OLD MUTUAL PROTECT

RSA REFERENCE GUIDE
NOVEMBER 2020

DO GREAT THINGS EVERY DAY

ABOUT THIS DOCUMENT

The purpose of this guide is to provide a comprehensive and clear summary of the Old Mutual Protect product range, in a way that will help users to understand and correctly market it. However, this reference guide does not constitute advice. The information is of a general nature and should not be relied on as a substitute for detailed financial planning and the contract.

Although reasonable care has been taken in compiling this guide, it may contain inaccuracies and typographical errors. The guide was drafted with information as at the date printed. The information may become outdated.

Where the contents of the customer's quote, application summary or terms and conditions differ from the descriptions or definitions in this guide, the quote, application summary or terms and conditions will prevail.

This document is correct as at 1 November 2020.

Old Mutual Protect Reference Guide RSA

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INTRODUCTION

Old Mutual Protect is our new, comprehensive risk insurance product range. This flexible solution is supported by a fully centralised and agile digital platform.

The new proposition delivers

- One flexible protection product range.
- One online sales and servicing platform for advisers.
- Customers give us their information once.
- We issue a contract immediately.

Advisers across all channels now have the ability to offer individually tailored plans, adding and removing features from our product range as their customers' needs change. This enhances our customer value proposition (the value we offer our customers) which is:

- The best protection proposition in the industry, in terms of both breadth and quality.
- Modular benefits: customers only pay for the features they need.
- Use of the latest health and medical test technology to drive speed and immediate decisions.
- Comprehensive funeral insurance: customers can insure up to 22 family members, an unlimited number of children and the option of a 3-in-1 Funeral Paid-up benefit.
- Unmatched future insurance: customers can add protection when they need it.

Old Mutual Protect is designed to meet the personal or business needs of our customers

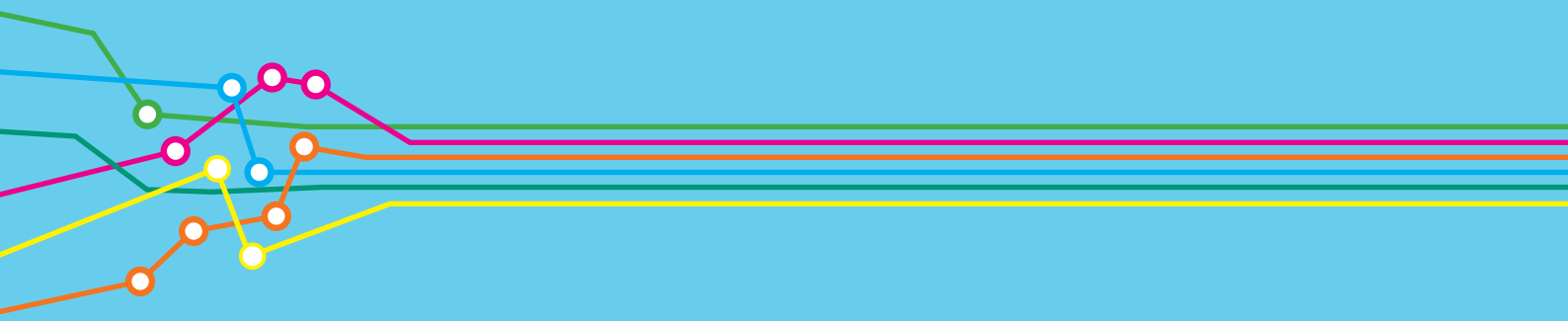
The customers' needs can be matched to the cover we offer. There are 18 Old Mutual Protect products in the range, with each product addressing a specific insurance need.

You need to understand each customer's specific needs so you can:

- package a solution to meet their needs
- present them with options that will best suit their pockets

In this Old Mutual Protect Reference Guide you will learn more about the Old Mutual Protect products and how they relate to our customers' needs.

GENERIC



1. THE INSURANCE LANDSCAPE

Insurance plays an important role in the lives of millions of people and it's important to have an innovative industry that's also sustainable. For the market to continue to grow, the industry needs to manage its reputation by respecting all regulations and continuing to increase access to insurance products. Industry players will need to be aware of insurance industry regulatory requirements and abide by them for compliance and customer service purposes. The changing regulatory environment stems from continuous changes in the industry. Ongoing changes in legislation have also resulted in a financial sector that largely meets the requirements of the South African insurance regulator, the Financial Sector Conduct Authority (FSCA). The FSCA's mandate is to enhance the efficiency and integrity of financial markets, promote fair customer treatment by financial institutions, provide financial education and assist in maintaining financial stability. The regulatory intervention is to ensure insurers deliver on the promises made to their markets.

Life insurance

'Life insurance' is the general term we give to the range of insurance solutions that look after a person if something unexpected happens to their body or mind. It's designed to protect their quality of life, the future they've planned for their loved ones, and business if they suffer an illness, injury or when they die. Most people have only heard of the product 'life insurance', so this has become the accepted term which includes:

- Life insurance
- Funeral insurance
- Disability insurance
- Illness insurance
- Future insurance
- Retrenchment insurance

The owner (often the insured person) pays an ongoing premium (let's say around R200 each month). If that insured person suffers an illness, injury or dies during the term of the contract (let's say in 10 to 30 years), their beneficiary (usually their family in the case of life cover and funeral cover or themselves in the case of disability cover or illness cover), receives a payout.

Long-term insurance

Long-term insurance is a term for the type of insurance products that are governed by the Long Term Insurance Act, for example life cover, funeral cover, disability cover and illness cover. These products are designed to provide customers either with an income or a single amount if they become disabled, critically ill or pass away. How much of each type of these insurances a customer needs will depend on a variety of factors. Customers need to be assessed individually to establish the risk associated with that individual. Based on this assessment, an adviser will be able to suggest the appropriate type and level of cover for each customer.

Association for Savings and Investment South Africa (ASISA)

ASISA's aim is to play an integral part in achieving a greater savings culture in South Africa. It represents the majority of the country's asset managers, collective investment scheme management companies, linked investment service providers, multi-managers and life insurance companies. They work as a united body towards making financial services more relevant to the customer. Through ASISA, the SA savings and investment industry also actively work with the government on the SA Incorporated strategy, aimed at promoting the country as the economic gateway to Africa.

