Welcome to OUTsurance "where you always get something OUT".

This facility document is an essential part of your OUTsurance documents. It defines the cover we provide under the following headings:

✓ **WHAT DO WE COVER?**

× **WHEN YOU ARE NOT COVERED?**

➡ *Examples are highlighted by the arrow and help explain specific, practical ways in which the cover is applied.*

This is a plain language document, ensuring that it is easy to read and conveys the details of your facility in the clearest possible way.

Please read the documents to make sure that you understand the scope of your cover. Call us on **08 600 70 000** for any queries or to update your information.

Contents

Your OUTsurance Life facility

'You' and 'your' are references to the Facility Holder or the Life OUTsured, as the context requires:

- the Facility Holder is responsible for paying the premiums
- the premium is determined by various factors that affect the risk of the Life OUTsured
- the Sum OUTsured noted on your schedule is payable where the Life OUTsured suffers an event that is covered

This document together with your schedule, any written correspondence and verbal agreements form the basis of the contract between you and us.

It is important that you read and understand these documents and that you make sure that all the information supplied by anyone about the Facility Holder and the Life OUTsured is correct. Any incorrect information will affect the validity of this contract.

Should any legislation or regulation change that impacts this Facility or OUTsurance we may change the benefits payable, the premiums charged or the charges and fees levied under this Facility. Any such changes will be communicated in writing.

When does your cover start and end?

Your cover start and end dates are noted on your schedule under the cover period heading. Your cover may also end after certain claims or if your facility is cancelled.

Facility cancellations

You may cancel your facility with immediate effect at any time. If you cancel your facility, we will refund your premium on a pro-rata basis for the remaining portion of the period for which you will not be covered.

In the event we receive a written or verbal instruction from any person other than you to cancel your facility, we will first contact you telephonically to confirm the validity of the instruction before your facility is cancelled. If we are unable to contact you the facility will remain active.

Your facility will automatically be cancelled when:

- your monthly premiums are not paid for two consecutive months either on the payment dates or within the grace period in those months; or
- your annual premium is not paid on the payment date or within the grace period; or
- you have reached the end of your Cover Term that you have selected which is noted on your schedule; or
- you deliberately fail to pay your premium by cancelling or stopping your debit order

Facility changes

You may make changes to your facility at any time. Any change you make will be effective from the agreed date.

Your OUTbonus

The OUTbonus is a cash refund of your premiums that rewards you for your loyalty and for being claim free. If you have selected the OUTbonus, the OUTbonus cycle, including payment intervals and the appropriate percentages, is shown on your schedule.

If you have selected the OUTbonus, your OUTbonus will be forfeited following the submission of any claim and this forfeiture will be irreversible.

Replacement of cover

If this facility replaces any of your existing cover, you must make sure that the cover and conditions of cover are similar if required. Changes in your health and age could influence the cover and conditions when you apply for new cover. There may be some duplicated costs or fees payable on your new cover.

Your responsibilities

We do not conduct a full financial needs analysis and it is your responsibility to make sure that you are adequately covered.

In order to have cover you need to:

- pay your premiums
- comply with all our reasonable instructions and requests
- provide us with true and complete information when you apply for cover, submit a claim or make changes to your facility. This also applies when anyone acts on your behalf. We act on the information provided, therefore any information that is misleading, incorrect or false will prejudice the outcome of a claim
- inform us immediately if the information you provided changes before the cover start date. We will have to re-assess your cover based on this new information
- inform us immediately of the following changes to the circumstances of the Life OUTsured:
  - change in occupation
    - ➡ *Example: if you work as an accountant and start a different occupation, you have to let us know immediately. However, if you change companies, still working as an accountant, you do not have to let us know.*
  - living outside South Africa
    If you live outside South Africa for more than a total of three months in any 12 month period.
  - travelling for business
    If you travel for business purposes for more than a total of four weeks in a year to countries other than the USA, Canada, Australia, New Zealand or countries in Europe.
  - if you start smoking or start using any form of tobacco product
  - if you start using any illegal drugs
  - participating in hazardous sports or activities
    If you start participating in a hazardous sport or activity that was not disclosed when you took out the cover. This excludes:
    - if you scuba dive up to 30 meters while in possession of a recognised diving qualification; or
    - any once-off casual participation in a hazardous sport or activity in an appropriately controlled environment
  - about convictions, cancellations or offences related to dishonesty by you or any person covered under this facility

  These changes may influence whether your cover continues, the conditions of cover or the premium we charge. Failure to notify us of any of these changes will result in the benefit being re-assessed at claims stage in line with our underwriting practice at the time when your circumstances changed. This may result in a claim being rejected or the claim payment being reduced.

  Unless approved in writing by OUTsurance, you may not transfer, cede, assign or novate any of your rights, expectations or obligations in terms of this Facility including your OUTbonus to any other person or entity. Doing so will affect the validity of this Facility.

Claims

Our responsibilities

When you submit a claim, we will assess the claim by evaluating all relevant medical and circumstantial evidence. A claim will only be settled once we are satisfied that it is a valid claim. This facility is subject to the laws of South Africa and any claims payments will be made into South African bank accounts in Rands.

When you have a valid Disability or Critical Illness claim, the applicable Sum OUTsured will be paid to the Facility Holder. For valid Death cover claims, the applicable Sum OUTsured will be paid to the nominated beneficiaries noted on your schedule.

Your responsibilities

You need to inform us of any claim within six months of becoming aware of the condition or incident giving rise to any claim.

We will need information from you or anyone acting on your behalf to validate a claim. We may request medical evidence in support of a claim. The evidence must be provided by relevant medical specialists. You need to give all information and documentation we require, at your cost, within the timeframe we set otherwise your claim may be rejected.

If we have made a funeral and final expense benefit payment and determine that the Death cover claim was invalid you will have to refund that benefit amount on OUTsurance's request.

