Sanlam

Gap cover policy document

UNDERWRITTEN BY

CENTRIQ INSURANCE

Insurance | Financial Planning | Retirement | Investments | Wealth

Contents

Statutory Notice

In accordance with regulation 7.5(1)(c), please note the following statement:

"This is not a medical scheme and the cover is not the same as that of a medical scheme. This policy is not a substitute for medical scheme membership."

Kaelo Risk (Pty) Ltd is an authorised financial services provider (FSP: 36931).

This product is underwritten by Centriq Insurance Company Limited (FSP 3417).

Master Policy No: Sanlam/Comprehensive/012020

Effective: 01 January 2020

General

Upon the payment of the Premium by or on behalf of the Insured, in accordance with this Policy Document and any schedules attached thereto and the receipt of such Premium by or on behalf of the Underwriter before the Inception Date (or renewal date, as the case may be) and subject to the terms, conditions, exclusions and provisions of this Policy Document and any schedules attached thereto, the Underwriter agrees to pay Benefits to the Eligible Member for an Insured Event in accordance with the sum insured, limits of indemnity and other criteria as stated in this Policy and the schedules attached thereto.

A. Definitions

In this Policy all words and expressions signifying the singular shall include the plural and vice versa and all words and expressions signifying any one gender shall include the other gender.

The following words and expressions shall have the following meanings:

1. "Accidental Harm" means bodily injury caused by violent, unintentional, external and physical means.
2. "Administrator" or "Kaelo Risk" means Kaelo Risk (Pty) Ltd (Registration No: 2008/019335/07), who is appointed to administer this Policy on behalf of the Underwriter and is registered to do so in terms of the Short Term Insurance Act No. 53 of 1998.
3. "Balance Billing" is a practice where a medical practitioner or other medical service provider charges a separately identifiable fee that is over and above the Tariff fee (or set of such fees) that relates to a medical procedure (or procedures), and is billed together on one statement or invoice and is not considered as a refundable benefit by a Medical Scheme.
4. "Basic Dentistry" is defined as the following dental treatment: cleaning, extractions (including wisdom teeth), fillings, inlays, bonding, root canal treatment, and treatment for pain and abscess.
5. "Benefit" or "Benefits" means the benefit amount payable to the Eligible Member in relation to an Insured Event, as calculated in terms of the Benefit Schedule, as defined.
6. "Benefit Schedule" means the relevant Benefit Schedule outlined in Section F of this policy that defines the Benefits provided herein and which may be changed from time to time in accordance with Section E.8 of this policy.
7. "Condition-Specific Waiting Period" means a period in which a policyholder is not entitled to claim policy benefits in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within a period of 12 months preceding the day on which cover commenced.
8. "Deductible" or "Co-payment" means a defined, fixed amount specified in rands by the Insured's medical scheme that is subtracted from the Insured's medical scheme benefit entitlement when undergoing defined Medical Procedures or Insured Events. For the purposes of this definition it explicitly excludes any deductible or co¬payment that is specified by the Insured's medical scheme as a percentage of costs and not a specified rand amount (this does not apply to the 20% Oncology co-payment as per clause F.9 of this policy).
9. "Designated Service Provider" or "DSP" means a medical service provider designated by a Medical Scheme as one of their preferred suppliers.
10. "Eligible child" means a child born to either the Eligible Member or Eligible Spouse, as defined, of this policy. An Eligible Child includes a legally adopted child, or stepchild of an Eligible member who is an eligible dependant on the Eligible member's medical scheme. In the event that the child reaches the age of 27 years the child will no longer be an Eligible Child and will therefore no longer be covered under this Policy. On the attainment by the Eligible Child of 27 years, the Eligible Child may take up a new Policy in their own capacity, within thirty (30) days of them reaching the aforementioned age, without any additional waiting periods or exclusions being applied. The above age limitation will not be applicable to a Special Needs Child, as defined in this policy, who remains a beneficiary of the Eligible member's medical scheme.
11. "Eligible member" means the Insured who applied for cover under this Policy and who is a paid up member, including his Family as designated by him on inception of this Policy, and accepted by the Underwriter as eligible for participation in the insurance cover provided by this Policy.
12. "Eligible special dependant" means a dependant who is neither the Eligible Spouse nor an Eligible Child of the Eligible member but who is an eligible dependant on the Eligible Member's medical scheme and has been explicitly accepted by Centriq for such cover under this policy. In the event that no such explicit acceptance is provided by Centriq, such special dependants are not covered even though they are dependants of the Eligible member's medical scheme.
13. "Eligible Spouse" means the partner of the Eligible member with whom a spousal union exists, whether by virtue of South African law or religious tenet, and who is an eligible spouse dependant on the Eligible Member's medical scheme. Where a person shares an abode with an Eligible Member in a spousal union and has done so for at least six months and lives together in a manner accepted in

common law as that of a married couple, the person shall be regarded as an Eligible Spouse in terms of this Policy Document. Should an Eligible Member have more than one spouse who could qualify as an Eligible Spouse then that Eligible Member must make an irrevocable nomination of one (1) spouse as the Eligible Spouse. No benefits will be paid in respect of any other spouse unless the Eligible Member has nominated the other spouse (or spouses as the case may be) as an Eligible Special Dependant from the time of inception of the Policy, or from the time that the other spouse became a spouse of the Eligible Member, and the requisite Premium has been paid to Centriq on behalf of such other spouse. On the death of the Eligible member the nominated Eligible Spouse may transfer the Policy of cover into their own capacity within thirty (30) days of the death of the Eligible member without any additional waiting periods or exclusions being applied.

