiple Claims will be allowed under the Disability Cover Benefit. This means that once 100% of the Benefit Sum Assured is paid out, then no further Claim payments will be made from the Disability Cover Benefit.

Please note that the Claim Events covered under this Benefit, as described in this section, must have occurred after the commencement of this Benefit in order for the Claimant to be eligible for a Claim pay-out.

Should the Administrator/Insurer exclude or decline cover for any previous or Pre-Existing Medical Condition, We will not pay out for any Claims that arise under any body system that is directly related to or is a consequence of the conditions or body system that was declined or excluded.

7.5 WHEN DOES THE BENEFIT END?

The Benefit will cease when

- The Life Insured dies; or
- The Policy has been terminated by any party, for whatever reason; or

- A valid Disability Cover Benefit Claim has occurred; or
- The Life Insured turns age 65 (sixty-five).

All termination events defined in section 19.2 apply here as well.

7.6 THINGS TO NOTE

Please note that:

- Disability Cover Claims will be subject to an overall maximum Claim amount. Please refer to the General Benefit Limits Document for this maximum amount. The maximum amount will be reviewed annually and may be amended by the Administrator and/or Insurer, at either's sole discretion.
- Occupations affect the Premiums charged – if the Life Insured's occupation changes, the Administrator/Insurer requests that You inform Us. We reserve the right to amend Your Premiums and/or Benefits should You alter the Life Insured's occupation to one considered to be of a higher risk than Their previous occupation. The classification of whether the new occupation is deemed to be a higher risk occupation will be made at the sole discretion of the Administrator/Insurer.
- The Dis-Chem Life Policy is a living, dynamic Policy which changes as the Life Insured and the world around Them changes. This means it evolves and updates with the changing medical landscape. Therefore, the Administrator and/or Insurer reserves the right, at their sole discretion, to review and amend the specified list of Disability Objective Medical Criteria conditions as well as Activities of Daily Living (found in Appendix 1 and Appendix 4) as well as the Occupational Claims Criteria from time to time, after consultation with medical experts. Amendments may be due to, but not limited to, changes in the relevance, prognosis, occurrence, recovery rates, survival rates, mortality rates (following the onset of the condition) and lifestyle impacts of each condition. This means that the Administrator and/or Insurer may add or remove conditions from the Disability Objective Medical Criteria and/or Occupational Claims Criteria, from time to time at their sole discretion. The Administrator and/or Insurer reserves the right to review and adjust the Disability Cover Premium, at their sole discretion, in light of any amendments.

8. Income Protection Benefit

The Income Protection Benefit is a Benefit which pays out a regular Income should the Life Insured experience an illness, disease, impairment or injury preventing the Life Insured from working and earning an Income. It consists of 2 (two) income protection components. These are the:

- Temporary Income Protection Benefit – This Benefit will provide protection in situations where the Life Insured is unable to perform Their Nominated Occupation and are losing income, but are not deemed Permanently Disabled; and
- Permanent Income Protection Benefit – This Benefit will provide protection on Permanent Disability Claims.

8.1 TEMPORARY INCOME PROTECTION BENEFIT

8.1.1 What is the purpose of the Benefit?

The Temporary Income Protection Benefit pays out a regular Income should the Life Insured experience an illness, disease, impairment or injury preventing the Life Insured from working and earning an Income upon becoming Temporarily Disabled and where the Life Insured is unable to perform Their Nominated Occupation. This Benefit is used to replace lost Income when the Life Insured cannot work and cannot earn an Income as a result of a Temporary Disability.

The Benefit is designed to complement the Permanent Income Protection Benefit, which only pays on Permanent Disability. Please see section 8.2 for further details.

8.1.2 Overview

An amount equal to, but not exceeding, the Temporary Income Protection Benefit Sum Assured (as specified in Your Policy Schedule) will be paid if the Life Insured suffers a valid Claim Event under the Temporary Income Protection Benefit.

Please note that valid Benefit payouts will not reduce the Life Cover Sum Assured or any other Benefits on the Policy on Claim.

8.1.3 How does the Benefit change?

The Benefit Sum Assured will change each year, at Your Policy Anniversary, by CPI.

The Policyholder may also select for the Sum Assured to change by the Dynamic Benefit Adjustment, specified by the Dynamic Financial Needs Analysis. The algorithm automatically and dynamically adjusts cover to match the Life Insured's changing needs as the Life Insured's life and financial needs change. The Temporary Income Protection Benefit Sum Assured will grow in line with the Life Insured's projected net of tax salary, as projected by the Dynamic Financial Needs Analysis.

Please note that the above adjustments are made when the Life Insured is not claiming under the Temporary Income Protection Benefit. The In-Claim Escalations (increases) can be found in section 8.3.4.

8.1.4 Claims

A payout for a valid Claim under the Temporary Income Protection Benefit will be defined as the lesser of the Temporary Income Protection Benefit Sum Assured and the Life Insured's Pre-Claim Income at the Claim Event Date. Payments will only be made for full Days that the Life Insured qualifies for payouts under the Temporary Income Protection Benefit.

The first payment to You will be made at the end of the month in which the Waiting Period expires. Thereafter, Benefit payments will always be made at the end of the month.

Under the Temporary Income Protection Benefit, You can claim under the Loss of Income Claims Criteria by providing proof that the Life Insured is unable to perform at least 25% of the main duties of Their Nominated Occupation due to injury or illness, and as a result are unable to maintain Their income level.

The Claim payment that the Life Insured receives will depend on the Income that They are losing whilst They are in claim. If the Life Insured suffers a partial loss of income, You will be paid a proportionate claim payment which will equal the Temporary Income Protection Sum Assured multiplied by the proportion of Income lost.

Whilst the Life Insured is in claim, the Temporary Income Protection Benefit Premiums will be waived, that is, You will not pay any Temporary Income Protection Benefit Premiums during claim. Even if the Life Insured is only claiming for a portion of Their income, the Temporary Income Protection Premiums will be waived, that is, You do not need to be claiming for 100% of the Temporary Income Protection Benefit Sum Assured to have the Temporary Income Protection Benefit Premiums waived.

However, during claim, You will continue to pay Premiums for other Benefits (i.e. for Life Cover, Disability Cover, Critical Illness and Permanent Income Protection). If You do not pay the Premiums for these Benefits, they will fall away.

There is a 1 (one) month or 3 (three) months Waiting Period for the Temporary Income Protection Benefit. Please refer to Your Schedule to see which Waiting Period applies to Your Policy. This means that this Benefit will only pay out after the Waiting Period has expired and only once the Administrator/Insurer are satisfied that the Life Insured has satisfied the Temporary Income Protection Benefit claims criteria.

The Temporary Income Protection Benefit pays out, as long as the Benefit remains in force, until the earlier of:

- The Life Insured has recovered sufficiently to return to work;
- The end of the month in which the Life Insured turns age 65 (sixty-five);
- The Life Insured's death;
- The date on which the Life Insured qualifies for a Permanent Disability Claim, irrespective if You have the Permanent Income Protection Benefit or the Disability Cover Benefit on Your Policy.

In order to receive a Claim payout, You will have to send in a certified bank statement at month end as well as any other documents as required by the Administrator/Insurer, showing that the Life Insured has lost Income. The actual payment will be made at the month end of the relevant month for valid Claims.

Please note that:

- You may only Claim under this Benefit if the Life Insured is losing more than 25% (twenty-five percent) of Their Pre-Claim Income.
- You may only Claim if the Life Insured is unable to perform at least 25% (twenty-five percent) of the main (material and substantial) duties of Their Nominated Occupation. This is in addition to the point above.
- Benefits will be aggregated against income earned in claim as well as against other disability product payouts received in claim. Please see section 8.3.7 for further details.
- Mental and Behavioural conditions will have a 6 (six) months Waiting Period on Claim, and will only be eligible for payout under the Temporary Income Protection Benefit if the Life Insured meets all of the following conditions listed below (in addition to the 6 (six) month Waiting Period):
    - 21 (twenty-one) consecutive Days hospitalisation / institutionalisation in a registered psychiatric facility; and
    - Has chronic unremitting symptoms, and
    - Has not responded to comprehensive management and treatment which the person has completed based on best clinical practice for more than 6 (six) months, and
    - Has resulted in the inability to perform any type of work for payment or reward for a period of at least 6 (six) months and
    - Diagnosis and impairment must be confirmed by 2 (two) independent specialists
- All lower back conditions will be excluded from the Temporary Income Protection Benefit, and no claims will be made under the Temporary Income Protection Benefit for these conditions.

- The wording for the lower back Exclusion is defined as follows: *No amount or Sum Assured under this Benefit shall be payable for a disability which is caused wholly or partly, directly or indirectly, by an injury to, or a disorder of Lumbar Sacral spine or any complications thereof.*

- No Claim payout will be made if the Claim Event condition is due to an Exclusion, as defined in sections 8.3.6 and 14.2.
- Claim Events covered under this Benefit, as described in this section, must have occurred after the commencement of this Benefit in order for the Claimant to be eligible for a Claim pay-out.

The Claimant may at any time apply for a review of the existing Claim, provided that new medical information is submitted. The Administrator/Insurer may also at any stage review whether the Claim qualifies for the Loss of Income Claims Criteria, under the Temporary Income Protection Benefit claims criteria.

Should the Administrator/Insurer exclude or decline cover for any previous or Pre-Existing Medical Condition, We will not pay out for any Claims that arise under any body system that is directly related to or is a consequence of the conditions or body system that was declined or excluded.

8.1.5 When does the Benefit end?

The Benefit will cease when:

- The Life Insured turns 65 (sixty-five);
- The Life Insured dies; or
- The Policy has been terminated by any party, for whatever reason.
- The Life Insured qualifies under the Permanent Disability claims criteria, whether or not the Life Insured has the Disability Cover or Permanent Income Protection benefit on the Policy.

All termination events defined in section 19.2 apply here as well.

8.1.6 Things to note

Please note that:

- Temporary Income Protection Benefit Claims will be subject to an overall maximum Claim amount. Please refer to the General Benefit Limits Document for this maximum amount. The maximum amount will be reviewed annually and may be amended by the Administrator and/or Insurer, at either's sole discretion.
- Occupations affect the Premiums charged – if the Life Insured's occupation changes, the Administrator/Insurer requests that You inform Us. We reserve the right to amend Your Premiums and/or Benefits should You alter the Life Insured's occupation to one considered

to be of a higher risk than Their previous occupation. The classification of whether the new occupation is deemed to be a higher risk occupation will be made at the sole discretion of the Administrator/Insurer.

- In order to qualify for a Benefit payment for a Claim arising from fibromyalgia, a rheumatologist's confirmation of the diagnosis and inability to work is required. In order to qualify for a Benefit payment for a Claim arising from chronic fatigue syndrome, a specialist physician's confirmation of the diagnosis and inability to work is required.
- The Dis-Chem Life Policy is a living, dynamic Policy which changes as the Life Insured and the world around changes. This means it evolves and updates with the changing medical landscape. Therefore, the Administrator and/or Insurer reserves the right, from time to time and at either of their sole discretion, to review and amend the claims criteria under the Temporary Income Protection Benefit, after consultation with medical experts. Amendments may be due to, but are not limited to, changes in the relevance, prognosis, occurrence, survival rates, recovery rates, mortality rates (following the onset of the condition) and lifestyle impacts of different illnesses, diseases or injuries as well as of different claim underpins. This means that the Administrator and/or Insurer may add or remove claims criteria under the Temporary Income Protection Benefit, from time to time at their sole discretion. The Administrator and/or Insurer reserves the right to review and adjust the Temporary Income Protection Benefit Premium, at their sole discretion, in light of any amendments to the claim criteria (and/or individual conditions) under the Temporary Income Protection Benefit.

8.2 PERMANENT INCOME PROTECTION BENEFIT

8.2.1 What is the purpose of the Benefit?

The Permanent Income Protection Benefit pays out a regular income should the Life Insured experience a disease, illness, impairment or injury preventing the Life Insured from working and earning an Income upon becoming Permanently Disabled. This Benefit is used to replace lost Income when the Life Insured cannot work and cannot earn an Income as a result of suffering a Permanent Disability Claim Event.

The Permanent Income Protection Benefit is designed to complement the Temporary Income Protection Benefit, which pays on Temporary Disability, where the Permanent Income Protection Benefit will begin to pay out once permanence is established.

8.2.2 Overview

Please note that an amount equal to, but not exceeding, the Permanent Income Protection Benefit Sum Assured (as specified in Your Policy Schedule) will be paid if the Life Insured suffers a valid Claim Event under the Permanent Income Protection Benefit.

Please note that valid Benefit payouts will not reduce the Life Cover Sum Assured or any other Benefits on Claim.

8.2.3 How does the Benefit change?

The Benefit Sum Assured will change each year, at Policy Anniversary, by CPI.

The Policyholder may also select for the Sum Assured to change by the Dynamic Benefit Adjustment, specified by the Dynamic Financial Needs Analysis. The algorithm automatically and dynamically adjusts cover to match the Life Insured's changing needs as the Life Insured's life and financial needs change. The Permanent Income Protection Benefit Sum Assured will grow in line with the Life Insured's projected net of tax Salary, as projected by the Dynamic Financial Needs Analysis.

Please note that the above adjustments are made when the Life Insured is not claiming under the Permanent Income Protection Benefit. The In-Claim Escalations can be found in section 8.3.4.

8.2.4 Claims

A payout for a valid Claim under the Permanent Income Protection Benefit will be defined as the lesser of Your Permanent Income Protection Benefit Sum Assured and the Life Insured's Pre-Claim Income at the Claim Event Date. Payouts will only be made for full Days that the Life Insured qualifies for payouts under the Permanent Income Protection Benefit

The first payment will be made at the end of the month in which the Waiting Period expires. Thereafter, Benefit payments will always be made at the end of the month.

This Benefit will pay out on 2 (two) different claims criterion, namely the Permanent Disability Claim Events:

- The Disability Objective Medical Criteria
- The Occupational Claims Criteria

Objective Medical Criteria

The Disability Objective Medical Criteria is an objective, transparent and fair Claim system used to assess the severity of the Life Insured's disability. The disability is assessed based on the severity of the Life Insured's medical impairment.

Occupational Claims Criteria

The Benefit will pay out if the Life Insured's disability meets the Occupational Claims Criteria definition.

Please note that the Occupational Claims Criteria is not available for certain occupations. Please refer to Your Policy Schedule to see if the Life Insured's occupation qualifies for the Occupational Claim Criteria.

Please note that chronic fatigue syndrome (and any manifestations thereof), fibromyalgia (or conditions similar thereto), chronic pain disorders, any Mental and Behavioural Conditions and any lower back conditions are excluded under the Occupational Claims Criteria. The lower back Exclusion is defined as follows: *No amount or Sum Assured under this Benefit shall be payable for a disability which is caused wholly or partly, directly or indirectly, by an injury to, or a disorder of Lumbar Sacral spine or any complications thereof.*

Please note that You will still be able to claim for Mental and Behavioural or lower back conditions if the Life Insured meets one of the Disability Objective Medical Criteria definitions.

Please note that the maximum specified timeframe for the claims assessment under the Disability Objective Medical Criteria or Occupational Claims Criteria is 12 (twelve) months from the Claim Event Date (longer periods will be allowed if specified in any of the individual Disability Objective Medical Criteria definitions). A Claim decision, and payment, will only be made when the Administrator/Insurer are satisfied that the Claim meets the Permanent Disability Claims Criteria.

Please note that whilst there is a Permanent Income Protection Claim being paid out, the Permanent Income Protection Benefit Premiums will be waived - that is, You will not pay any Permanent Income Protection Benefit Premiums during claim. Please note that even if the Life Insured is only claiming a portion of Their income, the Permanent Income Protection Premiums will be waived.

However, You will need to continue paying for Your other Premiums on Your Policy (Life Cover, Disability Cover and Illness Cover) whilst in claim. If You do not pay the Premiums for these individual Benefits, they will fall away.

There is a 1 (one) month or 3 (three) months Waiting Period for Claims on the Permanent Income Protection Benefit. Please refer to Your Schedule to see which applies to Your Policy. This Benefit will only begin to pay out on the later of the Waiting Period having expired and permanence being established (permanence being established is when the Claimant meets the Permanent

Disability Claim Criteria). Payment will only commence once the Administrator/Insurer are satisfied that the Life Insured has met the Permanent Distality Claims Criteria, after the Waiting Period has elapsed.

Example

Example Details:

- You take out a Dis-Chem Life Policy with both Temporary and Permanent Income Protection Benefits.
- You are both the Policyholder and Life Insured on the Policy.
- You become really ill and are unable to work.
- Your Income Protection Benefit starts to pay out under the Temporary Income Protection Benefit, once the Waiting Period has expired. In this example, the Waiting Period is 3 (three) months. You remain Temporarily Disabled for 6 (six) months in total. The Insurer pays out for 3 months.
- After 6 (six) months from the start of the condition, You are deemed to be Permanently Disabled.

Here the Income Protection Benefit begins to pay out under the Permanent Income Protection Benefit and the Temporary Income Protection Benefit stops paying out.

Please note that the Permanent Income Protection Benefit Premiums are required to be paid whilst (and until) the date where permanence is established by the Administrator/Insurer at either's sole discretion.

The Permanent Income Protection Benefit pays out, as long as the Benefit remains in force, until the earlier of:

- The Life Insured has recovered sufficiently to return to work;
- The end of the month in which the Life Insured turns age 65 (sixty-five); or
- The Life Insured's death.

Once You have claimed under the Permanent Income Protection Benefit, Your Temporary Income Protection Benefit (if selected on Your Policy) will fall away.

Please note that:

- Benefits will be aggregated against income earned in claim as well as against other income protection benefits received from other companies in claim, for Claims under all of the Permanent Disability Claims Criteria. Please see section 8.3.7 for further details.
- No Claim payout will be made if the Claim condition is due to an Exclusion, as defined in section 9.2.

If the Claim has not been assessed as permanent as yet (even after the Wating Period has expired), then no payout will be made from the Permanent Income Protection Benefit until

permanence is established. Once Permanent Disability is established in accordance with the claim's assessment procedure for the Permanent Income Protection Benefit, then the Permanent Income Protection Benefit will start paying out and the Temporary Income Protection Benefit will stop paying out (if selected on the Policy).

Please note that no Claim payout will be made if the Claim condition is due to an Exclusion, as defined in sections 8.3.6 and 14.2. Certain condition specific Exclusions can also be found in Appendix 1.

The Claimant may at any time apply for a review of the existing Claim, provided that new medical information is submitted. The Administrator/Insurer may also at any stage review whether the Benefit qualifies for the Occupational Claims Criteria (if not previously allowed), under the Permanent Income Protection Benefit claims criteria.

Please note that the Claim Events covered under this Benefit, as described in this section, must have occurred after the commencement of this Benefit in order for the Claimant to be eligible for a Claim pay-out.

Should the Administrator/Insurer exclude or decline cover for any previous or Pre-Existing Medical Condition, We will not pay-out for any Claim Events that arise under any body system that is directly related to or is a consequence of the conditions or body system that was declined or excluded.

8.2.5 When does the Benefit end?

The Benefit will cease when:

- The Life Insured turns 65 (sixty-five);
- The Life Insured dies; or
- The Policy has been terminated by any party, for whatever reason.

All termination events defined in section 19.2 apply here as well.

8.2.6 Things to note

Please note that:

- Permanent Income Protection Benefit Claims will be subject to an overall maximum Claim amount. Please refer to General Benefit Limits Document for this maximum amount. The maximum amount will be reviewed annually and may be amended by the Administrator and/or Insurer, at either's sole discretion.
- Occupations affect the Premiums charged – if the Life Insured's occupation changes, the Administrator/Insurer requests that You inform Us. We reserve the right to amend Your Premiums and/or Benefits should You alter the Life Insured's occupation to one

considered to be of a higher risk than Their previous occupation. The classification of whether the new occupation is deemed to be a higher risk occupation will be made at the sole discretion of the Administrator/Insurer.

- The Dis-Chem Life Policy is a living, dynamic Policy which changes as the Life Insured and the world around changes. This means it evolves and updates with the changing medical landscape. Therefore, the Administrator and/or Insurer reserves the right, at their sole discretion, to review and amend the specified list of Disability Objective Medical Criteria conditions as well as Activities of Daily Living (found in Appendix 1 and Appendix 4) as well as the Occupational Claims Criteria from time to time, after consultation with medical experts. Amendments may be due to, but not limited to, changes in the relevance, prognosis, occurrence, recovery rates, survival rates, mortality rates (following the onset of the condition) and lifestyle impacts of each condition. This means that the Administrator and/or Insurer may add or remove conditions from the Disability Objective Medical Criteria and/or Occupational Claims Criteria, from time to time at their sole discretion. The Administrator and/or Insurer reserves the right to review and adjust the Permanent Income Protection Premium, at their sole discretion, in light of any amendments.

8.3 INCOME PROTECTION BENEFIT GENERAL TERMS AND CONDITIONS

Please note that all sections in 8.3 are related to both the Temporary and Permanent Income Protection Benefits, falling under the Income Protection Benefit. The wording 'Income Protection Benefit' is used to refer to both the Temporary and Permanent Income Protection Benefits, throughout section 8.3.

8.3.1 Take-A-Break Benefit

The Administrator/Insurer will allow clients a maximum Sabbatical term of 6 (six) months every 3 (three) years. An Income Protection Benefit Claim submitted during a Sabbatical will be assessed on whether the Life Insured is medically certified to be able to perform Their Nominated Occupation.

Please note that You still need to pay Your Temporary Income Protection Benefit and Permanent Income Protection Benefit Premiums during the Sabbatical, in order to receive coverage under the Temporary Income Protection and Permanent Income Protection Benefits.

The Sabbatical will exclude certain countries where the risks, in the opinion of the Administrator/Insurer and at their sole discretion, are greater than those to which They would have been exposed in South Africa. This list will be reviewed and changed, from time to time, at the Administrator's/Insurer's sole discretion.

8.3.2 Proof of Income on Claim

You have 90 (ninety) Days from the Claim Event Date to prove the Life Insured's Income (Pre-Claim Income) over the last 12 (twelve) months before disability.

- Should You not correctly disclose the Life Insured's Income to Us at application stage or when You have affected changes to Your Policy, the Administrator reserves the right to recoup any Benefit overpayments as well as terminate the Benefit with no further Benefit payouts.
- If the Life Insured has no Income at the time of the condition giving rise to the Claim and the Life Insured is not on a Sabbatical, You will not be able to Claim as there is no loss of Income due to the condition (for example if the Life Insured has been retrenched or if the Life Insured has resigned from Their Nominated Occupation or if They are in prison).
- Any Claim made within 12 (twelve) months of returning to work following a period of retrenchment will exclude the period of retrenchment for the purposes of calculating the Life Insured's Pre-Claim Income.
- Please note that Claim payouts will be made during this 90 (ninety) Days period (where applicable).
    - If the Benefit Amount is reduced after receiving such proof, the Administrator/Insurer reserves the right to recoup any previous overpayments.

It is in Your and the Life Insured's (if different) interest to make sure all details are up to date (and redo the Dynamic Financial Needs Analysis where the DFNA is selected) each year before Policy Anniversary to make sure the Life Insured remains fully insured.

- This will assist in preventing the Life Insured from becoming over or under-insured.
- Note that only Income received from the Life Insured's Nominated Occupation will be covered by this Benefit. Please see section 8.1 and 8.2 for more details.
- The Administrator/Insurer assume no liability if You do not update Your or the Life Insured's details and cover is not in line with the Life Insured's current needs.

Please note that all the above the terms, conditions, rules, calculations and formulas in section 8.3.2 (for example, but not limited to, the definition of Pre-Claim Income, the period over which it is determined, the period to prove Income and the methods of calculation) will be reviewed from time to time and may be amended by the Insurer and/or Administrator from time to time, at either's sole discretion.

8.3.3 Waiting Period

The Waiting Period is the period for which the Life Insured will need to be continuously disabled (and for scenarios where the Claim is assessed against Their occupation, unable to perform Their Nominated Occupation) due to injury or illness in the opinion of the Administrator/Insurer after

the Date of Disability before You can start claiming for a Temporary or Permanent Disability Claim.

Both the Temporary Income Protection Benefit and Permanent Income Protection Benefit will have the same Waiting Period from the Date of Disability.

Each month, the payout for the time that the Life Insured satisfies the relevant Claims criteria in that month will be made at the end of that relevant month, after proof of loss of Income is received from You, where relevant.

No Benefit payout will be made for Temporary or Permanent Income Protection Benefit Claims during the Waiting Period and only once the Waiting Period has ended will the Benefit payments commence. Please note that no retrospective payments will be made in relation to the Waiting Period. In other words, the Claim payouts only commence after the expiration of the Waiting Period and will only be paid in respect of the period after the Waiting Period expires.

Please note that the usual Annual Benefit Increases will be applied to the Temporary and Permanent Income Protection Benefit Sum Assureds if Your Policy Anniversary either comes before the end of the Waiting Period or coincides with it (but also which is after the Date of Disability). No other Policy changes will be allowed in the time period from the Date of Disability until the end of the Waiting Period or until permanence is established, whichever comes later.

Note that only full Days which the Life Insured satisfies the Claims criteria contribute towards the Waiting Period.

If the Life Insured recovers or is rehabilitated and Claims again for the same cause which resulted in Their original inability to perform Their Nominated Occupation within 3 (three) months of recovery, the Waiting Period will be waived for the subsequent Claim. This is known as the Off-Period. Please note that no Temporary or Permanent Income Protection Benefit payouts will be made in the period between the date of recovery and the new Benefit Claim Event Date.

Example

Example Details:

- You take out a Dis-Chem Life policy with the Income Protection Benefit.
- You are both the Policyholder and Life Insured on the Policy.
- Unfortunately, You become disabled and start losing more than 25% (twenty-five percent) of Your Income from Your Nominated Occupation.
- After the 3 (three) months Waiting Period, You begin to receive monthly Benefit payouts from the Temporary Income Protection Benefit.
- 6 (six) months later You recover, Your monthly Benefit payouts have stopped, and You go back to work.

- 2 (two) months after Your recovery, You become disabled again (due to the same illness or injury) for a second time and again begin to lose more than 25% (twenty-five percent) of Your Income.

In this scenario, You will not have to go through a further 3 (three) months Waiting Period again and will start to receive monthly Benefit payouts immediately from the date of the new valid Claim Event.

Please note that Premiums are payable during the Waiting Period. If a client does not pay the Temporary and Permanent Income Protection Benefit Premiums during the Waiting Period, then the Temporary and Permanent Income Protection Benefits will fall away.

Please note that if the Life Insured dies within the relevant Waiting Period, no Income Protection Benefit will be paid. To remove any doubt, if the Life Insured dies during the Temporary Income Protection Benefit Waiting Period, then no Temporary Income Protection Benefit will be paid If the Life Insured dies during the Permanent Income Protection Benefit Waiting Period, then no Permanent Income Protection Benefit will be paid.

8.3.4 In-Claim Escalation

The In-Claim Escalation Factor is the percentage that the Temporary and Permanent Income Protection Benefits will increase by each year, at Your Claim Anniversary.

Please note there are 2 (two) claim escalation options, namely the:

- CPI option
- Occupational In-Claim Escalation Option, which has 3 (three) categories:
  - Core Option
  - Standard Option
  - Executive Option

  These all apply an increase of CPI plus a certain factor to take into account the Claimant's age as well as expected future occupational increases relating to their specific occupation. The category within the Occupational In-Claim Escalation Option will be automatically applied to Your Policy based on the Life Insured's Nominated Occupation.