When you submit a claim, we can act on your rights or obligations against other people to recover costs, damages and losses or to defend any claim they may have against you. You need to do all things necessary to enable us to act on your behalf.

Disputed claims

If you dispute the outcome of a claim you have 90 days from the day you are first informed of the outcome to notify us about your objection. Immediately following this, you have a further six months within which to serve us with a summons. If you do not do so within this period, your right to challenge the decision is forfeited.

Non-disclosure or misrepresentation

This contract is based on the information provided during the application process which determines whether we cover you, the premium we charge and the terms and conditions applicable to your cover. If any information has been withheld or misrepresented, this will affect the validity of the agreement.

If at claims stage we gather information which differs from any previous information supplied, it will affect the validity of your cover, and any claim. All premiums will also be forfeited. The following applies:

- your claim will be settled if the non-disclosure or misrepresentation would not have changed the premium or terms and conditions of cover
- your claim will be proportionately settled if the non-disclosure or misrepresentation is not relevant to the cause of the claim but would have changed the premium you paid. We will determine how much cover you could have bought with the premium you paid
- your claim will be rejected if the non-disclosure or misrepresentation would have resulted in us not giving you cover or if it is directly relevant to the cause of the claim

Fraud or dishonesty

We have a responsibility to all our Facility Holders to ensure that fraudulent claims are eliminated in order to keep premiums as competitive as possible. If your claim is rejected you will need to reimburse us for any expenses we incur relating to the claim. If you or anyone acting on your behalf submits a claim, or any information or documentation relating to any claim that is in any way fraudulent, dishonest or inflated, we will reject that entire claim and cancel your facility retrospectively to the reported incident date or the actual incident date, whichever date is earliest.

Sharing of information

We respect the confidentiality of your information. In terms of legislation applicable to all insurance companies, we require your consent to confirm and disclose information relating to claims, insurance and financial history with other insurers, government bodies and credit bureaus. This is applicable to anyone who is covered under this policy. This will enable us to ensure sound insurance practices, prevent fraud and to offer our product effectively. If you are not willing for this information to be confirmed or disclosed we will not be able to provide you with cover.

Premiums

Premium payments

Your premiums must be paid on the agreed payment date at the start of each period for which you want cover.

Premiums not paid

If the premium is not paid on the payment date, you have a 15 day grace period after which we will automatically deduct the premium from the same account to ensure continuous cover. If this premium is also not paid you will have no cover for the period for which you did not pay. If your premiums are paid monthly, the grace period will only apply from the second month of cover.

Should you cancel or stop your debit order, it will be deemed that you have cancelled your facility and you will not enjoy the 15 day grace period.

In the event that you reinstate your facility thereafter, your facility will be treated as a new facility and the grace period will only apply from the second month of cover thereafter.

If you claim for a condition and the claim is rejected because your premium was not paid, any other claim related to the initial claim will also be rejected.

Premium review and guarantee period

Your premium is calculated for the full period of cover you selected and the guarantee period is noted on your schedule. After this period, we may change your premium by giving you 30 days' written notice. When making any changes we look at the experience of all clients with similar profiles, rather than individual circumstances.

➡ *Example: If you are diagnosed with cancer after your cover start date, we will not change your premium. If however, there is a new technology that can detect cancer more effectively and the number of cancer claims increases significantly, we would have to review our premiums.*

When you are not covered?

There is no cover for any condition or event arising directly or indirectly from any of the following:

- ✘ if you commit suicide within the first 24 months of cover
- ✘ intentional self-inflicted injury or illness
- ✘ driving while the concentration of alcohol in your blood exceeds the legal limit
- ✘ intentional intake of drugs, narcotics or medication unless prescribed by a registered medical practitioner and used as prescribed
- ✘ if you refuse any treatment recommended by a registered medical practitioner or by our Chief Medical Officer (CMO)
- ✘ if you (or any person acting on your instruction) are involved in any criminal activity
- ✘ war, armed international conflict, rebellion, civil commotion, sabotage or any activity associated with the forgoing or the defence, investigation or containment thereof by any security force
- ✘ nuclear reaction or nuclear radiation
- ✘ any act of terrorism by any person or group, whether acting alone or under instruction

You are not covered if a critical illness is a result of excessive alcohol consumption or use of drugs other than as prescribed by a medical practitioner.

What do we cover?

We offer Death, Critical Illness and Disability cover. Your schedule indicates the cover and structure you have selected. The following three structures are available:

- **Level premium - level Sum OUTsured**
  Your premium and Sum OUTsured will remain level for the cover period.
- **Increasing premium - level Sum OUTsured**
  Your premium will increase on your facility's anniversary with the percentage noted on your schedule. Your Sum OUTsured will remain level for the cover period.
- **Increasing premium - increasing Sum OUTsured**
  Your premium and Sum OUTsured will increase on your facility's anniversary with the different percentages noted on your schedule.

Free-standing or accelerated benefits

In addition to the above structure your Disability and Critical Illness cover can be free-standing or accelerated as explained below. Your schedule indicates the option you have selected.

✓ Death cover

There are two options for Death Cover. Your schedule indicates the option you have selected.

Death - Accidental

We will pay the Sum OUTsured if you die as a direct result of an accident. The accident and your death must occur during the period of cover. The accident must be the result of bodily injury caused by external and accidental means.

Death - Comprehensive

We will pay the Sum OUTsured if you die during the cover period. For accidental related claims, the accident and your death must occur during the period of cover.

This cover includes a terminal illness benefit. If we confirm that you are terminally ill and have a life expectancy of less than 12 months, we will pay 50% of your Sum OUTsured, to a maximum of R1 million, at that stage. Your Sum OUTsured will be reduced by the amount paid.

There is no terminal illness benefit during the last 12 months of cover.

Optional funeral cover

We offer Own funeral and final expense, Spouse funeral and Child funeral benefits. Your schedule indicates the benefits you have selected including the amount, start dates, waiting periods and details of each benefit.

