essential
employee benefits

wellness

HOSPITAL PLAN WORDING

ILLNESS, ACCIDENT AND DREAD DISEASE COVER

1. BACKGROUND

1.1 The Principal Member named in the Policy Schedule has applied to the Insurer for the insurance as hereinafter set out. The Insurer hereby agrees to accept the risk in terms of this contract of insurance or any endorsement, alteration or variation to it, made in writing, subject to:

1.1.1 any proposal or other information supplied by or on behalf of the Insured Person;

1.1.2 disclosing all facts and circumstances known to the Insured Person that might be material to the assessment of the risks insured hereby, and which information forms part of the underwriting basis of this policy; and

1.1.3 The condition of prior payment of the Premium by or on behalf of the Insured Person and the receipt thereof by or on behalf of the Insurer notwithstanding anything to the contrary set out in this Policy or any section thereof.

2. DEFINITIONS

2.1. In this Policy, unless the context indicates a contrary intention, the following words and expressions bear the meanings assigned to them and cognate expressions bear corresponding meanings –

2.2. "Accident" means a sudden, unexpected, unusual, specific event which occurs at an identifiable time and p lace during the period of the Policy;

2.3. "Adult" means a member who is 21 years or older, excluding full-time students who are younger than 25 and dependants who are permanently physically and/or mentally disabled.

2.4. "Acute medicine" means medicine used for diseases or conditions that have a rapid onset, severe symptoms, and that require a short course of medicine treatment.

2.5. "Admission" means admission into a Hospital as an Inpatient;

2.6. "ASISA" means the Association for Savings and Investments South Africa;

2.7. “Bodily Injury” means Bodily Injury by violent external and visible means caused by an Accident but shall include Bodily Injury caused by starvation, thirst and exposure to the elements as a result of a Road Accident;
2.8. “Benefit” means the Benefit amounts as set out in the Policy Schedule, provided by the Insurer in terms of this Policy;
2.9. “Chronic medicine” means medicine that meets all the following requirements:
  2.9.1. Is within the Essential Employee Benefits formulary as amended from time to time and prescribed by a network medical practitioner for an uninterrupted period of at least three months;
  2.9.2. Is for a condition appearing on the list of approved chronic conditions, as amended from time to time;
  2.9.3. Which has been applied for in the manner and at the frequency prescribed and which application has been approved and accepted.
  2.9.4. Maximum benefits per annum may be applied on certain conditions.
2.10. “Commencement Date” means the date specified in the Policy Schedule;
2.11. “Compensation” means the amount payable to the Insured Person in the event of a Benefit claim;
2.12. “Day” means 24 consecutive hours from time of Admission;
2.13. “Defined event” means the event which gives rise to the member having to seek medical treatment as set out in the schedule hereto, but excludes instances where, in the opinion of the insurer, multiple treatments are sought and/or accepted where fewer treatments will suffice or other non-essential and premeditated acts of selection against the insurer.
2.14. “Dependent Child(ren)” means:
  2.14.1. The named child of a Principal Member under the age of 21 (twenty-one) years, including a stepchild, sisters and brothers, a natural child or legally adopted child, including a child adopted in terms of a customary adoption under a tradition practised by the people of South Africa provided that the child’s natural parents are both deceased, or an adoption under the tenets of any religion practice by the people of South Africa provided that the child’s natural parents are both deceased;
  2.14.2. a stillborn child of a Principal Member born after the 28th (twenty-eighth) week of pregnancy or posthumous child;
  2.14.3. a child of a Principal Member being permanently mentally or physically disabled and totally dependent upon the Principal Member; a child of a Principal Member under the age of 26 (twenty-six) years who is a full time student at any registered university, technikon or tertiary education institution, registered in terms of any legislation in the Republic of South Africa or such other institution as may be approved in Writing by the Insurer, and who is unmarried;
  2.14.4. child of a Principal Member under the age of 26 (twenty-six) years who is a full time student at any registered university, technikon or tertiary education institution, registered in terms of any legislation in the Republic of South Africa or such other institution as may be approved in Writing by the Insurer, and who is unmarried;
2.15. “Dread Disease” means any of the following:
  2.15.1. Heart Attack: being a heart attack as defined in the ASISA SCIDEP, set out in clause 2.4 of Annexure 1.

2.15.2. Chronic Coronary Heart Disease: Open bypass surgery or surgical treatment of Coronary disease. This excludes angioplasty and / or any similar intrarterial procedures.

2.15.3. Stroke: being a stroke as defined in terms of the ASISA SCIDEP set out in clause 2.5 of Annexure 2.

2.15.4. Cancer: being cancer as defined in ASISA SCIDEP set out in clause 2.3 of Annexure 1.

2.15.5. Kidney Failure: means end stage renal failure presenting a chronic irreversible failure of both kidneys to function, as a result of which regular renal dialysis is required on a long-term basis.