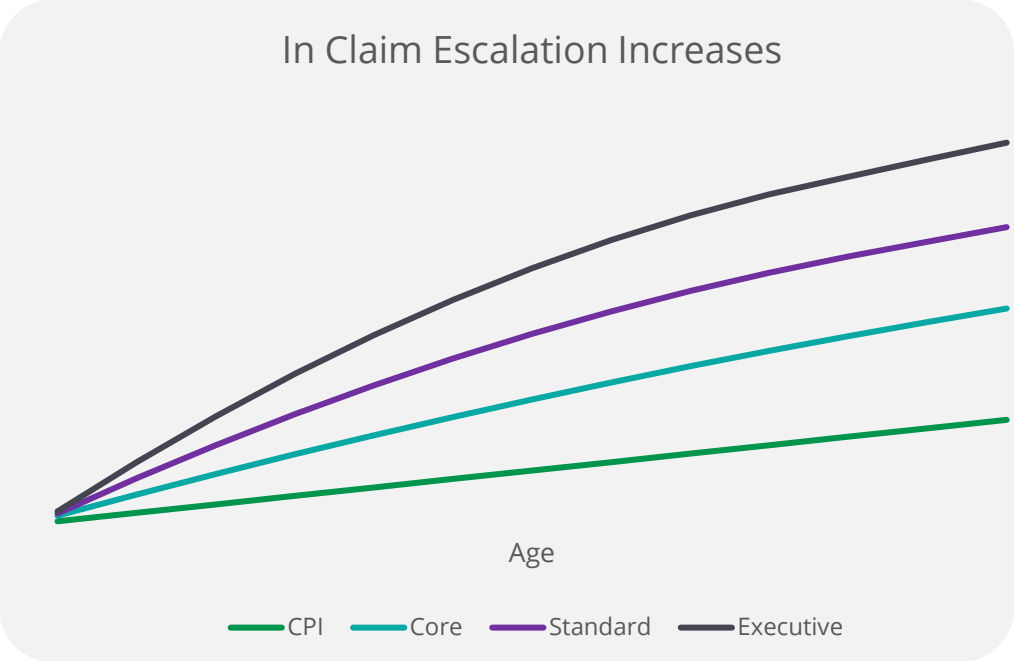
Please refer to Your Policy Schedule to see which option has been selected on Your Policy, as well as the relevant category that the Life Insured falls under (for the DFNA option).

Depending on the option selected, each year on the Claim Anniversary Date, the Temporary and Permanent Income Protection Benefit Sum Assureds will increase by a specified factor. The specified factor will be based on the following factors:

- CPI
- The Life Insured's Nominated Occupation (for the DFNA option)

- The Life Insured's age each year in claim (for the DFNA Option)

The In-Claim Escalation increase option look as follows:



CPI used in the above calculation will be subject to an overall maximum percentage of 10% (ten percent). Please note that these maximums will be reviewed annually by Administrator and may be amended by the Administrator, at its sole discretion.

These In-Claim Escalation increases will be applied each Claim Anniversary after each 12 (twelve) full calendar months period of Benefit payments. The Administrator will use the CPI figure as released by Statistics South Africa 3 (three) months before the Claim Anniversary.

Example 1

Example Details

- You take out a Dis-Chem Life Policy on 1 August 2020.
- You are the Policyholder and Life Insured on the Policy.
- You take out cover of R50 000 on the Income Protection Benefit (meaning You have R50 000 coverage under the Temporary Income Protection Benefit and R50 000 coverage under the Permanent Income Protection Benefit)
- You have the Core Occupational In-Claim Escalation Option on Your Policy.
- Unfortunately, later in that year, You become Permanently Disabled.
- CPI is assumed to be 5% (five percent) for each year.

Assume the CPI and Occupational In-Claim Escalation Percentages are as follows:

Age	CPI	Core increases (in addition to CPI)	Total Increase
25	5%	5.25%	**10.25%**
26	5%	5.00%	**10.00%**
27	5%	4.75%	**9.75%**
28	5%	4.50%	**9.50%**
29	5%	4.25%	**9.25%**
30	5%	3.80%	**8.80%**

The Claim payout made to You will be under the Permanent Income Protection Benefit and will be as follows:

Age	Year since Disability Claim Event Date	Total Increase	Monthly Permanent Income Protection Benefit	Calculation
25	0	10.25%	R50 000.00	
26	1	10.00%	R55 000.00	R50 000 x (1 + 10.00%)
27	2	9.75%	R60 362.50	R55 000 x (1 + 9.75%)
28	3	9.50%	R66 096.94	R60 362.50 x (1 + 9.50%)
29	4	9.25%	R72 210.90	R66 096.94 x (1 + 9.25%)
30	5	8.80%	R78 565.46	R72 210.90 x (1 + 8.80%)

Example 2

Example Details

- You take out a Dis-Chem Life Policy on 1 August 2020.
- You are both the Policyholder and Life Insured on the Policy.
- You take out cover of R50 000 on the Income Protection Benefit (meaning You have R50 000 coverage under the Temporary Income Protection Benefit and R50 000 coverage under the Permanent Income Protection Benefit)
- You select the CPI In-Claim Escalation Option.
- Unfortunately, later in that year, You become Permanently Disabled.
- CPI is assumed to be 5% (five percent) for each year.

The Claim payout made to You will be under the Permanent Income Protection Benefit and will be as follows:

Age	Year since Disability Claim Event Date	CPI	Monthly Permanent Income Protection Benefit	Calculation

25	0	5%	R50 000.00	
26	1	5%	R52 500.00	R50 000 x (1 + 5.00%)
27	2	5%	R55 125.00	R52 500.00 x (1 + 5.00%)
28	3	5%	R57 881.25	R55 125.00 x (1 + 5.00%)
29	4	5%	R60 775.31	R57 881.25 x (1 + 5.00%)
30	5	5%	R63 814.08	R60 775.31 x (1 + 5.00%)

Please note that if the Life Insured recovers and the payments cease, the Temporary and Permanent Income Protection Benefit Sum Assureds will change back to the amounts that would have applied if no Claim had been submitted. In other words, Your Benefit Amounts will revert to the Benefit Amount that applied at the start of the Claim payments, increased by any applicable Annual Benefit Increases for the duration that You were receiving payments.

Please note that the In-Claim Escalation factors described in this section will also be used to increase the Life Insured's Pre-Claim Income amount (Section 8.3.2).

Please note that all rules, terms, conditions , formulas, calculations and workings described in section 8.3.4 will be revised, from time to time, and may be amended at the Administrator's/Insurer's sole discretion.

8.3.5 Taxation

The Benefit payments under the Income Protection Benefit (both the Temporary and Permanent Income Protection Benefits) will not be subject to tax. Additionally, the Premiums for the Temporary and Permanent Income Protection Benefits are not tax-deductible.

The Administrator/Insurer reserves the right, at its sole discretion, to adjust the Benefits and/or Premiums applicable to Your Temporary and Permanent Income Protection Benefits in the event of a change to the tax laws applicable to these Benefits.

8.3.6 Claim terminations and Exclusions

Payment of any Temporary Income Protection Benefits and Permanent Income Protection Benefits will be terminated in the following circumstances:

- If the Life Insured unreasonably refuses to undergo or is not complying with recommended medical treatment or rehabilitation to reduce the extent of Their disability, impairment or illness.
    - Recommended medical treatment will be as defined by the Life Insured's treating Specialist to the satisfaction of the Administrator/Insurer.
    - This includes the Life Insured failing or refusing to manage Their lifestyle or chronic (medical) condition with appropriate and reasonable

recommendations and treatment protocols from Their treating medical Specialist.
    - Please note that Benefit payments will cease on the occurrence of the Life Insured being deemed rehabilitated by the Administrator/Insurer.
- If You fail to provide the Administrator/Insurer with satisfactory proof of the Life Insured's disability within 30 (thirty) Days of being requested to do so, and if You fail to submit to a physical examination and tests required at the Administrator/Insurer's request and expense.
    - If You cannot provide this proof, the payment of Benefits will terminate.
- If the Life Insured is not performing Their Nominated Occupation for 3 (three) consecutive months before the Claim Event Date.
    - Note that this requirement does not apply if the Life Insured is on Sabbatical.
- If You fail to inform the Administrator/Insurer of a change in the Life Insured's occupation, We reserve the right to terminate the Temporary and Permanent Income Protection Benefits if the Life Insured's new occupation would not normally be covered by Your Policy.
- Both the Temporary and Permanent Income Protection Benefit payments will end immediately when the Life Insured begins earning an income that is equal to or more than the Life Insured's Pre-Claim Income level, notwithstanding Their injury or illness, except for specified scenarios as defined in section 8.3.7.
- If there has been a material change in the Life Insured's health or income that affects the continuation or validity of the Claim, We reserve the right to terminate Your Temporary and Permanent Income Protection Benefits payments immediately.
- If You fail to provide satisfactory evidence of the Life Insured's continued incapacity and/or loss of Income when requested to do so by the Administrator/Insurer from time to time.
- On termination of Your Policy, by the Administrator or by You, for any reason whatsoever.
- Benefit payments will cease on the date, as decided by the Administrator/Insurer, on which the Life Insured no longer suffers a reduction in Income that is solely attributable to the injury, illness, disease or surgical operation that gave rise to the Claim.
- If You refuse to submit to any physical examinations or tests required by the Administrator/Insurer to assess the continuation of an admitted Claim.
- Please note that Claims resulting in loss of access to gainful employment for reasons unrelated to the Life Insured's medical condition or disability will not be taken into consideration for any Claim payouts whatsoever, for example, retrenchment or redundancy. These will not be covered under the Temporary or Permanent Income Protection Benefits.
- If the Life Insured is claiming under the Income Protection Benefit and the Life Insured recovers sufficiently to return to work (in the opinion of the Administrator/Insurer). If the Life Insured returns in a reduced capacity, We will aggregate Benefit payouts against the percentage of the material and substantial

duties that the Life Insured can perform of Their Nominated Occupation (in the opinion of the Administrator /Insurer).

- **For Temporary Income Protection Benefit Claims only**: If the Life Insured is claiming under the Loss of Income Claims Criteria and the Life Insured recovers sufficiently to return to work (in the opinion of the Administrator/Insurer). If the Life Insured returns in a reduced capacity, We will aggregate the payout against the income the Life Insured earns (Please see section 8.3.7 for further details).
- **For Permanent Income Protection Benefit Claims only**: If the Life Insured is claiming under the Permanent Disability Claims Criteria and the Life Insured recovers sufficiently to return to work (in the opinion of the Administrator/Insurer). If the Life Insured returns in a reduced capacity, We will aggregate the payout against the income the Life Insured earns (Please see section 8.3.7 for further details).

The Administrator/Insurer also reserves the right, at its sole discretion, to refuse Claims for the Temporary and Permanent Income Protection Benefits (from the outset of a submitted Claim) when the Claim is a result of any of the following:

- Treatment/rehabilitation for alcohol or narcotic abuse;
- All cosmetic procedures (however reconstructive surgical procedures where a medical condition is present will be covered);
- Organ donation;
- Routine pregnancy, including maternity leave (complications of pregnancy will be covered provided they are confirmed by the Life Insured's treating gynaecologist).
    - The first 30 (thirty) Days after the birth of a baby will be regarded as maternity leave regardless of the Waiting Period on the Policy.

Please note that the above lists (all rules, terms and conditions as contained in section 8.3.6) will be reviewed from time to time and may be amended by the Insurer and/or Administrator from time to time, at either's sole discretion.

The above Exclusions apply in addition to the terms and conditions stated in Section 14.2.

8.3.7 Aggregation

Below are some scenarios when both the Temporary Income Protection and Permanent Income Protection Benefits Claim payouts may be different, owing to scenarios where aggregation takes place against income earned and other income protection policies. These are as follows:

8.3.7.1 Claim Amount when aggregating against income earned

You may not receive more than 100% (one hundred percent) of the Life Insured's Pre-Claim Income (or Your Sum Assured, whichever is less) when taking into account the Benefit Amount that the Administrator pays out to You plus income earned, whilst in claim.

In order to assist the Life Insured in returning to work and getting the treatment They require, for the first 6 (six) months post Claim Event, the Administrator encourages clients to go back to work and allows them to earn in excess of 100% (one hundred percent) of their Pre-Claim Income or Claim Amount (whichever is lower at Claims stage). This will be for Claims under the Occupational Claims Criteria only (a subset of the Permanent Disability Claims Criteria).

These months are the total period since the Claim Event Date. This means the period for the actual payout is the number of months specified below minus the Waiting Period duration. So, 6 (six) months in the table below with a 1 (one) month Waiting Period means 5 (five) months of payments.

The Insurer will only ever pay out a maximum of 100% (one hundred percent) of the Life Insured's Pre-Claim Income or Claim Amount (whichever is lower at Claims stage) in all cases, that is, the Insurer will never pay more than 100% (one hundred percent) of the amount defined in sections 8.1.4 and 8.2.4 above.

The Administrator will aggregate the Claim amount against income earned for all Claims assessed under both the Temporary and Permanent Disability Claims criteria. Income will be aggregated in all scenarios, irrespective of whether the Life Insured is working in Their Nominated Occupation or any other occupation (or job) during Claim.

The payment calculation by the Administrator is as follows:

Adjusted Claim Amount for Income Earned = Min {(Claim Amount / (income earned whilst in claim + Claim Amount)) x Maximum Percentage Amount x Claim Amount, Claim Amount}

Claim Amount is the Temporary or Permanent Income Protection Benefit claim amount defined in sections 8.1.4 and 8.2.4 above.

The Maximum Percentage Amount is as follows (from the Claim Event Date):

Benefit being Claimed on	First 3 months (1-3 months)	3 - 6 months	More than 6 months
Temporary	100%	100%	100%
Permanent (Disability Objective Medical Criteria)	100%	100%	100%
Permanent (Occupational Claims Criteria)	130%	130%	100%

Please note that the above Maximum Percentage Amount will be reviewed from time to time by the Administrator/ and or Insurer and may be amended, at either's sole discretion.

The Administrator will not reduce the Benefit payments as a result of the following earnings (these are passive earnings):

- Interest;
- Rent;

- Dividends;
    - However, dividends payable by a private company/close corporation of which the Life Insured is the owner and in terms of which They actively participate (after the Life Insured's disability) in the management of the company will be included.
- Earnings generated before disability but only received after disability.

You must notify the Administrator/Insurer if the Life Insured starts earning an income while a Claim is in payment. Should the Administrator/Insurer determine that We were not notified of this while a Claim was in payment, the Administrator/Insurer may recover any amount that was paid in excess of the amount that would have been paid if You had notified Us that the Life Insured was earning an income.

8.3.7.2 Claim Amount when receiving other income protection benefits

If You or Life Insured receives disability income or sickness benefits from other policies (either from the Administrator or any other insurers) and these benefits together with Your Claim amount (as defined in sections 8.1.4 and 8.2.4) exceed 100% (one hundred percent) of the Life Insured's Pre-Claim Income, the payment made to You will be adjusted proportionately. The formula to calculate the adjusted payment is as follows:

Adjusted Claim Amount for other Benefits = Min {[(Claim Amount) / (Claim Amount + benefit amounts from other disability income or sickness Benefits)] x 100% of the Pre-Claim Income, Claim Amount}

Claim Amount is the Temporary or Permanent Income Protection Benefit Claim amount defined in sections 8.1.4 and 8.2.4.

This adjustment will apply up to the end of the Temporary and Permanent Income Protection payment periods (as described in section 8).

8.3.8 Re-assessment of Claims

Under the Temporary Income Protection Benefit, reassessments of the Life Insured's ability (or inability) to perform Their Nominated Occupation are allowed at any time, at the Administrator or Insurer's sole discretion. This will be performed on a case-by-case basis.

Under the Permanent Income Protection Benefit, reassessments of the Life Insured's ability (or inability) to perform Their Nominated Occupation are also allowed at any time, at the Administrator or Insurer's sole discretion. This will be performed on a case-by-case basis.

8.3.9 Scenarios when the Life Insured travels, moves or lives outside of South Africa whilst in claim

If the Life Insured travels or moves outside South Africa while a Claim is in payment, and We require proof that the Life Insured is still disabled and still have a loss of Income (where relevant), We will require the medical and financial proof issued in a foreign country to be in English.

- You will be primarily responsible for the cost of medical proof. We will refund You in South African currency for an amount equal to what We usually pay for such medical proof in South Africa.
- You will be responsible for the cost of financial proof of loss of Income, where required.
- The amount paid will always be in the local currency of South Africa.

We will make Benefit payments for disability and loss of Income in a foreign country for a maximum period of 12 (twelve) months.

- Thereafter, We will consider the continuation of Benefit payments only after the Life Insured has been medically assessed by a doctor nominated by Us, which may require the Life Insured to travel back to South Africa for such an assessment.
- We will only cover the cost of the assessment.
- We will not cover any other costs associated, that is, costs for travel, accommodation, food and so on will not be covered.
- The Administrator/Insurer also reserves the right, from time to time and at their sole discretion, to call for continuous assessments, if so required.

Please note that when calculating the Pre-Claim Income at Claims stage, We will use the average exchange spot rate between the Life Insured's country of residence and South Africa, for the last 12 (twelve) months or any other period as required by the Insurer as per the Pre-Claim Income definition in section 1.2.

Please note that the above rules as specified throughout section 8.3 will be reviewed from time to time and may be amended by the Insurer and/or Administrator from time to time, at either's sole discretion.

9. Standalone Temporary Income Protection Benefit

9.1.1 What is the purpose of the Benefit?

The Standalone Temporary Income Protection Benefit pays out a regular income should the Life Insured experience an illness, disease, impairment or injury preventing the Life Insured from working and earning an Income upon becoming Temporarily Disabled and where the Life Insured is unable to perform Their own Nominated Occupation. This Benefit is used to replace lost Income when the Life Insured cannot work and cannot earn an Income as a result of a Temporary Disability.

The Benefit is designed to complement the Disability Cover Benefit, which pays out a lump sum on Permanent Disability. Please see section 7 for further details.

9.1.2 Overview

This Benefit may be selected instead of the Income Protection Benefit. A Policyholder cannot select both the Income Protection Benefit and the Standalone Temporary Income Protection Benefit on the same Policy.

The Standalone Temporary Income Protection Benefit may also only be selected if You also select the Disability Cover Benefit on the Policy.

All rules, terms, conditions and Benefit workings relating to the Temporary Income Protection Benefit, as described in section 8.1 and 8.3 will apply to the Standalone Temporary Income Protection Benefit.

10. Accidental Benefits

The following Benefits provide cover for Accidental Claims only.

10.1 THE ACCIDENT LIFE COVER BENEFIT

10.1.1 What is the purpose of the Benefit?

The Benefit will provide Life Cover for Accidental Deaths. These are deaths that are due to Accidents and will exclude all Natural Deaths Claims and self-inflicted Claims.

10.1.2 How does it work?

The Accidental Life Cover Benefit will have all the same rules applying to it as the Life Cover Benefit, as defined in section 5. The only difference is that only Accidental Deaths are protected under the Accidental Life Cover Benefit and no Natural Deaths will be covered.

10.1.3 Things to note

Please note that:

- The Life Insured cannot have both the Life Cover Benefit and the Accidental Life Cover Benefit on the same Policy.
- The life Insured cannot select the Recurring Payment option on the Accidental Life Benefit.

10.2 THE ACCIDENT DISABILITY COVER BENEFIT

10.2.1 What is the purpose of the Benefit?

The Benefit will provide Disability Cover for Accidental Disability Claim Events. These are disabilities sustained that are due to Accidents and will exclude all Natural Disabilities and self-inflicted Claims.

10.2.2 How does it work?

The Accidental Disability Cover Benefit will have all the same rules applying to it as the Disability Cover Benefit, as defined in section 7. The only differences between the 2 (two) Benefits are as follows:

- Only Accidental Disabilities are protected under the Accidental Disability Cover Benefit and no Natural Disabilities will be covered under this Benefit.
- The Benefit is a non-accelerated Benefit, meaning that it will not reduce the Accidental Lifer Cover Benefit Sum Assured on a valid Claim.
- There is a 3 (three) months Survival and Waiting Period from the Claim Event Date for the Accidental Disability Benefit, and the disability must have endured continuously throughout the Waiting Period.
- Only Accidental Disability Claim Events under the Disability Objective Medical Criteria will be covered on this Benefit. No Claims will be assessed, considered or covered under the Occupational Claims Criteria under this Benefit.
    - To remove any doubt, there will be no cover for any sickness, disease or any naturally occurring condition or degenerative process under this Benefit.
    - Self-inflicted injuries are also excluded.

10.2.3 Things to note

Please note that:

- The Life Insured cannot have both the Disability Cover Benefit and the Accidental Disability Cover Benefit on the same Policy.

10.3 RULES FOR BOTH THE ACCIDENTAL LIFE AND ACCIDENTAL DISABILITY BENEFIT

Accident Cover will be offered in circumstances where the Life Insured's does not qualify for the full Benefits under section 5 and 7.

Depending on the scenario, You may be able to unlock the full cover (including all natural Claim Events) if the Life Insured undergoes additional medical underwriting. Please refer to Your Schedule or contact the Administrator for more details.

The Accidental Life and Disability Accidental Benefits exclude any Claims from the Life Insured as a result of:

- The Life Insured being under the influence of alcohol, drugs or narcotics, unless a registered Medical Practitioner has prescribed the drugs or narcotics. The Life Insured and their Dependants may not perform the role of registered Medical Practitioner.
- Participating in any type of aviation or airborne pursuit, except as a passenger travelling in, or a pilot piloting a registered passenger aircraft that is owned and operated by a licensed airline or air-

transport company, or in a military passenger aircraft. The aircraft must be flown on a recognised route between licensed airfields, and the pilot must hold a current commercial pilot's license.

- Participating in hazardous pursuits.
- All other Exclusions as described in section 14.2.

11. Chronic Care Plan

11.1 WHAT IS THE PURPOSE OF THE PLAN?

Dis-Chem Life is revolutionising life insurance for individuals with chronic conditions through the groundbreaking Chronic Care Plan. Designed for those managing specific chronic illnesses, this plan offers an unprecedented opportunity to access comprehensive, affordable life insurance. At the core of the Chronic Care Plan is the belief that when individuals actively manage their health, they significantly reduce their risk - transforming how life insurance works for them.

With dynamic underwriting, the Life Insured pays a Premium that truly reflect Their personal risk profile, receiving discounted rates upfront as a reward for proactively managing Their condition. This is not just life insurance; it's life-changing insurance.

With this pioneering product, Dis-Chem Life empowers individuals to take control of their health while securing vital life cover—creating a future where their proactive efforts directly translate into premium savings and peace of mind.

The Chronic Care Plan has the following enhancements:

- A Life Insured with one or more qualifying chronic conditions will obtain cover at reduced rates upfront.
- Annual underwriting will allow the Life Insured to improve Their risk rating by effectively managing Their health over time. Their Sum Assured may be adjusted over the Policy term, based on their risk level at the time of Their annual underwriting.

11.2 BENEFIT WORKINGS

11.2.1 Eligibility

The Chronic Care Plan will be offered for the following qualifying conditions:

- Hypertension
- Hypercholesterolemia
- Diabetes
- HIV
- Asthma

Please note that the above list will be reviewed and may be amended by the Administrator and/or Insurer from time to time, at either's sole discretion.

To qualify for the Chronic Care Plan, the following criteria must be met:

- One of the 5 (five) Chronic Care Plan conditions (mentioned above) are disclosed or identified during the Life Insured's underwriting process; and
- The Life Insured receives a loading on at least 1 (one) of the Benefits on their Policy.

Policy Benefits for individuals who qualify for the Chronic Care Plan will follow the same terms, conditions, rules, Exclusions, Waiting Periods, Survival Periods, Annual Premium Increases, Annual Benefit Increases and general Benefit workings (as described throughout this Policy Guide) for each specific Benefit, unless specified otherwise.

Exceptions to above are as follows:

- The Education Legacy Protector, Accidental Life Cover and Accidental Disability Cover Benefits will not be included on the Chronic Care Plan.
    - This means that no premium discounts will be given on these Benefits and they will work as per the normal Benefits, defined throughout this Policy Guide.
- There also will not be any conversion of cover to Critical Illness for Life Cover, Income Protection and Disability Cover Benefits.
- Critical Illness and Disability Cover will be accelerated Benefits on the Policy.

Additionally, the Life Insured will only qualify for the Chronic Care Plan if the Life Insured:

- Moves, and then continues to refill, their chronic medication script at a Dis-Chem Pharmacy.
    - This is done to ensure that Dis-Chem Life can accurately monitor and help manage the Life Insured's condition.
- Use Dis-Chem pharmacies to do their annual HealthChecks.

If the Life Insured does not satisfy the above two criteria at any point in the Policy term, then the Life Insured will be classified as the lowest Chronic Care Plan classification (Chronic Care Plan Level 1) until they resume the two above qualifying criteria.

11.2.2 Upfront Chronic Care Classification

Based on the results of the Life Insured's underwriting at Commencement Date, the Life Insured will receive an upfront discount on Their Premium. The discount received reflects the specific chronic condition(s) that the Life Insured has, as well as how well They are managing the condition(s).

The discount received will be based on the Chronic Care Health Level attained by the Life Insured. The Chronic Care Health Levels will be based on the outcomes of Their HealthChecks, as well as the Life Insured's chronic script adherence score, which is a score that looks at the script usage and adherence of the Life Insured. Please refer to the General Benefit Limit Document for more details on the health metrics as well as the script adherence scores.

Please refer to the Schedule to see what discount has been applied, as well as what Chronic Care Health Level the Life Insured qualifies for. Additionally, the General Benefit Limits Document details the workings of the Chronic Care Health Levels.

11.2.3 Ongoing Reviews

At each future date where the Life Insured goes for their HealthChecks, the Life Insured's Sum Assured will be adjusted based on the outcome of their new health metrics. The adjustment factor is called the Chronic Care Benefit Adjustment and will be applied to the Sum Assured at the next Policy Anniversary following the relevant HealthCheck.

The Chronic Care Benefit Adjustments will be multiplied by the Benefit Sum Assured to give the new Sum Assured once the Life Insured has completed the new HealthChecks.

The calculation of the new adjusted Sum Assured is as follows:

Adjusted Sum Assured = Sum Assured x Chronic Care Benefit Adjustment

The Life Insured would be classified at a certain Chronic Care Health Level for the first 12 (twelve) months ,that is, the validity period for the first tests from Commencement Date would be 12 (twelve) months. Each set of HealthChecks thereafter will be valid for 12 (twelve) months from the date of the new tests.

The Chronic Care Plan offers the Life Insured reduced Premiums upfront. These Sum Assured terms will be reviewed at the first Policy Anniversary. One set of HealthChecks will be funded per calendar year. Thereafter, the Life Insured can go for an additional review anytime in a calendar year, but Life Insured will need to fund the cost of these tests.

At the first Policy Anniversary, the Life Insured will be placed in Chronic Care Health Level 1 (one) to 5 (five). The Benefit Sums Assured on the Policy will be adjusted based on the Life Insured's Chronic Care Health Level.

Thereafter the assessment will be required annually. Each test will be valid for a 12 (twelve) months period. The Administrator will use the latest tests results on record to determine the Chronic Care Benefit Adjustment. After the 12 (twelve) month validity period, the Life Insured will revert back to Level 1 above (if no new HealthChecks have been performed).

The Chronic Care Benefit Adjustment will be applied to the full Sum Assured, including all initial Benefit Amounts at the Benefit inception dates, as well as any elective increases in cover.

The Life Insured will be required to go for 1 (one) test per calendar year. The Administrator will always use the latest tests results on record for assessment.

Example 1:

- The Policyholder is the Life Insured on the Policy
- The Life Insured has the following characteristics:
    - Age: 45
    - Chronic Conditions: Hypertension and Diabetes
    - Commencement Date: 1 January 2025
    - Life Cover: R1 000 000

Upfront Chronic Care Health Level Classification

- Health metrics at Commencement Date:
    - Blood Pressure: Relatively high.
    - Blood Sugar: Slightly above recommended range.
    - Chronic Script Score: 100% (refills consistently at Dis-Chem).
- Chronic Care Health Level: **Level 2** (based on metrics and script score).
- Upfront Premium Discount: 15%.
    - Adjusted Premium: R1 020 (R1 200 x (1 - 15%)).