All optional funeral cover will terminate when the related comprehensive death cover cancels.

There is no funeral cover for death due to suicide within the first 24 months after the funeral benefit commences.

Valid funeral claims will be paid within 48 hours of receiving all the documentation we requested. If

there is a reason to suspect that the claim is invalid, we have the right to withhold any funeral claim payment until we are satisfied that the claim is valid.

Should any person have multiple funeral benefits with OUTsurance, the maximum amount of funeral cover that will be paid within the 48 hours will be limited to R100,000. The balance of the funeral cover will be paid after the claim has been validated.

Funeral claims will be paid to the Facility Holder. In the event that the Facility Holder passed away, payment will be made to a responsible person as determined by us in consultation with your next of kin.

- Own funeral and final expense benefit

  This benefit advances a percentage of the Death cover Sum OUTsured in the event of the death of the Life OUTsured.

- Spouse funeral benefit

  This benefit will pay the Spouse funeral Sum OUTsured in the event of the death of the Life OUTsured's spouse. The incident and the death of the spouse must occur during the period of cover.

  A spouse is defined as the person married (by law, customary law or common law) to the Life OUTsured and must be noted in the schedule.

- Child funeral benefit

  This benefit will pay the Child funeral Sum OUTsured, up to a maximum of any legal limits, in the event of the death of the Life OUTsured's child due to an incident that occurs during the period of cover.

  These legal limits apply per child and not per Life OUTsured. In the event that a child is claimed for under more than one policy, the maximum as per the legal limits will still be upheld.

  A maximum of four children can be claimed for during the period of cover. A child is defined as a biological child, stepchild or adopted child of the Life OUTsured who is unmarried, dependent and under the age of 21, or a stillborn child after 26 weeks.

✓ Disability cover

We will pay the Sum OUTsured if you become disabled during the period of cover. The validity of a claim is determined by:

- the condition or event resulting in disability being present for 180 consecutive days and premiums being paid during this period; and
- meeting the Maximum Medical Improvement (MMI) requirement. MMI measures the extent to which the condition is stabilised and unlikely to change substantially in the following 12 months with or without medical treatment, and where further recovery is not expected; and
- you being alive for 60 days after meeting the MMI requirement

There are two options for Disability cover: "own occupation" and "own or suitable occupation". Your schedule indicates the option you have selected. It will also indicate if the Disability cover is accelerated or free-standing.

Disability - own occupation

The illness or injury must result in you:
- being medically certified, to the satisfaction of our CMO, with a total and permanent disability that is incurable or untreatable, and
- not being able to perform your own occupation as noted on your schedule

Disability - own or suitable occupation

The illness or injury must result in you:
- being medically certified, to the satisfaction of our CMO, with a total and permanent disability that is incurable or untreatable, and
- not being able to perform your own occupation (as noted on your schedule) or any other suitable occupation, taking your training, education, ability and experience into account

Accelerated Disability cover

Your Disability and Death Sums OUTsured are noted separately on your schedule. Your accelerated Disability Sum OUTsured can never exceed the Death Sum OUTsured. If you claim for disability, your Disability cover will stop and your Death cover Sum OUTsured will be reduced by the amount we pay.

Free-standing Disability cover

Your Disability and Death Sums OUTsured are noted separately on your schedule. If you claim for Disability, your Disability cover will stop. The disability claim will have no impact on your Death Sum OUTsured.

✓ Critical Illness cover

We will pay a percentage of the Sum OUTsured if you are diagnosed with a critical illness as defined below. We will pay your claim if you survive for 14 consecutive days after the diagnosis. This survival period applies to all critical illness claims, regardless of whether there has been an earlier claim. Should you die in this period, there will not be a valid critical illness claim.

The validity of a claim and the payment percentage of the Sum OUTsured are determined by:
- the condition for which you claim which must fall within the scope of its definition which outlines its general and specific qualities
- meeting the Maximum Medical Improvement (MMI) requirement. MMI measures the extent to which the condition is stabilised and unlikely to change substantially in the following 12 months with or without medical treatment, and where further recovery is not expected

The validity of a claim and the payment percentage are also determined by the following measures which are noted for specific conditions in the "Specific definition and payment percentage (%)" tables:
- Advanced Activities of Daily Living (AADLs): this is a list of general daily activities which measure your inability to perform certain daily activities due to the condition you are claiming for.
  The AADLs are:
  - driving a car: being able to drive, depth and distance perception, awareness of road safety
  - shopping: lifting and carrying groceries
  - walking or walking with assistance (e.g. with a walking aid)
  - food preparation
  - housework and moving furniture
  - sport, both moderate and vigorous

- medical care: preparing and taking correct medications
- money management
- communication: using a phone, writing

- Whole Person Impairment (WPI): this is a scale based on the American Medical Association's Guide to the Evaluation of Permanent Impairment which measures the percentage impairment of the whole person due to the condition you are claiming for.

There are two options for Critical Illness cover: "Core" and "Comprehensive". Your schedule indicates the option you have selected. It will also indicate if the Critical Illness cover is accelerated or free-standing.

Critical Illness - Core

You are covered when you are diagnosed with one of 27 critical illnesses. The percentage of the Sum OUTsured payable for each critical illness is noted below.

Critical Illness - Comprehensive

You are covered when you are diagnosed with one of 40 critical illnesses. The percentage of the Sum OUTsured payable for each critical illness is noted below.

Accelerated Critical Illness cover

Your Critical Illness and Death Sums OUTsured are noted separately on your schedule. Your accelerated Critical Illness Sum OUTsured can never exceed the Death Sum OUTsured.

If you claim for Critical Illness, the claim percentage could depend on the severity of the specific condition as defined in the critical illness definitions below. Your Critical Illness and Death Sums OUTsured will reduce by the amount we pay. Once we have paid 100% of your Critical Illness benefit the cover will stop. This will apply to all related and unrelated claims as defined below.