ASISA membership can only be attained at the highest appropriate level in a company's corporate structure, never at a subsidiary company level. In addition, members can only be represented on the ASISA Board by their most senior representative. This to ensure that high-level strategic thinking shapes the future of the financial services industry, rather than product-aligned agendas.

The ASISA Academy was also set up to provide the South African savings and investment management industry with an independent and practical learning environment to further young talent in the industry. It is an independent entity with a separate board of directors. This approach to develop investment management skills will also assist in achieving a more rapid transformation of the savings and investment industry.

Treating Customers Fairly (TCF)

TCF is an outcomes-based regulatory approach designed to ensure that regulated financial companies deliver specific fairness outcomes for their customers. Some of these outcomes are already included in existing legislation such as the FAIS Act General Code, which requires financial service providers to render services honestly, fairly, with due skill, care and diligence and in the interest of the customer and the integrity of the financial services industry.

The main aim of TCF is to ensure that fair treatment of customers is embedded within the culture of financial companies. Companies have to demonstrate that they deliver the following six TCF outcomes throughout the product life cycle - from product design and promotion, through advice and servicing, to complaints and claims handling, and throughout the product value chain:

- **Outcome 1:** Fair treatment of customers must become central to the corporate culture
- **Outcome 2:** Products and services must be designed to meet the needs of specific customer groups
- **Outcome 3:** Customers are provided with clear information and kept appropriately informed before, during and after the point of sale
- **Outcome 4:** Advice is suitable and takes account of the individual's circumstances
- **Outcome 5:** Products and services are of an acceptable standard and deliver on the expectations created
- **Outcome 6:** Customers don't face unreasonable post-sale barriers to change product, switch provider, submit a claim or make a complaint

The stages of the product life cycle are defined as follows:

- **Product design** - the product must meet the needs of its target market
- **Promotion/marketing practices** - marketing and promotional material must be appropriate and understandable to its intended audience
- **Advice** - advice must be suitable and relevant with specific understanding of a customer's needs
- **Point of sale** - clear and appropriate information must be provided
- **Information and owner support after point of sale** - products must behave as expected and the service standard must be acceptable
- **Compliance and claims handling** - no unreasonable post-sale barriers may exist

TCF doesn't mean:

- Creating satisfied customers. A satisfied customer could still be treated unfairly and simply not know it
- That every company must have an identical service level. Different ways of doing things create healthy competition
- That customers are no longer expected to make decisions or take responsibility for their decisions

Advisers must demonstrate the adoption of a TCF culture in their businesses and the delivery of TCF outcomes for their customers. The responsibility of fair treatment lies with both the supplier of the product and the adviser. It's very important that we provide a joint value proposition which answers each of the six TCF outcomes.

2. CREATING AN OLD MUTUAL PROTECT CONTRACT

Old Mutual Protect offers 18 products, each targeting a particular personal or business protection need. By grouping the products under insurance needs, we're making it clear to everyone how the customer's protection needs are addressed with Old Mutual Protect.

Features of an Old Mutual Protect contract

- Owners can, at any point attach add-ons, benefits and other features to enhance their cover.
- Owners can add and remove the optional cover, benefits and other features as their needs, goals and responsibilities change.
- A product may consist of a combination of the following (subject to the specific rules):
  - Cover
  - Add-ons
  - Benefits and other features that can be attached to enhance the cover
- An Old Mutual Protect portfolio will contain all contracts owned by the owner. Each contract is considered a long-term contract under the Long Term Insurance Act of 1998.
- Ownership can only be changed at a contract level.

2.1 Overview of Old Mutual Protect products

The tables below provide a high-level summary of the Old Mutual Protect products and how they can be structured to suit customers' individual needs. Details of the cover, add-ons, benefits and features are contained in the relevant sections of this guide.

2.2 Add-ons, optional benefits and other features

Add-ons, optional benefits and other features can't exist on their own and can only be attached to cover to enhance it and will by default take on the attributes of the cover it's attached to.

Example:

- cover and premium increase patterns.
- increase dates.
- premium-paying duration.

If the cover stops for any reason any add-ons, optional benefits and features that are attached to it also stops.

2.2.1 Adding cover

- Only Life Cover and Business Life Cover can have add-on cover.
- Add-on cover will take on the following attributes of the cover it's attached to:
  - cover and premium increase patterns
  - premium payment term
  - the guarantee term
- Add-on cover will have its own premium
- Only the insured person who is covered is eligible for the add-ons attached to that cover.
- A maximum of two cover add-ons are allowed, each with their own cover amount.
- The cover amount and term of the add-on cover can be less, but not greater than, the cover it's attached to. For example, the cover may have whole-life benefit term while the add-on cover may have a term of 20 years.
- A claim payout on add-on cover will reduce the cover amount of the cover it's attached to. See Claiming Life Cover for more details.

2.2.2 Adding linked cover

Retrenchment Cover is the only type of cover that is classified as linked cover.

- A person can only be insured under Retrenchment Cover if they are also an insured person on another existing Old Mutual Protect product to which the Retrenchment Cover is linked.
- Retrenchment Cover has its own cover and add-ons. Its add-ons may be selected completely independently from the cover to which it's linked. This is subject only to the specific constraints on Retrenchment Cover and the additional constraint that the cover amount and term of Retrenchment Cover must be less than the cover amount and duration of the cover it's linked to.
- If the cover which the Retrenchment Cover is linked to stops for any reason, Retrenchment Cover also stops.
- Retrenchment Cover can be added to:
  - Life Cover
  - Life Income Cover
  - Last Survivor Cover
  - Accidental Death Cover
  - Disability Income Cover
  - Functional Impairment Income Cover
  - Disability Cover
  - Functional Impairment Cover
  - Physical Impairment Cover
  - Accidental Disability and Death Cover
  - Severe Illness Cover

2.2.3 Adding optional benefits

- Optional benefits can't exist on their own and must be attached to cover (depending on the type of cover).
- They will by default take on the cover and premium increase patterns and increase dates of the cover it's attached to.
- The following are optional benefits:
  - Funeral Paid-up
  - Family Support Benefit
  - Partial Functional Impairment Benefit
  - Child Impairment Benefit
  - Income Extender Benefit
  - Own Occupation Benefit
  - Returning Illness Benefit
  - Mild Illness Benefit
  - For Women Benefit
  - Child Illness Benefit
  - Sickness Benefit
  - Disability and Illness Benefit
  - Top-up Benefit