14. "Family" means collectively the Eligible Member, his Eligible Spouse, Eligible Children and/or Eligible Special Dependants as defined in this Policy Document.
15. "General Waiting Period" means a period in which a policyholder is not entitled to claim any policy benefits, except for benefits directly arising from Trauma, as defined herein.
16. "Hazardous Sport" includes but is not limited to participation in or use of any of the following:
    • All forms of motorised/jet racing or motorised/jet aerobatics, whether by land, sea or air;
    • Mountaineering, trekking or hiking above an altitude of 4,000 (four thousand) metres;
    • Hunting, shooting or deploying firearms in any manner other than for self-defence purposes;

    The above definitions apply regardless of whether these activities are performed privately, socially, during practice sessions, while participating in organised events or as an amateur or a professional.
17. "Hospital" means any institution in the territory of the Republic of South Africa which, in the opinion of Kaelo Risk, meets all of the following criteria:

a. Provides diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment and care of sick or injured persons by or under the supervision of Medical Practitioners.

b. Provides 24 (twenty four) hour nursing services to sick or injured persons within the aforementioned facilities.

c. Is not a day clinic or unattached operating theatre.

d. Is not an institution that primarily cares for persons who are mentally retarded, blind, deaf, mute or in any other way physically handicapped.

18. "Hospital Episode" means the period of time between admission to hospital for an Insured until the time of discharge from hospital of the same Insured person for the same Insured Event.
19. "Hospital Network" means a list of hospitals specified by the Insured member's medical scheme, as the Designated Service Provider of one or more benefit options of the medical scheme.
20. "Illness" means any physical disease or sickness which manifests in an Insured but is not a disease or sickness which is of such a nature as to be incapable of diagnosis by objective evidence or which, even though capable of diagnosis by such evidence, has not been diagnosed as such.
21. "Inception Date" means the first day of the month on which cover commences as defined in the Policy schedule of the relevant Eligible Member.
22. "Insured" or "Insured Person" means either the Eligible Member or the Eligible Spouse or the Eligible Child or the Eligible Special Dependant, as is applicable, and as defined in this Policy.
23. "Insured Event" means any one or more, as the case may be, of the following: -

a. Accidental Harm, Illness or other health incident that causes an Insured to be admitted to a hospital and to undergo Treatment or Medical Procedures during the Hospital Episode.

b. Chemotherapy, radiotherapy or other drug regimen, approved by an Insured's medical scheme, that is administered to an Insured for the purposes of treating a tumour, growth or other body tissue that has cancer (malignant neoplasm).

c. An Insured receives kidney dialysis for the treatment of acute or chronic renal failure.

d. Accidental Harm that directly causes an Insured to receive emergency medical treatment at the outpatient casualty or trauma ward of a hospital.

24. "Kaelo Risk" is a registered trademark and the trading name of Kaelo Risk (Pty) Ltd, as defined herein.
25. "Medical Expense Shortfall Policy" means an accident and health policy, as defined in Category 1 of section 7.2(1) of regulations to the Short-Term Insurance Act, No 53 of 1998.
26. "Medical Practitioner" means a qualified medical practitioner, who is registered with the Health Professions Council of South Africa and is authorised to practice in the Republic of South Africa.
27. "Medical Procedure" means any procedure defined under the National Health Reference Price List (NHRPL). In the event that any procedure or operation is not listed Kaelo Risk will calculate, at their sole discretion, an appropriate benefit to be paid to the Eligible Member.
28. "Medical Scheme" means a medical scheme as registered under the Medical Schemes Act.

29. “Medical Schemes Act” means the Medical Schemes Act No. 131 of 1998 as amended and includes the regulations thereto.
30. “Multiple” means the percentage cover of the Tariff of the benefit option of the Eligible Member’s Medical Scheme, which may differ for different benefit categories of that benefit option, and which constitutes a key component of the Benefit calculation as defined in the Benefit Schedule.
31. “National Health Reference Price List” or “NHRPL” means the benefit tariff set annually by the Department of Health as a guideline for charges by medical service providers or any replacement of the NHRPL effected by a change in law or statute or the generally accepted industry equivalent thereof.
32. “Participating Employer” means an employer who pays Premiums to the Underwriter on behalf of their employees who are Eligible Members under this Policy.
33. “Penalty” means any co-payment, deductible, exclusion or reduction, applied against the benefits of an Insured’s medical scheme, that would otherwise not have been applied had the authorisation rules of that medical scheme been adhered to or the benefits had been attained from the Designated Service provider or Hospital Network of that medical scheme benefit option.
34. “Permanent Disability” means any accidental harm or physical illness that renders a person permanently unable to work in their own or other occupation for which they are suited by training, education or experience.
35. “Policy” or “Policy Document” means collectively this Policy and any relevant Schedule related thereto, all of which shall apply conjunctively.
36. “Policy Exclusions” means the list of services, conditions or events in Section D of this Policy which are excluded at all times from cover.
37. “Premature Birth” is defined as the natural or surgically assisted birth of one or more infants by an Insured that occurs more than 41 days before the originally expected natural birth date. For the purpose of this clause, the originally expected natural birth date is accepted as being 40 weeks from date of conception and will be verified by the clinical records of the mother’s attending physician.
38. “Premium” or “Premiums” means the monthly amount payable by or on behalf of the Eligible Member to the Underwriter as defined in the Premium Schedule applicable to this Policy Document.
39. “Premium Schedule” means the Schedule attaching to and forming part of this Policy that defines the monthly Premium that pertains to the cover provided under this Policy for the Family and which may be changed from time to time in accordance with Section E.7 of this Policy.
40. “Principal Member” means the Eligible Member.
41. “Special Needs Child” means any child, including a legally adopted child or stepchild, of the Insured who, by virtue of either a physical or mental disability, is unable to financially support themselves and remains reliant on the Insured for support and care.
42. “Split Billing” is a practice where a medical practitioner or other medical service provider charges a separately identifiable fee that is over and above the Tariff fee (or set of such fees) that relates to a medical procedure (or procedures), and is billed separately from the Tariff fees on two or more statements or invoices, and is not considered as a refundable benefit by a Medical Scheme.
43. “Tariff” means either the NHRPL tariff or a specific tariff registered by a Medical Scheme to determine the rate at which its benefits are payable.
44. “Trauma” means Accidental Harm, as defined, to an Insured that gives rise directly to an Insured Event.
45. “Treatment” means any form of diagnosis, treatment or care provided by a medical practitioner during an Insured Event for the purpose of treating or monitoring the medical condition of an Insured Person.
46. “Underwriter” means Centriq Insurance Company Limited (registration number 1998/007558/06) that underwrites the cover on this Policy and is registered to do so in terms of the Short Term Insurance Act No. 53 of 1998.