Free-standing Critical Illness cover

Your Critical Illness and Death Sums OUTsured are noted separately on your schedule. If you claim for Critical Illness, the Critical Illness claim will have no impact on your Death Sum OUTsured, but will impact future related Critical Illness claims. There is a maximum of 100% of the Sum OUTsured payable for related claims, but there is no limit for unrelated claims.

Related Claims refer to:

- any incident which gives rise to a claim within 180 days of a previous claim, or
- any condition listed under "related claims" for each Critical Illness definition, or
- any condition, directly or indirectly related to a previously paid claim, which:
  - is a complication of the previous condition; or
  - is a result of treatment or drugs taken for the previous condition; or
  - shares a common cause or effect

Critical Illness definitions

1. Cancer

A malignant tumour characterised by the uncontrolled growth of malignant cells and invasion of normal tissue. This includes leukaemia, lymphoma and sarcoma. The following conditions are not covered:

- all cancers *in situ* and all pre-malignant conditions
- all tumours of the prostate unless classified with a Gleason score greater than 6 or having progressed to at least clinical classification T2N0M0
- all skin cancers, other than malignant melanoma classified as having caused invasion beyond the epidermis (outer layer of skin)

The payment percentages are classified by the American Joint Committee for Cancer (2002 6th Edition) for the type of cancer involved.

Specific definition and payment percentage (%)

Solid tumours excluding prostate cancer: stage 1

Prostate cancer stage 2: T2, N0, M0 any Grade (T1a,b,c are excluded)

Leukemia and lymphoma

- chronic lymphocytic leukaemia (stage 0 or 1);
- hairy cell leukaemia;
- Hodgkins/Non-Hodgkins lymphoma stage 1 on Ann Arbor classification.

Payment %: Core 0%, Comprehensive 25%

Specific definition and payment percentage (%)

Solid tumours excluding prostate cancer: stage 2

Prostate Cancer Stage 3: T3, N0, M0 any Grade

Leukemia and Lymphoma

- chronic lymphocytic leukaemia stage 2 on the RAI classification;
- chronic myeloid leukaemia (no bone marrow transplantation);
- Hodgkins/Non-Hodgkins lymphoma stage 2 on Ann Arbor classification;
- multiple myeloma stage 1 and 2 on the Durie-Salmon classification scale.

Payment %: Core 0%, Comprehensive 50%

Solid tumours excluding prostate cancer: stage 3 or greater

Prostate cancer Stage 4: T4, N0, M0 any Grade, or
Any T, N1, M0 any Grade, or
Any T, N0, M1 any Grade

Leukemia and lymphoma
- chronic lymphocytic leukaemia stage 3 or greater on the RAI classification;
- chronic myeloid leukaemia (requiring bone marrow transplant);
- Hodgkins/Non-Hodgkins lymphoma stage 3 or greater on Ann Arbor classification system;
- multiple myeloma stage 3 on the Durie-Salmon scale;
- acute myeloid leukaemia;
- acute lymphocytic leukaemia (adults).

Payment %: Core 100%, Comprehensive 100%

Related claims: aplastic anaemia, coma, paralysis, stroke, cancer.

2. Heart Attack

Death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area as a consequence of coronary artery disease.

The evidence must show an acute myocardial infarction. Two of the following three criteria must be met:
- compatible clinical symptoms
- characteristic ECG changes, which can be either of the following:
  - new pathological Q-waves, or
  - ST-segment and T-wave changes indicative of myocardial injury, but only when accompanied by raised cardiac markers as described hereafter
- raised cardiac markers:
  - trop T > 1,0 ng/ml or Trop I > 0,5 ng/ml, or
  - total CPK elevation of more than 2 times normal values, with at least 6% being CK-MB, or
  - raised CK-MB mass:
    - more than 2 times normal values in acute presentation phase, or
    - more than 4 times normal values post-intervention

Other acute coronary syndromes, including but not limited to angina, are not covered by this definition.

Specific definition and payment percentage (%)

Heart attack

Payment %: Core 0%, Comprehensive 50%

Heart attack with mild permanent impairment in function

There must be permanent impairment in one or more of the following functional criteria, as measured 6 weeks post-infarction:

Criterion	Value
NYHA classification	Class 2 or worse
METS	<=7
LVEF	<=50%
LVEDD	>=59
Ultrasound FS in %	<=25%

Payment %: Core 100%, Comprehensive 100%

Related claims: aortic surgery, coronary artery bypass, cardiomyopathy, carotid artery surgery, coronary artery angioplasty, heart valve surgery, kidney failure, major organ transplant, pericarditis, stroke, heart attack.

3. Stroke

The death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in neurological deficit lasting more than 24 hours, confirmed by neuro-imaging investigation and appropriate clinical findings.

The following are not covered:
- transient ischaemic attack
- vascular disease affecting the eye or optic nerve
- migraine and vestibular disorders
- traumatic injury to brain tissue or blood vessels

The degree of permanent impairment will be assessed any time after three months and permanent neurological changes must be present.

Specific definition and payment percentage (%)

Stroke

Payment %: Core 0%, Comprehensive 25%

Stroke with mild impairment: can function independently, but has permanent impairment as measured by:
- the inability to do 3 or more AADLs, or
- a WPI of 11% to 20%

Payment %: Core 0%, Comprehensive 50%

Stroke with moderate or severe impairment: cannot function independently, and has permanent impairment as measured by: ▪ the inability to do 6 or more AADLs, or ▪ a WPI of 21% or more **Payment %: Core 100%, Comprehensive 100%**

Related claims: Alzheimer's disease, blindness, coronary artery bypass, cardiomyopathy, carotid artery surgery, coronary artery angioplasty, dementia, heart attack, heart valve surgery, loss of hearing, loss of speech, paralysis, stroke.

4. Coronary Artery Bypass

Undergoing surgery to correct the narrowing of, or blockage to, one or more coronary artery/ies by means of a by-pass graft.