2.2.4 Adding optional features

- The following are optional features:
  - Premium Protection Death
  - Premium Protection Disability **OR**
  - Premium Protection Functional Impairment
  - Premium Protection Retrenchment
  - Cashback (Except Business Life Cover and Business Expenses Cover)
  - Double Accidental Benefit (Only on Family Funeral Cover and Extended Family Funeral Cover)
  - Monthly Grocery Benefit (Only on Family Funeral Cover)
  - Monthly Education Benefit (Only on Family Funeral Cover)

2.3 BENEFIT STRUCTURE

2.3.1 Life Insurance

LIFE COVER - PAYS A SINGLE AMOUNT WHEN THE INSURED PERSON DIES

Life Cover	Add-ons	Optional benefits
A choice between Disability Cover or Functional Impairment Cover or Physical Impairment Cover, (only one of these three add-ons may be chosen) plus Severe Illness Cover.	Disability Cover	· Own Occupational Benefit · Partial Functional Impairment Benefit · Child Impairment Benefit
	Functional Impairment Cover	· Partial Functional Impairment Benefit · Child Impairment Benefit
	Physical Impairment Cover	· None
	Severe Illness Cover	· Top-up Benefit · Mild Illness Benefit · For Women Benefit · Child Illness Benefit

Other features

- Premium Protection Death
- Premium Protection Disability or Premium Protection Functional Impairment
- Premium Protection Retrenchment
- Cashback

LIFE INCOME COVER - PAYS A MONTHLY AMOUNT FOR AT LEAST FIVE YEARS OR UNTIL THE END OF THE BENEFIT TERM WHEN THE INSURED PERSON DIES

Other features

- Premium Protection Death
- Premium Protection Disability or Premium Protection Functional Impairment
- Premium Protection Retrenchment
- Cashback

LAST SURVIVOR COVER - PAYS A SINGLE AMOUNT WHEN THE LAST SURVIVING INSURED PERSON DIES

Other features

- Premium Protection Death
- Premium Protection Disability or Premium Protection Functional Impairment
- Premium Protection Retrenchment
- Cashback

ACCIDENTAL DEATH COVER - PAYS A SINGLE AMOUNT IF THE INSURED PERSON DIES BECAUSE OF AN ACCIDENT.

Other features

- Premium Protection Death
- Premium Protection Disability or Premium Protection Functional Impairment
- Premium Protection Retrenchment
- Cashback

2.3.2 Funeral Insurance

FAMILY FUNERAL COVER - THE OWNER CAN COVER THEMSELVES, SPOUSES, CHILDREN AS WELL AS NOMINATED CHILDREN FOR FUNERAL EXPENSES. PAYS A SINGLE AMOUNT WHEN THE INSURED PERSON DIES. IF A MONTHLY EDUCATION BENEFIT OR MONTHLY GROCERY BENEFIT IS SELECTED, MONTHLY PAYMENTS WILL ALSO BE MADE WHEN THE INSURED PERSON DIES.

- Individual	**Add-ons** - Funeral Paid-up	**Optional benefits** - Children and/or Nominated Child - Spouse/Partner
- Spouse/Partner	**Add-ons** - Funeral Paid-up	- None

Other features

- Premium Protection Death
- Premium Protection Disability or Premium Protection Functional Impairment
- Premium Protection Retrenchment
- Cashback
- Double Accidental Benefit
- Monthly Education Benefit
- Monthly Grocery Benefit

EXTENDED FAMILY FUNERAL COVER - EXTENDED FAMILY FUNERAL ALLOWS OWNERS TO COVER NON-CORE FAMILY MEMBERS. EACH FAMILY MEMBER IS COVERED UNDER A SEPARATE CONTRACT WITH A MAXIMUM NUMBER OF LIVES WHICH CAN BE COVERED UNDER EACH COVER TYPE.

- Parent
- Sibling
- Other family

Add-ons (applicable on the owner's life)

- Funeral Paid-up

Other features

- Cashback
- Double Accidental Benefit

2.3.3 Disability Insurance

DISABILITY INCOME COVER - PAYS A MONTHLY AMOUNT WHEN THE INSURED PERSON BECOMES PERMANENTLY AND IRREVERSIBLY OCCUPATIONALLY DISABLED OR IS PERMANENTLY AND IRREVERSIBLY FUNCTIONALLY IMPAIRED AND THE WAITING PERIOD IS MET.

Disability Income Cover

Add-ons

- Income Extender Benefit
- Sickness Benefit
- Family Support Benefit

Other features

- Cashback

FUNCTIONAL IMPAIRMENT INCOME COVER - PAYS A MONTHLY AMOUNT WHEN THE INSURED PERSON BECOMES FUNCTIONALLY IMPAIRED OR SUFFERS A FRACTURE. THE WAITING PERIOD MUST ALSO BE MET.

Functional Impairment Income Cover

Add-ons

- Family Support Benefit

Other features

- Cashback

BUSINESS EXPENSES COVER - PAYS A MONTHLY AMOUNT FOR A LIMITED PERIOD OF TIME TOWARD BUSINESS EXPENSES IF THE INSURED PERSON CAN NO LONGER WORK, DUE TO ILLNESS OR INJURY OR SUFFERS A FUNCTIONAL IMPAIRMENT. THE WAITING PERIOD MUST ALSO BE MET.

Business Expenses Cover

Add-ons

- None

DISABILITY COVER - PAYS A SINGLE AMOUNT WHEN THE INSURED PERSON BECOMES PERMANENTLY AND IRREVERSIBLY OCCUPATIONALLY DISABLED OR IS PERMANENTLY AND IRREVERSIBLY FUNCTIONALLY IMPAIRED AND THE SURVIVAL PERIOD IS MET.

Disability Cover

Add-ons

- Own Occupational Benefit
- Partial Functional Impairment Benefit
- Child Impairment Benefit

Other features

- Premium Protection Death
- Premium Protection Disability or Premium Protection Functional Impairment
- Premium Protection Retrenchment
- Cashback

FUNCTIONAL IMPAIRMENT COVER - PAYS A SINGLE AMOUNT WHEN THE INSURED PERSON BECOMES PERMANENTLY AND IRREVERSIBLY FUNCTIONALLY IMPAIRED AND THE SURVIVAL PERIOD IS MET.