2.15.6. Major Organ Transplant: The human to human organ transplant from a donor to the Insured Person of one or more of the following organs: Kidney, Heart, Lung, Liver, Pancreas or Bone Marrow. The transplantation of all or other organs, parts of organs or any other tissue transplant is excluded.

2.15.7. Paraplegia: The Insured Person suffers the total and irreversible loss of use of both legs or both arms as a result of an Illness.

2.15.8. Blindness: The Insured Person suffers the total and irrecoverable sudden loss of vision in both eyes as a result of an Illness;

2.16. "EMS" means the emergency medical response unit available to the Insured Persons for urgent medical assistance;

2.17. "Family" means the Principal Member (being a natural person) in whose name this policy is effected and includes the Principal Member's Spouse and Dependent Children under the age of 21 (twenty one) years which form part of the Principal Member's household and who are resident in the Republic of South Africa;

2.18. "Formulary" means the exhaustive lists of procedures, prices and service providers as approved and amended from time to time by Essential Employee Benefits which together constitutes the maximum limit of benefits which Essential Employee Benefits will be bound to pay in terms of this policy. It is the express obligation of the insured to check against the formulary each and every time to establish the exact level of benefits as per paragraph 13 hereunder.

2.19. "High Care" A high care unit is an area in a hospital, usually located closely to the Intensive Care Unit, where patients can be cared for more extensively than a normal ward, but not to the point of intensive care. It is appropriate for patients who have had major surgery, and for those with single-organ failure. Patients may be admitted to a high care unit because they are at risk of requiring intensive care admission, or as a step down between intensive care and normal ward-based care.

2.20. "Hospital" means an establishment which meets all the following requirements:

2.20.1. 1 holds a licence as a hospital or day clinic or nursing home (if licensing is required in the province or government jurisdiction);

2.20.2. operates primarily for the reception, care and treatment of sick, ailing or injured persons as inpatients;

2.20.3. provides organised facilities for diagnosis and surgical treatment;

2.20.4. is not primarily a rest or convalescent home or similar establishment and is not, other than incidentally, a place for rehabilitation of alcoholics or drug addicts;

2.21. ICU or Intensive Care Unit (ICU), also known as a critical care unit (CCU), is a special department of a hospital or health care facility that provides intensive care medicine. Intensive care units cater to patients with severe and life-threatening illnesses and injuries, which require constant; close monitoring and support from specialist equipment and medications in order to ensure normal bodily functions.

2.22. "Illness" means the onset of any acute somatic, unforeseeable, unpredictable Illness (excluding mental Illness) which requires Admission to Hospital, and which was not a Pre-Existing Condition (unless otherwise provided for herein). A recurrence of any Illness will only be considered a separate Illness if 6 (six) months have elapsed from the date of onset of the preceding Illness;

2.23. "Inception date" means the date on which the application for this insurance, including any variables or options as regards benefits as selected by the insured becomes effective.

2.24. "Insured Persons" means the Principal Member as named on the Policy Schedule and their named Spouse and Dependent Children.

2.25. "Insurer" means, Lion of Africa Life Assurance Company Ltd, registration 1942/015587/06, an authorised financial service provider, FSP No. 15283.

2.26. "Insuring Section" means the Benefits payable and types of insurance cover granted to the Insured Person as more fully set out in clause 7;

2.27. "Main member" means a person who has been registered as the

principal insured.

2.28. "Member" means each individual under cover, including a dependant.

2.29. "Minor" means a dependant who is not yet 21 years old, and a dependant who is over the age of 21, but not over the age of 26 years, who is studying full time at a recognised institution, as defined in clause 2.6 above.

2.30. "Option" means a product registered under Essential Employee Benefits, which offers a specific structure of benefits.

2.31. "the/this policy" means the insurance agreement concluded between the Insurer and the employer or between the Insurer and clients who purchase policies in their personal capacity in respect of the benefits underwritten by the insurer;

2.32 "Policy Holder" means Employer or clients who purchase policies in their personal capacity.

2.33. "Policy Schedule" means the long-term insurance policy schedule issued to the Principal Member in terms of section 48 of the Long-term Insurance Act;

2.34. "Pre-Existing Condition" means any Bodily Injury or Illness or Dread Disease for which the Insured Person received medical advice and or treatment in the 12 (twelve) months prior to the Commencement Date stated in the Policy Schedule (unless otherwise provided for herein) Signs and symptoms present prior to inception of the Policy but which were not yet made the subject of treatment or medical advice are also considered to be pre–existing;

2.35. "Premium" means the premium payable to the Insurer on a monthly basis in terms of this Policy in order to secure the Benefits;

2.36. "Principal Member" means the person who applies for Insurance Cover under this Policy; includes a parent or person responsible for a minor

2.37. "Professional Sport" means a sporting activity in which an Insured Person engages and from which such Insured Person derives the majority of their monthly income;

2.38. "SCIDEP" means the ASISA Standardised Critical Illness Definitions Project;

2.39. "Service Provider" means a medical practitioner, dentist, optometrist or pharmacist.