Balloon angioplasty (PTCA), heart catheterization, laser relief, rotablade, stenting and all other intra-arterial catheter based techniques are excluded.

Specific definition and payment percentage (%)

Coronary artery bypass graft of 1 artery **Payment %: Core 0%, Comprehensive 50%**
Coronary artery bypass graft of 2 arteries **Payment %: Core 0%, Comprehensive 75%**
Coronary artery bypass graft of 3 or more arteries **Payment %: Core 100%, Comprehensive 100%**

Related claims: cardiomyopathy, coronary artery angioplasty, heart attack, major organ transplant, stroke, coronary artery bypass.

5. Paralysis

The total and irreversible loss of use of two or more limbs due to paralysis as a result of either an injury or disease of the spinal cord. The loss of use must be present for at least three months. This includes paraplegia, hemiplegia and quadriplegia.

Partial paralysis, temporary post-viral paralysis and paralysis due to psychological causes are not covered.

Payment %: Core 100%, Comprehensive 100%

Related claims: coma, loss of hearing, loss of speech, stroke, paralysis.

6. Kidney Failure

Chronic and irreversible end-stage failure of both kidneys to function as a result of which regular renal dialysis is instituted.

Payment %: Core 100%, Comprehensive 100%

Related claims: coma, dementia, major organ transplant, kidney failure.

7. Blindness

Permanent blindness that is not correctable with aides or surgery.

Specific definition and payment percentage (%)

Blindness in one eye **Payment %: Core 0%, Comprehensive 25%**
Blindness in both eyes **Payment %: Core 100%, Comprehensive 100%**

8. Major Organ Transplant

The undergoing, as a recipient, of a transplant of a human donor heart, lung, liver, pancreas, bone marrow or kidney to treat the irreversible end-stage failure of the relevant organ.

We do not cover other stem cell transplants, islet cell transplants or transplantation of any other organ or parts of an organ.

Payment %: Core 100%, Comprehensive 100%

Related claims: cancer, cardiomyopathy, coma or kidney failure, major organ transplant.

9. Coma

A state of unconsciousness, not induced by sedation, persisting for at least 96 hours, involving continuous unresponsiveness to external stimuli or internal needs and requiring the use of life support. The coma must result in a permanent impairment which must be present for at least three months.

A medically induced coma is not covered.

Specific definition and payment percentage (%)

Coma with mild impairment: can function independently, but has permanent impairment as measured by: ▪ the inability to do 3 or more AADLs, or ▪ a WPI of 11% to 20% **Payment %: Core 0%, Comprehensive 50%**
Coma with moderate impairment: cannot function independently, and has permanent impairment as measured by: ▪ the inability to do 6 or more AADLs, or ▪ a WPI of 21% or more **Payment %: Core 100%, Comprehensive 100%**

Related claims: Alzheimer's disease, coma.

10. Loss of Speech

The total and permanent inability to produce intelligible speech as a result of irreversible damage to the larynx or its nerve supply from the speech centres of the brain, which has lasted for more than six months continuously.

Psychiatric causes of loss of speech are not covered.

Payment %: Core 100%, Comprehensive 100%

11. Loss of Limbs

The permanent and complete severance of two or more limbs through or above the elbow or knee joint due to injury or accident.

Loss of limbs as a result of illness is not covered.

Payment %: Core 100%, Comprehensive 100%

12. Major Burns

The diagnosis of 3rd-degree burns, where the total body area involved is confirmed using standardised, clinically accepted body surface area charts.

Specific definition and payment percentage (%)

3rd-degree burns covering at least 10% of the body's surface area. **Payment %: Core 0%, Comprehensive 50%**
3rd-degree burns covering at least 20% of the body's surface area. **Payment %: Core 100%, Comprehensive 100%**

Related claims: kidney failure, major burns.

13. Heart Valve Surgery

The undergoing of open heart surgery requiring a median sternotomy to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease affected cardiac valve(s).

Payment %: Core 75%, Comprehensive 75%

Related claims: coronary artery bypass, cardiomyopathy, carotid artery surgery, coronary artery angioplasty, heart attack, major organ transplant, paralysis, stroke, heart valve surgery.

14. Aortic Surgery

Undergoing surgery to excise and replace a portion of the diseased thoracic or abdominal aorta with a graft.

We do not cover any surgery to treat peripheral vascular disease of the aortic branches.

Payment %: Core 100%, Comprehensive 100%

Related claims: coronary artery bypass, carotid artery surgery, aortic surgery.

15. Accidental HIV

Infection with HIV (Human Immunodeficiency Virus) resulting from, or transmitted by, a physical assault or road traffic accident involving exposure to blood, blood-stained body fluids or semen (in the case of rape). All the following criteria must also be met:

- the incident must have been reported to the police within 24 hours
- a blood test showing no HIV or HIV antibodies must be carried out within 72 hours of the incident
- seroconversion must be proven with another HIV test within 180 days of the incident indicating presence of infection by HIV
- you must have completed a course of clinically accepted anti-retroviral therapy

We must be given access to independently test all the blood samples and to take additional samples. If an effective cure for HIV is found in the future, this benefit will not pay out.

HIV infection that is acquired through consensual sexual activity, recreational intravenous drug use, occupational hazards or deliberate self-infliction is not covered.

Payment %: Core 100%, Comprehensive 100%

Related claims: cancer or full blown AIDS.

16. Benign Brain Tumour resulting in impairment

The diagnosis of a life threatening tumour in the brain causing permanent neurological impairment that is progressively worsening with objective evidence of motor or sensory dysfunction and of the tumour growing.

We do not cover cysts, granulomas, cholesteatomas and malformations in the arteries or veins of the brain, haematomas, abscesses, acoustic neuroma, or micro-tumours of the pituitary gland, meninges or spinal cord.