B. General details

1. The Benefits apply only for services rendered within the territory of the Republic of South Africa. Any services provided outside of the borders of South Africa are excluded from cover.
2. Kaelo Risk and the Underwriter reserve the right to alter the Premiums, the basis on which the Benefits are calculated or the terms and conditions of this Policy by giving 30 (thirty) days written notice of the change.

C. Waiting periods

Kaelo Risk shall apply Waiting Periods to the cover of an Insured as outlined below:

1. During the first 3 (three) months of membership, a general waiting period, as defined herein, shall apply.
2. During the first 12 (twelve) months of membership, a condition-specific waiting period, as defined herein, shall apply.
3. Waiting periods shall be applied to the cover of the relevant insured person, from the time that such insured’s cover commences under this policy.
4. In the event that an Insured under this policy

previously had a Medical Expense Shortfall Policy, as defined, the period of the condition-specific waiting period above shall be reduced by the expired portion of the condition-specific waiting period served under such previous policy.

5. In the event that there is no unexpired portion of the condition-specific waiting period of such previous policy, the condition-specific waiting period of this policy will be waived. Such waiver only applies if the break in cover between the two policies is 90 (ninety) days or less.
6. Kaelo Risk reserves the right to waive the Waiting Periods for the Eligible Members of Participating Employers based upon pre-determined criteria. Any such waiver applied will be indicated on the policy schedule of the Insured Member.

D. Policy exclusions

Kaelo Risk or the Underwriter shall not be liable for any claim caused by or related to, whether such cause or related cause is as a direct or indirect consequence of any of the following:

1. Any Treatment or Medical Procedure related to obesity.
2. Cosmetic surgery except in the case where reconstructive cosmetic surgery is necessitated, in the sole opinion of Kaelo Risk, as a direct result of Trauma or other essential non-elective Treatment or Medical Procedure.
3. Suicide, attempted suicide or wilful injury to oneself.
4. Abortion, attempted abortion or any complications related thereto unless treatment is, in the sole opinion of Kaelo Risk, of a non-elective nature.
5. Any procedure or examination where there is no objective indication of impairment in normal health.
6. The consumption of any drug or narcotic, whether legal or illegal, unless legally prescribed by and taken in accordance with the instructions of a Medical Practitioner.
7. The failure of an Insured to follow any medical advice given by a Medical Practitioner.
8. Any incident, Illness, Accidental Harm or event directly or indirectly caused by the continuous and excessive consumption of alcohol or where the insured suffers from alcoholism.
9. Any incident, Illness, Accidental Harm or event directly or indirectly attributable to the member having a blood alcohol content exceeding thirty milligrams per one hundred millilitres of blood.
10. Nuclear weapons, nuclear material, ionising radiations or contamination by radioactivity from any nuclear fuel, or from any nuclear waste, or from the combustion of nuclear fuel which includes any self-sustaining process of nuclear fission.
11. Participation or attempted participation by any Insured Person in any of the following:
    - 11.1. Defence force, police force, medical rescue service, firefighting service, correctional services facility or the disarming of explosives;
    - 11.2. Aviation activities where any medical expense incurred in relation to such activities are insured by any other party (excludes fare-paying passengers in a licensed passenger carrying aircraft);
    - 11.3. Hazardous sport (amateur or professional) as defined;
    - 11.4. Form of race or speed test (other than on foot or involving any non- mechanically propelled vehicle, vessel, craft or aircraft).
12. Riots, wars, political acts, public disorder or any acts or attempted acts of any of the following:
    - 12.1. Civil commotion, labour disturbances, riot, strike, lock-out or public disorder or any act or activity which is calculated or directed to bring about any of the above;
    - 12.2. War, invasion, act of foreign enemy, hostilities, civil war or warlike operations (regardless of whether war is declared or not);
    - 12.3. Mutiny, military rising or usurped power, martial law or state of siege, or any other event or cause which determines the proclamation or maintenance of martial law or state of siege, insurrection, rebellion or revolution;
    - 12.4. Any act (whether on behalf of an organisation, body, person or group of persons) calculated or directed to overthrow or influence any state or government or any provincial, local or tribal authority with force or by means of fear, terrorism or violence;
    - 12.5. Any act calculated or directed to bring about loss or damage to further any political aim, objective or cause, or to bring about any social or economic change, or in protest against any state or government, or any provincial, local or tribal authority, or for the purpose of inspiring fear in the public, or any section thereof;
    - 12.6. Terrorism. An act of terrorism means the use or threat of violence for political, religious, personal or ideological reasons. This may or may not include an act that is harmful to human life. It could be committed by any person or group of persons, acting alone, on behalf of or with any organisation or government. It includes any act committed with the intention to influence any government or inspire fear in the public;
    - 12.7. The act of any lawfully established authority in controlling, preventing, suppressing or in any other way dealing with any event referred to in any of

clauses 12.1 to 12.6 above.