2.40. "Spouse" means the named Spouse of a Principal Member, including any life partner. Not more than one Spouse shall be covered in respect of each Principal Member;

2.41. "Temporary Total Disability" means the Insured Person being admitted to Hospital as an in-patient; costs to be covered up to maximum stated benefit amounts;

2.41. "Territorial Limits" means the Republic of South Africa, Lesotho, and Swaziland;

2.42. "Writing" (or words of similar meaning) means legible writing and in English and includes any form of electronic communication contemplated in the Electronic Communications and Transactions Act, 25 of 2002.

2.43. "Waiting period" means the number of months/days you have to wait from inception before you can access your benefits.

2.44. "Year" means a calendar year.

2.45. Any reference to the singular includes the plural and vice versa; and

2.46. Any reference to a gender includes the other gender.

2.47. The clause headings in this Policy have been inserted for convenience only and shall not be taken into account in its interpretation.

2.48. If any provision in a definition is a substantive provision conferring rights or imposing obligations on any party, effect shall be given to it as if it were a substantive clause in the body of the Policy, notwithstanding that it is only contained in the interpretation clause.

2.49. This Policy shall be governed by, construed and interpreted in accordance with the law of the Republic of South Africa.

3. GENERAL PROVISIONS

It is agreed that:

3.1 The age of the Principal Member cannot exceed 54 years when first making application to this Policy (unless otherwise provided for herein);

3.2 An Insured Person may not be covered for more than one Policy under this type of Insurance. In the event of this policy not being the first policy, then this policy shall be invalidated and no claim shall be recognised. In the event that this policy is the first policy, then this policy shall pay benefits only when it can be demonstrated to the satisfaction of the insurer, that no other benefit is paid to the insured by any other insurer;

4. PAYMENT OF PREMIUM

4.1 Premiums shall be payable monthly in advance on the first day of the month. In the event of non-payment of the Premium on the due date, and subject to the provision of a 15 (fifteen) day grace period to pay the Premium in arrears, insurance cover in respect of

the Insured Person shall lapse after written notification of the non-payment by the Insurer in terms of Rule 15A of the PPR's.

4.2 Premiums shall be payable by means of a debit order from a bank account nominated by the Principal Member or deducted by the Employer and paid over to Essential Employee Benefits. All costs associated in respect thereof shall be borne by the Principal Member.

5. GENERAL EXCLUSIONS AND LIMITATIONS

The Insurer shall not be liable to pay Compensation for Bodily Injury or Illness / Dread Disease in respect of any Insured Person if:

5.1 caused by attempted suicide, or any other self-injury or intentional exposure to obvious risk of Injury (unless in an attempt to save a human life);

5.2 caused by a Pre-Existing Condition (unless otherwise provided for herein);

5.3 the member is over 54 years of age (unless otherwise provided herein);

5.4 caused by or as a result of the influence of alcohol, drugs or narcotics upon such Insured Person unless administered by or prescribed by and taken in accordance with the instructions of a member of the medical profession (other than himself);

5.5 caused by or arising from exposure to or contamination by atomic energy and/or nuclear fission or reaction;

5.6 whilst travelling by air other than as a passenger and not as a member of the aeroplane crew or technical staff for the purpose of any technical operation thereon or therein;

5.7 whilst participating in any riot or civil commotion or public disorder, including authorised and sanctioned union activity or active involvement in war, acts of terrorism, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection or political risk of any kind;

5.8 whilst participating in a Professional Sport;

5.9 for any mental and/or nervous disorders, other than those caused by Accident as defined in this Insurance;

5.10 who is in employment or service in the permanent force of the South African National Defence Force, South African Police Service or any other armed forces;

5.11 for any claims for mountaineering or rock climbing necessitating the use of ropes or guides, potholing, hang gliding, sky diving, riding or driving in a race or rally, underwater activities involving the use of artificial breathing apparatus unless the Insured Person has an open water diving certificate or is diving with a qualified instructor to a depth no greater than 30 meters and/or similar activities, unless agreed by the Insurer;

5.12 for any claim arising whilst the Insured Person is perpetrating an intentional unlawful act in terms of South African Law;

5.13 caused by any gradually operating cause of which the Insured Person is aware;

5.14 for pregnancy or childbirth unless the mother has been insured under this Policy for more than 10(ten)) consecutive months nor for any congenital abnormalities;

5.15 for claims in respect of expenses arising out of regular medical treatments on an on-going (chronic) basis;

5.16 for elective, elective cosmetic, corrective optical and laser surgery, including surgery related to the treatment of obesity or treatment and costs resulting there from;