Specific definition and payment percentage (%)

Benign brain tumour with mild impairment: can function independently, but has permanent impairment as measured by: ▪ the inability to do 3 or more AADLs, or ▪ a WPI of 11% to 20% **Payment %: Core 0%, Comprehensive 50%**
Benign brain tumour with moderate impairment: cannot function independently, and has permanent impairment as measured by: ▪ the inability to do 6 or more AADLs, or ▪ a WPI of 21% or more **Payment %: Core 100%, Comprehensive 100%**

17. Accidental Brain Damage

The death of brain tissue due to traumatic injury caused by external physical force where the diagnosis is confirmed by brain imaging.

The degree of permanent impairment will be assessed any time after three months and permanent neurological changes must be present.

Specific definition and payment percentage (%)

Accidental brain damage with mild impairment: can function independently, but has permanent impairment as measured by: ▪ the inability to do 3 or more AADLs, or ▪ a WPI of 11% to 20% **Payment %: Core 0%, Comprehensive 50%**
Accidental brain damage with moderate impairment: cannot function independently, and has permanent impairment as measured by: ▪ the inability to do 6 or more AADLs, or ▪ a WPI of 21% or more **Payment %: Core 100%, Comprehensive 100%**

Related claims: blindness, coma, dementia, loss of hearing, loss of speech, paralysis, accidental brain damage.

18. Loss of Hearing

The total, bilateral and irreversible loss of hearing of all sounds as a result of illness or accident where the diagnosis is confirmed by audiometric and sound-threshold testing.

The deafness must not be correctable by aides or surgical procedures.

Payment %: Core 100%, Comprehensive 100%

19. Multiple Sclerosis

A diagnosis of Multiple Sclerosis (MS) must be made which satisfies clinically accepted criteria. There must be a history of documented neurological dysfunction.

The diagnosis must also be confirmed with objective neurological investigations, such as lumbar puncture, visual evoked responses, auditory evoked responses and/or magnetic resonance imaging. The MS must result in a permanent impairment which must be present for at least six months and is deemed to be permanent.

Neurological disease due to acute disseminated encephalomyelitis, lupus, bacterial or viral illnesses, or diseases of the blood vessels are not covered.

Specific definition and payment percentage (%)

Multiple sclerosis with mild impairment: can function independently, but has permanent impairment as measured by:

- the inability to do 3 or more AADLs, or
- a WPI of 11% to 20%

Payment %: Core 0%, Comprehensive 50%

Multiple sclerosis with moderate impairment: cannot function independently, and has permanent impairment as measured by:

- the inability to do 6 or more AADLs, or
- a WPI of 21% or more

Payment %: Core 100%, Comprehensive 100%

Related claims: blindness, chronic respiratory failure, coma, loss of hearing, loss of speech, paralysis, accidental brain damage, multiple sclerosis.

20. Alzheimer's Disease

Progressive and permanent deterioration of memory and intellectual capacity as evidenced by accepted standardised questionnaires and cerebral imaging. There must be progressive and significant reduction in mental and social functioning for a continuous period of at least six months.

Psychiatric illnesses and alcohol related brain damage are excluded. The cover for this benefit ceases at age 65.

Specific definition and payment percentage (%)

Alzheimers with mild impairment: cannot function independently, and has permanent impairment as measured by:

- the inability to do 3 or more AADLs, or
- a WPI of 11% to 20%

Payment %: Core 0%, Comprehensive 50%

Alzheimers with moderate impairment: cannot function independently, and has permanent impairment such that a medical specialist is of the opinion that the insured requires continuous supervision.

Payment %: Core 100%, Comprehensive 100%

Related claims: dementia, Alzheimer's disease.

21. Parkinson's Disease

The diagnosis of idiopathic Parkinson's disease based on the clinical history, physical examination and appropriate testing.

Toxic causes of Parkinsonism are excluded. The cover for this benefit ceases at age 65.

Specific definition and payment percentage (%)

Parkinson's with mild impairment: cannot function independently, and has permanent impairment as measured by:

- the inability to do 3 or more AADLs, or
- a WPI of 11% to 20%

Payment %: Core 0%, Comprehensive 50%

Specific definition and payment percentage (%)

Parkinson's with moderate impairment: cannot function independently, as measured by:

- the inability to do 6 or more AADLs, or
- a WPI of 21% or more

Payment %: Core 100%, Comprehensive 100%

Related claims: Alzheimer's disease, coma, dementia, loss of speech, paralysis, Parkinson's disease.

22. Cardiomyopathy

A heart muscle disease preventing the heart from functioning properly causing heart failure.

The limitation must be sustained for at least six continuous months once stabilized on appropriate therapy and must be deemed to be permanent with no hope of recovery despite any ongoing medical or surgical therapy.

Specific definition and payment percentage (%)

Cardiomyopathy resulting in moderate cardiac dysfunction: cardiomyopathy must result in permanent impairment in two or more of the following functional criteria

Criterion	Value
NYHA classification	Class 3
METS	2-5
LVEF	30-40%
LVEDD	66-72
Ultrasound FS in %	16-20%

Payment %: Core 0%, Comprehensive 50%

Specific definition and payment percentage (%)

Cardiomyopathy resulting in severe cardiac dysfunction: cardiomyopathy must result in permanent impairment in two or more of the following functional criteria:

Criterion	Value
NYHA classification	Class 4
METS	1
LVEF	<=30%
LVEDD	>=72
Ultrasound FS in %	<=16%

Payment %: Core 100%, Comprehensive 100%

Related claims: aortic surgery, coronary artery bypass, chronic respiratory failure, heart attack, heart valve surgery, major organ transplant, pericarditis, cardiomyopathy.

23. Chronic Respiratory Failure

End stage lung disease, causing chronic respiratory failure, the diagnosis of which requires all four of the following:

- FEV1 test results consistently less than 1 litre measured on 3 occasions, 3 months apart
- requiring continuous permanent supplementary oxygen therapy for hypoxemia
- arterial blood gas analyses on room air with partial oxygen pressures of 55mmHg or less (PaO2 < 55mmHg)
- dyspnea at rest

Payment %: Core 100%, Comprehensive 100%

Related claims: cardiomyopathy, coma, dementia, major organ transplant, chronic respiratory failure.