13. Any claim that is excluded or rejected by the Eligible member's medical scheme.
14. Any claim that does not form part of the registered benefits of the Eligible member's medical scheme but has been paid on an ex-gratia basis.
15. The following procedures, items, services, service providers or events:
    - 15.1. External prosthesis;
    - 15.2. Any appliances including, but not limited to, wheelchairs, beds or convalescing equipment;
    - 15.3. All dental procedures including, but not limited to, crowns, bridges, dental implant related procedures, orthognathic surgery, temporo-mandibular joint ("TMJ") surgery, labial frenectomy, bone augmentations, bone or tissue regeneration. The above definition does not include basic dentistry, as defined in Section A.4 of this Policy);
    - 15.4. Harvesting and/or preserving of human tissues, including but not limited to stem cell regeneration;
    - 15.5. Breast augmentation;
    - 15.6. Gastroplasty, lipectomy or otoplasty;
    - 15.7. Gender reversal procedures;
    - 15.8. Therapeutic massage therapists;
    - 15.9. Rehabilitation, frail care or hospice services;
    - 15.10. Step-down facilities;
    - 15.11. TTO (to-take-out) medicines;
16. Any expenses incurred as a result of an injury in a motor vehicle accident that are subsequently recoverable by the relevant Insured Person from the Road Accident Fund.
17. Any expenses incurred as a result of an injury on duty that are subsequently recoverable by the relevant Insured Person from the Workmans Compensation Fund.
18. Any co-payment or deductible applied by the Eligible Member's medical scheme against the benefits to be received or paid out from the medical scheme, other than those specifically listed in the Benefit Schedule outlined in Section F.
19. Any Penalty, as defined in this policy document, applied by the Eligible Member's medical scheme.
20. Any fee charged by a Medical Practitioner, Hospital or other medical service provider that constitutes Split Billing as defined in Section A of this policy. This exclusion does not apply to Balance Billing, also defined in Section A of this policy.
21. Any criminal act or attempted criminal act by an Insured which shall include the submission of any fraudulent information or the use of any fraudulent means to obtain any benefit under this Policy;
22. Any treatment or Medical Procedure for infertility.
23. Expenses incurred for transport charges or for services rendered whilst being transported in any vehicle, vessel or craft whether or not such vehicle, vessel or craft is specifically designed for the purposes of medical emergency transport.
24. Any act by an Insured that wilfully exposed the Insured to danger (except where such act was necessitated in order to save human life).
25. Any Treatment or Medical Procedure that, in the sole opinion of Kaelo Risk, is of such a nature that it is not considered to be medically necessary, or where alternative conservative treatment would provide a similar outcome, or is of such a nature that there is no likely improvement in the medical condition of the insured patient.

Kaelo Risk reserves the right to amend the above Policy Exclusions from time to time.

E. General terms and conditions

1. **Claims Procedure**
   Following an Insured Event the Insured Person or the Eligible Member, as the case may be, shall at his own expense:
   a. Notify Kaelo Risk of any claim in writing as soon as possible but in any event not later than 6 (six) months after the end of the Insured Event. Claims submitted more than 6 (six) months after the end of the Insured Event are excluded from cover.
   b. Supply written proof, copies of medical accounts or other information as may reasonably be required for Kaelo Risk to process the claim or to ensure the validity of the claim.
   c. Provide authority for Kaelo Risk to inspect as often as is necessary all current or past medical information or clinical records including the results of any diagnostic tests and submit to medical examination on behalf of and at the expense of Kaelo Risk.
   d. Where the Insured Person is not the Eligible Member, the Eligible Member shall provide or obtain the necessary permission or consent from the Insured Person to comply with the above condition failing which the processing of the relevant claims shall be suspended until such time as the requisite permissions or consents are obtained.
   e. Any Benefit payable in respect of an Insured Event shall only become payable after the end of the Treatment relating to the Insured Event.
   f. Interim Benefit payments can be made to the Eligible Member at the end of a 30

day period during an Insured Event at the sole discretion of Kaelo Risk.

g. All Benefits payable shall be paid to the Eligible Member or his legal representative whose receipt of the Benefits shall in every case be a full discharge of liability.

h. In the event of the death of the Eligible Member, any Benefit due shall be payable to the surviving Eligible Spouse, failing which the Benefit will be paid to the Eligible Children (or their legal guardians in the event of them being minors) or failing any of the above, the Benefit shall be paid to the Eligible Member's estate.

i. No Benefit payable shall carry interest.

j. Any discount accrued by an Insured, against the amount owing by the Insured to any medical provider, shall be factored into the calculation of the Benefits of this Policy.

2. Premiums and Premium payment

a. The Premium is due monthly in arrears.

b. Should your Premium become outstanding any benefit payable will be suspended until all arears premiums have been received by Kaelo Risk or the Underwriter.

c. Should your premium remain outstanding for a third consecutive month your cover will be cancelled at midnight on the last day of the month for which premium has been received.

d. At the sole discretion of Kaelo Risk, premiums may be accepted in arrears under the same terms and conditions as outlined in 2(a) and 2(b) above.

5. Termination of cover

a. The Eligible Member or Participating Employer may cancel this Policy at any time by giving 30 (thirty) days written notice thereof.

b. An Insured Event will only qualify as a valid claim if the Hospital Episode, Treatment or Medical Procedure relating to the Insured Event commences before the date of cancellation of this Policy.

c. In the event that any fraudulent act is committed by an Insured Person, Kaelo Risk reserves the right to immediately cancel this Policy and/or to institute legal proceedings against the Insured Person to recover any losses.

4. Medical examination

Payment of any Benefit is conditional on the Insured supplying such medical evidence as is required for Kaelo Risk to adequately assess the validity of the claims or for an Insured to undergo any medical examination if requested and paid for by Kaelo Risk.

5. Jurisdiction and Currency

This Policy shall be subject to the jurisdiction of the courts of the Republic of South Africa and South African law will apply. The payment of all Premiums and Benefits shall be made in the currency of the Republic of South Africa

6. Commencement of cover

Cover shall commence on the first day of the calendar month for which the Premium has been paid by or on behalf of the Eligible Member, subject to all the terms and conditions of this Policy.

7. Premium Amendments

Kaelo Risk and the underwriter may adjust the Premiums by giving at least 30 (thirty) days written notice thereof to the Eligible Member, or the Participating Employer, as the case may be.