First Annual Review (1 January 2026)

- Based on the Life Insured's current health metrics, the Chronic Care Matrix that applies to Them is as follows:

Chronic Care Health Level	Chronic Care Benefit Adjustment
5	200%
4	150%
3	120%
2	100%
1	75%

- The Life Insured diligently continues to refill Their prescriptions at Dis-Chem and undergoes an annual HealthCheck at the pharmacy in December 2025.
- Updated health metrics:
    - Blood Pressure: Excellent
    - Blood Sugar: Improved to be perfect.
    - Chronic Script Score: 100%.
- New Chronic Care Health Level: **Level 5**
- Chronic Care Benefit Adjustment: 200%.

New Adjusted Sum Assured:
Adjusted Sum Assured= R2 000 000 = (R1 000 000 x 200%)

- The Life Insured's Sum Assured increases to R2 000 000 without increasing the Premium.

Example 2

Details:

- A Life Insured takes out a Dis-Chem Life Policy and qualifies for the Chronic Care Plan.
- The Life Insured is also the Policyholder on the Policy.
- Dis-Chem Life covers the cost of the initial tests during underwriting.
- The cost of the first HealthCheck is also funded.
- The Life Insured has R1 000 000 Life Cover
- The Policy premium is R1 000.
- The Life Insured receives a 50% (fifty percent) discount on their Premium.
    - The market Premium in this example will be R2 000.
- Ignore Annual Premium Increases and Annual Benefit Increases
- The Life Insured undergoes medicals and will start on **Level 3** from the Policy Commencement Date and qualifies for a 50% Premium discount.
- The Life Insured qualifies for the following Chronic Care Benefit Adjustments

Chronic Care Health Level	Chronic Care Benefit Adjustment
5	125%
4	115%
3	100%
2	75%
1	50%

- The Life Insured qualifies for R1 000 000 Life Cover for a Premium of R1 000 (R2 000 x (1 - 50%)).

Months 1 (one) to Month 12 (twelve):

In month 12 (twelve), the Life Insured goes for Their HealthChecks.

The Life Insured manages Their health to a certain degree, is adherent on Their scripts and thus will continue to be classified as Chronic Care Health **Level 3**. This means they will continue to enjoy cover of R1 000 000 (R1 000 000 x 100%), for a R1 000 Premium.

The Life Insured will remain at Level 3 until the next Policy Anniversary.

Month 13 (thirteen) to Month 24 (twenty-four):

From month 13 (thirteen) through to month 24 (twenty-four), the Life Insured's current health metrics remain valid and thus stays at **Level 3**.

The Life Insured will be required to take a test before the end of the 24th (twenty fourth) month to retain Their preferential rates.

At month 23 (twenty-three), the Life Insured goes to Dis-Chem to have their HealthChecks done. They have not been as adherent as of late and their health metrics have deteriorated slightly. They

are now on a **Level 2** and their Sum Assured adjusts to R750 000 (R1 000 000 x 75%), for a Premium of R1 000.

11.2.4 Buying Back lost cover

The Policyholder may apply to buy back cover on each Policy Anniversary to the value of any loss in cover from to the Chronic Care Benefit Adjustments that decreased the Cover Amount over the previous year. If the Policyholder chooses not to take up this option within 6 (six) months of the Policy Anniversary, they will forfeit the option. This cover can be repurchased at the correct loaded rates (from the new ones given at the latest Policy Anniversary), provided the Insurer would have offered cover to the Life Insured after their latest HealthChecks. If the Insurer would not have offered cover based on the outcomes of the HealthChecks, the option to buy back cover will not be available.

- The buy back is subject to the following conditions:
    - This option is only available if the Benefit inception of the cover is before the Life Insured's 55th birthday.
    - You may buy back the full cover adjustment within 6 (six) months of the Chronic Care Benefit Adjustment being applied.
    - If You don't use this option to buy back the full Chronic Care Benefit Adjustment within 6 (six) months of the Chronic Care Benefit Adjustment being applied, it may be used to buy back 50% of the Chronic Care Benefit Adjustments in the following 6 (six) months after the adjustment has been applied.
    - If a full 12 (twelve) month period passes without the Policyholder buying back any lost cover as described above, the right to exercise this option at any future time (in respect of any year's Chronic Care Benefit Adjustment) is forfeited.

If there is a Claim on the Critical Illness Benefit, the Disability Benefit or the Permanent Income Protection Benefit, future options to increase the Life Insured's cover will apply only to the Life Cover and not the other Benefits on the Policy.

Options to increase the Disability Benefit or Permanent Disability Benefit will not be granted should a Claim under the Income Protection Benefit have been made within three years of the option date.

11.3 THINGS TO NOTE

Please note that:

- Once a Life Insured has entered onto the Chronic Care Plan, they cannot opt out or go off the Chronic Care Plan voluntarily.
    - However, if the Life Insured manages Their health and meets the metrics to qualify for standard cover for two consecutive periods, then They may move off Chronic Care Plan, at Their own discretion, and receive normal cover.
- If a Life Insured does not qualify for the Chronic Care Plan at the Commencement Date, then they will not be allowed to enter into it at a later date.

- On reinstatement (the reinstatement period here is defined as a period of 12 (twelve) months from the date of the Policy being terminated), the reinstated policy will have the same terms, conditions and workings as per the current Policy. For all periods thereafter, no upfront Premium discounts will be given and the Life Insured will fall under the standard Benefit structure.
- The Life Insured's Chronic Care Matrix may change over the Policy term, depending if Their chronic conditions change. Please refer to Your Schedule for more details on the Chronic Care Matrix for this Policy.
- If a Life Insured increases their Benefit Sum Assured on their Policy after Commencement Date, the same Premium discounts and Chronic Care Benefit Adjustment will apply to those tranches.
- All rules, terms, conditions, calculations and benefit formulas and benefit workings stated throughout section 11 above will be reviewed from time to time by the Administrator/Insurer and may be changed or amended, from time to time, at the Administrator/Insurer's sole discretion.

12. Education Legacy Protector

12.1 WHAT IS THE PURPOSE OF THE BENEFIT?

The Education Legacy Protector Benefit is designed to safeguard a Child's access to quality education from crèche through to the completion of university. In the event of a Life Changing Event affecting the Life Insured, this Benefit ensures that educational expenses are covered, relieving the financial burden on the Insured Life.

The payments provided under this Benefit are specifically intended to maintain the Child's education without disruption, ensuring that they can continue to receive the high-quality learning they deserve, regardless of the Life Insured's ability to pay. This empowers families to secure their children's future, giving them access to the opportunities that education provides, even in challenging times.

12.2 BENEFIT WORKINGS

The Education Legacy Protector provides indemnity cover for the education of an Insured Life's Child in the event of a Claim Event.

The Benefit will cover the official compulsory school or tertiary tuition fees charged by the educational institution that the Life Insured's Child attends, subject to maximum benefit limits set by the Administrator. The maximum amounts covered per stage of education for each Benefit option can be found in the General Benefit Limits Document.

The Education Legacy Protector works on an indemnity basis. This means that the education payments/fees for which the Life Insured was responsible, or which were actually being made by the Life Insured in the 12 (twelve) months period before their Education Legacy Protector Claim Event, or for which the Insured Life would have become responsible in the future, will be continued by the Education Legacy Protector. These will be the actual compulsory education fees for tuition subjects to maximums set out by the Administrator for each education phase.

In line with the indemnity principle, the Education Legacy Protector will pay the actual educational fees charged by the institution attended by the Child at the time of the Life Insured's Education Legacy Protector Claim Event.

Such fees will exclude any fees that are paid separately or in addition to the normal standard education fees applicable to all the learners in the Child's particular year/grade. Examples of such excluded fees are described, but are not limited to, those fees mentioned in section 12.2.7.

If the Child attends a no-fees school or are exempted from paying total fees (for whatever reason), no Benefit will be paid from the Education Legacy Protector, except for university fees. If fees are partially exempted (that is fees payable are discounted), the Insurer will still cover the partially discounted amount due.

The Policyholder may cover multiple Children on a single policy, up to a maximum of 5 (five) Children. The 5 (five) Child limit will be subject an overall Rand maximum, which will be determined by the Administrator on a case by case basis, at their sole discretion.

An annual discretionary benefit amount will be paid from the primary school stage upwards. These amounts are detailed in section 12.2.5.

If a Benefit option is selected and in Claim, and the Child upgrades to a school of higher fees (please see section 12.2.9 for more details when Children change education phases), the Benefit will continue to pay fees at the rate of the previous school. This will always be capped at the maximum, as stipulated by the Administrator and which can be found in the General Benefit Limits Document.

Example

If the Insured Life paid R2 000 per month for their Child in Grade 3 at ABC School, these payments would be continued after their Death.

For future years of education, the fees payable at ABC School would be the fees paid under the Education Legacy Protector to indemnify the Insured Life and would form the basis of future payments taking into account inflationary increases.

This means that if a Child has moved to a more expensive school, payments will be restricted to those that would have been payable at ABC School.

The rules, terms, conditions, and claim procedures applicable to the Life Cover Benefit, Critical Illness Benefit, and Disability Benefit also apply to the Education Legacy Protector. These include:

- All Exclusions;
- The same loadings will apply from the base benefits;
- Waiting and Survival Periods;
- Claims rules

12.2.1 Benefit Options

The Policyholder may select to be covered under the Life Cover only option or the Life Cover, Disability and Critical Illness Cover option.

Under the Life Cover only option, the Insurer will pay out on a valid Death Claim of the Insured Life. Under the Life Cover, Disability Cover and Critical Illness Cover option, the Insurer will pay out a valid Death Claim, valid Disability Claim (same definitions and workings as per the Disability Cover Benefit in section 6), and

Severity A or B Critical Illness Claims (same definitions and workings as per the Critical Illness Cover Benefit in section 7). These Claim Events are referred to as the Education Legacy Protector Claim Events. Please refer to Your Policy Schedule to see which option You have selected on Your Policy.

The Policyholder may select from one 3 (three) Benefit options: Public, Private or Elite. Each has different Benefit maximums and limits, which can be found in the General Benefit Limits Document. Please refer to Your Policy Schedule to see which option You have selected on Your Policy.

This Benefit is a non-accelerated Benefit offered as an ancillary on the Life Policy. The Life Insured must be the Parent of the Child.

12.2.2 What years of education will the Education Legacy Protector cover?

Depending on which option was selected, the Benefit payments cover the following years of education:

Creche – 3 (three) years (the 3 (three) years preceding Grade 00)
Pre-school (grade 00 and grade 0/R) – 2 (two) years
Primary school (grade 1 to 7) – 7 (seven) years
High school (grade 8 to 12) – 5 (five) years

- Tertiary education:

Tertiary education for 1 (one) undergraduate degree, diploma or trade certificate up to a maximum age of 24 (twenty-four).
Optional Honours and Masters degrees Benefit – 3 (three) years

- This will be an add on feature for Public and Private and automatically included in the Elite option, which may be selected by the Policyholder for each Child.
- The Insurer will only pay 1 (one) year for an Honours degree and then a maximum of 2 (two) years for a Masters degree, so a total maximum of 3 (three) years under this Benefit.
- Honours would be available post completion of an undergraduate degree. Masters availability would be subject to completion of an Honours degree.

The Education Legacy Protector will only cover the number of years related to the degree for which the student initially applied for after completion of grade 12. The Benefit will not cover any additional years if a change is subsequently made to a longer degree.

Example

If the student begins a 3 (three) year undergraduate degree and then decides to change to a 6 (six) year medical degree, the Benefit will only pay for 3 (three) years.

12.2.3 What education institutions are covered under this Benefit?

All registered education institutions (public and private schools, schools for learners with special educational needs and home schooling) as set out in the South African Schools Act 84 of 1996, as amended from time to time, are included in this Benefit.

All South African universities are included in this Benefit, as well as universities of technology (technikons), recognised institutions providing for a trade (such as plumbing and electrical) and all overseas universities, provided they are accredited institutions.

12.2.3.1 Overseas Institutions

In the case of university, Benefit payments will be based on education fees at a South African university for a similar or equivalent degree, at the Administrator's/Insurer's sole discretion, if the Child is accepted at an overseas university.

In the event of the Child attending an overseas educational institution, Benefits paid will be based on the maximum education fees for South African facilities, and not the rate of fees that apply to education in their new country of residence.

- These maximums are defined in rand terms.
- The overseas benefit payments will thus be converted from foreign currency into rands when comparing the fees to the maximums applicable.
- The overseas university needs to be an accredited educational institution.

This will be verified as part of the claims process.
The Benefit paid will be in rands and will be transferred into a South African registered bank account.

In the event of the Spouse or the Children emigrating from South Africa, Benefits paid will be based on education fees for South African facilities, and not the rate of fees applicable to education in their new country of residence. This means that Benefits paid will be based on the education fees for South African facilities, and not the rate of fees applicable to education in their new country of residence. These will be subject to the maximum Benefit limits, as defined in section 12.2.4, and are defined in Rand terms.

12.2.3.2 Prestigious University Benefit

The Prestigious University Benefit is automatically available on both the Private and Elite options.

Please note that it is only applicable to Children who have been accepted into a pre-defined list of prestigious university institutions. The qualifying list of prestigious universities can be found in the General Benefit Limit Document.

Benefit payments for the tertiary institution will be paid in full, subject to the maximums applicable to the overseas facilities at the time, and applicable to either the Private or Elite option.

- The overseas university needs to be an accredited educational institution.
- This will be verified as part of the claims process.

In the event of the Spouse or the Children emigrating from South Africa, Benefits paid will be based on education fees applicable to education in their new country of residence. These will be subject to the maximum Benefit limits, as defined in section 12.2.4.

12.2.3.3 Prestigious High School Residence Benefit

The Prestigious High School Residence Benefit is a unique Benefit on the Elite option only.

The Prestigious High School (Local) Residence Benefit is paid when a Child is accepted into a pre-defined list of Prestigious High Schools and is residing at the school's residences.

The Benefit is paid on an indemnity basis up to the stated maximum. The list of qualifying institutions can be found in section General Benefits Limit Document.

The Prestigious High School (Local) Residence Benefit will be paid directly to the Education Institution.

Please note that these institutions, as specified in section 12.2.3 will be reviewed by the Administrator/Insurer from time to time and may be changed or amended, at the Administrator/Insurer's sole discretion.

12.2.4 Maximum Benefits per phase of education

Please refer to the General Benefit Limits Document which states the maximums for the three options of Public, Private and Elite.

These maximums will increase yearly at a rate which is linked to education inflation (as determined by the Administrator). The increases may also differ between the different phases of education. The education inflation used in the Annual Premium Increase will be limited to 20% (twenty percent).

12.2.5 Discretionary Payouts

These lump-sum payments are provided for use at the discretion of the learner's legal guardian and are intended primarily to assist with additional education-related expenses. These may include, but are not limited to, school uniforms, textbooks, stationery, transportation, sports gear, career guidance, and technology (such as laptops or tablets).

Payouts will be made annually at the start of each calendar year, provided there is a valid Education Legacy Protector Claim being paid.

Payments will be directed to the designated Claimants. In the case of a Death Claim, the payments will go to the Beneficiaries, and for Disability or Critical Illness Claims, they will be made to the Policyholder.

The annual payout amounts vary depending on the Benefit option selected by the Policyholder. Please refer to the latest General Benefit Limits Document for details on the specific payout amounts per Benefit option

These annual payout amounts will increase yearly at a rate which is linked to education inflation (as determined by the Administrator). The increases may also differ between the different phases of education. The education inflation used in the yearly premium increase will be limited to 20% (twenty percent).

12.2.6 EduTech Benefit

A Benefit payment will be made every 3 (three) years following a valid Claim Event, starting 3 (three) calendar years from the Claim Event Date and then every 3 (three) years thereafter. This will be made as long as an amount is being paid for this Education Legacy Protector Benefit.

This payment is designed to equip learners with the latest technology and tools essential for excelling in the 21st century. It can be used to purchase items such as laptops, tablets, and other educational resources that support their learning journey. The payment will be a lump sum of R20,000, made in addition to the discretionary lump sum benefit. This amount will increase annually with inflation to ensure learners have access to cutting-edge resources.

Payments will be directed to the designated Claimants. In the case of a Death Claim, the payments will go to the Beneficiaries, and for Disability or Critical Illness Claims, they will be made to the Policyholder.

12.2.7 What expenses are not covered directly by the Education Legacy Protector?

The following expenses, among others, will not be covered by the Education Legacy Protector Benefit:

- Any registration fees or administration fees for the school or institution in respect of the Child;
- Any book or residence fees for non-tertiary institutions or schools;
- Any utensils or equipment required;
- Excursion fees;
- Au pair fees;
- Aftercare fees;
- Extramural activity fees (as well as any equipment needed for the extramural activities, for example, but not limited to, sports equipment); and
- Fees that are paid separately or in addition to the normal standard education fees applicable to all the learners in the Child's particular year or grade, such as remedial fees or additional

mathematics fees or fees for studies that do not form part of the school or institution's normal curriculum.

Please note that:

- the discretionary payouts described in section 12.2.5 can be used to cover any of the above costs.
- the above excluded expenses will be reviewed from time to time by the Administrator/Insurer and may be changed or amended, from time to time, at the Administrator/Insurer's sole discretion.

12.2.8 What happens if a Child obtains a bursary?

Where a Child is the recipient of a partial or full exemption of school fees due to a bursary or other forms of assistance, the Insurer will cover the reduced education fee after the exemption of fees has been applied, subject to the maximums set by the Administrator.

12.2.9 What happens when education facilities are changed?

If a Child changes their educational facility, with no change to their educational phase (educational phase is defined to be each full phase of their educational journey such as creche, pre-primary, primary, high school (secondary) and tertiary education), after a valid Education Legacy Protector Claim Event, to a school or institution where fees are higher than the previous school or institution, the Insurer will continue making Benefit payments at the rate applicable to the facility at the Claim Event Date. The Insurer does not cover any additional costs of the new facility above the fees for the facility at the time of the Insured Life's Claim Event.

If a Child changes their educational facility, with no change to their educational phase, within the 12 (twelve) months prior to the Claim Event of the Insured Life to a school or institution where fees are higher than the previous school or institution, the Insurer will make Benefit payments at the rate applicable to the previous school or institution at the time of the Insured Life's Claim Event.

If a Child attends a free or low cost school, and wishes to upgrade to a semi-private or private school, the Insurer will not cover any additional costs of the new facility above the fees for the facility at the time of the Insured Life's Claim Event.

The same rule applies in the event of a Child changing from a local tertiary educational facility they were attending at the time of the Insured Life's death, to an overseas universities or other local tertiary education facilities. It also applies if a Child upgrades from, for example, a public to a private institution between primary and high school, where there will be no increase in payments to allow for the upgrade. The Benefit does make allowance for fees to increase on normal transition from one schooling level to the next (for example, from primary to secondary, or from secondary to tertiary).

There are maximum increases in payments, up to the maximum Benefit limits, which will be allowed as a Child transitions between education levels as follows:

- Before school-going age (grade 000/00) until grade 0/R: Up to 100%

- From pre-school (grade 0/R) to primary school: Up to 100%
- From primary school to high school: Up to 20%
- If the Child changes from a school with no fees to one with fees, the Insurer will pay the fees subject to a maximum amount (see section 12.2.4).

Please note the above maximum increases will be reviewed from time to time by the Administrator/Insurer and may be changed or amended, from time to time, at the Administrator/Insurer's sole discretion.

12.2.10 What happens if a Child fails a year of education?

For all the years up to the end of high school, the Child may fail 1 (one) year. In this case, the Insurer will only pay 33% (thirty-three percent) of the relevant fees to repeat the year.

If the Child fails again, Benefit payments will stop until the Child progresses to the next grade of schooling. Should a Child attend a school which completes a grade over 2 (two) years, the Child will not be worse off than someone who has repeated a grade. The Insurer will pay up to 133% (one hundred and thirty three percent) of the applicable risk maximum over the 2 (two) year period.

Example

A Child attends a school that completes grade 12 over a 2 (two) year period. The school fees for each year are R80 000. The maximum amount payable is R100 000 for this grade.

Should the Child's Parent pass away the following payments will be made for each year of grade 12:

Year	Applicable Risk Maximum	Actual tuition fees	Amount covered by the insurer
1	R100 000	R80 000	Min (R100 000, R80 000) = R80 000
2	R100 00	R80 000	Min (R100 000 x 133% - R80 000, R80 000) = R53 000

Note that the risk maximum above is just for illustrative purposes.

In the event of failing a year of university, diploma, trade qualification, or similar tertiary qualification in full, the Insurer will not pay any Benefit to repeat the year and Benefit payments will stop until the Child progresses to the next year of education.

The Insurer regards failing two-thirds or more of the subjects in a year as failing the year in full. The Insurer will only pay twice for a specific subject in the case of where the Child fails less than two-thirds of the subjects in a year.

If the Child progresses to the next year of education, having passed more than one-third of the previous year's subjects, the Insurer will continue to make Benefit payments in full. The only exception to the above is where a subject has already been failed two times or more. This will not be funded.

The Insurer will only pay once for each year of tertiary education. For example, if the Child changes course at the end of the first year when studying at university, the Insurer will only pay for the new course once the Child progresses to the second year of the new course.

If a Child has passed grade 12 and wishes to pass further subjects to get entry to a tertiary institution, a maximum of one-third of the actual fees payable during the matric year (or up to the benefit limit in the General Benefit Limits, if no fees were paid), may be payable. This will only be paid for a maximum of 1 (one) year.

12.2.11 Can a Child take a gap year?

Years of education must run consecutively. However, the Child may take off 1 (one) year (only) between completing high school and starting university or similar tertiary education. No Benefit payments will be made for this year. In order for the Child to be eligible to take this 1 (one) year off, the Insurer/Administrator must be informed In Writing of the Child's gap year before Child goes on it.

The rules on termination of Benefit payments will still apply, which may result in Benefit payments ending before the Child completes their education.

12.2.12 Does the Benefit payout affect the Life Cover amount?

When the Education Legacy Protector sits on the Life Policy, it will be regarded as a standalone policy, meaning Benefit payments from the Education Legacy Protector will have no impact on the Life Cover Sum Assured.

12.2.13 Conversion Option

Upon reaching the Benefit Expiry Age of the Education Legacy Protector (as defined in section 12.5), the Life Insured's Premiums for this Benefit will continue.

These Premiums are used to provide the Life Insured with an additional amount of cover under the Life Cover Benefit, the Disability Cover Benefit and the Critical Illness 200 Benefit on the Life Insured's existing Life Policy as the Education Legacy Protector Benefit is an ancillary on the Life Policy.

The details of the additional cover are as follows:

- If the Policyholder selected the Education Legacy Protector to pay in the event of death only, the full premium is applied to purchase additional Life Cover and the Benefit will be automatically converted to additional Life Cover.
- If the Policyholder selected the Education Legacy Protector to pay in the event of death, disability and critical illness, 40% (forty percent) of the Premium will be applied to purchase Life Cover, 40% (forty percent) is applied to purchase the Disability Benefit and the remaining 20% (twenty percent) is applied to purchase the Critical Illness 200 Benefit.
    - If the Life Insured is older than the maximum entry age for the Disability Benefit on the policy, 60% (sixty percent) of the Premium will be applied to purchase the Critical Illness 200 Benefit.
    - If the Life Insured is older than the maximum entry age for both Life Cover and Critical Illnesses Benefits on the Policy, then no conversion will apply in this instance and the premium for the Education Legacy Protector will cease.
- If You already have existing cover under the Life Cover Benefit, Critical Illness Benefit or Disability Benefit, the additional cover will be consistent with your existing cover option and Benefit construct selected on these Benefits. However, new business premiums will be charged for the converted cover.
- If You do not have existing cover under the Life Cover, Critical Illness Benefit or Disability Benefit on the Policy, the cover options selected for the additional cover will be the Critical Illness 200 Benefit and normal Disability and Life Cover Benefits.
    - The Critical Illness Benefit purchased is for whole of life. The Disability Benefit purchased will follow all the same rules as defined in section 7.
    - All Benefits in this scenario will increase at CPI at Policy Anniversary going forward.
- The amount of cover purchased is based on new business rates (including, but not limited to, the Life Insured's age, gender and smoker status) at the Benefit Expiry Age.
    - The same health loadings, hazardous pursuit loadings, occupational loadings and exclusions that applied to each Benefit on the Education Legacy Protector will be applied in calculating the additional cover purchased for each Benefit, without any additional medical underwriting. Such loadings and exclusions are automatically transferred to the additional cover.
- This conversion of Benefit is automatic, although the Policyholder has the option of cancelling this additional cover. In this case, Premiums for this additional cover will stop.
- The conversion of the Benefit will only occur where there has been no Claim on the Policy, under any Benefit.
- The conversion will only provide the Life Cover element if there has been any Claim on the Critical Illness or on the Capital Disability Benefit before the Benefit Expiry Date of the Education Legacy Protector.

The Premium will therefore be used to purchase this additional cover as well. This conversion happens each time a Child reaches the Benefit Expiry Age, so this may happen multiple times, for different children, if there are multiple Children on the Policy.

12.2.14 What other legal provisions will apply to the Education Legacy Protector?

The following legal provisions will apply to the Education Legacy Protector:

If an Insured Life has other individual or group life policies that also provide education cover, the Insurer will reduce its Benefit payments in the ratio of the potential other insurer payment to the total payment received from all policies.

If both parents are insured lives of different Dis-Chem Life Education Legacy Protector policies insured by the Insurer and then both die, no additional payments will be made in excess of the actual costs of the Child's education, subject to the maximum Benefit limits.

12.3 HOW DOES THE BENEFIT CHANGE?

The Benefit is an indemnity Benefit so there is no actual Sum Assured which changes each year. The maximum Benefit limits, Discretionary payouts and EduTech Benefits annual increases have been described in the relevant sections throughout section 12.

12.4 CLAIMS

The Benefit will be paid out on a valid Education Legacy Protector Claim Event of the Insured Life.

In the case of the Life Insured becoming severely ill or disabled, to qualify for a payment that covers the remaining years of education, the Life Insured must meet the Severity A or B level definition for the Critical Illness Benefit. All claims on the Disability Benefit will qualify for a payout.

All definitions for disability, illness and severity levels are as per the Critical Illness and Disability Cover sections (sections 6 and 7 respectively). If the Life Insured changes their occupation, the Administrator must be notified in writing of this change (within six months of the Insured Life changing their occupation).

Please take note of some Claims rules:

- To qualify for a Benefit payment, the Claimant must prove that the Life Insured was financially responsible for the Child's educational costs.
- A Child born after the Policy has started can be added to the Policy, subject to the Administrator's underwriting requirements at the time.
- The Benefit payments are made annually, directly to the institution where the Child is being educated. An invoice will need to be provided to The Administrator/Insurer in this regard. If any legislation or circumstances prevent funds being paid directly to the education facility, the Insurer reserves the right to pay the Policyholder (in the case of Illness or Disability) or the Insured Life's Beneficiaries directly for a Death Claim.
    - In certain circumstances, the payments will be made monthly. This will be decided on a case by case basis by the Insurer, at their sole discretion.
- If an upfront annual payment is made to an educational institution and the Child passes away in the calendar year of payment, then the unused funds will be recouped from the educational institution.

Please note that Claims submitted in respect of Education Legacy Protector Claim Events that arose before the Benefit Expiry Age will be assessed, but Claims where the Claim Event Date occurs after the Benefit Expiry Age will not be accepted.

12.4.1 Who does the Insurer pay out Claims to?

The Benefit payments are made to the institution where the Child is being educated and not to the Policyholder or Claimants directly.

If any legislation prevents funds being paid directly to the education facility, the Administrator reserves the right to pay the Policyholder or Beneficiaries directly.