5.17 for treatment, directly or indirectly arising from, or connected with male and female birth control, infertility and any form of assisted reproduction;

5.18 for any new-born children where the Illness or Dread Disease was known by the Principal Insured Person prior to the birth of that Dependent Child;

5.19 in respect of premature childbirth unless the expected date of birth is later than 10 (ten) consecutive months after inception of insurance;

5.20 The Insured Persons shall take all reasonable precautions to prevent Accidents and to comply with all statutory requirements and regulations;

5.21 if the consequences of an Accident shall be aggravated by any condition or physical disability of the Insured Person which existed before the Accident occurred, the amount of any compensation payable under this Insurance in respect of the Consequences of the accident shall be the amount which it is reasonably considered by the insurer would have been payable if such consequences had not been so aggravated.

5.22 In the case where the member is also covered by a Medical Aid as defined in the Medical Schemes Act, 131 of 1998. The Insurer

reserves the right to apply the average length of stay to the relevant admission based on the clinical guidelines as provided by the Department of Health

5.23 Where the Insured Person is covered in terms of a statutory body (such as the Compensation for Occupational Injuries and Diseases Act No 130 of 1993 or the Road Accident Fund Act 56 of 1996) or their successors, or any other statutory cover, in relation to an Accident, this Policy shall be obliged to pay only the amounts for which the Insured Person is liable (i.e. shortfall between actual expense and amount paid to the Insured Person) up to the maximum benefit amount.

6. GENERAL CONDITIONS

6.1 Insurance cover shall commence on the Commencement Date subject to receipt of the first Premium by the Insurer.

6.2 This Policy and the Policy Schedule shall be read together as one contract and any word or expression to which a specific meaning has been attached in any part of this Policy or the Policy Schedule shall bear specific meaning wherever it may appear.

6.3 This Policy may be cancelled at any time by the Insurer giving 31 (thirty) days' notice in writing.

6.4 This Policy is not assignable. Compensation shall be payable only to the Insured Person or their estate whose receipt shall effectually discharge the Insurer.

6.5 This Policy shall be voidable in the event of misrepresentation, mis-description or non-disclosure by or on behalf of an Insured Person of any particular material fact to this Insurance.

6.6 Written notice on the prescribed form must be given to the Insurer in writing as soon as practicable of any occurrence which may give rise to a claim under this Insurance, but in any event within 3 months of such occurrence,

6.7 Costs associated with the claim need to be submitted to the Insurer within 120 days of service.

6.8 In the event that the Insurer repudiates liability for any claim under this Policy, the claimant shall have 90 (ninety) days from the date of notice of the repudiation within which to make representations to the Insurer disputing the repudiation of the claim. If the claimant concerned does not, in respect of the subject matter of such claim, within 3 (three) years, after the 90 (ninety) day period make representations, commence legal proceedings in a competent court and prosecute such proceedings to final judgement, any liability of the Insurer shall be extinguished and no benefits shall be payable in respect of such claim and/or the insured event concerned. Please contact the Insurer for access to its Complaints Management Policy.

6.9 All certificates, information and evidence required by the Insurer shall be furnished in the form prescribed and without expense to the Insurer. The Insured Person shall submit to medical examination on behalf of and at the expense of the Insurer as often as shall be required in connection with any claim.

6.10 Qualified medical advice shall be sought by the insured at the insured's own expense, and followed promptly on the occurrence of any Bodily Injury, Dread Disease or Illness and the Insurer shall not be liable for any part of any claim which in the opinion of the medical adviser arises from the unreasonable or wilful neglect or failure of an Insured Person to seek and remain under the care of a qualified member of the medical profession.

6.11 The Insured Person must notify EEBS Pre-Authorisations at least 48 (forty eight) hours prior to being hospitalised and give full particulars of the hospitalisation to EEBS Pre-Authorisations at the contact number as provided on the membership card. Failure to do so will result in the non-payment of claims. Where it is not possible to notify EEBS Pre-Authorisations prior to Hospitalisation due to an emergency this condition will not apply, subject to notification to EEBS Pre-Authorisations within 48 hours after Admission provided that the Insured Person is physically able to do so.

6.12 If any claim under this Insurance be in any respect fraudulent or intentionally exaggerated or if any fraudulent means or devices are used by Insured Person or anyone acting on his behalf to obtain any benefit under this Insurance all benefit hereunder shall be forfeited and no Premiums shall be refunded.

6.13 It is a condition precedent to Insurer's liability to pay Benefits on behalf of an Insured Person that all medical records, notes and correspondence referring to the subject of a claim or a related Pre Existing Condition shall be made available to any medical or other advisor appointed by Insurer and such advisor or advisors shall, for the purpose of reviewing the claim, be allowed so often as may be deemed necessary to make examination of the Insured Person or any other record pertaining to the claim.