8. Cover and Benefits

a. Cover shall only be of any force or effect if the Family, as defined in A.14, are also current and paid up beneficiaries of a registered medical scheme.

b. Cover will also be provided to the Family, as defined in A.14, regardless of whether or not they are covered under the same or separate medical scheme options. Under such circumstances, proof of the familial relationship may be required when claiming under this policy.

c. No benefit shall be payable in respect of any Treatment or Medical Procedure unless such treatment occurred during the period of an Insured Event.

d. No benefits shall be payable in respect of any additional costs incurred as a result of confinement in a private hospital ward (except where medically necessary).

e. This Policy, including any schedules and correspondence sent to the Policyholder, the Policyholder's application for insurance, specifically answers to medical questions or declarations of health status, and any written or spoken statement made by the Policyholder or on his/her behalf, forms the contract between the Policyholder and the Underwriter.

f. Kaelo Risk may alter the Benefits or the basis upon which Benefits are calculated under this policy by giving 30 (thirty) days written notice thereof.

In the event that the Policyholder, or any person acting on behalf of the Policyholder, has misrepresented, inaccurately described or not provided all the details that affect the risk insured under this Policy, Kaelo Risk and the underwriter may declare that the whole of this Policy or any part thereof is invalid. In such event Kaelo Risk and the underwriter shall be entitled to reject any claim under this Policy and/or to void this Policy from its original inception date.

F. Benefit schedule

1. The events listed in the clauses below are deemed as separate events and may qualify for coinciding yet distinct benefits, as the case may be.
2. The overall maximum benefit payable for

the Core benefit clauses below of this policy shall be limited to the statutory maximum of R165 000 (one hundred and sixty five thousand rand) per insured person per annum, as prescribed by Category 1 of regulation 7.2(1) prescribed minimum benefits (PMB) procedures are covered under this benefit.

3. Core Benefits are those in sections F5 through to F14.
4. The headings below are for reference purposes only and will not form part of any benefit definition.

Core benefits

Tariff Shortfalls

5.

a. Benefits relating to this clause will only be paid in respect of services occurring during a Hospital Episode that are rendered and charged for by an individual medical practitioner.

b. Any benefit provided for charges above the Medical Scheme tariff shall be limited to 5 (five) times (500%) of the medical scheme tariff. There is no limit on the rand amount or number of claims allowed per annum

Tariff Shortfalls Example

6.

Mr. S is on a medical scheme – plan A which covers him to a maximum of 100% of the medical scheme rate. This means that the medical scheme will pay all expenses at the defined medical scheme rate towards Mr. S' treatment costs.

The medical scheme rate for a total colonoscopy is R2000.00.(100%)

This means that the maximum that the medical scheme will pay is R2000.00. (100%)

The specialist performing the procedure charged R10 000.00 which is 5 times the medical scheme tariff (500%)

The maximum benefit payable by this policy for this procedure is therefore:

R10 000.00 – Fee charged by the specialist

LESS

R2 000.00 – Benefit paid by medical scheme

=

R8 000.00 – Your gap cover benefit

Co-Payments & Deductibles

7. Benefits relating to this clause will only be paid in respect of the defined diagnostic procedures listed in Table 1 below and which occur during an Insured Event.

The Benefit payable is equal to the fixed value Deductible or Co-Payment amount, as defined in the rules of the Insured member's medical scheme, and relating to the defined diagnostic procedure listed in Table 1 below.

Table 1 – Defined Diagnostic Procedures
Cystourethroscopy, colonoscopy, proctoscopy, sigmoidoscopy, gastroscopy, cystoscopy or hysteroscopy. CT Scan, MRI Scan or PET Scan.

8. Benefits relating to this clause will only be paid in respect of the defined medical procedures listed in Table 2 below and which occur during a Hospital Episode.

The Benefit payable is equal to the fixed value Deductible or Co-Payment amount, as defined in the rules of the Insured member's medical scheme, and relating to the defined medical procedure listed in Table 2 below.

Table 2 - Defined Medical Procedures
Conservative back and neck treatment, myringotomy, tonsillectomy, adenoidectomy, facet joint injections, arthroscopy, functional nasal procedures, non-malignant hysterectomy, laparoscopy, hysteroscopy, endometrial ablation, hernia repair, varicose vein surgery, percutaneous radiofrequency ablations, rhizotomies, confinement, circumcision, hymenectomy, Nissen fundoplication, spinal fusion or major joint replacement.

Shortfalls from Sub-Limits

9. Benefits relating to this clause will only be paid in respect of a service, provided during a Hospital Episode, where the charges relating to the service supplied has exceeded a relevant benefit sub-limit of the member's medical scheme benefit option.

The Benefit payable is equal to the charged amount, less the amount paid by the Eligible member's medical scheme, subject to a maximum of R52,100 (fifty two thousand one hundred rand) per event or medical condition.

Oncology Tariff Shortfalls

10. Benefits relating to this clause will only be paid in respect of an Insured Event as defined under Definition 23.b., that has been approved by the Insured's medical scheme, for the purposes of treating cancer (malignant neoplasm).

Any benefit provided for charges above the Medical Scheme tariff shall be limited to 5 (five) times (500%) of the medical scheme tariff. There is no limit on the rand amount or number of claims allowed per annum.

Oncology Tariff shortfalls Example

11. Mr. T is on a medical scheme – plan B which covers him to a maximum of 100% of the medical scheme rate. This means that the medical scheme will pay all expenses at the defined medical scheme rate towards Mr. T' treatment costs.

The medical scheme rate for the specific oncology treatment is R20 000.00. (100%)

This means that the maximum that the medical

scheme will pay is R20 000.00

The total cost for the specific Oncology treatment required by Mr. T is R100 000.00 which is 5 times the medical scheme tariff (500%)

The maximum benefit payable by this policy for this procedure is therefore:
R100 000.00 – Oncology Treatment Cost
LESS
R20 000.00 – Benefit paid by medical scheme
=
R80 000.00 – Your gap cover benefit

Oncology Co-Payments

12. Benefits relating to this clause will only be paid in respect of an Insured Event as defined under Definition 23.b, that has been approved by the Insured's medical scheme, for the purposes of treating cancer (malignant neoplasm).