For the Discretionary Payouts and EduTech Benefit (sections 12.2.5 and 12.2.6), payments will be directed to the designated Claimants. In the case of a Death Claim, the payments will go to the Beneficiaries, and for Disability or Critical Illness Claims, they will be made to the Policyholder.

12.4.2 What information is required for the payment of the Education Legacy Protector?

The burden of proof of eligibility for the Education Legacy Protector is that of the Claimant, or whomever they direct to provide this information. The Administrator/Insurer will determine the information required as proof of eligibility at Claim stage, at either's sole discretion, and if the Claim is accepted the Benefit payment will only take place when all the requested information has been received. At least an unabridged birth certificate for the Child and proof of payment by the Insured Life for the Child's school fees over the 12 (twelve) months before the Insured Life's qualifying Education Legacy Protector Claim Event will be required.

For subsequent years of education, the Administrator/Insurer will require proof of enrolment, proof of fees and the previous year's education results, where applicable. If there are no nominated child beneficiaries at the date of Education Legacy Protector Claim Event or notified to the Administrator/Insurer within 6 (six) months from the date of Education Legacy Protector Claim Event, no Benefits will be admitted for payment.

The Administrator/Insurer reserves the right to ask for further information to assess the validity of the Claim, if so required at any point time, both at Claim stage as well as during the Claim payment term. The information requested will be at either's sole discretion.

The information required in section 12.4.2 by the Administrator/Insurer will be reviewed from time to time by the Administrator/Insurer and may be amended, at either's sole discretion.

If the Elite option is selected, the Benefit payments may be based on the education fees of a select list of overseas universities (section 12.2.3), if the learner gains enrolment to a university on a specified approved list by the Administrator. The list of approved overseas universities may be altered by the

Administrator from time to time, at their sole discretion. A different maximum will apply if the Child attends an international university on the approved Administrator list.

Please note that if the Life Insured's Child's studies are covered by the Education Legacy Protector on multiple policies, the Education Legacy Protector Benefit will only be paid out on one policy and will be subject to the maximums set by the Administrator for this Benefit.

12.5 WHEN DOES THE BENEFIT END?

The Benefit will end at the earlier of the Child turning 24 (twenty-four) (at the end of the month turning 24 (twenty four), the death of the Child or the Child completing their tertiary studies.

If there are multiple Children on the Policy, then it will end when the youngest Child turns 24 (twenty-four) or completes their tertiary education, whichever is earlier.

The normal termination rules, as described in section 19.2, will apply to this Benefit. Below are additional scenarios where the Benefit may terminate.

Cover for the Benefit will also end on the earliest of:

- The youngest Child on the Policy finishing their last and final year of elected education; or
- The Child no longer qualifies under the 'Child' definition; or
- The Life Insured is no longer financial responsible for the 'Child'; or
- The Life Insured no longer qualifies under the 'Parent' definition; or
- Termination of the Policy, for whatever reason.

Please note that no Benefits are payable on or after the cancellation date of the Policy.

We may immediately cancel this Policy or place it on hold, refuse any transaction or instructions, or take any other action considered necessary in order to comply with the law and prevent or stop any undesirable or criminal behaviour.

12.6 THINGS TO NOTE

- Please note that:
    - Education Legacy Protector Claims will be subject to an overall maximum Claim amount as well as maximum duration of payments at different levels of education.
    - Occupations affect the premiums charged – if the Insured Life's occupation changes, the Administrator/Insurer requests that Insured Life inform Us within 2 (two) months of the change.

        - We reserve the right to amend the Insured Life's Premiums and/or Benefits should the Insured Life alter their occupation to one considered to be of a higher risk than their previous occupation. The classification of whether the new occupation is deemed to be a higher risk occupation will be made at the sole discretion of the Administrator/Insurer. If this information is not supplied within 2 (two) months of the change, some or all of this Benefit may be adjusted or removed. The Administrator/Insurer may also adjust some or all of the Insured Life's premiums in this scenario. This decision will be made at the Administrator's sole discretion
    - The Administrator/Insurer assesses the risk and sets the Insured Life's Benefit premium according to the information supplied on the application form and at the request for medical information.
    - If the Insured Life's occupation or hazardous pursuits change, it is important that the Administrator/Insurer is advised of such change to ensure that the Insured Life remains covered at all times. If this information is not supplied within 2 (two) months of the change, some or all of this Benefit may be adjusted or removed. The Administrator/Insurer may also adjust some or all of the Insured Life's premiums in this scenario. This decision will be made at the Administrator's sole discretion
    - All rules, terms, conditions, calculations and benefit formulas and benefit workings stated throughout section 12 above will be reviewed from time to time by the Administrator/Insurer and may be changed or amended, from time to time, at the Administrator/Insurer's sole discretion.

13. Additional Benefits

The following Benefits are included in Your Policy, at no extra cost to You. They apply to all Benefits on the Policy, unless otherwise specified.

13.1 WORLD TRAVEL, HOLIDAY AND SECONDMENT BENEFIT

13.1.1 What is the purpose of the Benefit?

The Administrator/Insurer will provide protection if the Life Insured travels or decides to temporarily reside or temporarily work overseas. A valid Benefit Claim will be payable on the submission of a valid Claim during this period.

13.1.2 How does it work?

This Benefit provides coverage for all Benefits on Your Policy, when the Life Insured travels or decides to temporarily reside or work outside of the Republic of South Africa for periods of less than 6 (six) consecutive months.

You will still need to pay the Premiums from a South African bank account for each relevant Benefit on Your Policy during the time the Life Insured is traveling, residing or working outside of the Republic of South Africa, in order to receive coverage for those individual Benefits.

If the absence, including secondment, continues in excess of 6 (six) consecutive months, then the cover will end, unless the Insurer, at their sole discretion, approves up to a further 12 (twelve) consecutive months' absence, In Writing, after receiving the following data for the Life Insured: occupation, description of work, date of secondment start, term of secondment, country of secondment.

After 18 (eighteen) consecutive months' absence from the Republic of South Africa, the Life Insured's cover will automatically terminate, unless the Insurer approves a further extension In Writing, at their sole discretion.

Upon the return to the Republic of South Africa by the Life Insured after the cover has ended as described above, the Life Insured's cover will recommence as if they were a new policy, with all new business rules applying.

13.1.3 Claims

Only Claims where the Life Insured meets the Insurer's standard Claim requirements will be accepted. For example, if the Insurer requires a Medical Practitioner's report at Claim stage, a Claim will not be admitted until the report has been received, irrespective of where the Life Insured is in the world. The Insurer will pay the South African medical scheme tariff rate for medical requirements and the Policyholder must pay any other costs.

The Insurer reserves the right, in certain cases, to require the Life Insured to return to South Africa for further assessment in terms of the payment of the Claim. These medical examinations are required to make sure that the Life Insured qualifies for a valid Claim. The Insurer will only be responsible for the cost associated with any medical examinations required to assess the validity of any Claim. All other costs incurred by the client (travel, transport, accommodation, food, etc), besides the required medical examinations, will be borne strictly by You, the Policyholder, or the Claimant. The parties responsible for the above costs will be reviewed annually and may be amended by the Insurer and/or Administrator, at either's sole discretion.

Coverage will not be provided, and Benefits will not paid out for Claim Events in certain countries where the risks, in the opinion of the Administrator/Insurer and at their sole discretion, are greater than those to which they would have been exposed in South Africa. This list will be reviewed and changed, from time to time, at the Administrator's/Insurer's sole discretion.

For the avoidance of doubt, it should be noted that Exclusions in sections 14.2 and 8.3.6 still apply for the Life Insured, while the Life Insured is absent from the Republic of South Africa, whether for reasons of work or otherwise.

13.1.4 Things to note

Please note that all rules, terms, conditions, costs (including parties responsible for the different cost) and Benefit workings specified throughout this section (section 13.1) will be reviewed from time to time and may be amended by the Administrator and/or Insurer, at either's sole discretion by giving the Life Insured 31 (thirty-one) days' written notice of its intention to do so.

13.2 LIFE COVER, DISABILITY COVER AND INCOME PROTECTION CONVERSION TO ILLNESS COVER

13.2.1 What is the purpose of the Benefit?

As the Life Insured gets older and retirement nears, Their need for financial protection typically reduces, meaning that the need for certain Benefits, such as Life Cover, Disability Cover and Income Protection reduces. In line with smart financial planning, our algorithm automatically converts unneeded cover on Your Policy into additional Illness Cover, which can be used to pay for additional healthcare costs as the Life Insured nears retirement as well as in retirement. This

additional cover, provided with no additional underwriting, can be used to cover the costs of a nurse, a nursing home, or any new age technology and/or medicine that is required in retirement.

13.2.2 Overview

This is an automatic feature on the Policy. As the need for Benefits such as Life Cover, Disability Cover and Income Protection starts to reduce in line with the Life Insured's financial needs as the Life Insured nears retirement, We will seamlessly channel these unneeded Benefits into further Critical Illness Cover, on an annual basis. This cover will be converted free of any medical underwriting and free of any further questionnaires.

13.2.3 How does it work?

Depending on whether the Policyholder selects the CPI or DFNA option on the Policy will dictate how the conversion works.

CPI Option

If the CPI option is selected on the Policy, then the Life Cover Benefit will not convert to Critical Illness Cover and will continue on as Life Cover throughout the Policy term.

Disability Cover and Income Protection Cover (Temporary, Permanent and Standalone) will convert at age 65 (sixty-five) to Critical Illness Cover. The conversion will be based on new business rates at the time of conversion.

All additional converted Critical Illness Cover will continue to increase in line with normal Critical Illness Annual Benefit Increase rules, as described in section 6, from age 65 (sixty-five) onwards.

This automatic conversion of Disability Cover and Income Protection to Critical Illness Cover will apply on at the end of the month when the Life Insured turns 65.

DFNA Option

The amount of Critical Illness Cover that will be converted will depend on the reduction in the Life Cover, Disability Cover and Income Protection Premiums, as they change in line with the Life Insured's needs. The conversion will occur automatically each year at Your Policy Anniversary.

The amount of Critical Illness Cover that will be converted will be equal to the cover (at new business rates at that point in time) that can be purchased at the time of conversion using the sum of the reduction in the Life Cover, Disability Cover and Income Protection (both Permanent

and Temporary Income Protection Benefits, as well as the Standalone Temporary Income Protection Benefit) Premiums. For example:

> Amount of Critical Illness converted = Sum Assured that can be purchased at new business Critical Illness rates using the sum of the reduction in Life Cover, Disability Cover and Income Protection Premiums

This automatic conversion of Life Cover, Disability Cover and Income Protection to Critical Illness Cover will apply on each Policy Anniversary starting from the first Policy Anniversary when either the Life Cover, Disability Cover, Permanent Income Protection or Temporary Income Protection (or Standalone Temporary Income Protection) Premiums begin to reduce. This will continue until the earliest of the relevant Benefit expiry age or the relevant Benefit Premium becoming zero in line with the Dynamic Financial Needs Analysis.

The additional converted Critical Illness Cover will increase in line with the Dynamic Benefit Adjustments applied to the Critical Illness Benefit, as described in section 6.

Example

Example Details:

- When You turn age 60 (sixty), You have:
  - R1 000 000 Life Cover, with a Premium of R1 000
  - R1 500 000 Disability Cover, with a Premium of R1 500
  - R500 000 Illness Cover, with a Premium of R500
- You are both the Policyholder and Life Insured on the Policy.
- At Policy Anniversary, Your financial needs have reduced as You near retirement as You have paid off Your mortgage and Your children have become independent. Thus, the Dynamic Financial Needs Analysis proposes a reduction in the amount of Life and Disability Cover that You have from R1 000 000 and R1 500 000, to R900 000 and R1 300 000, respectively.
- This corresponds to a reduction in Premium to:
  - Life Cover: R900
  - Disability: R1300
- The new business Critical Illness premiums are R100 for R50 000 of cover at the time of conversion.
- Your Critical Illness continues to increase with the Dynamic Benefit Adjustment.
- Assume CPI is equal to 5% (five percent) in this example.

The amount of Critical Illness converted is:

Amount of Critical Illness converted	= (Reduction in Disability Cover Premium + Reduction Critical Illness Premium) ÷ R100 x R50 000

= ((R1 000 - R900) + (R1 500 – R1 300)) ÷ R100 x R50 000
= R300 ÷ R100 x R50 000
= R150 000

Your new Critical Illness Sum Assured is:

New Critical Illness Sum Assured = Old Critical Illness Sum Assured x (1 + CPI) + Amount of Critical Illness converted
= R500 000 x (1 + 5%) + R150 000
= R525 000 + R150 000
= R675 000

The new additional R150 000 Sum Assured tranche will be purchased at the new business Premiums at that particular point in time.

General Rules for both CPI and DFNA options

This is an automatic Benefit on the Policy. The additional Critical Illness Benefit can be used to purchase additional medical treatment, medicines and nursing help and can also be used to cover the costs of a nursing home after Claim. Please note that You can always reduce Your Critical Illness Benefit Sum Assured if You do not want the additional Critical Illness Cover.

Please note that all rules relating to the original Critical Illness Cover will automatically apply to the converted Critical Illness Sum Assured. To remove any doubt:

- The converted Critical Illness Cover will have the same occupational and hazardous pursuit Premium loadings and Exclusions, if applicable, (as well as all Exclusions found in section 14.2) that were applied to the Critical Illness Benefit on the Policy beforehand.
- The same Waiting and Survival Periods will be applied to the converted Critical Illness Cover as was applied to the original Critical Illness Benefit on the Policy beforehand.
- Any other Exclusions that apply to other Benefits on Your Policy or at a Policy level will also apply to the converted Critical Illness Cover. This means that if there is a condition-specific, Benefit specific or any other policy specific Exclusions on Your Policy, these same Exclusions will also apply to the converted Illness Cover.

Please note that if there are any medical or health loadings and/or any medical or health related Exclusions on any of the Benefits on Your Policy, this conversion facility will not be available on Your Policy. Also, please note that if Critical Illness was at any point declined or deferred during any underwriting process with Us or at any other external insurer, the conversion option will not be available on the Policy.

Before Your cover converts, We will perform certain checks to ensure the Life Insured meets the minimum criteria for using the conversion:

- You must have held Your Policy for at least 2 (two) years;
    - The cover conversion facility will not apply if You've held Your cover for less than 2 (two) years, counted from the Commencement Date.
- Your Premiums must be up to date; and
    - You must be in good financial standing with Us.
    - If You owe Us any outstanding Premiums, You will not be able to use the cover conversion until this debt is settled.

The Critical Illness Conversion Option will not be available on a Policy with Accidental Life Cover and/or Accident Disability Cover Benefits.

Summary

Below is a summary of how the conversion will work under the two different Annual Benefit Increases options selected.

Category	CPI Option	DFNA Option
Converted at New Business Rates	✓	✓
Starting Conversion time	65	When Premiums begin to reduce
End Conversion time	65	65
Life Cover Conversion	×	✓
Disability Cover conversion	✓	✓
Income Protection conversion	✓	✓
Original and New Critical Illness to increase as per normal Benefit rules	✓	✓

13.2.4 Things to note

We will not allow the cover conversion if there has been a Claim on the Policy or if the Life Insured has claimed on any other life insurance policy previously:

- If You (or the Life Insured) have claimed on the Policy in the past, have submitted a Claim that is currently being assessed, or are currently in claim, it may affect Your ability to get cover using the cover conversion.
- When considering whether a Claim affects the cover conversion facility, We will always look at the Claim Event Date, and not the date on which the Claim is submitted or paid.
- If You (or the Life Insured) have Claimed on the Policy:

- If You (or the Life Insured) have received a pay-out from any Benefit on the Policy at any time before the conversion date, then the Critical Illness conversion option on the Policy will fall away from the Claim Event Date and no conversion will be allowed on the Policy after the Claim Event Date.
- If You (or the Life Insured) are receiving a pay-out from the Income Protection Benefit or the Standalone Temporary Income Protection Benefit at the conversion date, then the conversion option on the Policy will not be allowed and will fall away from the Claim Event Date.

- If You (or the Life Insured) have submitted a Claim that is still being assessed:
  - You will not be able to convert cover until the Claim decision has been finalised.
  - If the Claim is valid, then the conversion feature will fall away going forward backdated from the Claim Event Date, and no conversion will be allowed at the next conversion date and thereafter.
  - If the Claim is not valid, then the conversion feature will be allowed going forward. However, no conversion would have taken place at the previous conversion date (when the Claim was still being assessed).

Please note that limits may apply to the cover that You convert with the cover conversion facility:

- Maximum value of converted cover:
  - These amounts are subject to the overall Critical Illness Benefit maximums, set by the Administrator/Insurer from time to time, at either's sole discretion.
- No previous Critical Illness Cover was taken:
  - If You did not take out cover under the Critical Illness Benefit at Policy Commencement Date or at any time before the first conversion date, then the converted Critical Illness Benefit will exclude any Claims for Pre-Existing Conditions or any Claims for conditions, procedures or complications related to a Pre-Existing Condition.

Please note that the all terms, conditions, rules, Benefit workings, calculations and formulas specified in this section (section 13.2) will be reviewed from time to time and may be amended by the Insurer and/or Administrator, at either's sole discretion.

Please note that the conversion benefit, as specified in section 13.2, does not apply to Business Assurance policies.

14. General Benefit Terms and Conditions

This section specifies the general terms and conditions which apply to all Benefits on the Policy, unless otherwise specified.

14.1 NOMINATED OCCUPATION FOR DISABILITY BENEFITS

Your disability Benefits (Disability Cover, Accidental Disability Cover, Education Legacy Protector (where applicable), Income Protection Benefit and Standalone Temporary Income Protection Benefit) use the Life Insured's Nominated Occupation when assessing the validity of the Claim.

For any disability Claim assessed against the ability to perform the Life Insured's Nominated Occupation, disability will only be measured against the tasks and duties of the Life Insured's Nominated Occupation. That is, for any Claim assessed against the ability to perform the Life Insured's Nominated Occupation, the ability (or inability) to perform Their Nominated Occupation will only be measured against the tasks and duties of Their Nominated Occupation.

The monthly Income amount that You insure/protect (for the Life Insured's Nominated Occupation) must be what the Life Insured derives from Their Nominated Occupation that has been specified, or must be the monthly Income in respect of the Life Insured's Nominated Occupation that has been specified.

Please note that the Life Insured's Nominated Occupation affects the Premiums You are charged. If the Life Insured's occupation changes, We request that You inform Us. We reserve the right to amend Your Premiums or Benefits if the change to the Life Insured's occupation, in the opinion of the Administrator or Insurer, is considered to be of higher risk than Their previous occupation.

14.2 EXCLUSIONS

These are the general Benefit Exclusions for the Life Insured on the Policy. All Exclusions below apply to Claims relating to the Life Insured on the Policy for the Life Cover, Disability Cover, Critical Illness Cover, Education Legacy Cover, Income Protection Benefit (Temporary and Permanent Income Protection Benefits), Standalone Temporary Income Protection and Accidental Benefits (on death and disability), unless otherwise indicated.

The Insurer reserves the right to refuse Claims when:

- You/Life Insured fail to disclose information about physical disabilities or medical conditions that affect, or affected, the Life Insured at the time that cover starts;
- You/Life Insured fail to notify the Administrator/Insurer of the Life Insured's correct occupation and occupational duties at policy inception, or of a change in occupation from that nominated at policy inception or change in occupational duties where the new occupation or the change in occupational

duties are classified by the Administrator/Insurer as falling into a risk category for which the relevant Benefit/s would not have been granted on the same terms and conditions to the Claimant/Life Insured;

- The Administrator is unable to obtain sufficient medical or financial (if applicable) evidence from You or the Life Insured or treating Medical Practitioner to fulfil our criteria for making a Benefit payment;
- The Claim was as a result of:
    - The Life Insured's wilful and deliberate breaking of any law (whether the crime was committed or attempted to be committed) or the Life Insured's wilful participation in the commission of a criminal activity or the Life Insured's wilful involvement in any riot, insurrection, usurpation of power, act of terrorism martial law or war;
    - The Life Insured's regular participation in any hazardous sport or pursuit which was not disclosed to the Administrator at any point in time before the Claim;
    - The Life Insured's exposure to atomic energy, nuclear fission or reaction, terrorism, biological or chemical hazards and biological or chemical warfare agents;
    - The Life Insured's refusal to seek or follow medical advice;
    - Intentional and negligent consumption of poisons, drugs and narcotics by the Life Insured unless prescribed by a registered medical practitioner (neither You, nor the Life Insured, nor any of Your Family Members nor any of the Life Insured's Family Members may perform the role of registered Medical Practitioner in such a case);
- The Claim Event occurred outside of South Africa, in a country where the risks, in the opinion of the Administrator/Insurer, and at their sole discretion (at the time of Claim Event), are greater than those to which They would have been exposed to in South Africa. To remove any doubt, Claims will be excluded if the Life Insured is either travelling or temporality residing in any of these high-risk countries, as described above.
- The Life Insured's death is self-inflicted or is due to suicide (whether sane or insane) and occurs within 5 (five) years (60 (sixty) months) of the Commencement Date of Your Policy or within 5 (five) years (60 (sixty) months) of reinstatement of Your Policy or within 5 (five) years (60 (sixty) months) from adding additional Life Cover;
- The Life Insured's disability or illness Claim (for the Disability Cover, Critical Illness Cover, Education Legacy Cover, Income Protection, Standalone Temporary Income Protection and Accidental Disability Benefits) was as a result of:
    - Any cosmetic procedure (reconstructive surgical procedures where a medical condition is present will be covered), as well as any complications associated with the procedure;
    - Organ donation, as well as any associated complications;
    - Excessive consumption of alcohol by the Life Insured that would be known by a reasonable person to be harmful or if the Life Insured drives any form of motorised vehicle on a public road whilst the Life Insured's blood alcohol level exceeds the legal limit;
    - The Claim was deliberately self-inflicted by the Life Insured.

Please note that the above list will be reviewed from time to time and may be amended by the Insurer and/or Administrator from time to time, at either's sole discretion.

All Benefits have automatic COVID-19 cover.

14.3 HIGH RISK OCCUPATIONS

Please note that there are certain high-risk occupations for which Premium loadings and/or Exclusions are applied to Benefits on the Policy. Please refer to Your Policy Schedule to see if there are any occupational loadings/Exclusions on Your Policy.

The Administrator/Insurer reserves the right, at its sole discretion, to amend Your Premiums or Benefits in the following instances:

- The Life Insured's occupation is altered such that Their occupation is deemed to be higher risk than Their previous/current occupation; or
- The Life Insured's occupation becomes a high-risk occupation.

Should You or the Life Insured change Their occupation, the Administrator or Insurer must be notified in writing of this change (within 6 (six) months of the Life Insured's change of occupation). If the Administrator or Insurer is not notified within a reasonable time, some or all of the Benefits may be adjusted or removed. The Administrator or Insurer may also adjust some or all of Your Premiums in this scenario.

Please note that the Administrator's/Insurer's occupational exclusion list will be reviewed from time to time and may be amended by the Insurer and/or Administrator from time to time, at either's sole discretion.

14.4 HAZARDOUS PURSUITS

Please note that there are certain hazardous pursuits for which Premium loadings and/or Exclusions are applied to Benefits on the Policy. Please refer to Your Policy Schedule to see if there are any hazardous pursuit loadings/Exclusions on Your Policy.

The Administrator/Insurer reserves the right, at either's sole discretion, to amend Your Premiums or Benefits should the Life Insured begin regular participation in a hazardous pursuit after the Commencement Date. This may affect the Premiums for any Benefit on the Policy as well as the Benefit themselves. Failure to notify Us if the Life Insured partakes in any hazardous pursuits could result in a Claim being Repudiated, Benefits removed or reduced and/or Premiums adjusted.

Please note that regular participation in a hazardous pursuit is defined as participating in the activity more than once a year.

14.5 FINANCIAL UNDERWRITING

The Administrator/Insurer reserves the right to request proof of Income, for the Life Insured at any point in time, if We feel that a reasonability check needs to be done. This will be performed on an adhoc basis and at Administrator's/Insurer's sole discretion. This may be performed at Commencement Date, at the addition or amendment of any Benefit on the Policy, on Claim or at any time during the Policy term that is deemed necessary by the Administrator/Insurer. Examples of proof of Income may be (but are not limited to) in the

form of a pay slip, financial statements or ITA 34 (for self- employed individuals). The form of proof of Income required, will be decided at the Administrator/Insurer's sole discretion, on a case-by-case basis.

The Administrator/Insurer also reserves the right to call for proof of Income if We suspect that You/Life Insured have intentionally (and falsely) inflated Your or the Life Insured's salary or intentionally lied or have hidden material information pertaining to Your or the Life Insured's salary or Income. The Administrator/Insurer also reserves the right to call for proof of Income, at any time, if We suspect any fraud or Misrepresentation by the Life Insured/Policyholder (or any representative of the Life Insured or Policyholder) on the Policy, at any point during the Policy term.

14.6 CHANGE OF INDIVIDUAL DETAILS

If You would like to change certain individual details on Your Policy, then You must inform the Administrator/Insurer of these changes:

- Changing smoking status
- Change of highest education level
- Change of occupation
- Change of hazardous pursuits
- Change of Income

These changes may lead to a change of Premium or Benefits offered (for example, amendments may be made to the Occupational Claim Criteria).

When any of the factors influencing Your Premium change, Your Premium could increase (or decrease). For example, it's essential that You notify Us immediately should:

- The Life Insured ever take up smoking or use any other form of tobacco where You originally were paying non-smoking rates on Your Policy; or
- The Life Insured undertakes hazardous pursuits, such as extreme sport or dangerous hobbies on a regular basis, for example, motocross, skydiving, underwater diving, rock climbing, private aviation; or
- The Life Insured's occupation changes such that it now entails more travel or manual duties including travel outside the borders of South Africa.

In addition, if the Life Insured has indulged in or consumed narcotics (that were not prescribed by a Medical Practitioner) it is essential that You notify Us. The Administrator or Insurer may then adjust, review and amend Your Premiums accordingly. If the Administrator or Insurer is not notified within a reasonable time, some or all of Your Benefits may be adjusted or removed, and Claims may be repudiated.

15. Dynamic Financial Needs Analysis

15.1 WHAT IS IT?

The Dynamic Financial Needs Analysis is the smart algorithm that calculates the required cover on an ongoing basis, based on the Life Insured's individual and unique circumstances. The algorithm dynamically adjusts to match the Life Insured's changing needs as Their life and financial needs change. This is an option on the Policy, which must be selected by the Policyholder.

The Dynamic Financial Needs Analysis utilises the latest technology to meet the Life Insured's evolving financial needs as closely as possible. It increases faster than inflation in the Life Insured's younger years as Their earning potential increases and liabilities accrue, and less than inflation in Their older years as liabilities are settled and expenses reduce. Eventually, it starts to reduce as liabilities are paid off and the Life Insured approaches retirement. It attempts to cover the Life Insured as optimally as possible (assuming Cover is selected as suggested by the algorithm) such that if the Life Insured suffers a Claim Event, the Life Insured (or Their family) will be left in the same financial position as if the Life Insured didn't experience the Claim Event.

When selected by the Policyholder on the Policy, the Dynamic Financial Needs Analysis will propose a certain amount of cover for Benefits on the Dis-Chem Life Policy, depending on the Life Insured's unique circumstances at each point in time. Benefits will run for a duration of 1 (one) year from Policy Anniversary to Policy Anniversary (unless You updated the Life Insured's individual details or make Policy changes during the year). Thereafter, at each Policy Anniversary, Benefits will recalculate and re-adjust to match the Life Insured's updated financial Needs at that point. This ensures that the Life Insured is always as optimally protected as possible, given Their circumstances at that point in time as well as the information supplied to Us by You.

The Dynamic Financial Needs Analysis will not be available on any Business Assurance Policies. In those cases, the Cover Amounts will increase with CPI at Policy Anniversary.