Functional Impairment Cover

Add-ons

- Partial Functional Impairment Benefit
- Child Impairment Benefit

Other features

- Premium Protection Death
- Premium Protection Disability or Premium Protection Functional Impairment
- Premium Protection Retrenchment
- Cashback

PHYSICAL IMPAIRMENT COVER - PAYS A SINGLE AMOUNT IF THE INSURED PERSON BECOMES PERMANENTLY AND IRREVERSIBLY PHYSICALLY IMPAIRED AND SURVIVES FOR SIX MONTHS.

Physical Impairment Cover

Add-ons

- None

Other features

- Premium Protection Death
- Premium Protection Disability or Premium Protection Functional Impairment
- Premium Protection Retrenchment
- Cashback

ACCIDENTAL DISABILITY AND DEATH COVER - PAYS A SINGLE AMOUNT IF THE INSURED PERSON BECOMES PERMANENTLY AND IRREVERSIBLY OCCUPATIONALLY DISABLED OR PHYSICALLY IMPAIRED BECAUSE OF AN ACCIDENT OR DIES BECAUSE OF AN ACCIDENT.

Accidental Disability and Death

Add-ons

- None

Other features

- Premium Protection Death
- Premium Protection Disability or Premium Protection Functional Impairment
- Premium Protection Retrenchment
- Cashback

2.3.4 Illness Insurance

SEVERE ILLNESS COVER - PAYS A SINGLE AMOUNT IF THE INSURED PERSON SUFFERS A SEVERE ILLNESS AND THE RELEVANT SURVIVAL PERIOD IS MET.

Severe Illness Cover	Add-ons
	· Top-up Benefit · Mild Illness Benefit · For Women Benefit · Child Illness Benefit · Returning Illness Benefit

Other features

- Premium Protection Death
- Premium Protection Disability or Premium Protection Functional Impairment
- Premium Protection Retrenchment
- Cashback

2.3.5 Future Insurance

FUTURE LIFE COVER - ALLOWS OWNERS TO APPLY FOR COVER FOR THE INSURED PERSON WITH VERY LIMITED UNDERWRITING WHEN AN OPTION EVENT HAPPENS, USING THE STATE OF HEALTH OF THE INSURED PERSON AT THE TIME OF BUYING THIS FUTURE LIFE COVER.

Future Life Cover	Add-ons
	· Disability and Illness Benefit

Other features

- Premium Protection Death
- Premium Protection Disability or Premium Protection Functional Impairment
- Premium Protection Retrenchment
- Cashback

2.3.6 Retrenchment Insurance

RETRENCHMENT COVER - PAYS A MONTHLY AMOUNT FOR A MAXIMUM PERIOD OF SIX MONTHS IF THE INSURED PERSON IS RETRENCHED.

Retrenchment Cover	Add-ons
	· None

Other features

- Premium Protection Death
- Premium Protection Disability or Premium Protection Functional Impairment
- Cashback

2.3.7 Business Insurance

Allows for co-owners of a business to purchase each other's shares in the business if the insured person dies or becomes disabled.

BUSINESS LIFE COVER - PAYS A SINGLE AMOUNT WHEN THE INSURED PERSON DIES.

Business Life Cover	Add-ons	Optional benefits
A choice between Business Disability Cover or Functional Impairment Cover, (only one of these two add-ons may be chosen) plus Severe Illness Cover.	· Business Disability Cover	· Own Occupational Benefit
	· Business Functional Impairment Cover	· None
	· Business Severe Illness Cover	· Top-up Benefit (The Lifestyle Enhancer is not available on a Top-up Benefit added to Business Severe Illness Cover)

Other features

· None

BUSINESS EXPENSES COVER - PAYS A MONTHLY AMOUNT FOR A LIMITED PERIOD OF TIME TOWARD BUSINESS EXPENSES IF THE INSURED PERSON CAN NO LONGER WORK, DUE TO ILLNESS OR INJURY OR SUFFERS A FUNCTIONAL IMPAIRMENT. THE WAITING PERIOD MUST ALSO BE MET.

Business Expenses Cover	Add-ons
	· None

Other features

· None

2.4 PARTIES TO A CONTRACT

2.4.1 Owner

· The owner is the person who enters into legal agreement with Old Mutual.

· Multiple owners are allowed and can own an undivided share of the product.

· **For funeral insurance** the owner must be a permanent resident and be a:

  – South African citizens with a valid South African identity document or

  – Foreigner recognised as permanent resident with a South African identity document

· They can apply for:

  – Family Funeral Cover

  – Extended Family Funeral Cover

- **For all other insurance needs**, the owner must be a permanent resident and be a:
  - South African citizen with a valid South African identity document or
  - Foreigner recognised as permanent resident and who have any one of the following residence permits:

    Asylum seeker, refugee, temporary work; study; critical skills or business permit, temporary intra-company work visa.

    the following additional information will also be required:

    Nationality and passport details
- The owner may be an individual or an organisation. This includes both permanent residents of South Africa (South African citizens and foreigners recognised as permanent residents) and foreign nationals, or any organisation, including those not registered in South Africa.
- They can apply for:
  - Life Cover
  - Life Income Cover
  - Last Survivor Cover
  - Accidental Death Cover
  - Disability Income Cover
  - Functional Impairment Income Cover
  - Disability Cover
  - Functional Impairment Cover
  - Physical Impairment Cover
  - Accidental Disability or Death Cover
  - Severe Illness Cover
  - Retrenchment Cover
  - Future Life Cover
  - Business Life Cover
  - Business Expenses Cover

They have to indicate their current country of residence, the application will continue and a notification of such applications will be sent to the underwriters.

- Where the owner doesn't nominate a beneficiary, and by default becomes the beneficiary of the contract, or based on the reason for cover is the beneficiary by default, the owner will have to provide details of a valid South African bank account to be verified during the application process. If the owner is an individual and the South African bank account can't be provided or verified, the contract will be declined.
- The owner decides who the insured persons (subject to insurable interest), the beneficiaries, and the replacement owner will be.
- The owner is responsible for all premium payments. Someone other than the owner may pay the premiums, but the owner remains responsible for payment.
- If there is more than one owner and one of them dies without nominating a replacement owner, the deceased's ownership in the product(s) will be passed on to their estate.
- If the owner is a minor (younger than 18 years old), a guardian's consent will be required. This needs to be validated for the duration of the contract.