    The Benefit payable is equal to the Co¬Payment applied once related costs have exceeded the specific threshold defined by the medical scheme.

    This is subject to a maximum Co-Payment of 20%.

Oncology Sub-Limits

13. Benefits relating to this clause will only be paid in respect of an Insured Event as defined under Definition 23.b, that has been approved by the Insured's medical scheme, for the purposes of treating cancer (malignant neoplasm). Benefits relating to this clause will only be paid in respect of services, where the charges relating to the services supplied, have exceeded the benefit sub-limit that applies to Oncology treatment of the member's medical scheme benefit option. The Benefit payable is equal to the charged amount, less the amount paid by the Eligible member's medical scheme.

Out-of-Hospital Tariff Shortfalls

14.

    a. Benefits relating to this clause will only be paid in respect of the defined out-patient procedures or treatment listed in Table 3 below to that are rendered and charged for by an individual medical practitioner

    b. Any benefit provided for charges above the Medical Scheme tariff shall be limited to 5 (five) times (500%) of the medical scheme tariff. There is no limit on the rand amount or number of claims allowed per annum.

Tariff shortfalls Example

15. Mr. V is on a medical scheme – plan C which covers him to a maximum of 100% of the medical scheme rate. This means that the medical scheme will pay all expenses at the defined medical scheme rate towards Mr. S' treatment costs.

    Mr. V has opted to undergo an Arthroscopy of his shoulder out of hospital.

    The medical scheme rate for a total Arthroscopy is R2000.00.(100%)

    This means that the maximum that the medical scheme will pay is R2000.00. (100%)

    The specialist performing the procedure charged R10 000.00 which is 5 times the medical scheme tariff (500%)

    The maximum benefit payable by this policy for this procedure is therefore:

    R10 000.00 – Fee charged by the specialist for the Arthroscopy

    LESS

    R2 000.00 – Benefit paid by medical scheme

    =

    R8 000.00 – Your gap cover benefit

Table 3 – Defined Out-Patient Procedures/Treatment
• Cystourethroscopy, colonoscopy, proctosopy, sigmoidoscopy, gastroscopy, cystoscopy or hysteroscopy. • Surgical Extraction of Wisdom Teeth. • Home Births • Dialysis Treatment

Accidental Casualty

16. Benefits relating to this clause will only be paid in respect of emergency outpatient services that are a direct result of Accidental Harm and are provided within a casualty ward of a hospital.

    The Benefit payable is equal to the actual cost of the services, less any amount paid by the member's medical scheme from risk pool benefits, subject to a maximum of R15 000 (fifteen thousand rand) per event.

    No benefit is payable under this clause for services that are related to an illness or that are not delivered within a casualty ward of a hospital, as defined.

Penalty Co-Payment

17. Notwithstanding clause D.19, Kaelo Risk will pay a fixed value Penalty co-payment or deductible, as defined in this policy, or a percentage penalty co-payment that does not exceed 30%, for the voluntary use by an insured of a hospital that is not part of a Hospital Network, as defined in this policy.

    This is subject of a maximum of 1 such event per family per annum and a maximum of R15 000 (fifteen thousand rand).

    Any other liability arising against an Insured from a Penalty, as defined, that is not a fixed value penalty co-payment defined in the rules of the Eligible member's medical scheme, remains an exclusion as per clause D.19 of this policy.

Benefit Extender

Family Booster

18. A lump sum benefit of R14 000 (fourteen thousand rand) is payable when a Premature birth, as defined in Section A, occurs.

Hospital Booster

19. The following daily lump sum benefits are payable where an insured is admitted to a hospital, and such Insured Event occurred as a direct result of either Accidental Harm or Premature Birth, as defined, in this policy:
    i. R380 per day from the 1st to the 13th day (inclusive);
    ii. R750 per day from the 14th to the 20th day (inclusive);
    iii. R1500 per day from the 21st to the 30th day (inclusive);
    iv. And, for the purposes of the above benefit calculation, the first day is defined as commencing at the time of admission to hospital and ending 24 (twenty four) hours later;
    v. And all subsequent days are defined as commencing and ending on the same start and end times as the first day.
    vi. The following benefit limitations apply to this clause:
        - If more than one Insured person in the Family is hospitalised as a result of the same event, only the Insured person with the longest Hospital Episode will attract a benefit under this clause;
        - No benefit is payable under this clause after day 30 of any Hospital Episode;
        - A maximum of two Hospital Episodes per Family will attract benefits under this clause per annum, subject to an overall maximum benefit of R25 190 (twenty one thousand two hundred and ninety rand) per insured per annum.

Family Protector Benefit

20. The lump sum benefit listed below is payable upon the death or permanent disability of an Insured due to: Accidental Harm - R28 000 (twenty eight thousand rand)

Dental Reconstruction Benefit

21. Benefits relating to this clause will only be paid in the event of dental reconstruction surgery being required as a direct result of Accidental Harm or from Oncology Treatment that occurred after the inception of this policy. The Benefit payable is equal to the charged amount less the amount paid by the Eligible member's medical scheme, subject to a maximum of R48 000 (forty eight thousand rand) per event or medical condition.

Medical Scheme and Gap Cover Premium contribution waiver Benefit

22. The following lump sum benefit is payable upon the death or permanent disability of the principal member of the medical scheme only. The benefit amount will only apply (become payable) where there are dependents registered on the medical scheme, who are being paid for by the principle member.

    The Benefit payable is equal to the monthly medical scheme contribution applicable after the qualifying event above, multiplied by 6 (six) and subject to an overall maximum of R33 000 (thirty three thousand rand).

    In addition the Sanlam Gap cover premium will be waived for 6 (six) months.