15.2 DYNAMIC BENEFIT ADJUSTMENTS

Each year at the Policy Anniversary, each Benefit on the Policy will adjust in line with the Life Insured's changing circumstances. The annual adjustment percentage is called the Dynamic Benefit Adjustment, which will adjust to the level proposed by the algorithm of the Dynamic Financial Needs Analysis.

In line with the fact that different needs require different Benefit adjustments, each Benefit on the Policy will receive a different Dynamic Benefit Adjustment each year to ensure that the Life Insured's financial needs are holistically updated, so that the Life Insured and Their family are as optimally protected as possible throughout Their life.

15.3 DYNAMIC PREMIUM ADJUSTMENTS

Please note that the Premiums for each Benefit will adjust each year, at the Policy Anniversary, in line with the changing Dynamic Benefit Adjustments for that specific Benefit, as well as a factor to take into account the Life Insured's increasing age. The Dynamic Premium Adjustments will be different for each Benefit, depending on how the specific Benefit is adjusted each year in line with the Life Insured's changing needs.

15.4 DYNAMIC SALARY INCREASES

The algorithm is smart and will automatically adjust the Life Insured's salary each year, at Policy Anniversary, if no input is received, which will be based on the Life Insured's specific occupation, Their age and the various economic factors (this includes, but is not limited to, inflation). The adjustments have been calculated for people just like Them, at Their current life stage and for Their specific occupation, to replicate as far as possible the salary growth patterns of Their specific occupation, taking into account such things as Their expected promotional increases and various economic factors. This ensures that even if no input is received from You regarding the Life Insured's updated monthly salary at the Policy Anniversary each year, the algorithm will still provide (as close to possible) the optimal amount of coverage for someone in the Life Insured's unique circumstance.

As the Life Insured's gross salary increases each year, the Life Insured's net of tax salary will also increase. The increases to the Life Insured's gross salary may be different to the increases to the Life Insured's net salary. This is because as Their gross salary increases, the tax bracket that They fall into may change and thus the tax the They pay may change.

This is an option on the Income Protection Benefit and the Standalone Temporary Income Protection Benefit, which must be selected by the Policyholder.

15.5 INFLATION

CPI is used in most calculations in some form or another.

The CPI figure used throughout the Policy and in all the calculations is subject to an overall maximum of 10% (ten percent) each year, unless otherwise specified. This maximum will be reviewed, for each individual Benefit, annually by the Administrator and may be amended by the Administrator, at its sole discretion. This means that the Administrator reserves the right to change this maximum CPI percentage for different Benefits, at its sole discretion.

15.6 GENERAL RULES

The Dynamic Financial Needs Analysis is the algorithm which dynamically adjusts the Life Insured's cover to match Their changing needs, as Their life and financial needs change.

However, it is in Your and the Life Insured's interest to:

- Provide true and accurate information at all points in time during the Policy term;
- Ensure that, prior to each Anniversary, the information that We have on record for the Life Insured that is required for the Dynamic Financial Needs Analysis to re-calculate is accurate and up-to-date;
- Inform the Administrator/Insurer of any lifestyle changes, as well as any changes to the Life Insured's financial circumstances. Examples are as follows (but not limited to):
    - Changes to the Life Insured's monthly Income;
    - Occupational changes or promotions;
    - Changes to the Life Insured's debt levels;
    - Changes to the number of financial dependants that the Life Insured has;
    - Changes to the Life Insured's contribution to Their total household income;
    - Changes to the level of protection the Life Insured has at other insurers; or
    - Any other changes that may affect the Life Insured's financial situation;

    as and when the changes occur; and
- Answer any and all questions sent to You or the Life Insured from the Administrator/Insurer; in order to make sure that the cover and Benefits suggested by the Dynamic Financial Needs Analysis are in line with the Life Insured's changing needs.

Please note that in the event of the DFNA option being selected, the Administrator and Insurer cannot and will not be held liable in the event that the cover suggested does not match the Life Insured's Financial Needs if You and/or the Life Insured have not provided truthful or correct information or have omitted material information or have not answered the Dynamic Financial Needs Analysis at least on an annual basis or You have not informed the Administrator when the Life Insured experiences life events which materially affect Their financial needs, as discussed in the above paragraph.

Please note that rules, terms, conditions and calculations specified in section 15 will be reviewed from time to time by the Administrator/ and or Insurer and may be amended, at either's sole discretion.

15.7 ANNUAL RENEWABILITY OF COVER

Although the Policy provides lifetime protection (as long as Your Policy remains in force), Your cover and Premiums will be reviewed at least annually. The cover will change to account for the fact that the Life Insured's needs vary on an annual basis and should change in line with the Life Insured's evolving needs. This is in line with Our philosophy of not locking You into a static long-term contract, but rather varying cover every year to ensure that actual cover is equal to the Life Insured's needs at that point.

This will work by communicating to You 31 (thirty-one) Days prior to Your anniversary (see section 15) that You should review the Life Insured's financial needs to ensure the Cover Amounts are correct. The Life Insured will be asked to answer a few questions on the Dynamic Financial Needs Analysis about Their current circumstances. If They do not answer the questionnaire, then the cover will change in line with the Dynamic Financial Needs Analysis algorithm, that is, the relevant Sum Assureds (for each Benefit) will change with the proposed Dynamic Benefit Adjustments to align with the Life Insured's projected changing needs.

Example

You, aged 30 (thirty), take out a Dis-Chem Life Policy, on 1 January 2021. You are both the Policyholder and Life Insured on the Policy. You are married but do not have any children. You select the DFNA option on the Policy. At the Commencement Date, Dis-Chem Life's algorithm proposes R1,000,000 Life Cover and R500,000 Disability Cover to cover Your financial needs. Your monthly Premium would be R100 for your Life Cover benefit and R50 for Your Disability Cover Benefit. You decide to take out the recommended cover. You will pay these Premiums for the calendar year of 2021.

On 1 December 2021, You receive an Anniversary letter stating that You should review Your financial needs to ensure Your Cover Amounts remain relevant. You will have the choice to update these details or not.

The Anniversary letter will also contain what Your Cover Amounts will change to, based on Dis-Chem Life's unique algorithm if no input is received. The algorithm uses all Your unique characteristics and projects forward to try replicate Your unique situation as far as possible, to match Your changing needs.

Scenario 1

You decide to update the details around Your financial needs. In this scenario, all Your financial needs remain the same, except that You have a child during the year. This means Your financial needs have increased. If You were to pass away, You would need to leave money for Your Spouse as well as Your new born child.

Therefore, You will require more Life and Disability Cover to cover these needs. Dis-Chem Life's algorithm will take all these factors into account in re-assessing Your needs. In this example, it is proposed that You now require R1,200,000 Life Cover and R600,000 Disability Cover. Your Premium is expected to be R120 for Life Cover and R60 for Disability Cover. You can decide if You would like this cover or not. If not, you can keep your existing cover in place. If You decide to take the new cover, then a new Policy Anniversary letter will be sent to You confirming the changes.

Scenario 2

You decide to not update the details around Your financial needs. In this scenario, Your Cover Amounts and Premiums will automatically change in line with Dis-Chem Life's unique algorithm as indicated on Your Policy Anniversary letter. In this example (without inputs), the algorithm proposes that You require R1,180,000 Life Cover and R590,000 Disability Cover. Your Premium is expected to be R118 for Life Cover and R59 for Disability Cover.

Your Benefit and Premium will automatically adjust in line with the changes, but You can always amend Your cover, if so required.

16. Claims

16.1 OVERVIEW

Dis-Chem Life was started with the sole purpose of creating a transparent, fair and objective life insurance structure that optimally aligns the client and the Insurer's interests.

It is also why We have comprehensive Claims criteria covering both Objective Medical Criteria, which removes any subjectivity from the claims decision process, as well as Benefit specific criteria, covering such things as the inability to perform the Life Insured's Nominated Occupation, Loss of Income and Activities of Daily Living Criteria. Our broad range of Claims underpins ensures maximum protection for the Life Insured and Their family.

16.2 POST-CLAIM BENEFITS AND PREMIUMS

This section describes what happens on Your Policy after a specific Benefit Claim has occurred.

Please note that for Benefits which remain on the Policy post Claim, Premiums for those Benefits must be paid in order for those Benefits to remain on the Policy (unless specified otherwise in this Policy). If Premiums are no longer paid for those Benefits, those Benefits will fall away and no further protection will be provided by them.

After a Life Cover Claim Event

Life Cover payouts will always be a 100% (one hundred percent) pay-out and therefore the Life Cover Premiums will cease after a Life Cover Claim. The Policy and all other Benefit will be cancelled thereafter.

After a Critical Illness Claim Event

After a Critical Illness Benefit Claim, the Critical Illness Benefit as well as the Critical Illness Premiums will continue. Please note that the Critical Illness Premiums will not reduce after a valid Claim. After a valid Critical Illness Benefit Claim, the following will occur:

- The Policy will not be cancelled; and
- All other Benefits on the Policy will remain on the Policy.

Example

Example Details

- You have R 1 000 000 Critical Illness and R 500 000 Life Cover.
- You are both the Policyholder and Life Insured on the Policy.
- Your monthly Critical Illness Premium is R 100.
- Your monthly Life Cover premium is R 50.

You claim 75% (seventy-five percent) for a heart and artery Claim. You are paid out R750 000 (R1 000 000 x 75%).

After Your Claim, Your Critical Illness Benefit is reinstated to R1 000 000 since You are still protected for R 1 000 000 for all future Unrelated Claims. You will continue to pay Your Critical Illness Premium of R100 per month. Additionally, You will continue to pay Your Life Cover Premium of R 50 and You will retain Your full Life Cover Sum Assured of R 500 000.

After a Disability Cover Claim Event

Disability Cover payouts will always be a 100% (one hundred percent) pay-out and the Disability Cover Benefit and Premiums will cease after a valid Disability Cover Claim. After a valid Disability Cover Claim, the following will occur:

- The Policy will not be cancelled;
- The Disability Cover Benefit will cease on the Policy;
- The Standalone Temporary Income Protection Benefit will cease on the Policy; and
- All other Benefits on the Policy will remain on the Policy.

Income Protection Benefit Claim Event

After a Temporary Income Protection Benefit Claim Event

The Temporary Income Protection Benefit will pay up to 100% (one hundred percent) of the Life Insured's salary, depending on the salary You choose to protect, and the Premiums will cease whilst in claim. After a Claim, the following will occur:

- The Policy will not be cancelled; and
- All other Benefits on the Policy (including the Temporary Income Protection Benefit) will remain on the Policy.

After a Permanent Income Protection Benefit Claim Event

The Permanent Income Protection Benefit will pay up to 100% (one hundred percent) the Life Insured's salary, depending on the salary You choose to protect. The Premiums will cease whilst in claim. After a Claim, the following will occur:

- The Policy will not be cancelled; and
- All other Benefits on the Policy will remain on the Policy, except for the Disability Cover Benefit and the Temporary Income Protection Benefit which will both fall away thereafter.

The below table summarises what happens to Your Benefits after a Claim, excluding the Accidental Death and Disability Benefits:

Claimed Benefit	Life Cover	Disability Cover	Critical Illness Cover	Temporary / Standalone Income Protection	Permanent Income Protection	Education Protector
Life Cover	Remove	Remove	Remove	Remove	Remove	Remove
Disability Cover	Keep	Remove	Keep	Remove	Keep	Depends on option selected
Critical Illness Cover	Keep	Keep	Keep	Keep	Keep	Depends on option selected and Severity of Claim
Temporary / Standalone Income Protection	Keep	Keep	Keep	Keep	Keep	Keep
Permanent Income Protection	Keep	Remove	Keep	Remove	Keep	Depends on option selected
Education Legacy Protector	Remove (Death) Keep (Critical Illness / Disability	Remove (Death) Keep (Critical Illness / Disability	Remove (Death) Keep (Critical Illness / Disability	Remove (Death) Keep (Critical Illness / Disability	Remove (Death) Keep (Critical Illness / Disability	Remove (All)

The Education Legacy Protector will follow the Claim rules of either the Life Cover, Disability Cover or Critical Illness Cover (depends on which Claim Event are applicable).

For Policies with Accidental Benefits, the following will occur:

	After a valid Claim, what happens?	
Claimed Benefit	**Accidental Life Cover**	**Accidental Disability Cover**
Accidental Life Cover	Remove	Remove
Accidental Disability Cover	Keep	Remove

For Business Assurance policies, it works as follows:

- All death Claim Events will result in the Policy terminating.
- For scenarios where either the Disability or Critical Illness payout is less than the Life Cover Sum Assured, all other Benefits on the Policy will remain.

- For scenarios where either the Disability or Critical Illness payout is equal to the Life Cover Sum Assured, all other Benefits on the Policy will terminate.

A summary of the above Business Assurance rules are shown in the table below:

Claimed Benefit	Life Cover	Disability Cover	Critical Illness Cover
Life Cover	Remove	Remove	Remove
Disability Cover	Keep (provided the payout is lower than the Life Cover Sum Assured)	Remove	Keep (provided the payout is lower than the Life Cover Sum Assured)
Critical Illness Cover	Keep (provided the payout is lower than the Life Cover Sum Assured)	Keep (provided the payout is lower than the Life Cover Sum Assured)	Keep (provided the payout is less than 100%)

Please note that above rules, terms and conditions will be reviewed on an annual basis by the Administrator and/or Insurer and may be amended, at either's sole discretion.

16.3 MULTIPLE CLAIMS

There are 3 (three) types of subsequent multiple Claims (please see the definitions in section 1.2):

- Unrelated
- Related
- Progressive

The payment of the subsequent Claim is dependent on whether the Claim Event is Progressive, Related or Unrelated.

The Disability Benefit and the Accidental Disability Benefit will not have any multiple Claims since 100% (one hundred percent) is paid out on the first Claim. The Permanent Income Protection Benefit will not have any multiple Claims since 100% (one hundred percent) is paid out on a valid Claim Event, subject to the aggregation rules as can be found in section 8.3.7. The Education Legacy Protector will also not have any multiple Claims since 100% (one hundred percent) is paid out on the Claim.

The multiple Claims rules under the Temporary Income Protection Benefit and the Standalone Temporary Income Protection Benefit will be unlimited. If Related or Progressive Claims are made during the Off Period, then no Waiting Period will apply. For all Unrelated Claims, the full Waiting Period will always apply.

Multiple Claims for the Critical Illness Benefit work as follows:

- **Unrelated Claims**: A subsequent Unrelated Claim will be paid out, regardless if the severity of the new Unrelated Claim is higher or lower than the previous Unrelated Claim severity. In this case, the Claim payout amount is calculated as the full percentage payout, multiplied by the Benefit Amount.
- **Related and Progressive Claims**: A subsequent Claim will only be paid if the Claim Event is more severe than a previous Related or Progressive Claim. The Claim Amount that We pay is based on the difference between the percentage payout for the new Claim and the highest percentage paid for the previous Claim/s. In this case, the Claim amount is calculated as the additional percentage payout, multiplied by the Benefit Amount.

Please see the summary of how Claims will work in the different Benefits.

Benefit	Progressive	Related	Unrelated
Income Protection			
Permanent Income Protection	*Not applicable.*	No subsequent Claims will be paid. 100% (one hundred percent) payout of Sum Assured is made on the first Claim.	No subsequent Claims will be paid. 100% (one hundred percent) payout of Sum Assured is made on the first Claim.
Temporary Income Protection	Unlimited Claims allowed.	Unlimited Claims allowed.	Unlimited Claims allowed.
Standalone Temporary Income Protection	Unlimited Claims allowed.	Unlimited Claims allowed.	Unlimited Claims allowed.
Disability Cover	*Not applicable.*	No subsequent Claims will be paid. 100% (one hundred percent) payout is made on the first Claim. Maximum payout is 100% (one hundred percent) of the Benefit Amount.	No subsequent Claims will be paid. 100% (one hundred percent) payout is made on the first Claim. Maximum payout is 100% (one hundred percent) of the Benefit Amount.

Accidental Disability Cover	*Not applicable.*	No subsequent Claims will be paid. 100% (one hundred percent) payout is made on the first Claim. Maximum payout is 100% (one hundred percent) of the Benefit Amount.	No subsequent Claims will be paid. 100% (one hundred percent) payout is made on the first Claim. Maximum payout is 100% (one hundred percent) of the Benefit Amount.
Critical Illness Cover	Multiple Claims allowed, only when severity is higher. Difference in severity is paid. Maximum payout is 100% (one hundred percent) of the Benefit Amount (or the highest percentage of all the Progressive Claims).	Multiple Claims allowed, only when severity is higher. Difference in severity is paid. Maximum payout is 100% (one hundred percent) of the Benefit Amount (or the highest percentage of all the Related Claims).	Unlimited Claims allowed. Benefit Amount multiplied by full severity percentage is paid on each Claim.
Education	*No multiple claims.* Only one Claim allowed per Child	*No multiple claims.* Only one Claim allowed per Child	*No multiple claims.* Only one Claim allowed per Child

Please note that various symptoms and signs of a syndrome, overlapping syndromes, associated conditions or treatments thereof, will be regarded as one condition.

- Manifestations of other conditions as a result of the original condition will also be regarded as part of the original condition.
    - Examples are kidney failure due to severe systemic lupus erythematosus or manifestations of metastases in various organs.
- A syndrome is defined as a group of symptoms that frequently occur together or a condition characterized by a set of associated symptoms.
- In addition, all cardiac and nervous system pathologies or procedures that occur within 30 (thirty) Days of each other will be regarded as a single event.

16.4 MULTIPLE BENEFIT CLAIMS AND SIMULTANEOUS SAME BENEFIT CLAIMS

MULTIPLE BENEFIT CLAIMS

Multiple Benefit Claims arise when the Life Insured qualifies for payments from 2 (two) or more Benefits, as a result of the same incident or Claim Event. In this case, both Benefits will be paid i.e. The Life Insured qualifies for both a Critical Illness and Disability Cover payment.

Example

Example Details:

- You take out a policy with Life Cover, Critical Illness and Disability Cover.
- You are both the Policyholder and Life Insured on the Policy.
- The Life Cover Sum Assured is R1 000 000.
- The Disability Cover Sum Assured is R1 000 000.
- The Critical Illness Sum Assured is R500 000.

Unfortunately, You get diagnosed with a stage IV cancer 2 (two) years later. In this scenario, both the Sum assureds relating to the Critical Illness and Disability Cover Benefit will be paid out to You (both qualify for a 100% (one hundred percent) payment in this scenario), that is, the Disability Cover Sum Assured of R1 000 000 and the Critical Illness Sum Assured of R500 000 will be paid out to You.

Please note that if the 2 (two) Claims arise from the same incident or the same Claim Event and one of the Claims is for death, then the rules with respect to Waiting and Survival periods will apply, as detailed through this Policy.

16.4.1 Simultaneous Same Benefit Claims

Simultaneous Same Benefit claims are defined as the submission of Claims within 3 (three) months of each other, where the Claims were as a result of the same incident or Claim Event. This refers to Claims within the same Benefit category (i.e. 2 (two) Critical Illness Benefit Claims or 2 (two) Disability Cover Benefit Claims). Please note that when this occurs for lump sum disability Benefit Claims (Disability Cover and Accidental Disability Cover Claims), We will only pay 1 (one) Disability Benefit Claim since the maximum overall payout is 100% and therefore no pay out will be made for the second Claim.

Unrelated, Related and Progressive Critical Illness Benefit Claims

- In this scenario, we will pay the maximum of the 2 (two) Claims.
- If the first Claim is bigger than the second Claim, then no payment will be made to You.
  If the second Claim is bigger than the first Claim, then the difference between the 2 (two) Claims will be paid out to You.

Example

You take out a Policy with R1 000 00 Illness Cover. You are both the Policyholder and Life Insured. Unfortunately, You are involved in a terrible car accident and suffer the loss of use

of both arms, where You qualify for a 150% (one hundred and fifty percent) payment. You get paid out R1 500 000.

A month later, some of the injuries result in You becoming a quadriplegic, which qualifies for a 200% payment. In this scenario, a payout or R500 00 (200% -150% = 50% x R1 000 000) is made. If the new ailment was at 100% (one hundred percent), then no payout would have been made, since 150% (one hundred and fifty percent) is larger than 100% (one hundred percent).

Please note that this section (section 16.4) relates only to lump sum Benefits. This means that this section applies to all Benefits, except the Income Protection Benefit and Standalone Temporary Income Protection Benefit.

16.5 HOW TO CLAIM

If You or Your Beneficiaries or Cessionary (or other nominated person, such as the executor of the Life Insured's estate) needs to report a Claim, please contact the Administrator at:

Telephone : 0800 000 123
Email : claims@dischemlife.co.za

When the Policyholder or the Claimant wants to submit a Claim, We will send the Policyholder or the Claimant the forms to complete (the claim forms can also be found online at www.dischemlife.co.za.

The Policyholder or the Claimant must let Us know about the Claim Event within 3 (three) months from the Claim Event Date, unless there are extenuating circumstances for the late notice thereof (these extenuating circumstances will be examined and judged on a case by case basis). All relevant claim documents must be completed and submitted within 3 (three) months of the Claim Event Date, unless there are extenuating circumstances for the late completion and submission thereof. Please note that the Administrator/Insurer will decide, at their sole discretion, what constitutes an 'extenuating circumstance' on a case by case basis. If no notification is made to Administrator or Insurer within this period, no payout will be considered.

A Claim will be paid out once both the Administrator and Insurer are satisfied. There is no specified timeframe for this, unless specifically mentioned in the section relating to the relevant Benefit.

In the event that the Insurer/Administrator needs to request for further evidence, the Policyholder (or the Claimant) will be required to supply such further evidence to the Insurer/Administrator within 6 (six) months of the request. In terms of requesting further evidence, the Insurer/Administrator also reserves the right, at their sole discretion, to request an independent Medical Practitioner's diagnosis and report to determine validity of any Claim. The cost of obtaining medical information required by the Administrator/Insurer at

Claim stage must be paid by the Claimant or Policyholder. If the Administrator/Insurer requires additional medical evidence thereafter, the Insurer will cover those costs.

The Claim will be paid out once the Administrator/Insurer is satisfied that the specific claims definitions have been satisfied. There are no specified or regulated timeframes for this – please see the rules around Waiting and Survival Periods in as specified in sections 5, 6, 7, 8, 9 and 10.

If We Repudiate a Claim but subsequently agree to pay a Goodwill Payment, such payment action will not constitute a precedent and will be applied on fairness principals and equity based on merit. We, even though the Policyholder or any Insured Life have not fulfilled conditions of this Policy, are not prevented from Repudiating any future Claim for any similar or condition for which We apply the full terms and conditions of this Policy.

16.6 MISREPRESENTION, NON-DISCLOSURE AND FRAUD

16.6.1 Misrepresentation and non-disclosure

If any information given by You, the Life Insured or anyone acting on Your (or the Life Insured's) behalf or by any Claimants under this Policy is in any way Misrepresented by You, the Life Insured or anyone acting on Your (or the Life Insured's) behalf (or by any Claimants) or any material information has been omitted under this Policy, all Policy Benefits under the Policy will be voided.

It is Your responsibility to inform the Administrator or the Insurer if any of Your or the Life Insured's (if different) circumstances change and where this could affect the outcome of a potential Claim and/or invalidate this Policy and its Benefits.

In addition, in the event of Misrepresentation, mis-description or non-disclosure by You, the Life Insured or anyone acting on behalf of You or the Insured Life, of anything material to the assessment of the risk, the Policy will be voided ab initio and all Benefits under this Policy will be forfeited. Paid Premiums will be refunded by applying the legal remedy of rescission.

Should any Benefits have been paid out on the basis of the information provided by the Policyholder to the Administrator or Insurer, and such information, at the sole discretion of the Insurer subsequently proves to be deliberately incorrect in any material respect, the Insurer and Administrator both retain the right to take such steps as may be required to put them in the position that they would have been in if the correct information had been received timeously.

Please note that any Misrepresentation of age for the Life Insured on the Policy will not invalidate the Policy or any of its Benefits. This scenario will result in an adjustment to the Policy and its Benefits to be commensurate with the correct age and Premium(s).

Furthermore, should You or the Life Insured (or anyone acting on Your or the Life Insured's behalf) Misrepresent any information when applying for Your Policy, the Insurer will be entitled to suspend Your cover from the Commencement Date of Your Policy. In addition to this, the Insurer will also be entitled to:

- Refuse to pay out any current or future Claims that are related to the Misrepresentation or non-disclosure
- Adjust Your Premium from the date of the Misrepresentation or non-disclosure
- Recover monies already paid to You or Your Beneficiaries for Claims that relate to the Misrepresentation or non-disclosure
- Cancel or reduce certain Benefits or Your entire Policy with immediate effect.

16.6.2 Fraud

If any fraudulent means are used by You, the Life Insured or anyone acting on Your or the Life Insured's behalf (or by any Claimants) to obtain any Benefit Amount or to Claim under this Policy, all Policy Benefits under the Policy and all Premiums paid in terms of the Policy will be forfeited and the Policy will be voidable at Our option. Appropriate action will be taken as deemed necessary by the Insurer. Paid Premiums will not be refunded in this scenario.

Should any Benefits have been paid out on the basis of the information provided by the Policyholder to the Administrator or Insurer, and such information, at the sole discretion of the Insurer subsequently proves to be deliberately incorrect in any material respect, the Insurer and Administrator both retain the right to take such steps as may be required to put them in the position that they would have been in if the correct information had been received timeously.

If any fraudulent means are used by the Policyholder or Claimant or anyone acting on their behalf to obtain any Benefit under this Policy or if the Claim Event insured against is occasioned by the Policyholder or Claimant's intentional act, or with connivance, all Benefits under the Policy and all Premiums paid in terms of the Policy will be forfeited and the Policy will be voidable at the Insurer's option.

16.6.3 Intentional Acts

If any of the Claim Events insured against are occasioned by You or the Life Insured's (if different) intentional act, or with Your or the Life Insured's (if different) connivance (or by anyone acting on Your or the Life Insured (if different) behalf), all Policy Benefits under the Policy and all Premiums paid in terms of the Policy will be forfeited and the Policy will be voidable at Our option.

Appropriate action will be taken as deemed necessary by the Insurer. Paid Premiums will not be refunded in this scenario.

16.6.4 Set-Off

The Insurer and/or the Administrator has a right to deduct (set-off) from any Benefit payment due to You, any amount which You may owe to the Administrator and/or the Insurer as a result of any erroneous payment or overpayment of any Claim.

16.7 BENEFICIARIES

You may appoint a Beneficiary (or Beneficiaries, if requested by You) at any time to receive any of the Benefits payable on the Life Insured's Death. Beneficiaries are not entitled to any Benefits during the Life Insured's lifetime.

You may remove or change Your Beneficiary (or Beneficiaries) at any time. Notice of any changes must be made In Writing. Please refer to Your Schedule to see the Nominated Beneficiaries on Your Policy.

The appointment or removal of a Beneficiary will only be binding if the Insurer/Administrator lets You know In Writing that We have recorded Your Beneficiary nomination. An updated Schedule will be issued upon such a change being made.

Should Your entire Policy, or a portion of your Policy, be ceded to another person by You, the Cessionary will be paid out before any nominated Beneficiaries. Beneficiaries need not be aware of or give their consent to the ceding of a Policy.

16.8 CESSIONS

Your Policy may be ceded. This is the process where all the rights, title and interest in Your Policy are transferred or made over to another person or entity and who becomes the new owner (in the case of an Absolute Cession) or where all the rights to the Benefits are transferred or made over to another person or entity (in the case of a Collateral Cession).

Cessions are permitted at policy level. That means We do not allow the cession of individual Benefits under this Policy. Please note that no cession will be valid unless the cession is recorded by Us and confirmed in writing.

It is the responsibility of the Cedent to provide the Cessionary with the full Policy, including all documents and terms and conditions.