6.14 The Insurer reserves the right to permanently exclude the Benefits based on pre-existing conditions. Endorsements will be placed on applicable Policy Schedules.

7. INSURING SECTION

The following Insurance Cover and Benefits shall be available to the Insured Persons as follows:

7.1. DAILY ILLNESS BENEFIT

BENEFITS	AMOUNT
1st Day in Hospital	Up to R10 000
2nd Day in Hospital	Up to R7 500
3rd Day in Hospital	Up to R5 000

4th Day in Hospital	Up to R5 000
5th Day in Hospital	Up to R1 500
Every subsequent day thereafter	Up to R1 500
Maximum Benefit payable for a 21 Day period	R53 000
Dread Disease amount per day in Hospital (Subject to a 180-day waiting period unless by specific agreement). As per the Definition of Dread Diseases, Annexure 1, graded compensation shall be applicable; subject to a maximum of R250 000	Up to R9 000

7.2. ICU BOOSTER BENEFIT

Maximum of 5 (five) days benefit of a daily rate limited to an amount of R15 000 per day in ICU, if the ICU Booster Benefit has been taken out. Same waiting periods pertaining to Illness Hospitalisation, Specific Stated Benefit and Pre-Existing Conditions.

7.3. MATERNITY AND SURGERY BENEFIT AMOUNTS

Appendectomy	UP TO R30 000.00
Removal of Kidney Stones	UP TO R30 000.00
Ectopic Pregnancy	UP TO R20 000.00
Hernia	UP TO R25 000.00
Gallbladder removal	UP TO R35 000.00
Maternity, natural	UP TO R25 000.00
Maternity, C-section	UP TO R35 000.00
Miscarriage	UP TO R15 000.00

The above benefits are not paid out in addition to any other benefit amounts.

7.4. ACCIDENT STATED BENEFIT FOR THE HOSPITAL PLAN

For an Accident resulting in Hospitalisation, the compensation shall be:

7.4.1. Limited to an amount of R150 000 (one hundred and fifty thousand rand) per Insured Person per Accident; or R250 000 per insured Person per Accident if the benefit Booster has been taken out.

7.4.2. Limited to R250 000 (two hundred and fifty thousand rand) per Family per Accident.

7.5. TEMPORARY TOTAL DISABILITY (ILLNESS) IN THE HOSPITAL PLAN

7.5.1. For Temporary Total Disability (Illness), the compensation shall be as per Benefit amounts per Insured Person per day for a period not longer than 21 Days from the date of the onset of any Illness.

7.5.2. The Compensation specified for Temporary Total Disability shall cease as soon as the Insured Person has been discharged from Hospital.

7.5.3. If an Insured Person is admitted within a 6-month period for the same or similar Temporary Disability, the benefit amount will follow on from the last day of the previous admission's discharge.

7.6. DREAD DISEASE

7.6.1. If during the Period of Insurance any Insured Person be diagnosed as suffering from a Dread Disease, symptoms of which were not present in the Insured Person in the 12 months prior to the inception of the Policy Schedule and which symptoms first manifested itself after 180 days from the Commencement Date stated in the Policy Schedule, the Insurer agrees to pay the Insured as Compensation the sum stated in the Schedule of Compensation.

7.6.2. If diagnosed before or during the 180 days from Inception, the condition will be considered Pre-Existing and no Dread Disease Benefit will be available to the Member

7.6.3. Upon discharge from the Hospital and after the Insured Person has survived for a period of 30 (thirty) days the amount of Compensation specified in the Schedule less any amounts that have been paid shall be paid to the Insured Person upon request. In the event that the amount paid reaches R250 000 (two hundred and fifty thousand rand) or the applicable benefit no further benefit shall be payable in respect of any Dread Disease of any Insured person.

7.6.4. It is declared that upon payment of 100% of the Compensation for any one claim under Dread Disease in respect of any Insured Person, all cover provided shall be terminated and cannot be reinstated in respect of the Dread Disease Benefit that has been paid for that Insured Person.

7.6.5. Compensation under Dread Disease shall not be in addition to Temporary Total Disability Illness in Hospital.

7.6.6. Insurance Cover afforded any Insured person in terms of the Dread Disease will only come into effect 180 (one hundred and eight) days after the Commencement Date stated in the Policy Schedule.

8. DISPUTE RESOLUTION

8.1. Should any dispute, disagreement or claim arise between the parties concerning this Policy ("the Dispute"), the parties shall endeavour to resolve the Dispute referring the Dispute to the Arbitration Foundation of Southern Africa ("AFSA") for final resolution by way of arbitration in accordance with the rules of AFSA by an arbitrator or arbitrators appointed by AFSA.