24. Chronic Liver Failure

Permanent and irreversible failure of liver function, resulting in all three of the following:

- permanent jaundice
- ascites
- hepatic encephalopathy

Payment %: Core 100%, Comprehensive 100%

Related claims: coma, dementia, major organ transplant, chronic liver failure.

25. Full Blown AIDS

The diagnosis of AIDS must be confirmed by a positive HIV ELISA antibody test and a positive HIV confirmatory test (Western Blot or PCR Test).

The Life OUTsured must be on optimal treatment and the CD4 cell count must also be permanently less than 200 cells per µL of blood.

Independent test of all the blood samples are required and additional samples may be requested.

One of the following two scenarios must also be met:

- Scenario 1: at least 1 of the following conditions must exist:
  - Kaposi sarcoma under age 60
  - pneumocystic carinii pneumonia
  - progressive multifocal leukoencephalopathy
  - extra pulmonary tuberculosis
  - cryptococcal Meningitis
- Scenario 2: at least 3 of the following conditions must exist:
  - weight loss of more than 10% body mass in less than 6 months
  - shingles
  - oral thrush
  - chronic diarrhoea
  - active pulmonary tuberculosis

Payment %: Core 100%, Comprehensive 100%

Related claims: accidental HIV, Alzheimer's disease, aplastic anaemia, blindness, cancer, cardiomyopathy, chronic liver failure, chronic respiratory failure, coma, dementia, heart attack, infective meningitis, kidney failure, loss of hearing, loss of speech, paralysis, pericarditis, stroke, full blown AIDS.

26. Aplastic Anaemia

Total and permanent bone marrow failure. You must have received a bone marrow transplant or must have received treatment for more than three consecutive months with one of the following:

- frequent blood product transfusions; or
- bone marrow stimulating agents; or
- immunosuppressive agents

Temporary or reversible aplastic anaemia is not covered.

Payment %: Core 100%, Comprehensive 100%

Related claims: major organ transplant, aplastic anaemia.

27. Muscular Dystrophy

The diagnosis must be confirmed by appropriate laboratory, biochemical, histological, and electromyographic evidence and there must be evidence of permanent and progressive muscle weakness.

Specific definition and payment percentage (%)

Muscular dystrophy with mild impairment: can function independently, but has permanent impairment as measured by:

- the inability to do 3 or more AADLs, or
- a WPI of 11% to 20%

Payment %: Core 0%, Comprehensive 50%

Specific definition and payment percentage (%)

Muscular dystrophy with moderate impairment: cannot function independently, and has permanent impairment as measured by:

- the inability to do 6 or more AADLs, or
- a WPI of 21% or more

Payment %: Core 100%, Comprehensive 100%

Related claims: cardiomyopathy, chronic respiratory failure, paralysis, muscular dystrophy.

The following conditions are only covered under Critical Illness - Comprehensive cover

28. Cerebral Aneurysm

An abnormal dilatation of an intra-cranial artery diagnosed on cerebral imaging or angiography. The aneurysm must be operated on by either vascular embolization or by surgical clipping with a craniotomy.

Payment %: Core 0%, Comprehensive 25%

Related claims: stroke, cerebral aneurysm.

29. Pericarditis

Chronic constrictive pericarditis causing impaired cardiac function as evidenced on cardiac imaging. You must be either inoperable or have undergone pericardectomy. The impairment must be sustained over at least six months once stabilized on appropriate therapy or surgery and the impairment must be deemed to be permanent.

Only the chronic constrictive form of pericarditis is covered. All other forms of pericarditis are not covered.

Specific definition and payment percentage (%)

Pericarditis resulting in moderate cardiac dysfunction: pericarditis must result in permanent impairment in two or more of the following functional criteria:

Criterion	Value
NYHA classification	Class 3
METS	2-5
LVEF	30-40%
LVEDD	66-72
Ultrasound FS in %	16-20%

Payment %: Core 0%, Comprehensive 50%

Pericarditis resulting in severe cardiac dysfunction: pericarditis must result in permanent impairment in two or more of the following functional criteria:

Criterion	Value
NYHA classification	Class 4
METS	1
LVEF	<=30%
LVEDD	>=72
Ultrasound FS in %	<=16%

Payment %: Core 0%, Comprehensive 100%

Related claims: cardiomyopathy, major organ transplant, rheumatoid arthritis, systemic lupus erythematosus, pericarditis.

30. Infective Meningitis

The diagnosis must be proven by analysis of the cerebrospinal fluid. There must be permanent residual neurological functional deficit that is present for at least three months after the diagnosis of the meningitis infection.

Specific definition and payment percentage (%)

Infective meningitis with mild impairment: can function independently, but has permanent impairment as measured by:

- the inability to do 3 or more AADLs, or
- a WPI of 11% to 20%

Payment %: Core 0%, Comprehensive 50%

Infective meningitis with moderate impairment: cannot function independently, and has permanent impairment as measured by:

- the inability to do 6 or more AADLs, or
- a WPI of 21% or more

Payment %: Core 0%, Comprehensive 100%

Related claims: coma, dementia, infective meningitis.

31. Carotid Artery Surgery

Clinically necessary surgery to correct a significant stenosis of at least 70% diameter narrowing of a carotid artery. This must be done by angioplasty, stent insertion, bypass grafting or endarterectomy.

Payment %: Core 0%, Comprehensive 25%

Related claims: blindness, coronary artery bypass, coronary artery angioplasty, loss of hearing, loss of speech, paralysis, stroke, carotid artery surgery.