There are two types of cessions.

16.8.1 Absolute Cession

An Absolute Cession is where the Cessionary takes ownership of the Policy and becomes liable for the payment of Premiums on the Policy. All rights, title and interest to the Policy are permanently transferred. The Cedent has no further rights in respect of the Policy and cannot deal with the Policy. The prior Beneficiary nominations made by the Cedent will fall away (they are automatically revoked) and may be replaced by the Beneficiary nominations of the Cessionary, if any. For all Benefit payouts, if no Beneficiary nominations are made by the Cessionary then any proceeds payable on the death of the Life Insured (death Benefits) will be paid to the estate of the Cessionary (if the Cessionary and Life Insured are the same person) or to the Cessionary as the Policyholder. Benefits other than Death Benefits will be paid to the Cessionary. All terms and conditions agreed to by the Cedent will apply to the Cessionary in relation to the Policy.

Where the Income Protection Benefit is included on a Policy, an Absolute Cession could have adverse tax consequences. Tax advice should be sought.

16.8.2 Collateral Cession

A Collateral Cession is where the right to Death, Illness and Disability Benefits in the Policy are transferred to a third party as security for an unpaid debt or obligation (usually a bank). While the debt or obligation remains unpaid or outstanding the Cedent remains the owner of the Policy and responsible to pay Premiums but cannot deal in any way with the Policy without the permission of the Cessionary. When the debt or obligation is settled then full ownership automatically reverts to the Cedent.

The Income Protection Benefit will not form any part of a collateral cession agreement.

16.9 REPUDIATION OF THE CLAIM AND TIME BAR

In the event of a Claim being repudiated or the Claimant disputes the quantum of the Benefit Amount paid by the Insurer/Administrator, the Claimant is entitled to make representation to Us in respect of Our decision to repudiate the Claim or as to the manner in which the quantum of the Benefit Amount was calculated for a period of 180 (one hundred and eighty) Days from the date of receipt of the letter of repudiation or the date of the Claim payment.

If the representation is unsuccessful or the dispute is not resolved at the end of this 180 (one hundred and eighty) Day period then the Claimant has an additional 6 (six) months to institute legal action against Us by way of a summons, failing which We will no longer be liable in respect of the Claim and such legal action will no longer be possible.

Representation must be submitted In Writing to Guardrisk Life:

Address:	PO Box 786015, Sandton, 2146
Email:	LifeClaims@Guardrisk.co.za or info@Guardrisk.co.za
Tel:	011 669 1000

Where the Claimant is not satisfied with the response from Us, the Claimant is entitled to escalate the matter/a complaint to the National Financial Ombud Scheme on:

Physical address	
Cape Town:	Claremont Central Building, 6th Floor, 6 Vineyard Road, Claremont, 7708
Physical address	
Johannesburg:	110 Oxford Road, Houghton Estate, Illovo, 2198
Email:	info@nfosa.co.za
Tel:	0860 800 900
Website:	www.nfosa.co.za

In terms of Section 15 of the Financial Services Ombudsman Schemes Act No. 37 of 2004, that on receipt of the official referral to the aforementioned Ombudsman, any applicable time barring clause in terms of this Policy or the running of prescription in terms of the Prescription Act No 68 of 1969 from the date of referral to the date of withdrawal of the referral, or determination of the referral by the Ombudsman, shall be stayed. If the dispute is not satisfactorily resolved in this manner, legal action may be instituted against the Insurer for the enforcement of the Claim by way of the service of summons against the Insurer. Summons must be served on the Insurer within 6 (six) months from the date the Claimant receives the outcome in respect of the representations made, failing which all Benefits in respect of such Claim shall be forfeited and no liability can arise in terms of such Claim.

Additionally, if any person affected by a decision of the Insurer is dissatisfied with the decision, such person shall have the right to refer the matter for arbitration. Referrals to arbitration shall be in accordance with the provisions of the Arbitration Act, 1965. Notice of intention to excuse this right shall be given by the person concerned to the Insurer within 90 (ninety) Days of the Insurer's decision. Before the arbitration commences, the person concerned shall furnish such security for the costs of arbitration as the Insurer may reasonably require. The costs of the arbitration shall follow the award of the Arbitrator.

16.10 UNCLAIMED BENEFITS

If a Benefit under this Policy is an Unclaimed Benefit, We will take action to determine if the Principal Insured/Nominated Beneficiary is alive and/or aware of the Benefit payable to him/her under this Policy. Specifically, in the 3 (three) year period after the Unclaimed Benefit arises, We may:

- attempt to contact the Principal Insured/Nominated Beneficiary telephonically and electronically to advise them of the Unclaimed Benefit; or
- determine the last known contact information of the Principal Insured/Nominated Beneficiary by comparing internal and external databases, including the use of internet search engines and/or social media; or
- appoint an external tracing company to locate the Principal Insured/Nominated Beneficiary.

Before the end of the 3 (three) year period referred to above, We will confirm the Unclaimed Benefit and transfer the amount of the Unclaimed Benefit to an account in the name of the Insurer, and the Insurer will accept liability for the Unclaimed Benefit.

17. Premiums

17.1 PREMIUM PAYMENT

A Premium is payable each month. The owner of the Policy must pay the Premium of the total amount stated in the Policy Schedule. Premiums are payable monthly in advance from the first selected billing day for the duration of the Policy.

The monthly Premium will automatically be debited from Your selected payment method (Your bank account, debit card or credit card, whichever You select as Your preferred payment method) by Us on Your selected payment date. If Your selected payment date falls on a weekend or recognized South African Public Holiday, Your Premium payment date may change, and We may debit Your selected payment method on a different date. If a DebiCheck debit order is selected as the preferred payment method, then the monthly Premium may be deducted on a date different to the selected payment date. Your monthly instalment may also be debited earlier in December and / or April because of public holidays or on other days. If there are insufficient funds in Your account to cover Your Debit Order, We may track Your account until sufficient funds are available for Us to deduct.

A Premium will be debited from Your selected payment method on Your Date of Commencement. That is, once You have concluded the onboarding process, a deduction from Your selected payment method will be made on Your selected payment date (Commencement Date). This deduction will occur on the first Billing Day after the Policy was taken out.

We will only consider the Premium as paid when it is confirmed received by the Insurer. This is provided that the Premium is not reversed later. You will only have rights to ownership of the Policy when the first Premium is received. This means that the Insurer will only become liable to provide Policy Benefits, once the first Premium is received.

17.2 WHAT HAPPENS IF PREMIUMS ARE NOT PAID ON THE DUE DATE? (GRACE PERIOD)

Non-payment of Premiums work differently depending on whether the Policyholder has paid a Premium and the Policy has commenced, or before a Premium has been paid.

The scenarios work as follows:

- If Your Policy has not yet activated and You miss a premium payment, We will attempt to collect this the following month. If that attempt fails, We will try again the next month. If a total of three

Premiums remains unpaid, Your Policy will automatically lapse, and all associated Benefits will be terminated.

- If Your Policy has activated and You miss a premium payment, We will attempt to collect this and the next month's premium the following month. If a total of two premiums remains unpaid, Your policy will automatically lapse, and all associated benefits will be terminated. Any Claim occurring in a month where a Premium has not been paid will be considered and if approved, the outstanding Premium will be deducted from the Benefit Amount. Any Claim occurring in a month after the Policy has either lapsed or cancelled will be declined.

17.3 PREMIUM ESCALATION

For each Benefit on the Policy, the monthly Premium (relating to that specific Benefit) will escalate annually by factor at Your Policy Anniversary, specified by the Administrator each year, which takes into account either a CPI increase or a Dynamic Premium Adjustment for that specific Benefit, as well the age of the Life Insured at that point in time. The Policyholder will receive a notification of such increase 31 (thirty-one) Days before the Policy Anniversary date. This will be the Annual Premium Increase on the Policy.

The calculation is below:

*New Monthly premium = Current Monthly premium x (1 + age specific adjustment) * (1 + CPI/DFNA)*

The premium will increase each year by inflation which the Administrator will get from Statistics SA and will use the data that is present 3 (three) months before the Policy Anniversary. The premium will then also increase by a factor to take into account the increase in the risk due to a person ageing. This will be the age specific increase.

Example 1: CPI

A Policyholder takes out R1,000,000 Life Cover at a starting monthly premium of R100. Below is an example of what CPI and age specific adjustments will look like over the next 7 (seven) years.

Year	CPI	Age specific adjustment
1	5%	6%
2	5%	6%
3	5%	6%
4	5%	6%
5	5%	6%
6	5%	6%
7	5%	6%

Year	Starting Premium	Calculation
0	R100.00	
1	R111.30	=R100 x (1+6%) x (1+5%)
2	R123.88	=R113.40 x (1+6%) x (1+5%)
3	R137.88	=R128.60 x (1+6%) x (1+5%)

17.4 WHAT IF I CANNOT AFFORD MY PREMIUMS INCREASES?

Each year, 31 (thirty-one) Days before Your Policy Anniversary date, the Administrator will inform You of how Your Policy will change after Your Anniversary Date. If for any reason You are unable to afford the premium increases, You should notify Us before the Anniversary Date. If You cannot afford the changes, for whatever reason, You may adjust Your policy by reducing or removing Benefits to allow for a lower Premium, to suit Your individual situation and what You can afford at that point in time. A new Policy Schedule will be sent to You confirming the changes made.

17.5 PREMIUM ADJUSTMENT

The Insurer will not change or Vary the Premium rate during the first 12 (twelve) months after Commencement Date of the Policy unless there are reasonable actuarial grounds to change or Vary the Premium rate or when the variation will be to the benefit of the Policyholder. After the first 12 (twelve) months, the Insurer reserves the right to review and change the Premium and cover annually. Any changes to the Premium rate will be notified to the Policyholder 31 (thirty-one) Days prior to the change taking effect. Such notification will provide appropriate details of the reasons for the change to the Premium rate and will afford the Policyholder with reasonable steps, such as an option to terminate the policy, to mitigate the impact of the increase on the Policyholder.

The Premium rates may be amended or changed, based on the following factors: past and future expected economic factors (for example, but not limited to, interest rates, tax and inflation), past and future expected claims experience (mortality and morbidity experience), past and future expected lapse experience, expected future reinsurance, any past or future expected anti-selection or moral hazard exhibited the Life Insured, expected future costs of the Administrator, any regulatory and legislative changes impacting this Policy or any other factor impacting the Premium that the Insurer deems material at the time.

18. Reinstatements

If You cancel Your Policy or Your Policy lapses, and thereafter (within 2 (two) months only) decide to re-instate it at or below the original levels, the reinstatement will only be permitted on the receipt of all Your outstanding Premiums, together with the satisfactory completion of Our Declaration of Health form or whatever underwriting requirements the Administrator or Insurer may deem necessary from time to time. Your cover will be reinstated to the original levels just before You cancelled Your Policy or just before Your Policy lapsed. However, all Waiting Periods (such as the 60 (sixty) month suicide Waiting Period) will start again from the reinstatement date.

No reinstatement will be allowed after 2 (two) months from originally cancelling Your Policy. In this scenario, You will be treated as a new business client with all new business rules, terms and conditions applying.

Please note that:

- You can cancel Your Policy and then subsequently reinstate it a maximum of 2 (two) times over the entire duration of Your Policy term. Thereafter, this Policy will be treated as a new policy, with all the rules, terms and conditions applicable for a new policy.
- Reinstatements will only be allowed if You pay any and all outstanding Premiums before the reinstatement occurs.

19. General Policy Rules

19.1 SPECIFIC RESTRICTIONS ON LIABILITY

The Insurer's liability in terms of the Policy shall cease in the event of a Claim settlement being made for the Life Cover Benefit of the Life Insured. This is applicable to a once-off Claim payment.

The Insurer's liability in terms of the Policy shall also cease in the event of a Claim settlement being made for a Benefit of the Life Insured which depletes all the Life Insured's remaining cover and no further Benefits remain on the Policy.

19.2 TERMINATION OF THE POLICY

This Policy will terminate or end on the earliest of the following scenarios:

- On the last day of the billing cycle in which You paid the Insurer/Administrator a Premium;
- On the last day of the billing cycle in which You paid the Insurer/Administrator a Premium, where You have provided a cancellation instruction In Writing to the Administrator or Insurer;
    - No Benefits are payable on or after the cancellation date of Your Policy.
- Your Benefits are depleted due to a Benefit payment and You have no other Benefits on the policy. This will be the date when the last Benefit has been paid;
- The Policy is terminated with immediate effect due to non-disclosure, fraud or Misrepresentation as described in section 16.6;
- You have failed to pay Your Premiums for a second month in a row (please refer to section 17.2);
- We cancel the Policy by giving the Policyholder 31 (thirty-one) Days' notice; or
- We may immediately cancel this Policy or place it on hold, refuse any transaction or instructions, or take any other action considered necessary in order to comply with the law and prevent or stop any undesirable or criminal behaviour.

19.3 COOLING OFF PERIOD

This Policy can be cancelled by You, the Policyholder, within the Cooling-off Period by informing the Administrator In Writing of Your requested cancellation, provided no Benefit Amount has been paid or claimed or the Claim Event insured against has not yet occurred on the Policy. In this scenario, any Premium paid during this Cooling-off Period up to the date of receipt of the cancellation request will be refunded to You in full. All cover for the Life Insured on the Policy will cease immediately upon receipt of this cancellation request.

19.4 CANCELLATION PROCEDURE

Should You wish to cancel Your Policy at any time after the initial Cooling-off Period, You must provide a cancellation instruction In Writing to the Administrator or Insurer. We will provide cover until the end of the same billing cycle in which a Premium has already been paid in which the cancellation instruction has been received. Please note that such cancellations, after the initial 31 (thirty-one) Day Cooling-off Period, will not attract a refund of any Premiums paid.

19.5 NO SURRENDER, PAID-UP OR LOAN VALUES

This Policy acquires no surrender, paid-up or loan values. There is no cumulative effect of Premiums paid and each monthly Premium is used to cover the risk for that specific month. Each month a Premium is required to be paid to renew the cover.

There is no surrender value on the Policy and nothing will be paid out when the Policyholder cancels their Policy.

19.6 CONDITION PRECEDENT

Strict compliance by the Life Insured with all the provisions, conditions and terms of this Policy shall be a condition precedent to liability on the part of the Insurer hereunder.

19.7 INTERPRETATION

The decision of the Insurer as to the meaning of or interpretation of the Policy shall be final and binding on the Policyholder and every person claiming to be entitled to a Benefit in terms of this Policy.

19.8 DYNAMIC NATURE OF THE DIS-CHEM LIFE POLICY

When the DFNA option is selected, the Dis-Chem Life Policy becomes a living, dynamic policy which changes as the Life Insured does. It adapts to the Life Insured's life during the entire Policy term as well as on Claim. Due to the dynamic nature, the Administrator reserves the right to review, from time to time, and at their sole discretion change/amend any rules, terms, conditions, calculations, Premiums, formulas, Benefit workings, Benefit Claim criteria (Claim categories/definitions), Exclusions, term of the Policy or Benefits, Benefit Expiry Ages as well as any other workings (or wording extracts) stated or specified throughout this Policy. 31 (thirty-one) Days' notice will be given to the Policyholder if any of the above changes are made on the Policy.

Additionally, in order to give optimal cover and stay protected at every point in the Life Insured's life, please note that the Life Insured's personalised cover will continually be updated with changes in tax laws and tax exemptions (and allowances), the changing nature of occupations and the remuneration attached to each occupation, any regulatory or legislative changes impacting this Policy and calculations underpinning it, as well as changes to economic factors (such as, but not limited to interest rates and inflation), different asset class returns, investor risk profiles and investment management fees.

Please note that We rely on You to:

- Provide Us with true and accurate information at all points in time during Your Policy term;
- Ensure that, prior to each Policy Anniversary, the information that We have on record is accurate and up-to-date;
- Inform Us of any lifestyle changes, as well as any changes to the Life Insured's financial circumstances. Examples are as follows (but not limited to):
    - Changes to the Life Insured's latest monthly Income;
    - Occupational changes or promotions;
    - Changes to the Life Insured's debt levels;
    - Changes to the Life Insured's financial dependant situation;
    - Changes to the level of protection the Life Insured may have at other insurers; or
    - Any other changes that may affect the Life Insured's financial situation;

      as and when changes occur; and
- Answer any and all questions sent to You and the Life Insured form the Administrator/Insurer (if applicable);

  to make sure that the cover and Benefits suggested are in line with the Life Insured's changing needs. We also rely on the above information to be timeously received to ensure that Dynamic Financial Needs Analysis provide accurate and personalised cover.

19.9 PERSONAL LIABILITY

No director, agent, representative or employee of either the Insurer or Administrator shall be personally liable in respect of any Claim or demand in terms of this Policy.

19.10 CUSTODY OF POLICY

A copy of this Policy shall be held by the Policyholder and the Insurer who shall both attach thereto such Schedules as may form part of this Policy from time to time. In the event of any discrepancy arising between the Policy held by the Policyholder and the Insurer, the Policy and Schedules held by the Insurer, shall constitute *prima facie* proof of the applicable terms and conditions in force at any specific point in time.

19.11 BENEFIT NOT ASSIGNABLE

A Policyholder may not pledge, assign or otherwise alienate the Benefits or the rights to Benefits in terms of this Policy and such Benefits shall not be subject to any form of execution or judgment and shall not, on insolvency, or on surrender form part of the estate of the Life Insured.

19.12 POLICY VARIATION

This Policy is issued on the basis that the statements and information made and set forth in the application and all declarations made in respect thereof are true and correct and constitute a full disclosure of all facts and circumstances likely to materially affect the assessment of the risk at the time of the issue of this Policy.

The Insurer will not change or Vary the terms and conditions during the first 12 (twelve) months after the Commencement Date of the Policy unless there are reasonable actuarial grounds to change or Vary the terms and conditions or when the Variation to the terms and conditions will be to the benefit of the Policyholder. After the first 12 (twelve) months, the Insurer reserves the right to change or Vary the terms and conditions annually. Any changes to the terms and conditions will be notified to the Policyholder 31 (thirty-one) Days prior to the change taking effect. Such notification will provide appropriate details of the reasons for any change to the provisions, terms or conditions of the Policy and an explanation of the implications of the change. Any Variations and/or changes will be binding on both the Insurer and the Insured Life and can be applied only after Written Communication of these changes has been sent to the Policyholder's last known address as it appears in our records at that time.

No Variation to this Policy will be binding on the Insurer unless made In Writing and signed by a duly authorized officer of the Insurer and confirmed thereafter by payment of the Policyholder of the Premium whether varied or not. No act or omission to act by the Insurer or any officer or employee of the Insurer shall be deemed to be a representation on behalf of the Insurer upon which the Insured Life or the Insured Life's heirs, executors or assigns are entitled to act.

19.13 REMUNERATION PAYABLE TO THE ADMINISTRATOR AND INTERMEDIAIRES

Commission will be earned by the Administrator and is part of the Premium. The commission is 3.25% of each Premium over the lifetime of the Benefit, where the lifetime is subject to a minimum of 10 (ten) years and a maximum of 26.15 years. The Commission is regulated in terms of the Insurance Act. The Administrator also earns a 9% binder fee, 4.75% outsource fee and a specific Policyholder outsource fee (please refer to the Schedule for this percentage) for performing activities on behalf of the Insurer which is included in the monthly Premium and payable to the Administrator.

Any commission payable to any brokers or financial intermediaries will be specified in the Schedule.

20. General Legal Compliance

20.1 INDULGENCE, LENIENCY OR EXTENSION

No indulgence, leniency or extension of time which the Administrator or the Insurer may grant or show to an Insured Life, shall in any way prejudice the Administrator or the Insurer, or preclude the Administrator or the Insurer, from exercising any of their rights in the future.

20.2 JURISDICTION AND GOVERNING LAW

Only the courts of South Africa shall have jurisdiction to entertain any Claims arising out of or in respect of this Policy and the law of South Africa shall apply to this Policy.

The parties hereby consent to the jurisdiction of the High Court of South Africa (South Gauteng Division, Johannesburg), in respect of all Claims and causes of action between them, whether now or in the future, arising out of or in respect of this Policy.

20.3 PROCESSING AND PROTECTION OF PERSONAL INFORMATION

Your privacy (and that of the Life Insured, if different) is of utmost importance to the Administrator, our Affiliates and the Insurer. The Administrator/Insurer will take the necessary measures to ensure that any and all information, including Personal Information (PI) and Protected Health Information (PHI) (as defined in the Protection of Personal Information Act 4 of 2013) provided by You (or the Life Insured, if different) which is collected from You (or the Life Insured, if different) is processed in accordance with the provisions of the Protection of Personal Information Act 4 of 2013 and further, is stored in a safe and secure manner.

You (and the Life Insured, if different) hereby agree to give honest, accurate and up-to-date PI and PHI and to maintain and update such information when necessary.

You (and the Life Insured, if different) accept that all PI and PHI collected by the Administrator, our Affiliates and the Insurer may be used for the following reasons:

1. to establish and verify Your (and the Life Insured's, if different) identity in terms of the Applicable Laws;
2. to establish and assess Your (and the Life Insured's, if different) health in terms of the risk to be insured;

3. to enable the Administrator, our Affiliates and the Insurer to fulfil our obligations in terms of this Policy which includes but not limited to policy servicing, premium collection, claims management, required communication;
4. to enable the Administrator and our Affiliates to market our products to You unless you have opted-out of receiving any marketing from us or our Affiliates;
5. to enable the Administrator, our Affiliates and the Insurer to take the necessary measures to prevent any suspicious or fraudulent activity in terms of the Applicable Laws; and
6. to enable the Administrator, our Affiliates and the Insurer to take the necessary measures in the event of a data or security breach in terms of the Applicable Laws; and
7. reporting to the relevant Regulatory Authority/Body, in terms of the Applicable Laws.

The Administrator, our Affiliates and the Insurer will collect Your PI and PHI when You interact with the Administrator's services, including when You visit the Administrator's website, use the Administrator's applications, or communicate with the Administrator. The Administrator may use artificial intelligence (AI) technology to process and analyse the information the Administrator collect. This includes but is not limited to using AI algorithms to improve our services and enhance user experience.

The Administrator, our Affiliates and the Insurer may use third-party applications and platforms, such as social media platforms to process Your PI and PHI.

The Administrator, our Affiliates and the Insurer will only process Your PI and PHI with Your consent. These details will only be used by staff of the Administrator, the Administrator's Affiliates, the Insurer, the Administrator's agents and any third party subcontracted by the Administrator, the Administrator's Affiliates and the Insurer. Due to the nature of our business, at times the Administrator uses other third parties subcontracted by the Administrator, the Administrator's Affiliates and the Insurer who in turn process Your PI and PHI.

The Administrator, our Affiliates and the Insurer may further process Your PI and PHI in terms of Section 15 (3) of POPIA for historical, statistical or research purposes. The Administrator ensures that the further processing of Your PI and PHI will only be carried out solely for this purpose and that it will not be published or shared in any identifiable form. The Administrator, our Affiliates and the Insurer only processes PI and PHI of children with the consent of a parent or guardian. You may not provide PI and PHI to us if You are under the age of 18. If You are providing PI and PHI on behalf of the Life Insured, You confirm that You are authorised to do so and have the necessary consent to provide this PI and PHI to us for Processing.

You have the right to object to the Processing of Your PI and PHI but in order for the Administrator, our Affiliates and the Insurer to engage with You in order to activate and service Your Policy and Benefits, it is required that You accept this privacy statement.

The Administrator , our Affiliates and the Insurer may share Your (and the Life Insured's, if different) PI and PHI for further processing with third party service providers, agents, contractors, employees and law enforcement agencies. Your PI and PHI may also be shared between the Administrator , the Administrator's Affiliates and the Insurer and vice versa. PI and PHI will only be shared in a justified manner and in order to comply with a regulatory requirement in terms of legislation or during a legal process for a legitimate business requirement. Such third parties and the Administrator's Affiliates may have an obligation to keep Your (and the Life Insured's, if different) PI and PHI secure and confidential.

This will include information that will be shared with:

1. Payment processing service providers, merchants, banks and other persons that assist with the processing of Your payment instructions;

2. Law enforcement and fraud prevention agencies and other persons tasked with the prevention and prosecution of crime;
3. Regulatory authorities, industry ombudsmen, governmental departments, local and international tax authorities, and other persons that the Administrator , our Affiliates and the Insurer in accordance with the Applicable Laws, are required to share Your (and the Life Insured's, if different) PI and PHI with;
4. Credit Bureau's and any other service provider who performs credit and background checks, to contact, request and obtain credit information to verify Your identity, to verify Your contact information, perform an assessment of Your behaviour, profile, payment patterns, indebtedness, income, whereabouts, creditworthiness; to make reasonable enquiries to verify and research any details provided by You to the Administrator or our Affiliates;
5. Services providers, agents and sub-contractors that the Administrator, our Affiliates and the Insurer have contracted to receive and process medical information, to share relevant medical information, such as consultations with medical service providers, procedures, diagnoses, codes and medical aid information, as well as lifestyle and personal information that may be needed in terms of this product offering.
6. Service providers, agents and sub-contractors that the Administrator, our Affiliates and the Insurer have contracted with to offer and provide products and services to any customer as well as to determine the best product for any customer; and
7. Persons to whom the Administrator and Insurer cede their rights or delegate their authorities to in terms of this Policy.

You acknowledge that any PI and PHI supplied to the Administrator, our Affiliates and the Insurer in terms of this Policy is provided according to the Applicable Laws.

Unless consented to by Yourself, the Administrator/Insurer will not sell, exchange, transfer, rent or otherwise make available Your (and the Life Insured's, if different) PI and PHI (such as Your (and the Life Insured's, if different) name, address, email address, telephone or fax number) to any other parties and You indemnify the Administrator/Insurer from any claims resulting from disclosures made with Your consent.

The Administrator, our Affiliates and the Insurer will only send PI and PHI outside of South Africa, for further processing and storage, in adherence with the requirements in section 72 of POPIA. Currently data is being stored and processed in the European Union, Great Britain, Australia and the United States and may also be stored in other countries as advised in writing from time to time, for the purpose of cloud storage, monitoring of our systems and administering policies. The PI and PHI is transferred to foreign countries that has the same privacy protection laws similar to South Africa and the data subject has provided consent.

You have an obligation to advise us if any of Your (or the Life Insured's, if different) PI and PHI that is held by the Administrator, our Affiliates and the Insurer changes or is invalid, to ensure that our records are updates. Any changes can be sent to info@dischemlife.co.za

The Promotion of Access to Information Act (PAIA) together with POPIA provides an individual the right to access information that is held by a public or private body in certain circumstances. This right can be exercised as provided for in the Dis-Chem Life PAIA Manual on our website www.dischemlife.co.za

If You feel that we are not living up to our stated Privacy Policy, or if You have any questions about this Privacy Policy, please contact: privacyoffice@dischemlife.co.za or call 080 000 0123.

Alternatively, You have the right to lodge a complaint with the Information Regulator at:

Physical Address :JD House, 27 Stiemens Street, Braamfontein, Johannesburg, 2001

Postal Address	:P.O Box 31533, Braamfontein, Johannesburg, 2017
Complaints email	:POPIAComplaints@inforegulator.org.za
General enquiries email	:enquiries@inforegulator.org.za

You understand that if the Administrator/Insurer has utilised Your (or the Life Insured's, if different) Personal Information contrary to the Applicable Laws, You have the right to lodge a complaint with Guardrisk. Should the Insurer not resolve the complaint to Your satisfaction, You have the right to escalate the complaint to the Information Regulator.

You, the Policyholder, and the Life Insured (if different) hereby consent to the exchange of information, including medical information, between the Administrator, our Affiliates and the Insurer, any Medical Practitioner the Life Insured has consulted and any other life office. You and the Life Insured (if different) hereby give the Administrator, our Affiliates and the Insurer permission to access this information on the application form or on the online application/onboarding process. This does not remove or reduce Your and the Life Insured's (if different) obligations to provide full disclosure in Your application form.