2.4.2 Replacement owner

- If the owner isn't the insured person on the product, the owner may nominate a replacement owner.
- An owner may nominate multiple replacement owners.
- This person(s) will become the owner and assume all the responsibilities associated with the role on the death of the owner.
- Any replacement owner nomination received by us prior to:
  - a security cession shall be suspended when we record the cession for as long as the cession is in place
  - an outright cession shall be cancelled when we record the cession
- Any replacement owner nomination received by us must comply with the same rules and validations as the owner.

2.4.3 Insured person

- The insured person is the person whose life is insured against insurable events.
- The insured person must be an individual, i.e. natural person.
- For Family Funeral Cover and Extended Family Funeral Cover, the insured person must be a permanent resident of South Africa at the point of underwriting and hold a valid South African identity document.
- For all other Old Mutual Protect products, excluding Funeral Insurance, the insured person must be an individual with an interest within South Africa.
- Where the insured person is a foreign national but does not have a residence permit then: They can't be an insured person on personal cover or apply for:
  - Retrenchment
  - Premium Protection Retrenchment
  - They can be an insured person on Business Insurance

2.4.4 Single life

Covers the insurable events on a single insured person.

2.4.5 Last survivor

Covers the insurable events on two lives and a claim is incurred on the last occurrence of an insurable event on any of the insured persons under the cover.

Example

For Last Survivor Cover, the cover amount is payable on the last death of the two insured persons.

2.4.6 Multiple insured persons

Covers the insurable events on multiple insured persons and a claim is incurred on the occurrence of an insurable event on any of the insured persons.

Example

For Family Funeral Cover Children benefit, the cover amount on the benefit is payable on the death of each of the owner's children.

2.4.7 Beneficiary

A beneficiary is a person nominated by the owner to receive the payment when an event occurs.

- Nominating a beneficiary facilitates payment of the claim, and also eliminates the need for the estate to pay executor's fees in respect of the proceeds.
- Beneficiaries aren't usually nominated on "living benefits" such as disability, functional impairment, and illness cover. If a beneficiary is nominated on "living benefits" the cover will be paid to the beneficiary on our records, even if the owner is still alive.
- Beneficiary nominations may be made or removed at any time during the duration of the contract and before claim proceeds are paid.
- The beneficiary may be any individual or any organisation, including those not registered in South Africa.
- The beneficiary has no rights in respect to the contract other than receiving the proceeds from a claim (provided they are still the beneficiary at the time of payment).
- Claim proceeds are payable in Rand in the Republic of South Africa to a valid South African bank account.
- Where the owner is a foreign national (applicable to all types of cover except Funeral Cover) and has become the beneficiary either by default or requirement, the banking details of the owner are required. Where allowed, a beneficiary must be nominated such that the owner is no longer the default beneficiary. In all other instances the provision of banking details for a nominated beneficiary is optional.
- The owner may nominate multiple beneficiaries to share in the proceeds of any particular cover except for Life Income Cover, where only one beneficiary nomination is allowed and Family Funeral Cover where, in the instance of an installment payout selected in conjunction with the single amount, the number of beneficiaries is restricted to two per cover selected.
- A beneficiary must exist at the time of nomination. Where a beneficiary dies before the insured person or where an organisation nominated as a beneficiary no longer exists at the time of claim, the share of claim proceeds attributed to this nominated beneficiary will be paid to the owner (or their estate if the owner is deceased).
- Beneficiaries could be nominated per cover, add-on cover and benefits and other features. A product may therefore contain different beneficiaries to which claim proceeds will be paid based on the add-on cover, benefits and other features attached to the cover. Premium protections and Funeral Paid-up don't have beneficiaries as the purpose is to waive premiums on payout and not pay out claim proceeds.
- Future Life Cover doesn't have beneficiaries. The owner will have to exercise an option and select a type of cover at which point they may nominate a beneficiary.
- A beneficiary can't be nominated on Last Survivor Cover. Beneficiaries default to the owner/insured person and pays out to the estate of the last surviving owner.

2.4.8 Premium payer

The premium payer pays the premiums on the contract.

The premium payer may be:

- an individual or an organisation
- changed at any time during the benefit term
- different to the owner, however should the payment method "salary deduction" be selected, the premium payer must be the owner
- different across each product

2.4.9 Other third parties to a contract

Minor

A minor is someone who hasn't yet reached the age of 18, and who doesn't have the legal rights of an adult.

Emancipated minor

An emancipated minor is one who has achieved independence from their parents, such as by getting married before reaching age 18 or by petitioning a court.

Spouse/Partner

A spouse /partner is the individual to whom the insured person is married, customary union or union recognised under South African law, or in a relationship similar to marriage that is intended to be permanent.

Natural guardian (i.e. biological parent)

A minor's parents care for and make decisions on behalf of the minor. In divorce situations, one parent could be granted sole custody, but both parents could still be considered the natural guardian, unless the High Court grants an order stating that they are no longer guardians.

Legal guardian

A party who has the legal authority (and the corresponding duty) to care for the personal and property interests of a minor person/ward (under the age of 18). The legal guardian isn't a biological parent but a person who has been appointed by the court (or in a will) to care for and make decisions on behalf of a minor.

Curator

A curator is a legal representative appointed by a court to manage the finances, property or estate of another person who, for reasons satisfactory to the court, is unable to manage and control their own finances and property.

Power of attorney

A party to which a power of attorney has been given (called the agent) to act on behalf of the owner (called the principle). The agent assumes the owner's role in full or in part. The agent can have broad legal authority (general power of attorney) or limited authority (special power of attorney) to make legal decisions regarding the owner's property and finance.

Authorised person

An individual who agrees and is authorised to act on behalf of an organisation.

2.5 PREMIUMS

Premium means the amount of money that the owner must pay us at a selected frequency in order to enjoy cover under their contract.

2.5.1 Minimum premium

The minimum contractual premium is calculated as the total premium that the owner has to pay for all Old Mutual Protect contracts combined. For all cover sold (with the exception of funeral cover), a minimum contractual premium of (currently) **R200** per month or **R2 400** per year will apply per Old Mutual Protect owner per portfolio of products at inception. Premiums may go below the minimum if contract changes are made after inception.