    This benefit is limited to one event over the policy lifetime.

RAF Claims

23. An end-to-end legal service is provided by the nominated service provider of Kaelo Risk to assist Insured members with legitimate claims against the Road Accident Fund.
24. Services providers are contracted to Kaelo Risk and not to the Underwriter Centriq Insurance.

Notes

IMPORTANT - PLEASE READ CAREFULLY

Disclosure and Other Legal Requirements

(This notice does not form part of the Insurance Contract or any other document)

As a short-term insurance policyholder, or prospective policyholder, you have the right to the following information:

The Financial Advisory and Intermediary Services and Short-term Insurance Acts require compliance, by the Insurer (who is the product supplier), Underwriting Manager and your intermediary/broker, with the Acts, FAIS General Code of Conduct and Policyholder Protection Rules to enable you in making informed decisions about the insurance products that you purchase. It also aims to ensure that your Product Supplier, Underwriting Manager and intermediary/broker render financial services honestly, fairly, with due skill and diligence and in your interests and the integrity of the financial services industry.

You will receive two Disclosure Notices (one from your broker/intermediary and one from your Underwriting Manager and Insurer) at the inception of your policy and at each subsequent Renewal (or Anniversary) date. The Disclosure Notices contain information about your Insurer, Underwriting Manager and intermediary/broker, together with information about the Ombud and Financial Sector Conduct Authority. Should you experience any difficulties in obtaining required details,

please contact your intermediary/broker for further assistance.

ABOUT YOUR INTERMEDIARY/BROKER

Your intermediary/broker should provide you with their Disclosure Notice within a reasonable time from the time you are provided with a quotation, take out a policy or amend your policy. If they do not do so, even after you have requested it, please contact the Insurer or Underwriting Manager to assist.

ABOUT YOUR INTERMEDIARY/BROKER

Your intermediary/broker should provide you with their Disclosure Notice within a reasonable time from the time you are provided with a quotation, take out a policy or amend your policy. If they do not do so, even after you have requested it, please contact the Insurer or Underwriting Manager to assist.

a. *The UMA is Kaelo Risk (Pty) Ltd, an authorised Financial Service Provider - Registration no. 2008/019335/07 (FSP no 36931) e-mail: service@kaelo.co.za website: www.kaelo.co.za*
b. *Kaelo (Pty) Ltd is approved for Category 1 Short Term Insurance Personal Lines*
c. *The UMA holds preference shares in a cell captive arrangement with the insurer and as a result thereof has a share in the underwriting result of the cell captive.*
d. *In the past financial year the UMA received more than 30% of its income from the Insurer.*
e. *The UMA has a written mandate (Binder agreement) to act on behalf of the insurer.*
f. f) *The UMA holds Professional Indemnity Insurance Cover.*
g. *The UMA is paid a binder fee of 10% by the insurer for the performance of certain binder, claims and administrative functions.*
h. *The UMA may from time to time have representatives that are rendering services under supervision.*

Physical Address	2nd Floor, The Oval, East Wing, Wanderers Office Park, 52 Corlett Drive, Illovo, 2196
Postal Address	Postal address P.O. Box 3083, Houghton, 2041
Telephone Number	0861 111 167 / +27 11 759 9600
Facsimile Number	+27 86 501 8521
Compliance Officer	Eas-e-Comply (Pty) Ltd **Telephone:** 0861 266 759 **Email:** info@easecomply.com **Compliance Practice number:** C028 **Physical Address:** 80 The Valley Road, Parktown 2196
Claims Department	**Email:** sanlamclaims@kaelo.co.za **Subject:** Claims **Telephone:** 0861 111 167
Complaints Department	**Email:** sanlamesc@kaelo.co.za **Subject:** Complaints or Escalations **Telephone:** 0861 111 167 *All complaints must be reduced to writing and any of our representatives will be able to provide you with a copy of our complaints procedure on request*

ABOUT YOUR INSURER

Name	Centriq Insurance Company Limited
Company Registration Number	1998/007558/06
FSP Number	3417
VAT No	4230187124
Physical Address	The Oval, Second Floor, West Wing, Wanderers Office Park, 52 Corlett Drive, Illovo, 2196
Telephone Number	+27 11 268 6490
Facsimile Number	+27 11 268 6495
Email	info@centriq.co.za
Website	www.centriq.co.za
Compliance Department	The Internal Compliance Officer is contactable at the numbers above. **Email:** compliance@centriq.co.za
Claims Department	The Claims Specialist is contactable at the numbers above. **Email:** claims@centriq.co.za
Complaints Department	The Complaints department is contactable at the numbers above. **Email:** faiscomplaints@centriq.co.za **Email:** claimscomplaints@centriq.co.za *All complaints must be reduced to writing and any of our representatives will be able to provide you with a copy of our complaints procedure on request.*

a. The premium and all accompanying charges are detailed on your policy schedule. Your intermediary/broker receives up to, but never exceeding, the regulated maximum commission payable in terms of the Short-Term Insurance Act.

b. This policy is a Health & Accident policy offered under the Short-Term Insurance Act.

c. If premium is paid by debit order
   - it may only be in favour of one person and may not be transferred without your approval; and
   - the insurer must inform you at least 31 days before the cancellation thereof, in writing, of its intention to cancel such debit order.

d. Consequence of Non-Payment: Should you fail to make payment on or before the due date / payment date, you have a period of grace for the payment of premiums. You will be notified of the non-payment and given a grace period of 15 days to pay the outstanding premium. Your policy will remain in force for a period of 15 days after that due date / payment date. In the case of a monthly policy, this provision will apply with effect from the second month of the currency of the policy.

e. It remains the sole responsibility of the policyholder to ensure that full premiums are paid on the due date.