8.2. Unless otherwise agreed in writing by the parties, any such arbitration shall be held in Johannesburg.

8.3. Each Party to this Policy irrevocably:

8.3.1. Consents to any arbitration in terms of the aforesaid rules being conducted as a matter of urgency; and

8.3.2. Authorises the others to apply, on behalf of the parties to such Dispute, in writing to the secretariat of AFSA in terms of the aforesaid rules for any such arbitration to be conducted as a matter of urgency, provided that the party which intends so applying first notifies the other parties in writing of its intention to do so.

8.4. The provisions of this clause 9 shall not preclude a party from seeking urgent interim relief from the appropriate court of law.

8.5. For the purposes of clause 9 and for the purposes of having any award made by the arbitrator(s) being made an order of court, each of the parties hereby submits itself to the South Gauteng High Court of South Africa or its successor in title.

8.6. This clause 9 constitutes an irrevocable consent by each of the parties to any proceedings in terms hereof, is severable from the rest of the Policy and shall, notwithstanding the termination of this Policy, remain in full force and effect.

9. NEW LAWS

If, at any time after the Commencement Date, any legislation, rulings or regulations (including any taxation laws) applying to this Policy, comes into operation, the Insurer shall be entitled on a 31 (thirty-ones) days prior written notice to the Principal Member, to change, amend or alter any terms or conditions of this Policy in order to comply with such legislation, rulings or regulations (including any tax laws) or otherwise to be placed in the same position it would have been was it not for the legislation, rulings or regulations becoming applicable.

10. DOMICILIUM

10.1. The domicilium citandi et executandi of a Principal Member shall be the address set out in the application form or such later address as notified in writing.

10.2. For purposes of this Policy, the Insurer's addresses shall be at Physical Address: Springfield Office Park, 109 Jip de Jager Dr, Bellville, 7530

Postal Address: PO Box 4061, Durbanville, 7550

10.3. Any notice given in terms of this Policy shall be 31 days notice in writing and shall –

10.3.1. if delivered by hand be deemed to have been duly received by the addressee on the date of delivery;

10.3.2. if posted by prepaid registered post be deemed to have been received by the addressee on the 8th (eighth) day following the date of such posting;

10.3.3. if transmitted by facsimile be deemed to have been received by the addressee on the day following the date of dispatch, unless the contrary is proved;

10.3.4. Notwithstanding anything to the contrary contained or implied in the Policy, a written notice or communication actually received by the Insurer or a member from the other as the case may be, including by way of facsimile transmission shall be adequate written notice or communication to such party.

11. GENERAL

11.1. This Policy constitutes the entire insurance policy and that no other conditions, stipulations, warranties and representations whatsoever, have been made by any party or that party's agent, other than as specifically included herein.

11.2. No latitude, extension of time or other indulgence which may be given or allowed by either party to the other in respect of any payment provided for in the Policy or the performance of any other obligation shall under any circumstances be construed to be an implied consent by such party or operate as a waiver or a novation of or otherwise affect any of the third party's rights in terms of or arising from the Policy, or prevent such party from importing, at any time and without notice, strict and punctual compliance with each and every provision or term hereof.

11.3. No amendment or cancellation of the Policy shall be of any force and effect unless such amendment or cancellation is in writing and signed by the Insurer.

11.4. This Policy does not accumulate cash or surrender value and may not be converted into a paid up policy. The Insurer specifically determines that no loans will be allowed in terms of the Policy.

11.5. Statements made by the Insured Person relating to the Policy will be deemed to be true and incontestable.

11.6. The parties consent to the jurisdiction of the South Gauteng Division of the High Court of South Africa, to hear and determine any action or proceeding which may result from or arises from the Policy.

Annexure 1:

Definitions of Heart attack, Stroke and Cancer.

1. BACKGROUND

1.1. The Policy together with this Annexure 1 constitutes an indivisible agreement between the parties.

1.2. All words and expressions defined in the Policy shall have a similar meaning in this Annexure 1 unless expressly stipulated otherwise or inconsistent with, or otherwise indicated by the context.

2. SCIDEP DEFINITIONS

2.1. For purposes of this Policy, the Dread Diseases shall bear the meanings as assigned to it in the Policy or this Annexure 1, which ever applicable, which definitions are prescribed in terms of the SCIDEP definitions.

2.2. For the sake of convenience, a layman's definition is included herein due to the complexity of the medical definitions of Dread Diseases.

3. CANCER

3.1. Cancer is an uncontrolled growth that spreads into the normal tissue surrounding the organ where the cancer originates. The diagnosis must be supported by tests where a pathologist confirms the presence of cancer using a microscope. Some cancers have been specifically excluded because the long term outcome is good and the effect on quality of life is minimal; and treatment is neither expensive nor extensive.