32. Coronary Artery Angioplasty

Clinically necessary intervention to widen or open up a narrowing of two or more coronary arteries done by coronary angioplasty (PTCA), atherectomy, or insertion of a stent. There must be angiographic evidence of stenosis of at least 50% diameter narrowing of the coronary arteries, all of which are corrected during a single procedure.

The obstruction must have caused either impairment of ventricular function or disabling symptoms verified as ischemic in origin with a positive exercise stress test or unstable angina pectoris or myocardial infarction.

Payment %: Core 0%, Comprehensive 25%

Related claims: coronary artery bypass, cardiomyopathy, carotid artery surgery, heart attack, major organ transplant, coronary artery angioplasty.

33. Hydrocephalus requiring a shunt

The diagnosis must be made via a lumbar puncture or using imaging techniques. A shunt must be surgically implanted in order to treat the condition.

Payment %: Core 0%, Comprehensive 25%

Related claims: blindness, coma, dementia, infective meningitis, loss of hearing, loss of speech, paralysis, stroke, hydrocephalus requiring a shunt.

34. Motor Neurone Disease

A diagnosis of amyotrophic lateral sclerosis (Lou Gehrig's disease), spinal muscular atrophy, progressive bulbar palsy or primary lateral sclerosis. There must be progressive muscle dysfunction and the diagnosis must be based on your medical history along with Electromyogram (EMG) studies and biochemical testing as indicated clinically.

Payment %: Core 0%, Comprehensive 100%

Related claims: chronic respiratory failure, loss of speech, paralysis, motor neurone disease.

35. Dementia

Permanently impaired cognitive function arising from an irreversible organic degenerative brain disorder.

The diagnosis must be evidenced by the clinical state, accepted standardised questionnaires and neurological tests.

There must also be progressive and significant permanent reduction in mental and social functioning for a continuous period of at least six months.

Dementia caused by any psychiatric illness as well as reversible dementia is not covered. The cover for this benefit ceases at age 65.

Specific definition and payment percentage (%)

Dementia with mild impairment: cannot function independently, and has permanent impairment as measured by:
- the inability to do 3 or more AADLs, or
- a WPI of 11% to 20%

Payment %: Core 0%, Comprehensive 50%

Dementia with moderate impairment: cannot function independently, and has permanent impairment such that a medical specialist is of the opinion that the insured requires continuous supervision

Payment %: Core 0%, Comprehensive 100%

Related claims: Alzheimer's disease, coma, Parkinson's disease, stroke, dementia.

36. Rheumatoid Arthritis

Widespread chronic joint destruction with significant deformity affecting three or more major joint areas for example feet, hands, hips, knees. The diagnosis must be evidenced by at least three of the following:
- morning stiffness
- rheumatoid nodules
- positive rheumatoid factor
- symmetrical swelling in joints

Degenerative osteoarthritis and all other forms of arthritis are not covered.

Specific definition and payment percentage (%)

Rheumatoid arthritis with mild impairment: cannot function independently, and has permanent impairment as measured by:
- the inability to do 3 or more AADLs, or
- a WPI of 11% to 20%

Payment %: Core 0%, Comprehensive 50%

Rheumatoid arthritis with moderate impairment: cannot function independently, as measured by:
- the inability to do 6 or more AADLs, or
- a WPI of 21% or more

Payment %: Core 0%, Comprehensive 100%

Related claims: pericarditis, rheumatoid arthritis.

37. Systemic Lupus Erythematosus

The diagnosis of systemic lupus erythematosus (SLE) using the criteria as defined by the American College of Rheumatology.

The disease must be unresponsive to disease modifying drugs used for a minimum of 12 months. There must also be either widespread joint destruction requiring surgery on at least one major joint,

involvement of the heart or lungs, or involvement of the kidneys where GFR<30ml/min.

Discoid and medication induced lupus are not covered.

Payment %: Core 0%, Comprehensive 100%

Related claims: cardiomyopathy, kidney failure, major organ transplant, pericarditis, stroke, systemic lupus erythematosus.

38. Ulcerative Colitis

Histopathologically proven ulcerative colitis requiring colectomy with a permanent ileostomy or colostomy.

Payment %: Core 0%, Comprehensive 100%

Related claims: cancer, chronic liver failure, major organ transplant, ulcerative colitis.

39. Crohn's Disease

Histopathologically proven Crohn's disease requiring colectomy with a permanent ileostomy or colostomy.

Payment %: Core 0%, Comprehensive 100%

Related claims: cancer, chronic liver failure, major organ transplant, Crohn's disease.

40. Guillain-Barré

The disease must result in a permanent neurological impairment for least three months following the onset of the disease. The diagnosis must include nerve conduction studies as well as a lumbar puncture.

Specific definition and payment percentage (%)

Guillain-Barré with mild impairment: can function independently, but has permanent impairment as measured by: ▪ the inability to do 3 or more AADLs, or ▪ a WPI of 11% to 20% **Payment %: Core 0%, Comprehensive 50%**
Guillain-Barré with moderate impairment: cannot function independently, and has permanent impairment as measured by: ▪ the inability to do 6 or more AADLs, or ▪ a WPI of 21% or more **Payment %: Core 0%, Comprehensive 100%**

Related claims: chronic respiratory failure, coma, loss of limbs or paralysis, Guillain-Barré.

ASISA Critical Illness guideline

The Association for Savings and Investment SA (ASISA) has set out standard definitions for the four critical illnesses noted below. These define the different severity levels ranging from A (most severe) to D (almost full recovery) for each condition. The table indicates our payment % for each one.

Critical Illness - Core

Severity	Heart Attack	Cancer	Stroke	Coronary Artery Bypass
A	100%	100%	100%	100%
B	100%	100%	100%	0%
C	0%	0%	0%	0%
D	0%	0%	0%	0%

Critical Illness - Comprehensive

Severity	Heart Attack	Cancer	Stroke	Coronary Artery Bypass
A	100%	100%	100%	100%
B	100%	100%	100%	75%
C	50%	50%	50%	50%
D	0%	25%	25%	50%

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