A minimum contractual premium won't apply to funeral products, sold in isolation and/or when combined at an owner portfolio level. Even though a minimum contractual premium doesn't apply to funeral contracts, the premium paid on a funeral contract can count towards meeting the minimum contractual premium requirement at a portfolio level for the owner.

Example

John is the owner of a portfolio of Old Mutual Protect products. He has Life Cover for himself (R100), Physical Impairment Cover for his wife, Mary (R100), and Extended Family Funeral Cover (Sibling cover) for his brother, Peter (R100). The contractual premium that John owes Old Mutual is R300 for all products combined in his portfolio.

Example

John is an owner of an Old Mutual Protect product. He buys Family Funeral Cover for himself (R50) and his wife (R30). The total premium on his contract is R80. Subsequently John buys Severe Illness Cover for himself (R90). The total premium on his portfolio of products now equals R170. However, this is below the minimum premium requirement of R200. John will need to either increase cover on his Family Funeral Cover or on his Severe Illness Cover to meet the minimum premium requirement.

- The minimum contractual premium rules will be enforced at new business stage.
- On the cancellation of a contract which causes the minimum premium across the owner's contracts to fall below the minimum contractual premium requirement, both the owner and the adviser will be informed that the portfolio of products has breached the minimum contractual premium requirement.
- The minimum premium will be determined based on long-term risk cover premiums only.
- Cashback premiums can't be used to supplement a premium to meet the minimum requirement.
- Where the owner's portfolio consists of more than one premium frequency, premiums will be converted to the highest premium frequency, i.e. monthly, for the validation of the minimum contractual premium.

2.5.2 Payment methods

Bank deductions

- Premiums are always due on the same day of the month. The owner may specify the day of the month on which the debit order must be lodged.
- The premium due date on the contract may be changed.

Salary deductions

Premiums paid using the salary deduction method will be deducted on the salary deduction date of the respective salary deduction facility but are always due on the first of the month. The premium due date can't be changed under the salary deduction payment method. Public and private salary deduction facilities will be accommodated. This is restricted to certain companies/institutions with whom we have relationships.

Ad-hoc (once-off) premium collections

Only applicable for collecting arrear premiums or the repayment of premium holidays.

2.5.3 Premium frequency

Bank deductions: monthly, or yearly premiums will be allowed depending on the type of cover.

Salary deductions: only monthly premiums will be allowed.

2.5.4 Premium skip month

Monthly premium frequency allows one month's premium to be skipped per year. If they choose to skip a premium, the owner can select any month during the year that they don't want us to collect premiums except for when the first premium is due on the contract. The owner may choose to change this month at a later date. The yearly premium is then allocated into 11 equal premiums.

If the month selected coincides with the first premium due on the contract, the first premium missed will be one year from the first premium due date.

2.5.5 First premium due date

Old Mutual Protect provides immediate cover, which means that the customer is covered before payment of the first premium, from the date of issue, subject to a maximum of 30 days. The owner may specify a future start date and a premium deduction date of no more than the balance of the current month plus two calendar months into the future. Salary deductions may not be further than the above period plus the lead time of the salary deduction.

No premium backdating will be allowed on Old Mutual Protect, since the owner would then have paid for cover they didn't receive.

All future premium due dates will be scheduled to occur on the same day of the month as per the premium start date taking into account the premium frequency for the interval between premium payments.

Each contract anniversary will be calculated yearly from the start date. The anniversary date won't change for the duration of the contract.

Example

The owner applies for an Old Mutual Protect product on 15 August. Assuming lead time for the selected method of payment is one month, the latest future start date will be 1 November in the same year.

2.5.6 Premium increases

The owner can choose a fixed rate compulsory yearly increase of 0% or 5% or an age-linked compulsory yearly premium increase that will assist in meeting their risk needs.

- Future Insurance can only have a compulsory yearly increase of 0%.
- The cover amount will remain level over the term except for Future Insurance.
- Premium increases offer a lower initial premium, but one that gets more expensive with time.
- Premiums will increase yearly on the compulsory yearly premium increase date.
- At the end of the guarantee term, premiums may increase by more than the compulsory yearly premium increase selected. After this, premiums will continue to increase by the compulsory yearly premium increase percentage every year.
- The final increased premium will be rounded to the nearest Rand.
- Once compulsory yearly premium increases are selected, these premium increases become an obligation under the product and will occur automatically every year.
- If the owner can no longer afford compulsory yearly premium increases, we should be contacted to adjust the cover or premium schedule. There's various ways of getting to more affordable premiums but cover may never be reduced below the minimum cover limit applicable at the time of this change.
- If the owner makes a voluntary cover increase, the premium will increase to reflect the new increased level of cover. If cover is increased in the future, whether by scheduled yearly cover increases or voluntarily, premiums will also increase. The premium increase will be determined based on the cost of the extra cover at the time of the increase.
- Premiums for Future Life Cover and premium protection benefits can be reviewed yearly.

2.5.6.1 Fixed rate compulsory yearly premium increase (0%)

Premiums will remain level for a level amount of cover.

If cover is increased in the future, whether by scheduled yearly cover increases or voluntarily, premiums will also increase. The premium increase will be determined based on the cost of the extra cover at the time of the increase. The owner then pays level premiums for the new amount of cover amount.

2.5.6.2 Fixed rate compulsory yearly premium increase (5%)

PREMIUMS WILL INCREASE EVERY YEAR BY THE FIXED RATE OF 5% PER YEAR. THIS INCREASE IS OFFERED ON THE FOLLOWING PRODUCTS:

- Life Cover
- Disability Cover
- Functional Impairment Cover
- Physical Impairment Cover
- Severe Illness Cover
- Accidental Death Cover
- Accidental Disability and Death Cover
- Life Income Cover
- Last Survivor Cover
- Disability Income Cover
- Functional Impairment Income Cover
- Business Life Cover
- Business Expenses Cover
- Family Funeral Cover
- Extended Family Funeral Cover

If cover is increased in the future, whether by scheduled yearly cover increases or voluntarily, premiums will also increase. The premium increase will be determined based on the cost of the extra cover at the time of the increase. The owner then continues to pay a compulsory yearly premium increase of 5% for the new cover amount.

2.5.6.3 Age-linked compulsory yearly premium increase

Premiums will increase every year by a rate that depends on the age of the insured person on the increase date.