3.2. There are specific exclusions to this definition that include:

3.2.1. Cancerous cells that have not invaded the surrounding or underlying tissue;

3.2.2. Early cancer of the prostate gland and breast; and

3.2.3. All cancers of the skin except cancerous moles that have invaded underlying tissue.

3.3. Staging of Cancer:

3.3.1. As a general rule there are four stages of cancer.
Stage 1 cancer is defined by an invasive cancer confined to the tissue or organ of origin.
Stage 2 cancer is defined by the involvement of adjacent structures or organs.
Stage 3 cancer involves spreading to regional lymph nodes.
Stage 4 cancer is characterized by distant metastasis.

3.3.2. However, each type of cancer is staged specifically by the American Joint Committee for Cancer (AJCC). This staging is based on the outcome of the specific cancer and does not always follow the general rule as stated above.

4. HEART ATTACK

Four levels of severity of heart attacks are defined:

4.1. 1 Level D is the mildest and Level A the most severe;

4.2. In both Levels C and D the patient recovers fully and the heart function returns to normal;

4.3. In Levels A and B, more permanent damage has resulted, which means the heart function is less than 100% after recovery;

4.4. The effect of the heart attack on heart function should be measured 6 weeks after the heart attack.

4.5. Level A: Heart attack severe impairment in function

4.5.1. These are heart attacks where a significant proportion of the heart muscle was damaged. The same tests are used to measure the damage as under Level B but the results would show a more serious level of impaired function.

4.5.2. This person will have difficulty coping with normal activities of daily living, and will most likely not be able to work.

4.6. Level B: Heart attack with mild permanent impairment in function

4.6.1. This is usually a heart attack that does not recover 100% of normal function. The degree of permanent damage can be measured by a heart sonar, an exercise tolerance test or a measurement of physical abilities. These measurements should be performed 6 weeks after the heart attack.

4.7. Level C: Moderate heart attack of specified severity

4.7.1. In this case damage to the heart muscle is more than in Level D. In some cases a cardiologist will intervene early and reverse the potential damage. This intervention may include administration of drugs to dissolve the blood clot in the coronary artery(ies), balloon stretching of the coronary artery, with or without a stent.

4.7.2. Because the clinical methods of diagnosing this level of heart attack are unambiguous, only two of the three criteria are required:

4.7.2.1. Typical chest pain or other symptoms typically associated with a heart attack;

4.7.2.2. Certain defined ECG changes. At this level the changes are more marked and more specific to a heart attack;

4.7.2.3. Elevated blood test results greater than required for Level D.

4.8. Level D: Mild heart attack with full recovery

4.8.1. This is a heart attack where the ECG changes and blood test results are mildly abnormal. Therefore, all three criteria are required, e.g. typical chest pain or other symptoms associated with a heart attack; and certain defined ECG changes and an elevation in certain blood test results.

SEVERITY Essential Employee Benefits Tiered Benefits as per SCIDEP Definitions (Applicable to all Dread Disease Benefits)
Severity A100%
Severity B75%
Severity C50%
Severity D25%

5. STROKE

5.1. A stroke occurs when the blood supply to a portion of the brain is obstructed and this part of the brain tissue dies. It can also happen when there is bleeding into the brain tissue due to a weakening or abnormality of the blood vessel wall. A common cause of the rupture of a brain blood vessel is longstanding uncontrolled high blood pressure.

5.2. The result of a stroke is usually paralysis of an arm and leg, sometimes with one half of the face affected as well. In some cases people also lose their ability to speak. The paralysis can recover to varying degrees. Some recover fully, whereas others may retain permanent weakness of a limb(s).

5.3. A Transient Ischaemic Attack (TIA) occurs when the blood supply is momentarily interrupted, but restored before any permanent damage can occur. It usually results in one or more of the following symptoms:

5.3.1. A loss of sensation;

5.3.2. Dizziness;

5.3.3. Lameness of a limb;

5.3.4. Loss of speech, which only occur for a few minutes to hours and recovery is quick and spontaneous and is therefore excluded from any benefits.

Annexure 2:

Policy Schedule

Policy Schedule	
INSURED PERSON:	The Principal Member as named on the Policy Certificate and their named spouse and Dependent Children.
PERIOD OF INSURANCE:	Monthly
COMMENCEMENT DATE:	Refer to Membership Certificate
PREMIUM:	Refer to Membership Certificate
INSURER:	Lion of Africa Life Assurance Company Ltd registration 1942/015587/06, an authorised financial service provider, FSP No. 15283.
UNDERWRITING MANAGER:	Essential Employee Benefits (Pty) Ltd

DISCLOSURE AND OTHER LEGAL REQUIREMENTS:

As a Financial Services Provider, Essential Employee Benefits (Pty) Ltd is committed both under legislation and in terms of our own ethical code, to provide you, our client, with all the information you need to ensure that you are in possession of all relevant facts about the various parties supplying you with your insurance product. These facts are set out for you below, as required by the Financial Advisory and Intermediary Services Act (FAIS) and for clients who purchase policies in their personal capacity, the Policy Holder Protection Rules. Whilst this information is important it does not form part of your actual policy wording. Not only should you be in possession of the facts set out below, but you should have been provided with a full understanding of the product you have purchased. An authorised representative will have provided you with the financial advice you have received.