Other matters of importance:

a. You will be informed in the event of any material changes to this information provided.

b. A polygraph or lie detector test is not compulsory in the event of a claim and the failure thereof may not be the sole reason for repudiating a claim.

c. You will be given reasons, in writing, by the Insurer in the event of a claim being repudiated, as well as full details of steps that can be taken, and timelines that you will need to stick to, if you do not agree with the Insurer's decision.

d. The insurer must give you at least 31 days' written notice of its intention to cancel the policy.

e. You will always be entitled to a copy of the policy free of charge.

f. If you decide that this cover does not suit your needs and no benefit has yet been claimed, you have 31 days from when you receive our policy documents to cancel the policy in writing and any premiums that have been collected before then, will be refunded within 31 days after your cancellation notice is received.

How to institute a claim:

a. Claims must be submitted to the UMA for processing within 6 months of an event. Claims submitted after 6months will not be paid, should the late submission result In Insurers being prejudice.

b. On receipt of your claim you will receive an email and sms notification confirming receipt of your claim as well as updates regarding the status of your claim.

c. Once your claim has been approved, funds will be paid into the personal bank account of the principle member via EFT and not to the service provider directly., unless instructed by the principal member to pay into the service provider's account.

How to submit a complaint:

a. If you have a complaint, please contact us on any of the Complaint contact details given above.

b. Please note that all complaints must be addressed to us in writing.

c. If any complaint about your intermediary/broker is not resolved to your satisfaction, you may submit your complaint to the FAIS Ombudsman, whose address appears at the foot of this notice.

d. If any complaint to the UMA is not resolved to your satisfaction, please contact the Insurer and if it is still not resolved to your satisfaction, you may submit your complaint to the Short Term Insurance Ombudsman or the FSCA, whose addresses appear at the foot of this notice.

How to submit a complaint:

a. Do not sign any blank or partially completed application forms.

b. Complete all forms in ink.

c. Make notes of what was said to you and keep all documents handed to you.

d. Do not be pressurised into buying the product.

e. Study the policy with care immediately when it is received. If you have any uncertainties, discuss these with your intermediary/broker or UMA.

f. Incorrect or non-disclosure by you of relevant facts may influence the assessment of a claim.

OTHER CONTACT DETAILS

THE FAIS OMBUDSMAN	SHORT-TERM INSURANCE OMBUDSMAN
Physical Address: Kasteel Park Office Park, Orange Building, 2nd Floor, c/o Nossob & Jochemus Street, Erasmus Kloof, Pretoria, 0048	**Physical Address:** 1 Sturdee Avenue, Cnr Bolton & Baker Roads, First Floor, Block B, Rosebank.
Postal Address: P O Box 74571, Lynnwood Ridge, 0040	**Postal Address:**P.O. Box 32334, Braamfontein, 2017.
Telephone Number: +27 12 470 9080	**Telephone Number:** +27 11 726 8900 / 0860 726 890
Facsimile Number: +27 12 348 3447	**Facsimile Number:** +27 11 726 5501
Email: info@faisombud.co.za	**Email:** info@osti.co.za
Website: www.faisombud.co.za	**Website:** www.osti.co.za

SHARING OF INSURANCE INFORMATION

Insurers share information with each other regarding policies and claims with a view to prevent fraudulent claims and obtain material information regarding the assessment of risks proposed for insurance. By reducing the incidents of fraud and assessing risks fairly, future premium increases may be limited. This is done in the public interest and in the interest of all current and potential policyholders.

The sharing of information includes, but is not limited to information sharing via the Information Data Sharing System operated by TransUnion ITC on behalf of the South African Insurance Association. By the insurer accepting or renewing this insurance, you or any other person that is represented herein, gives consent to the said information being disclosed to any other insurance company or its agent.

You also similarly give consent to the sharing of information in regards to past insurance policies and claims that you have made. You also acknowledge that information provided by yourself or your representative may be verified against any legally recognised sources or databases.

By insuring or renewing you insurance you hereby not only consent to such information sharing, but also waive any rights of confidentiality with regards to underwriting or claims information that you have provided or that has been provided by another person on your behalf.

In the event of a claim, the information you have supplied with your application together with the information you supply in relation to the claim, will be included on the system and made available to other insurers participating in the Information Data Sharing System.

USE OF YOUR PERSONAL INFORMATION

When you enter into this policy you will be giving us your personal information that may be protected by data protections legislation, including but not only, the Protection of Personal Information Act, 2013 (“POPI”). We will take all reasonable steps to protect your personal information.

You authorise us to:

a. Process your personal information to
   - Communicate information to you that you ask us for.
   - Provide you with insurance services.
   - Verify the information you have given us against any source or database.
   - Compile non-personal statistical information about you.

b. Transmit your personal information to any affiliate, subsidiary or re-insurer so that we can provide insurance services to you and to enable us to further our legitimate interests including statistical analysis, re-insurance and credit control.

c. Transmit your personal information to any third party service provider that we may appoint to perform functions relating to your policy on our behalf.

d. You acknowledge that this consent clause will remain in force even if your policy is cancelled or lapsed.

WAIVER OF RIGHTS

No intermediary/broker, Underwriting Manager or Insurer may request or induce in any manner a client to waive any right or benefit conferred on the client by or in terms of any provisions of the General Code of Conduct, or recognise, accept or act on any such waiver by a client. Any such waiver is null and void.

CONFLICT OF INTEREST

We have considered the conflict of interest provisions in terms of the FAIS Act 37 of 2002 and the Policyholder Protection Rules and have not identified any actual or potential conflicts of interest, either ownership interest, financial interest, third party relationships, associates or distribution channels as defined.

We adopted a values based approach where the spirit of the legislation is embraced. This is reviewed at least annually and reported on to the Financial Sector Conduct Authority. A conflict of interest management policy is available to clients upon request.

Sanlam Wealthsmiths™

UNDERWRITTEN BY
CENTRIQ INSURANCE

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Sanlam Life Insurance Limited Reg no 1998/021121/06.
Licensed Financial Services and Registered Credit Provider (NCRCP43).

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