The age-linked compulsory yearly premium increase rates are:

AGE NEXT BIRTHDAY	INCREASE RATE
Under 31	0%
31 - 35 years	4%
36 - 40 years	6%
41 - 50 years	8%
51 - 60 years	9%
61 years and older	10%

If the cover is increased in the future, whether by scheduled yearly cover increases or voluntarily, premiums will also increase. The premium increase will be determined based on the cost of the extra cover at the time of the increase. The owner then continues to pay the age-linked compulsory yearly premium increase according to their age at the time of the change or the new cover amount.

AGE-LINKED COMPULSORY YEARLY PREMIUM INCREASES ARE OFFERED ON THE FOLLOWING PRODUCTS:

- Life Cover
- Life Income Cover
- Accidental Death Cover
- Disability Income Cover
- Functional Impairment Income Cover
- Disability Cover
- Functional Impairment Cover
- Physical Impairment Cover
- Accidental Disability and Death Cover
- Severe Illness Cover
- Business Life Cover
- Business Expenses Cover

2.5.7 Guarantee term and review date

The following guarantee terms will be available:

- 1 year
- 5 years
- 10 years
- 15 years

Below is a summary of the guarantee terms for each product.

GUARANTEE TERM	COVER, ADD-ONS, BENEFITS AND OTHER FEATURES	
1 year	· Family Funeral Cover · Extended Family Funeral Cover · Funeral Paid-up · Disability Income Cover · Functional Impairment Income Cover · Business Expenses Cover	· Future Life Cover · Retrenchment Cover · Premium Protection Death · Premium Protection Disability · Premium Protection Functional Impairment · Premium Protection Retrenchment
5 years	· Life Cover · Last Survivor Cover · Life Income Cover · Accidental Death Cover · Family Funeral Cover · Extended Family Funeral Cover · Disability Income Cover · Functional Impairment Income Cover	· Disability Cover · Functional Impairment Cover · Physical Impairment Cover · Accidental Disability and Death Cover · Severe Illness Cover · Business Life Cover · Business Disability Cover · Business Functional Impairment Cover
10 years	· Life Cover · Last Survivor Cover · Accidental Death Cover · Disability Cover · Functional Impairment Cover · Physical Impairment Cover	· Accidental Disability and Death Cover · Severe Illness Cover · Business Disability Cover · Business Functional Impairment Cover · Business Life Cover
15 years	· Life Cover · Last Survivor Cover · Accidental Death Cover	· Accidental Disability and Death Cover · Business Life Cover

2.5.7.1 Guarantee term

The guarantee term is the term during which we guarantee that the premium will remain unchanged assuming that the owner makes no changes to the cover.

- Add-ons, benefits and other features will take on the guarantee term of the cover it's attached to, except for premium protection.
- The shorter the guarantee term selected, the lower the premium.
- Premiums will change during the guarantee term if:
  - compulsory yearly premium increases (5% or age-linked compulsory yearly premium increases) are selected – premiums will increase by the compulsory yearly premium increase rate every year.
  - scheduled yearly cover increases are selected – premiums will increase to pay for the extra layers of cover every time a scheduled yearly cover increase is exercised.
  - scheduled yearly cover increases are selected with compulsory yearly premium increases – premiums will increase by the compulsory yearly premium increase rate plus the amount needed to pay for the extra layer of cover every time a scheduled yearly cover increase is exercised.
  - changes are made by the owner (e.g. voluntary cover increase), or changes occur in the insured person's rating factors (e.g. occupation).
  - legislation or regulation (whether related to taxation or otherwise) is introduced or changed, or the interpretation thereof by a court or regulatory authority is changed, and impacts an owner's product.
- At the end of the guarantee term, the premium is reviewed. This premium may change and a new guarantee term will start.

2.5.7.2 Review date

- The date when premiums are reviewed is called the review date. All premiums in the contract will be reviewed on the same date.
- Correspondence is generated and sent to the owner about three months before the guarantee review date.

Example: Limited guarantee terms

If the guarantee term options under Life Cover are 5, 10 and 15 years and the add-on cover guarantee term options are 5 and 10 years, the owner who chooses to buy a contract consisting of the cover with add-on cover at new business stage will only have the choice of 5 and 10 years for both.

- Any add-on cover attached at any stage will inherit the guarantee review date and guarantee term of the cover it's attached to.

Example: Add-on cover purchased after start date

Mike purchased cover with a five-year guarantee term on 1 June 2015. On 1 June 2017 he decides to action a voluntary cover increase. Although the guarantee term of the cover increase is set to five years, inheriting the term of the cover, the first review date will be in three years on 1 June 2020 to coincide with the original review date of the cover.

- If the change to the contract after new business stage requires adding cover which doesn't have the prevailing guarantee term option available, the guarantee term of the underlying cover will change with a recalculated premium being offered to the owner on the add-on cover.

Example

Layla purchased cover with a 15-year guarantee term on 1 April 2016. Three years later, on 1 April 2019 she decides to add cover but the add-on cover only provides guarantee term options of 5 and 10 years. The guarantee term for the add-on cover selected is 10 years which requires the underlying guarantee term to change to 10 years. The review date for the both types of cover will coincide on 1 April 2026. The premium on the cover will be recalculated to represent the shorter guarantee period and closer review date.

- The new guarantee term will be defaulted to the original guarantee term unless the remaining term is less. The premium won't automatically change at the review date. When our pricing basis change, premiums will be reviewed.
- These premiums are not expected to change, but may be adjusted if there has been a change to the pricing basis. At premium review:
  - If a guarantee term of 10 years is selected, the premium is guaranteed for a given level of cover within this 10-year period.
  - At the end of the guarantee term, the best estimate of future experience at that point will be used to determine whether the premium needs to be reviewed. If so, there may be a decrease or an increase in premium at this point.

2.5.8 Premium term

There are two premium payment terms available. An owner may select to pay premiums either for the benefit term or until a specified retirement age of the owner.