LIST OF ROLE PLAYERS AND EXPLANATION OF ROLES

Insurer: The insurance company which ultimately underwrites the risk as determined by the policy wording under the hospital and dread disease insurance policy is the Lion of Africa Life Assurance Company Ltd and under the short term medical expense policy is New National Assurance Company Ltd. The details about the insurers are to be found in the document titled
"Disclosure Notice" that form part of this pack.

The **Binder Holder** is a company who performs certain binder functions which in essence are reserved for underwriters and receive a remuneration for completing these functions on behalf of the underwriter. Essential Employee Benefits (Pty) Ltd performs binder functions on behalf of Lion of Africa Life Assurance Company Ltd (Long-Term Insurance) and also on behalf of Guardrisk Insurance (Short-Term Insurance).
For a complete list of Binder functions which Essential Employee Benefits (Pty) Ltd perform, contact Essential Employee Benefits (Pty) Ltd on 010 593 7158.

Intermediary: The intermediary is the company/person who sold the policy. In the case of the long term insurance policy, the intermediary is also Essential Employee Benefits and in the case of the short term insurance policy, the broker appointed by you, the client. A detailed disclosure document should be provided by the Broker. Complaints regarding the sales process should be directed at the intermediary.

DISCLOSURE NOTICE:

1. ABOUT YOUR FINANCIAL SERVICES PROVIDER

a. Essential Employee Benefits (Pty) Ltd Registration Number:2015/1307/42; 1st Floor, 11 Wellington Road, Parktown, Johannesburg 2000;
Tel: 010 593 7158; Email: enquiries@eeb.co.za; www.eebs.co.za
ESSENTIAL EMPLOYEE BENEFITS IS A REGISTERED FINANCIAL SERVICES PROVIDER FSP NUMBER 46244

b. Essential Employee Benefits does not earn more than 30% of its total remuneration from any single Insurer and no Insurer holds shares in Essential Employee Benefits nor is Essential Employee Benefits associated to any one Insurer.

c. Essential Employee Benefits is in possession of Professional Indemnity insurance.

d. Compliance arrangements: Maria Flack-Davison is Essential Employee Benefits's compliance officer and can be contacted Tel: 072 697 7552 or via email on mariafd@eeb.co.za.

e. The fees and commissions payable are detailed in the quotation and policy schedule. The consequences of non-payment of the premium will be subject to Rule 15A of the PPR's.

2. ABOUT THE UNDERWRITERS/INSURERS

Product	Underwriter	Reg Number	FSP Number	Contact Number
Long term insurance	Lion of Africa Life Assurance Company Ltd	1942/015587/06	15283	021 461 8233
Medical Insurance	Lion of Africa Life Assurance Company Ltd	1942/015587/06	15283	021 461 8233

3. HOW TO INSTITUTE A COMPLAINT

Should you have any complaint about your policy or the service you have received, please contact Essential Employee Benefits. **Complaints procedure**: Contact our complaints facilitator, on complaints@eebs.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. If the enquiry is not dealt with satisfactorily, contact the appropriate Ombudsman listed below.

4. OTHER MATTERS OF IMPORTANCE

a. You must be informed of any material changes to the information referred to in paragraphs 1 and 2 with 31 days written notice.
b. If any complaint to the Broker or Insurer is not resolved to your satisfaction, you may submit your complaint to the FAIS Ombud.
c. If your premium is paid by debit order, the debit order must be in favour of one person and may not be transferred without your approval.
d. aThe Product Supplier (Insurer) or its appointed representative, and not the Broker must give reasons in 31 days in writing for the rejection of any claim submitted by you.
e. The Product Supplier (Insurer) must give you written notice of its intention to cancel your policy.
f. You are entitled to a copy of your policy free of charge.

5. CONFLICT OF INTEREST

We are pleased to report that there are no Conflicts of Interest or potential Conflicts of Interest identified within our organisation. A copy of our Conflict of Interest management policy is available on our website.

6. WARNING

a. Do not sign any blank or partially completed application form.
b. Complete all forms in ink.
c. Keep all documents handed to you.
d. Make notes as to what is said to you.
e. Ask for a letter of representation from your adviser.
f. Do not be pressurised into buying the product.

7. PARTICULARS OF FAIS OMBUD: |

PO Box 74571,Lynnwood Ridge 0040;
Tel: 012 470 9080 to 012 470 9097;
Fax: 012 348 3447;
Email: info@faisombud.co.za;
Website: www.faisombud.co.za

8. PARTICULARS OF SHORT TERM INSURANCE OMBUD:

PO Box 32334, Braamfontein 2017;
Tel: 011 726 8900;
Fax: 011 726 5501;
Email: info@osti.co.za