You further consent to the sharing of relevant medical information, such as consultations with medical service providers, procedures, diagnoses, codes and medical aid information as well as lifestyle and personal information that may be needed in terms of this product offering. By accepting these terms and conditions You confirm that You are informed and understand that Your (or the Life Insured's, if different) medical information will be treated with the utmost confidentiality and respect and will only be used for the purposes of a HealthCheck.

You, the Policyholder, and the Life Insured (if different) hereby consent to the exchange of information, including that of debt levels and the like, between the Administrator, our Affiliates and the Insurer and any second- or third-party data source. You and the Life Insured (if different) hereby give the Administrator, our Affiliates and the Insurer permission to access this data to assist in calculating various Benefits, Premiums and features such as (but limited to) the proposed cover for the Dynamic Financial Needs Analysis, on an ongoing basis, to make sure Your cover is up to date and in line with ever-changing financial needs.

21. Complaint Resolution Process

If You have a complaint or if You believe You did not receive enough information about the Policy, please contact the Administrator at:

Telephone:	080 0000 123
Email:	complaints@dischemlife.co.za

If You remain dissatisfied with the response, You may escalate the complaint to the product supplier directly at:

Telephone:	0860 333 361
Email:	complaints@guardrisk.co.za

If You are unhappy with any terms of the Policy or anything We have done in relation to the Policy, You can contact the Ombudsman at:

National Financial Ombud Scheme (for claims / service related matters)

Physical Address Cape Town: Claremont Central Building, 6th Floor, 6 Vineyard Road, Claremont, 7708

Physical Address Johannesburg:	110 Oxford Road, Houghton Estate, Illovo, 2198
Tel:	0860 800 900
Email:	info@nfosa.co.za
Website:	www.nfosa.co.za

FAIS Ombudsman (for product / advice related matters)

Postal Address:	PO Box 41, Menlyn Park, 0063
Tel:	(012) 762-5000
Sharecall:	(086) 066 3274
Email:	info@faisombud.co.za

Financial Sector Conduct Authority (for market conduct related matters)

Postal Address:	PO Box 35655, Menlo Park, 0102
Tel:	(012) 428-8000
Fax:	(012) 346 6941
Email:	info@fsca.co.za

Information Regulator (for complaints relating to the use of Personal Information)

Postal Address:	PO Box 31533, Braamfontein, Johannesburg, 2017
Tel:	+27- 010- 023- 5200
Email:	POPIAComplaints@inforegulator.org.za

22. Treating Customers Fairly Principles

The Treating Customers Fairly principles are viewed seriously by the Insurer and Administrator, and all 6 (six) outcomes are practiced at all times. The Administrator/Insurer will, in all interactions with You, endeavour to deliver excellent customer experiences which the Administrator/Insurer will achieve through the ongoing review of all business practices and analysis of complaints. It is the Administrator/Insurer's objective to be fair in the treatment of all clients and partners and being compliant, in all aspects, of the 6 (six) outcomes of the Treating Customers Fairly framework. These Outcomes are:

1. You are confident that Your (and the Life Insured's, if different) fair treatment is key to the Administrator/Insurer's culture;
2. Products and services are designed to meet Your (and the Life Insured's, if different) needs;
3. The Administrator/Insurer will communicate clearly, appropriately and on time;
4. The Administrator/Insurer provide advice which is suitable to Your (and the Life Insured's, if different) needs and circumstances;
5. The Administrator/Insurer's products and services meet Your (and the Life Insured's, if different) standards and are of an acceptable level; and
6. There are no barriers to access the Administrator/Insurer's services, change Benefits, switch providers, make a Claim or to lodge any complaints.

23. Appendices

23.1 APPENDIX 1

23.1.1 Objective Medical Criteria for Disability Cover and Permanent Income Protection Benefits

GENERAL PROVISIONS

All changes reflected in the below definitions (Claim Events) must be total, permanent (and irreversible) despite treatment according to recognized medical protocols.

The diagnosis of the disease causing the impairment must be confirmed by an appropriate Specialist. The diagnosis must be supported by the appropriate objective investigations and test results.

Please also note that the Activities of Daily living categories and definitions are described in Appendix 4.

Please note that for all organ transplants, the Life Insured must be the organ receiver and not the organ donor.

The Claim Events described in this section must have occurred after the commencement of the Benefit in order to be eligible for a Claim pay-out.

1. CANCER

All the below definitions are paid out at 100%.

DEFINITION	PAY-OUT
Stage IV Cancer	100%
Stage III Cancer scoring 4 on the ECOG performance scale continuously for a period of over six months	100%
Leukaemia scoring 4 on the ECOG performance scale continuously for a period of over six months	100%
Brain Tumour WHO Grade III	100%
Brain Tumour WHO Grade IV	100%
Stage III Multiple Myeloma*	100%

*Permanence will be re-assessed 5 (five) years from the Date of Disability.

2. MUSCULOSKELETAL SYSTEM*

All the below definitions are paid out at 100%.

DISEASE	DEFINITION	PAY-OUT
Upper Limbs	Total and permanent loss of use of both upper limbs at the level of the wrists or higher (proximal to the wrist)	100%
	Amputation of both upper limbs at the level of the wrists or higher (proximal to the wrist)	100%
Lower Limbs	Total and permanent loss of use of both lower limbs at the level of the ankle or higher (proximal to the ankle)	100%
	Amputation of both lower limbs at the level of the ankle or higher (proximal to the ankle)	100%
Upper and lower limb	Total and permanent loss of use of one upper limb above (proximal to) the wrist and one lower limb above (proximal to) the ankle	100%
	Amputation of one upper limb above (proximal to) the wrist and one lower limb above (proximal to) the ankle	100%
Spine	Cauda equina Syndrome	100%
	Loss of bowel integrity consequent upon irreversible neurologic damage.	100%
	Loss of bladder integrity consequent upon irreversible neurologic damage.	100%
	Paraplegia	100%
	Quadriplegia	100%

	Cervical spine impairment resulting in 30% WPI after surgery unless surgery is medically contra-indicated	100%
	Thoracic spine impairment resulting in 22% WPI after surgery unless surgery is medically contra-indicated	100%
	Lumbar spine impairment resulting in 33% WPI after surgery unless surgery is medically contra-indicated	100%
	Permanent inability to perform 3 Self-Care Activities of Daily Living	100%
Soft tissue	Severe facial disfigurement as per AMA guide Class four**	100%
	25% body surface area full thickness burns resulting in contractures with 50% WPI**	100%

* Disorders include muscle, bone, nerve or joint impairments.

** Based on AMA guides to the Evaluation of Permanent Impairment; latest edition - examining doctor will be provided with specific valuating protocols.

WPI - Whole person impairment

3. CARDIOVASCULAR

All the below definitions are paid out at 100%.

DISEASE	DEFINITION	PAY-OUT
Heart failure due to Myocardial Infarction or Valvular heart disease or Cardiomyopathy or Cardiac Arrhythmias or Congenital heart disease or Hypertensive heart disease	NYHA III and EF less than 40%	100%
	Maximum METs achieved on effort ECG less than 2	100%
	Awaiting cardiac transplantation	100%
	NYHA IV confirmed by a cardiologist	100%

Hypertension	Cardiac end organ damage as defined by an estimated LV mass Males: more than 255 g (greater than 131g/m2) Females: more than 193g (greater than 113g/m2) or Inter-ventricular septum or posterior wall thickness of more than 17mm	100%
Constrictive Pericarditis	Constrictive pericarditis as confirmed on transthoracic echocardiography with all of the following: Dilatation of the inferior vena cava and hepatic veins, calcifications in the pericardium, abnormal septal wall motion and atrial enlargement.	100%
Peripheral arterial disease	Permanent ABI less than 0.4 following vascular surgery unless surgery is medically contra-indicated	100%
	Gangrene of a limb	100%
	Amputation of a limb	100%

4. NERVOUS SYSTEM

All the below definitions are paid out at 100%.

DEFINITION	PAY-OUT
Total and permanent loss of speech	100%
Total and permanent loss of comprehension of language	100%
Permanent inability to perform four or more categories of Activities of Daily Living	100%
Permanent inability to perform three or more Self-care Activities of Daily Living	100%
Persistent vegetative state for more than three months	100%

Permanent loss of memory recall or orientation to person, place and time, confirmed by a persistent MMSE score of less than 21	100%
Permanent non-progressive cognitive impairment with a MMSE score of less than 21	100%
Dementia with progressive neurocognitive disorders with a permanent CDR score of 2 or more	100%
Persistent quadriplegia	100%
Persistent hemiplegia	100%
Persistent paraplegia	100%
Visual Impairment* defined as best corrected binocular Snellen rating of less than 20/200	100%
Hearing loss* (deafness) of 90db or more in both ears measured over the frequencies (500, 1000, 2000 Hz) in two measurements over six months with a hearing aid	100%

All changes must be total, permanent and irreversible. All definitions to be confirmed by corresponding findings on specialist investigation.

* All measurements are with appropriate aids.

5. RESPIRATORY SYSTEM

All the below definitions are paid out at 100%.

DISEASE	DEFINITION	PAY-OUT
Chronic obstructive airways disease (chronic bronchitis emphysema)	FVC less than 40% of predicted* or FEV1 less than 40% of predicted* or Dco less than 40% predicted*, and all with constant use of prescribed oxygen due to blood oxygen saturation levels below 88%	100%

Asthma	FVC less than 40% of predicted* or FEV1 less than 40% of predicted* or Dco less than 40% predicted*, and all with constant use of prescribed oxygen due to blood oxygen saturation levels below 88%	100%
Restrictive or Mixed Lung Disease	FVC less than 40% of predicted* or FEV1 less than 40% of predicted* or Dco less than 40% predicted*, and all with constant use of prescribed oxygen due to blood oxygen saturation levels below 88%	100%

* Pulmonary function tests should be performed by a pulmonologist, including post-bronchodilatation testing, and show less than 5% variation between three successful readings - these tests must be technically acceptable to the treating Specialist as well as to the Insurer's medical panel.

6. DIGESTIVE SYSTEM

All the below definitions are paid out at 100%.

DISEASE	DEFINITION	PAY-OUT
Upper and lower digestive tract disease*	Anatomical loss and alteration in the gastrointestinal tract with medical evidence of established gastrointestinal pathology and weight loss of more than 25% below the lower limit of normal BMI or BMI of less than 14, if unable to be corrected medically	100%
	Faecal incontinence defined as permanent, continuous uncontrolled passage of faecal material. Colostomies and ileostomies are not covered under this definition	100%

	Permanent disturbance of bowel function resulting in a malabsorption syndrome with evidence of any two of the following: 1) Steatorrhoea or more than 20g of fat in the stool 2) Refractory anaemia of Hb less than 9g/dl 3) Refractory hypoalbuminaemia of less than 28g/l	100%
	Irreparable hernia with previous bowel obstruction and the permanent inability to perform 4 or more categories of Activities of Daily Living.	100%
	Permanent inability to swallow due to an anatomical or neurological abnormality as confirmed by abnormal oesophageal manometry or imaging studies	100%
Liver and biliary disease	Chronic liver disease classified as Child-Pugh Class C	100%
	Awaiting liver transplant on a recognised SA or international transplant list	100%

*Functional disorders with no demonstrable gastrointestinal pathology are excluded under this Benefit.

7. MENTAL AND BEHAVIOURAL DISORDERS

This Benefit category covers mental and behavioural disorders.

DEFINITION	PAY-OUT
Any mental health episode that has resulted in all of the following: • Institutionalisation/hospitalisation* in a registered psychiatric facility at least 3 times during the last 12 months, with each admission lasting for longer than 4 weeks; and • Chronic unremitting symptoms; and	100%

• Has not responded to comprehensive management and treatment which the person has completed based on best clinical practice for more than 24 months; and • Has resulted in the inability to perform any type of work for payment or reward for a period of at least 24 months; and • Diagnosis and impairment to be confirmed by two independent specialists.	

* Excluding institutionalisation/hospitalisation for drug or alcohol abuse or a violation of South African criminal law.

8. ENDOCRINE SYSTEM

All the below definitions are paid out at 100%.

DISEASE	DEFINITION	PAY-OUT
Diabetes mellitus	Claims as a result of type 1 or type 2 diabetes mellitus with evidence of end-organ damage are assessed under the relevant body systems	100%
Cushing's syndrome	Claims as a result of any endocrine disease are assessed under the relevant body systems	100%
Phaeochromocytoma	Claims as a result of any endocrine disease are assessed under the relevant body systems	100%
Syndrome of inappropriate anti-diuretic hormone secretion (SIADH)	Claims as a result of any endocrine disease are assessed under the relevant body systems	100%
Chronic adrenal insufficiency	Claims as a result of any endocrine disease are assessed under the relevant body systems	100%
Parathyroid associated chronic hypo- or hypercalcaemia	Claims as a result of any endocrine disease are assessed under the relevant body systems	100%
Chronic hyperaldosteronism	Claims as a result of any endocrine disease are assessed under the relevant body systems	100%

9. HAEMATOLOGY

All the below definitions are paid out at 100%.

DEFINITION	PAY-OUT
A permanent treatment resistant pancytopaenia (anaemia leukopenia, thrombocytopenia) resulting in ongoing monthly transfusions of at least 4 units of blood or blood products. This excludes cancer-related pancytopaenias	100%

10. ADVANCED AIDS

All the below definitions are paid out at 100%.

DEFINITION	PAY-OUT
Despite optimal treatment and full adherence to prescribed antiretroviral therapy for at least one year, a permanent CD4 count less than 50 and a positive PCR	100%
OR	
Despite optimal treatment and full adherence to prescribed antiretroviral therapy for at least 2 years, a CD4 cell count of less than 200 and a positive PCR	100%
And	
At least one of the following diseases must be diagnosed:	
1) Kaposi's sarcoma	
2) Pneumocystis jirovecii pneumonia (PJP)	
3) Confirmed progressive multifocal leukoencephalopathy	
4) Active extra-pulmonary tuberculosis	
5) Cryptococcosis	
6) Disseminated non-tuberculous mycobacteria infection	
7) Confirmed diagnosis of any other condition as defined as stage 4 on the WHO clinical criteria list	

11. OTHER

This category provides for diseases or conditions that do not fall into any other listed category, or combination of signs and symptoms resulting in ADL impairment. All changes must be total, permanent and irreversible. Mental and Behavioural related conditions are not covered under this section.

All the below definitions are paid out at 100%.

DEFINITION	PAY-OUT
Permanent inability to perform 4 or more categories of Activities of Daily Living	100%
Permanent inability to perform 3 Self-care activities of Daily Living	100%

12. NON - OCCUPATIONAL CLAIMS CRITERIA

This category provides specific coverage for diseases or conditions for lives insured who do not qualify for coverage under for the Occupational Claims Criteria. All changes must be total, permanent and irreversible.

DISEASE	DEFINITION	PAY-OUT
Hand	Total loss of use of dominant hand at the level of the wrist or higher.	100%
Renal	Permanent kidney dysfunction with a GFR of less than 15ml / min / 1.73m^2 according to the internationally recommended GFR equation, requiring dialysis	100%
	Ongoing peritoneal dialysis haemodialysis	100%
	Total and continuous permanent urinary incontinence	100%

23.2 APPENDIX 2

23.2.1 Objective Medical Criteria for the Critical Illness Benefit

GENERAL PROVISIONS

- The Claim Events described in this section must have occurred after the commencement of the Benefit in order to be eligible for a Claim pay-out.
- Symptoms and signs must be compatible with the diagnosis and the relevant Specialist investigations (including blood tests, imaging, histology and other tests) must confirm the diagnosis.
- Inability to perform Activities of Daily Living must be due to and compatible with the diagnosis of the Claim Event. The Activities of Daily living categories and definitions can be found in Appendix 4.
- Psychiatric illness, chronic fatigue syndrome (and synonyms) and fibromyalgia (and synonyms) and related terms are not covered under the Critical Illness Benefit.
- Major organ transplant Claims include being on an official South African or international transplant waiting list for the relevant transplant.
- Specialist reports are required to assess all Claims.
- The Claims definitions in the Dis-Chem Life Critical Illness Benefit are compliant with the Standardised Critical Illness definitions Project (SCIDEP). The document is available at https://www.asisa.org.za/asisadocs/Standards/SCIDEP
- Please note that Claims relating to conditions which may have been identified as a result of screening tests (e.g. genetic tests) but where there are no medical symptoms of the disease will not be covered under these definitions.
- Please note that for all organ transplants, the Life Insured must be the organ receiver and not the organ donor.

1. CANCER

This Benefit covers certain cancers, as specified below.

Cancer is a malignant tumour characterised by the uncontrolled growth of cells, invasion of normal tissue and spread to distant organs. The term malignant tumour includes leukaemia, lymphoma and sarcoma.

Pre-malignancy and carcinoma-in-situ tumours except for carcinoma-in-situ of the breast treated by mastectomy are not covered under this Benefit.

A current internationally recognised staging system will be used to assess the Claim Event.

A report from the treating Specialist, including the histology and stage of the cancer, the relevant imaging

reports and other tests must confirm the diagnosis.

Once a payment for a cancer listed under Severity A or Severity B cancer has been made, further cancer claims will only be considered for unrelated cancers. An unrelated cancer is a cancer that is not regarded as being of the same tissue and the same organ. The unrelated cancer will be considered as a new Life Changing Event.

Where stem cell or bone marrow transplants are performed as treatment for cancer, only one Severity A or B Claim will be paid. Only one bone marrow or stem cell transplant will be paid during the lifetime of the Policy.dIf two cancers of two different tissue types are present and have manifested independently of each other then, subject to the limits of the Policy as well as the terms of the Policy payment rules, each cancer will be considered as a separate Life Changing Event. These two claims will be regarded as claims within the same body system.

SEVERITY A & B

Malignant Melanoma Stage IV	100%
Malignant Melanoma Stage III	100%
Stage IV cancer	100%
Stage III cancer unless specified elsewhere	100%
Acute Myelocytic Leukemia	100% 200%**
Chronic Lymphocytic Leukemia: Stage III or IV on the Rai classification system	100%
Acute Lymphoblastic Leukemia	100%
Bone marrow transplant or stem cell transplant	100% 200%**
Severe Aplastic Anaemia as defined by the International Aplastic Anaemia Study Group	100%
Multiple myeloma: Stage III on the Durie-Salmon scale or equivalent on an appropriate international staging system	100%
Hodgkin's or Non-Hodgkin's lymphoma: Stage III on the Ann-Arbor staging system or equivalent on an appropriate staging system	100%
Hodgkin's or Non-Hodgkin's lymphoma: Stage IV on the Ann-Arbor staging system or equivalent on an appropriate staging system	100%
Prostate cancer T4N0M0 or with affected lymph nodes or distant metastases	100%
Neuroendocrine tumour stage III	100%
Neuroendocrine tumour stage IV	100%
Carcinoid syndrome with evidence of liver metastasis	100%
Borderline Ovarian Tumours Stage III	100%

Borderline Ovarian Tumours Stage IV	100%
Pseudomyxoma Peritonei with Disseminated Peritoneal Adenomucinosis	100%
Post organ transplant lympho-proliferative disorders	100%
Gastrointestinal Stromal Tumours Stage III	100%
Gastrointestinal Stromal Tumours Stage IV	100%
Dermatofibrosarcoma Protuberans stage III	100%
Dermatofibrosarcoma Protuberans stage IV	100%
Neuroendocrine tumour stage II	100%

**Payouts are boosted under the Critical Illness 250 Plus and 500 Plus Benefits.

The below conditions will be covered under the Critical Illness 250 Plus and 500 Plus Benefits:

SEVERITY D

Stage II cancer unless specified elsewhere	50%
Chronic Myelocytic Leukemia	50%
Chronic Lymphocytic Leukemia: Stage II on the Rai classification system	50%
Multiple myeloma: Stage 1 or 2 on the Durie-Salmon scale or equivalent on an appropriate international staging system	50%
Hodgkin's or Non-Hodgkin's lymphoma: Stage II on the Ann-Arbor staging system or equivalent on an appropriate staging system	50%
Prostate Cancer T3N0M0	50%
Basal cell carcinoma stage III	50%
Neuroendocrine tumour stage II	50%
Hairy Cell leukemia with myelofibrosis transformation	50%
Borderline Ovarian Tumours Stage II	50%
Gastrointestinal Stromal Tumours Stage II	50%
Dermatofibrosarcoma Protuberans stage II	50%
Malignant Melanoma stage II	50%

SEVERITY E

Stage 1 cancer unless specified elsewhere	25%
Chronic Lymphocytic Leukemia: Stage 0 or I on the Rai classification system	25%
Moderate Chronic Aplastic Anaemia as defined by the International Aplastic Anaemia Study Group	25%
Hodgkin's or Non-Hodgkin's lymphoma: Stage I on the Ann-Arbor staging system or equivalent on an appropriate staging system	25%
Prostate cancer T1N0M0 with Gleason score higher than 6	25%
Prostate cancer T2N0M0	25%
Malignant Melanoma Stage 1	25%
Mastectomy for carcinoma in situ	25%
Hairy Cell leukemia	25%
Neuroendocrine tumour stage 1	25%
Borderline Ovarian Tumours Stage I	25%
Gastrointestinal Stromal Tumours Stage I	25%

2. HEART AND ARTERIAL

This Benefit covers conditions of the heart and arteries as specified below.

Only one payment will be made per coronary event. A single coronary event is defined as incorporating all cardiac pathologies or procedures that occur within 30 Days of each other.

The diagnosis must be confirmed by a cardiologist, cardiothoracic surgeon, neurosurgeon, vascular surgeon or specialist physician. Relevant special investigations such as ECGs, echocardiograms, other imaging studies and blood tests must confirm the diagnosis.

All measurements and assessments are done while the Claimant is alive.

For a Claim under the heart attack definitions above, establishment of the severity of the Claim Event will depend on the assessment of the Claimant at least 30 Days post infarction.

Permanence of the ejection fraction Impairment will be established in two measurements taken three months apart unless otherwise proven to the satisfaction of the Insurer/Administrator.

SEVERITY A

Heart and lung transplant	200%

	250%**
Peripheral arterial disease with gangrene, where the severity of the impairment is in line with a Musculoskeletal severity A condition, as found in Musculoskeletal section in Appendix 2.	200%
Peripheral arterial disease with amputation, where the severity of the impairment is in line with a Musculoskeletal severity A condition, as found in Musculoskeletal section in Appendix 2.	200%
Heart transplant	175%

SEVERITY B

Bilateral carotid artery endarterectomy or bypass surgery	100%
Coronary artery bypass graft to three or more vessels	100%
Permanent ejection fraction of less than 30%	100%
Severe myocardial infarction with an ejection fraction of less than 30% at least 14 Days after the acute myocardial infarction	100% 150%**
SCIDEP Level A Heart Attack	100% 150%**
SCIDEP Level A Coronary artery bypass graft	100%
Chronic diastolic heart failure NYHA class 4 with raised Pro-BNP levels according to age bands. Ages under 50 years Pro-BNP more than 450 µg/mL; ages 50 years and older Pro-BNP more than 900 µg/mL	100%
Heart valve replacement	100%
Surgical repair of the Aortic Root	100%
Surgical repair of Thoracic Aortic Aneurysm	100%
Surgical repair of Thoracoabdominal Aortic Aneurysm	100%

**Payouts are boosted under the Critical Illness 250 and 500 Benefits.

SEVERITY C

Peripheral arterial disease with absent doppler readings, persistent claudication and leg ulcers	75%

The conditions below will be covered under the Critical Illness 250 Plus and 500 Plus Benefits:

SEVERITY C

SCIDEP CABG Level B	75%
Permanent ejection fraction between 30 and 50%	75%
SCIDEP Level B Heart Attack	75%

SEVERITY D

SCIDEP CABG Level C	50%
Moderate myocardial infarction of specified severity, as evidenced by any one of the following three criteria: 1. Compatible clinical symptoms and new pathological Q waves with raised cardiac	50%

markers; or 2. Raised cardiac markers and compatible clinical symptoms, or 3. Raised cardiac markers and characteristic ECG changes defined as either pathological Q waves or ST segment and T wave changes indicative of myocardial ischaemia or myocardial infarction. Raised cardiac markers are defined as either: - Troponin T of 1.0ng/mL or more (1000ng/L for high sensitivity troponin T), or equivalent, or - CK-MB mass of more than two times the upper limit of normal in the acute presentation phase, or - CK-MB mass of more than four times the upper limit of normal after intervention, or - Total CPK elevation of more than two times the upper limit of normal with at least 6% being CK-MB	
SCIDEP Level C Heart Attack	50%

SEVERITY E

Mild myocardial infarction of specified severity, as evidenced by all three of the following three criteria: 1. Compatible clinical symptoms 2. Imaging or ECG evidence 3. Raised cardiac markers Under criterion two, imaging or ECG evidence is defined as either: - Characteristic ECG changes for example ST segment and T wave changes indicative of myocardial ischaemia or myocardial infarction, or - Angiographic evidence of stenosis of 50% or more of a coronary artery treated with a stent, or - Hypokinesis of the myocardium on echocardiogram. Under criterion three, raised cardiac markers are defined as either: - Troponin T of 0.5ng/mL (500ng/L or more for high sensitivity troponin T), or equivalent or - CK-MB mass of more than the upper limit of normal up to two times the upper limit of normal in the acute presentation phase, or - Total CPK elevation of more than two times the upper limit of normal with at least 6% being CK-MB	25%
SCIDEP Level D Heart Attack	25%
SCIDEP CABG Level D	25%

3. NERVOUS SYSTEM

This Benefit covers specified conditions of the brain, spinal cord nerves and arteries to the brain.

The Claimant must be treated by a neurologist or neurosurgeon registered as such with the Health Professions Council of South Africa.

Stroke is defined as death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in neurological deficit lasting longer than 24 hours, confirmed by neuro-imaging investigation and appropriate clinical findings by a specialist neurologist.

Symptoms and signs as well as imaging (Computerised Tomography or magnetic resonance imaging) must confirm a new stroke. Transient ischaemic attacks are specifically excluded.

Neurological deficits and ADL Impairments must be compatible with the diagnosis and objective medical evidence.

Permanence, including permanent inability to perform any Activities of Daily Living, will be established after 90 Days unless otherwise proven to the satisfaction of the Insurer/Administrator. Establishment of permanence is made while the Claimant is alive.

Brain tumours are assessed according the World Health Organisation's grading. Pituitary microadenomas are specifically excluded under this Benefit.

SEVERITY A

Quadriplegia	200% 250%**
Paraplegia	200%
Definite diagnosis of Motor Neuron Disease	200%
Stroke with permanent inability to perform three or more of the Self-Care Activities of Daily Living (as defined in the ADL section below)	125% 150%**
Permanent inability to perform four or more categories of the Activities of Daily Living Score Sheet (as defined in the ADL section below)	125%
Stroke with permanent inability to perform four or more categories of the Activities of Daily Living Score Sheet (as defined in the ADL section below)	125%
Permanent inability to perform three or more of the Self-Care Activities of Daily Living (as defined in the ADL section below)	125%
Total permanent loss of speech including expressive or receptive aphasia	125%
Hemiplegia or diplegia	125%

SEVERITY B

Glasgow Coma Scale of less than 8/15 lasting longer than 96 hours	100%
WHO Grade III and IV brain tumours	100%
Definite diagnosis of dementia with permanent MMSE score of 10/30 or less as confirmed by formal neuropsychometric testing. There must be permanent cognitive dysfunction with progressive deterioration in the ability to do all of the following: • Remember • Reason; and • Perceive, understand, express and give effect to ideas	100%

SEVERITY C

The permanent inability to perform three categories of Activities of Daily Living	75%
The permanent inability to perform two Self Care Activities of Daily Living	75%
Extracranial monoplegia	75%

SEVERITY D

Definite diagnosis of dementia with permanent MMSE score of 20/30 or less as confirmed by formal neuropsychometric testing There must be permanent cognitive dysfunction with progressive deterioration in the ability to do all of the following: • Remember • Reason; and • Perceive, understand, express and give effect to ideas	50%

**Payouts are boosted under the Critical Illness 250 Plus and 500 Benefits.

The conditions below will be covered under the Critical Illness 250 Plus and 500 Plus Benefits:

SEVERITY D

Stroke with permanent inability to perform three categories of the Activities of Daily Living Score Sheet (as defined in the ADL section below)	50%

SEVERITY E

Stroke with permanent, minor neurological deficit but still able to perform 6 categories Activities of Daily Living	25%

4. GASTROINTESTINAL

This Benefit covers specified conditions of the liver, pancreas, biliary system, upper and lower gastrointestinal system.

Conditions related to drug or alcohol abuse are not covered under this Benefit.

The Claimant must be treated by a specialist physician, gastroenterologist or surgeon registered as such with the Health Professions Council of South Africa.

The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations such as blood tests, histology or imaging.

SEVERITY A

Liver transplant	150%
Pancreas transplant	150%

SEVERITY B

Chronic liver disease classified as Child Pugh Class C	100%
Fulminant hepatic failure	100%
Portal hypertension with either varices, or refractory ascites and splenomegaly, or refractory pancytopenia	100%
Complete pancreatectomy	100%
Primary Sclerosing Cholangitis with a Mayo model risk score co-efficient of 0.8333 or higher	100%

SEVERITY C

Chronic liver disease classified as Child Pugh Class B	75%
Primary billiary cholangitis	75%

5. CONNECTIVE TISSUE DISEASES

This Benefit covers the following connective tissue diseases below.

The Claimant must be treated by a specialist rheumatologist registered as such with the Health Professions Council of South Africa. The diagnosis must be made in accordance with current internationally recognised criteria and supported by the relevant histology, serology and imaging.

SEVERITY A

Multiple organ dysfunction meeting two defined Severity C criteria under 2 or more body systems due to a connective tissue disease	200%

SEVERITY B

Permanent inability to perform four or more categories of the Activities of Daily Living Score Sheet due to a listed connective tissue disease	100%
Permanent inability to perform three or more Self-Care Activities of Daily Living due to a listed connective tissue disease	100%

SEVERITY C

Definite objective evidence of involvement of two or more organs excluding the skin as an organ	75%
Permanent inability to perform 2 Self-Care Activities of Daily Living	75%

6. UROGENITAL TRACT AND KIDNEY

This Benefit covers specified conditions of the urogenital tract and kidneys.
Surgery for gender reassignment is not covered under this Benefit.

The Claimant must be treated by a specialist nephrologist or urologist registered as such with the Health Professions Council of South Africa.

The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations such as blood tests, histology or imaging.

SEVERITY A

Renal transplant	150%

SEVERITY B

Chronic renal failure with ongoing, permanent haemodialysis or a GFR of less than 15ml/min/1.73m^2 according to the internationally recommended GFR equation	100%
Ongoing permanent peritoneal dialysis	100%

7. RESPIRATORY DISEASE

This Benefit covers specified conditions of the respiratory system.

The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations such as lung function tests, blood tests, histology or imaging.

The Claimant must be treated by a pulmonologist registered as such with the Health Professions Council of South Africa. Lung function tests should be performed by a pulmonologist. The test should include pre and post dilatation measurements and show less than 5% variation between three successive FVC or FEV_1 readings. Two Dco tests must be done with results within three units. Corrections must be made for anaemia and carboxyhaemoglobin on the Dco test.

SEVERITY A

Heart and lung transplant	250%
Lung transplant	150%

SEVERITY B

Presence of irreversible cor pulmonale, with class 3 or 4 WHO functional classification for pulmonary hypertension being met.	100%
Confirmed diagnosis of pulmonary hypertension groups 1 to 5, including pulmonary veno-occlusive disease, with class 3 or 4 WHO functional classification for pulmonary hypertension being met.	100%

SEVERITY C

Requiring removal of more than one lobe of the lung	75%
Pulmonary venous occlusive disease not specified elsewhere	75%

SEVERITY D

Chronic obstructive or restrictive lung disease with a permanent FEV1 or FVC or Dco of 40% or less than predicted	50%
Chronic obstructive or restrictive lung disease with a permanent FEV1 or FVC or Dco of 41% to 45% of predicted	50%

8. ADVANCED AIDS/ACCIDENTAL HIV

This Benefit covers advanced AIDS and accidental HIV seroconversion as specified below.

A positive Human Immunodeficiency Virus antibody test and confirmatory Polymerase Chain Reaction test is required to confirm the diagnosis.

The diagnosis of the specified AIDS defining conditions must be supported by compatible signs and symptoms and confirmed by relevant special investigations such as blood tests, antibody test and histology or imaging.

SEVERITY B

Advanced AIDS evidenced by positive blood tests as specified above and a CD4 cell count of less than 50 while on antiretroviral therapy for at least six months	100%
Advanced AIDS evidenced by positive blood tests as specified above and a CD4 cell count of less than 200 while on antiretroviral therapy for at least three months AND diagnosis of at least one of the following diseases :	100%
- Kaposi's sarcoma	
- Pneumocystis jirovecii pneumonia (PJP)	
- Confirmed progressive multifocal leukoencephalopathy	
- Active extra-pulmonary tuberculosis	
- Cryptococcosis	
- Disseminated non-tuberculous mycobacteria infection	
- Confirmed diagnosis of any other condition as defined as stage 4 on the WHO clinical criteria list	
Advanced AIDS evidenced by positive blood tests as specified above and a CD4 cell count of less than 200 while on antiretrovial therapy for at least three months, with definite diagnosis of any three conditions defined as stage 3 AIDS on the WHO clinical criteria list	100%

9. MUSCULOSKELETAL

This Benefit covers specified conditions of the muscle, bones, joints and nerves.

The Claimant must be treated by a Specialist registered as such with the Health Professions Council of South Africa. The diagnosis must be supported by the relevant investigations and reports.

SEVERITY A

Total and permanent loss of use of both lower limbs at the level of the ankle or higher (proximal to the ankle)	150%
Amputation of both lower limbs at the level of the ankle or higher (proximal to the ankle)	150%
Total and permanent loss of use of both upper limbs at the level of the wrists or higher (proximal to the wrist)	150%
Amputation of both upper limbs at the level of the wrists or higher (proximal to the wrist)	150%

Total and permanent loss of use of one upper limb above (proximal to) the wrist and one lower limb above (proximal to) the ankle	150%
Amputation of one upper limb above (proximal to) the wrist and one lower limb above (proximal to) the ankle	150%

SEVERITY B

More than 25% full thickness body surface area burns	100%

SEVERITY C

Full thickness burns involving 15 to 25% of the body surface area	75%
Total and permanent loss of use of a lower limb at the level of the ankle or higher (proximal to the ankle)	75%
Amputation of a lower limb at the level of the ankle or higher (proximal to the ankle)	75%
Total and permanent loss of use of the upper limb above (proximal to) the wrist or higher	75%
Amputation of the upper limb above (proximal to) the wrist or higher	75%

SEVERITY D

Total and permanent loss of use of a hand below (distal to) the wrist	50%
Amputation of a hand below (distal to) the wrist	50%
More than 10% full thickness body surface area burns	50%

10. EYE

This Benefit covers specified conditions of the globe, retina, optic nerve, cornea and orbit.

The Claimant must be treated by an ophthalmologist registered as such with the Health Professions Council of South Africa. The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations such as visual acuity tests or imaging.

SEVERITY A

Complete Blindness	150%

SEVERITY C

Best corrected binocular Snellen rating of less than 20/125 (as defined by the AMA* guide)	75%

* American Medical Association Guides to the Evaluation of Permanent Impairment

11. EAR, NOSE AND THROAT

This Benefit covers specified conditions of the ear and neural pathways that relate to hearing as well as specified conditions of the nose, paranasal sinuses and venous sinuses of the brain.

The Claimant/Life Insured must be treated by a specialist ear, nose and throat surgeon, registered as such with the Health Professions Council of South Africa.

The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations such as blood tests, histology or imaging.

SEVERITY B

Hearing loss of 90dB or more in both ears measured over the frequencies 500Hz, 1000Hz, 2000Hz and 3000Hz in 2 measurements six months apart, with a hearing aid	100%

SEVERITY C

Hearing loss of 70dB in both ears measured over the frequencies 500Hz, 1000Hz, 2000Hz, 3000Hz in 2 measurements six months apart, with a hearing aid	75%

12. INTENSIVE CARE

This Benefit covers ICU stay for various durations.

SEVERITY B

ICU admission for more than five weeks with assisted mechanical ventilation for more than three weeks	100%

SEVERITY C

ICU admission for more than four weeks with assisted mechanical ventilation for more than two weeks	75%

Further Notes

The Claimant must be treated by a specialist in a recognised trauma or intensive care unit. The intensive care unit must be a recognised ICU unit as defined by the Critical Care Society of South Africa.

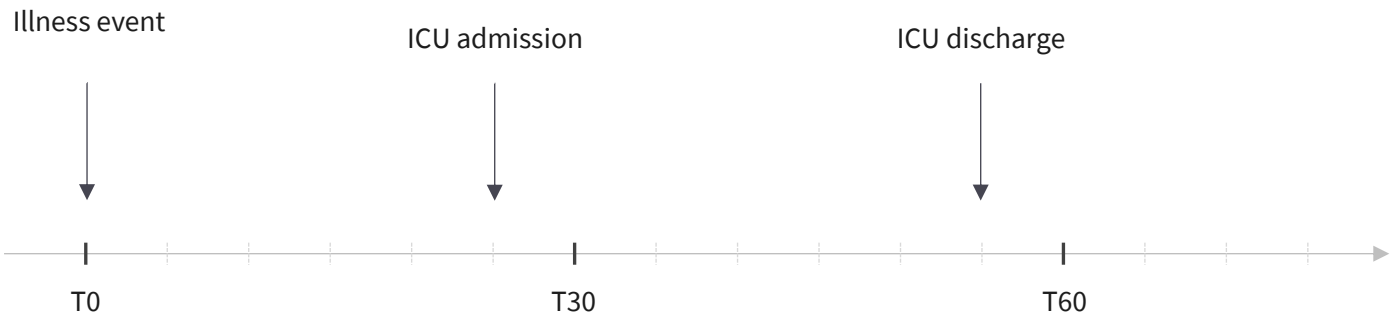
Please note that, if the ICU stay criteria are met, then in the case of the ICU stay:

- Being related to any other Critical Illness Benefit claims criteria claimed under,
- Starting within 30 Days after the Claimant becomes eligible for any other Critical Illness Claims criteria claimed under,
- Ending within 60 Days before the Claimant becomes eligible for any other Critical Illness Claims criteria claimed under,

Then only the highest severity Claim Event will be paid for (and not the sum of the payments of the ICU and the other Claim Event).

For example, if the Life Insured is admitted to ICU 27 Days after a 4-vessel CABG and stay in ICU for twenty-nine Days with assisted mechanical ventilation for fifteen Days, then only the Severity B CABG will be paid, and not the Severity C ICU Benefit.

The timeline below illustrates the progression of events.



23.3 APPENDIX 3

23.3.1 Rare Disease Benefit

GENERAL PROVISIONS

- The Claim Events described in this section must have occurred after the commencement of the Benefit in order to be eligible for a Claim pay-out.
- Symptoms and signs must be compatible with the diagnosis and the relevant Specialist investigations (including blood tests, imaging, histology and other tests) must confirm the diagnosis.
- No Claims will be paid for conditions that come from congenital conditions prior to taking out the Policy.
- Psychiatric illness, chronic fatigue syndrome (and synonyms) and fibromyalgia (and synonyms) and related terms are not covered under the Benefit.
- Specialist reports are required to assess all Claims.
- Please note that Claims relating to conditions which may have been identified as a result of screening tests (e.g. genetic tests) but where there are no medical symptoms of the disease will not be covered under these definitions.
- Please note that for all organ transplants, the Life Insured must be the organ receiver and not the organ donor.

1. CANCER RARE DISEASES

DEFINITION	PAY-OUT
Chromophobe renal cell carcinoma	300%
Somatostatinoma	300%
Goblet cell carcinoma	300%
Astroblastoma	300%
Central neurocytoma	300%
Primary effusion lymphoma	300%
Malignant triton tumour	300%
Disseminated myeloid sarcoma	300%
Undifferentiated carcinoma of esophagus	300%
Composite lymphoma	300%
Alpha heavy chain disease (also a type of cancer)	300%
Oligoastrocytic tumour (tumour)	300%
Pleomorphic liposarcoma	300%
Malignant teratoma of the ovary	300%
Acinar cell carcinoma of the pancreas	300%

2. NON-CANCER RARE DISEASES

DEFINITION	PAY-OUT
Klippel – Trenouney syndrome	300%
Sialidosis Type1	300%
Heritable pulmonary artery hypertension	300%
Evans Syndrome	300%

Hermansky-Pudlak syndrome	300%
Dense deposit disease	300%
Creutzfeld-Jacobs disease	300%
Gerstmann-Straussler-Scheinker syndrome	300%
Fatal familial Insomnia	300%
Kuru disease	300%
Variably protease-sensitive prionopathy	300%
Moyamoya Disease	300%
East Texas bleeding disorder	300%
Malignant teratoma of the ovary	300%
Acinar cell carcinoma of the pancreas	300%

23.4 APPENDIX 4

23.4.1 Activities of Daily Living Definitions

GENERAL PROVISIONS

The Activities of Daily Living (ADLs) is an internationally used scoring system that assesses the functional ability of a person including the physical, cognitive and interactive abilities. Dis-Chem Life uses the ADLs to assess functioning in the Illness Cover, Disability Cover and Income Protection Benefits when objective criteria of impairment are needed – for example when neurological and connective tissue diseases are assessed. Changes to the ADLs must be permanent, must have occurred after the Commencement Date of the Policy, and must be due to the condition, illness or event that is being claimed for.

Dis-Chem Life reserves the right to request an occupational therapist's or neuropsychologist's assessment of ADL functioning, using standardised assessment methods.

THERE ARE SIX CATEGORIES OF ADLS:

- Self-care
- Communication
- Physical Activity
- Sensory Function
- Hand Function
- Advanced Activities.

SCORING OF THE CATEGORIES:

The terms '**no impairment**', '**moderately impaired**', '**severely impaired**' and '**very severely impaired**' are used in the Advanced Activities category. The terms '**independent**', '**impaired**', '**unable**' are used in all the other categories. These terms are defined in the Activities of Daily Living Score Sheet below.

SELF-CARE

- If a person is **unable** to do **one** activity within this category, it is scored as the inability to perform the Self-care category of the ADL Score Sheet.
- If a person is **impaired** in doing **two** activities within this category, it is scored as the inability to perform the Self-care category of the ADL Score Sheet.

COMMUNICATION

- If a person is **unable** to do **one** activity within this category, it is scored as the inability to perform the Communication category of the ADL Score Sheet.
- If a person is **impaired** in doing **two** activities within this category, it is scored as the inability to perform the Communication category of the ADL Score Sheet.

PHYSICAL ACTIVITY

- If a person is **unable** to do **three** activities within this category, it is scored as the inability to perform the Physical Activity category of the ADL Score Sheet.
- If a person is **impaired** in doing **six** activities within this category, it is scored as the inability to perform the Physical Activity category of the ADL Score Sheet.

SENSORY FUNCTION

- If a person is **unable** to do **one** activity within this category, it is scored as the inability to perform the Sensory Function category of the ADL Score Sheet.
- If a person is **impaired** in doing **two** activities within this category, it is scored as the inability to perform the Sensory Function category of the ADL Score Sheet.

HAND FUNCTION

- If a person is **unable** to do **one** activity within this category, it is scored as the inability to perform the Hand Function category of the ADL Score Sheet.
- If a person is **impaired** in doing **two** activities within this category, it is scored as the inability to perform the Hand Function category of the ADL Score Sheet.

ADVANCED ACTIVITIES

It is scored as the inability to perform the Advanced Activity category if: A person is **moderately impaired** in all **four** areas; or

- A person is **severely impaired** in **two** of the four areas; or
- A person is very **severely impaired** in **one** of the four areas.

ACTIVITIES OF DAILY LIVING SCORE SHEET

SELF-CARE

ACTIVITY	INDEPENDENT	IMPAIRED	UNABLE
Bathing	• No assistance is required, or • The Life Insured is able to perform bathing or showering independently with the aid of hand rails and a non-slip bath mat.	• Hands-on assistance is required, or • Assistive devices such as an electronic bath bench is required when getting in or out of the tub or shower, or • The Life Insured generally baths Themself but needs some assistance with cleaning hard to reach areas.	• The Life Insured is totally dependent on others in all areas of bathing; The Life Insured would be at risk if left alone.
Grooming	• No assistance is required.	• Hands-on assistance is required with some activities of personal hygiene.	• The Life Insured is totally dependent on others in all areas of grooming.
Dressing	• No assistance is required, or • The Life Insured may perform dressing with an adapted method (such as sitting to dress lower limbs).	• Hands-on assistance is required with some activities, or • The Life Insured is unable to dress Themself completely (e.g. tying shoes, zipping or buttoning) without the help of another person.	• The Life Insured is totally dependent on others in all areas of dressing.
Eating and feeding	• No assistance is required, or • The Life Insured is able to perform the activity independently with the aid of modified cutlery.	• Hands-on assistance is required, e.g. help with cutting up food or pushing food within reach, or help with applying an assistive device (such as a universal cuff).	• The Life Insured is totally dependent on others in all areas of eating.
Toilet use and continence	• No assistance is required with toilet use, and the Life Insured has no incontinence.	• Hands-on assistance is required with some activities, e.g. transferring onto the toilet, but the constant presence of another person while toileting is not necessary, or • Intermitted	• The Life Insured is totally dependent on others in all areas of toileting, or • The Life Insured has no control of bowel or bladder, or • Permanent catheter, or • Permanent colostomy.

		catheterising.	
Mobility in home	• The Life Insured goes about the home independently.	• Walking and transferring requires the assistance of another person, or a railing, cane, walker or wheelchair.	• The Life Insured sits unsupported in a chair or wheelchair, but cannot propel Themself alone or transfer from bed to chair alone, or • The Life Insured is bedridden.

COMMUNICATION

ACTIVITY	INDEPENDENT	IMPAIRED	UNABLE
Listening	• The Life Insured is able to comprehend verbal communication in Their first language.	• The Life Insured is significantly impaired to comprehend verbal communication in Their first language.	• The Life Insured is permanently unable to comprehend verbal communication in Their first language.
Speaking	• The Life Insured is functionally able to communicate verbally in Their first language.	• The Life Insured is significantly impaired to communicate verbally in Their first language.	• The Life Insured is permanently unable to communicate verbally in Their first language.
Reading	• The Life Insured is able to comprehend written language in Their first language.	• The Life Insured is significantly impaired to comprehend written language in Their first language.	• The Life Insured is permanently unable to comprehend written language in Their first language.
Writing	• The Life Insured is able to complete personal information documents in Their first language independently.	• The Life Insured requires assistance when completing forms in Their first language.	• The Life Insured is permanently unable to write in Their first language.
Keyboard use	• The Life Insured can use a cell phone, keyboard, ATM and credit card machine independently.	• The Life Insured requires assistance when using a cell phone, keyboard, ATM or credit card machine.	• The Life Insured is permanently unable to use a cell phone, keyboard, ATM or credit card machine.

PHYSICAL ACTIVITY

ACTIVITY	INDEPENDENT	IMPAIRED	UNABLE

Standing	• The Life Insured can stand independently for longer than 10 minutes.	• The Life Insured needs external support or assistive devices (such as a walking frame), to stand, or • The Life Insured can stand independently but not for longer than 10 minutes.	• The Life Insured is unable to stand independently and therefore require hands-on support when standing; The Life Insured would be at risk if unassisted.
Sitting	• The Life Insured can sit independently for longer than 20 minutes.	• The Life Insured needs support to sit, or • The Life Insured can sit independently but not for longer than 20 minutes.	• The Life Insured is unable to sit independently.
Walking	• The Life Insured can walk independently (even though some difficulty or discomfort may be experienced) for six minutes, covering a distance of more than 300 metres.	• The Life Insured needs assistive devices (such as a walking frame) to walk, or • The Life Insured can walk independently but the distance covered in six minutes is less than 300 metres.	• The Life Insured is totally dependent on others for walking, or • The Life Insured must be pushed in a wheelchair or gurney at all times.
Crouching	• The Life Insured is able to assume and maintain the crouching position independently.	• The Life Insured requires external support getting in or out of the crouching position, or in maintaining the crouching position.	• The Life Insured is unable to assume the crouching position.
Squatting	• The Life Insured is able to perform five repetitive knee squats.	• The Life Insured is able to perform repetitive knee squats but are unable to perform five, or • The Life Insured requires external support when squatting.	• The Life Insured is unable to perform a knee squat.
Kneeling	• The Life Insured is able to assume and maintain the kneeling position independently.	• The Life Insured requires external support getting in or out of the kneeling position, or in maintaining the kneeling position.	• The Life Insured is unable to assume the kneeling position.

Reaching	• The Life Insured is able to reach to full arm length (above head height).	• The Life Insured is able to reach past eye level height, but unable to reach to full arm length.	• The Life Insured is unable to reach past eye level height.
Bending	• The Life Insured is able to bend forward independently.	• The Life Insured requires external support when bending forward.	• The Life Insured is unable to bend forward.
Carrying	• The Life Insured is able to carry 4.5kg for 5 meters with both hands, and • The Life Insured is able to carry 2kg with the left hand for 5 meters, and • The Life Insured is able to carry 2kg with the right hand for 5 meters.	• The Life Insured is able to carry some weight with both hands but are unable to carry 4.5kg with both hands for 5 meters, or • The Life Insured is unable to carry 2kg with the left hand for 5 meters, or • The Life Insured is unable to carry 2kg with the right hand for 5 meters	• The Life Insured is unable to carry any weight.
Lifting	• The Life Insured is able to lift (from floor to waist) 4.5kg with both hands, and • The Life Insured is able to lift (from floor to waist) 2kg with the left hand, and • The Life Insured is able to lift (from floor to waist) 2kg with the right hand.	• The Life Insured is able to lift some weight with both hands but is unable to lift (from floor to waist) 4.5kg with both hands, or • The Life Insured is unable to lift (from floor to waist) 2kg with the left hand, or • The Life Insured is unable to lift (from floor to waist) 2kg with the right hand.	• The Life Insured is unable to lift any weight.
Stair use	• The Life Insured is able to climb 20 steps independently, during which a handrail may be used and one step at a time is climbed.	• The Life Insured requires hands-on assistance when climbing stairs, or • The Life Insured is unable to climb 20 or more steps.	• The Life Insured is unable to negotiate stairs.

Travel (driving, riding)	• The Life Insured is able to drive a vehicle independently, or • The Life Insured is able to use public transport independently.	• The Life Insured requires assistance when using public transport, or • The Life Insured requires a driver if They had previously been able to drive a motor vehicle independently.	• The Life Insured is unable to travel.

SENSORY FUNCTION

ACTIVITY	INDEPENDENT	IMPAIRED	UNABLE
Hearing	• The Life Insured has functional hearing with or without the use of a hearing aid.	• The Life Insured's best corrected, permanent binaural hearing loss exceeds 50%.	• The Life Insured 's best corrected, permanent hearing loss exceeds 70dB as measured over the frequencies 500Hz, 1000Hz, 2000Hz and 3000 Hz.
Seeing	• The Life Insured has normal vision with or without correction.	• The Life Insured has a permanent visual field defect of 25% or more in one eye due to a scotoma.	• The Life Insured has a permanent visual field defect of 25% or more in both eyes due to scotomas or permanent quadrantanopia.
Tactile sensation	• The Life Insured has normal sensory function (sensation of the hands is assessed under hand function).	• The Life Insured has impaired sensory function in a dermatome corresponding with objective pathology (sensation of the hands is assessed under hand function).	• The Life Insured has complete loss of sensory function in a dermatome corresponding with objective pathology (sensation of the hands is assessed under hand function).
Tasting and Smelling	• The Life Insured has normal ability to taste and smell.	• The Life Insured has significant Impairment to taste or smell as a result of an injury or disease.	• The Life Insured is permanently unable to taste, or permanently unable to smell, as a result of an injury or disease.

HAND FUNCTION

ACTIVITY	INDEPENDENT	IMPAIRED	UNABLE
Grasping and Holding	• The Life Insured has grip strength better than 2 standard deviations below the average age and	• The Life Insured has grip strength weaker than 2 standard deviations below average age and	• The Life Insured is unable to grasp.

	gender values (according to Mathiowetz normative data for adults).	gender values (according to Mathiowetz normative data for adults).	
Pinching/Tip pinch	• The Life Insured has pinch strength better than 2 standard deviations below average age and gender values (according to Mathiowetz normative data for adults).	• The Life Insured has pinch strength weaker than 2 standard deviations below average age and gender values (according to Mathiowetz normative data for adults).	• The Life Insured is unable to pinch.
Coordination/Dexterity	• This is better than two standard deviations below the norm according to standardised hand coordination tests (for example the Minnesota Rate of Manipulation).	• This is two standard deviations below the norm according to coordination test (for example the Minnesota Rate of Manipulation).	• The Life Insured is unable to perform percussive movements (finger touching or diadochokinesis).
Sensory discrimination/Tactile sensation	• The Life Insured has normal sensory function in hands.	• The Life Insured has impairment of sensory function, but retained protective sensibility in the hands.	• The Life Insured has no sensation in hands.

ADVANCED ACTIVITIES

The following areas are assessed under this category:

- Concentration
- Memory
- Problem solving, judgement and reasoning
- Executive function including planning, initiation, organizing, error monitoring.

The above four areas can be tested by a neuropsychologist and stratified according to percentiles.

ACTIVITY	NO IMPAIRMENT	MODERATELY IMPAIRED	SEVERELY IMPAIRED	VERY SEVERELY IMPAIRED

Memory	• Neuropsychological testing results fall above the 30th percentile, or higher than half a standard deviation below the norm.	• Neuropsychological testing results fall between the 15th and 30th percentile, or between half and 1 standard deviation below the norm.	• Neuropsychological testing results fall between the 5th and 15th percentile, or between 1 and 2 standard deviations below the norm.	• Neuropsychological testing results fall below the 5th percentile, or 2 standard deviations below the norm (or worse).
Concentration	• Neuropsychological testing results fall above the 30th percentile, or higher than half a standard deviation below the norm.	• Neuropsychological testing results fall between the 15th and 30th percentile, or between half and 1 standard deviation below the norm.	• Neuropsychological testing results fall between the 5th and 15th percentile, or between 1 and 2 standard deviations below the norm.	• Neuropsychological testing results fall below the 5th percentile, or 2 standard deviations below the norm (or worse).
Problem solving, judgment and reasoning	• Neuropsychological testing results fall above the 30th percentile, or higher than half a standard deviation below the norm.	• Neuropsychological testing results fall between the 15th and 30th percentile, or between half and 1 standard deviation below the norm.	• Neuropsychological testing results fall between the 5th and 15th percentile, or between 1 and 2 standard deviations below the norm.	• Neuropsychological testing results fall below the 5th percentile, or 2 standard deviations below the norm (or worse)./
Executive function including planning, initiation, organizing and error monitoring	• Neuropsychological testing results fall above the 30th percentile, or higher than half a standard deviation below the norm.	• Neuropsychological testing results fall between the 15th and 30th percentile, or between half and 1 standard deviation below the norm.	• Neuropsychological testing results fall between the 5th and 15th percentile, or between 1 and 2 standard deviations below the norm.	• Neuropsychological testing results fall below the 5th percentile, or 2 standard deviations below the norm (or worse).