Premium term to retirement

- Premiums can be paid to a pre-selected age when the owner (individuals only) is expected to retire. At this stage cover will continue to the end of the selected term.
- Minimum retirement age is 55 years.
- Maximum retirement age is 70 years.
- Minimum premium-payment term to retirement is 10 years.
- Cover increases will stop at the retirement date selected.
- The premium-payment term to retirement may only be selected as an option if the term to retirement is shorter than the term of the cover.
- The premium-payment term will be equal to the contract anniversary in the year that the owner retires.
- The premium duration to retirement is only available on the following products:
  - Life Cover
  - Last Survivor Cover
  - Life Income Cover
  - Accidental Death Cover
  - Disability Cover
  - Functional Impairment Cover
  - Physical Impairment Cover
  - Severe Illness Cover
  - Accidental Disability and Death Cover
  - Future Life Cover

Example: Minimum premium payment to retirement

A retirement age of 70 may only be selected if the owner is currently age 60 or younger. The last premium collection will be just before the cover anniversary in which their next birthday equals the retirement age specified.

2.5.9 Premium holidays

The premium holiday is a feature that allows the owner to miss a premium during times of financial difficulty such as retrenchment, unemployment, maternity leave and study leave.

This feature is only applicable to Funeral Insurance including the attached benefits with a monthly premium frequency. See Funeral Cover for more details.

2.6 GRACE PERIOD, LAPSING AND RESTARTING A CONTRACT

2.6.1 Grace period

- The grace period comes into effect from the first premium due date.
- The contract will enter a 45-day grace period after any premium is missed.
- The grace period of 45 days starts on the date that the last premium was due and not paid.
- Cover will continue during the grace period, i.e. a claim will be considered if the cover event occurs during this period.
- If the missed premium hasn't been paid before the end of the grace period or if a second premium becomes due and is missed, the cover will lapse immediately.
- For the premium protection, the grace period will be the same as the grace period of the cover.
- When missed premiums are paid, they will automatically be allocated to the earliest premium recorded as outstanding.

2.6.2 Lapsing a contract

- The cover will lapse if the missed premium hasn't been received by the end of the grace period or if there is more than one premium outstanding i.e. as soon as a second premium becomes due and is missed, the cover will lapse.
- The effective date of the lapse will be the first day following the end of the grace period.
- When cover lapses, the cover (including all add-ons, benefits and other features attached to the cover) stops and no claims can be made for an event on or after the cover end date. The obligation to pay premiums also ends.

2.6.3 Restarting a contract

- A "restart" refers to the reinstatement of lapsed or cancelled cover and resuming premium payments on that cover.
- A restart will be allowed within six months of the date of cancellation or lapse.

- The owner doesn't have cover between the date of cancellation or lapse and the date that the cover restarts.
- The insured person will need to provide updated information on their health and lifestyle to restart cover (subject to further requirements if necessary). If the contract lapses and a restart is processed within one month, no health and lifestyle questions are required.
- Missed premiums don't have to be repaid. On restart, cover will start once a premium is received.
- Cover can be restarted a second time, provided at least six full monthly premiums, or the equivalent of six monthly premiums for other frequencies have been collected since the first restart.
- Certain contract changes will be allowed at time of restart and the premium amount will change.

2.7 COVER

2.7.1 Cover start date

- For all Old Mutual Protect products except for Family Funeral Cover (where the underwriting method is "no medical tests or questions") and Extended Family Funeral Cover, cover will start on the latter of:
  - the date on which we issue the contract, i.e. the contract start date, or
  - 30 days before the first premium due date where the cover has been added as part of new business.
- Where add-ons or benefits and other features are attached at the same time as when the cover is purchased, the cover start date will be the same.
- Where add-ons or benefits and other features are attached after the cover has started, they will have a different start date to the cover to which they are attached.
- For Family Funeral Cover (where the underwriting method is 'no medical tests or questions') and Extended Family Funeral Cover, cover on the add-ons will start on the date on which we issue the cover, i.e. the contract start date where the cover has been added as part of new business.
- We'll issue the cover after underwriting has been completed, all outstanding information has been received, and we've accepted the Old Mutual Protect application.

Example

John applies for Life Cover on 18 May and opts to pay his first premium on 1 July. We receive and verify all outstanding information on 20 May. Underwriting is completed and the contract is issued on 22 May. John's cover starts on 1 June. A letter will be sent to John along with his contract. This will show the date the contract was issued and cover started - i.e. 1 June.

2.7.2 Cover increases

The owner has the option of increasing their cover by means of voluntary cover increases or scheduled yearly cover increases.

2.7.2.1 Voluntary cover increases

Underwriting will apply on the additional slice of cover (on products where underwriting is applicable or where the cover amount for no medical tests or questions is exceeded).

2.7.2.2 Scheduled yearly cover increases

- Product maximums shouldn't prevent a scheduled yearly cover increase from applying unless explicitly stated.
- With every scheduled yearly cover increase, premiums will increase to reflect the new level of cover (irrespective of the premium pattern selected).
- Increased cover will start on the selected scheduled yearly cover increase date.
- No medical tests or questions will be required for such scheduled cover increases.
- If the increase is refused, there will be no negative effect on the cover. If increases are refused for three consecutive years, the facility will be removed. If they want to re-add scheduled yearly cover increases, they will have to undergo underwriting.
- If increases are added to existing cover, underwriting might apply. The scheduled yearly cover increases would only apply after the underwriting outcome is accepted and the owner has accepted the terms of the transaction.

2.7.2.3 Fixed-rate scheduled yearly cover increases

- These cover increases can be fixed at 0%, 5% or 10% every year.
- Premiums will remain level when the 0% fixed rate scheduled yearly cover increase is selected unless compulsory yearly premium increases were selected.
- For income cover where a scheduled yearly cover increase greater than 0% is selected, the initial premium will be greater than with the 0% fixed rate scheduled yearly cover increase. This is to pay for the fact that once a claim is made and no more premiums are paid, the cover payment that the insured person will receive will still increase at the rate that was initially selected.

2.7.2.4 Inflation-linked scheduled yearly cover increases

- These cover increases can be linked to inflation by + 0%, 1%, 2%, 3%, -1%, -2%.
- The maximum yearly increase will be capped at 15%, reviewable depending on the level of it's link to inflation.
- The minimum yearly increase will be capped at 0%, reviewable depending on the level of it's link to inflation.
- For income cover where a scheduled yearly cover increase greater than 0% is selected, the initial premium will be greater than with 0% inflation linked scheduled yearly cover increase. This is to account for the fact that once a claim is made and no more premiums are paid, the cover payment that the insured person will receive will still increase at the rate that was initially selected.

2.7.2.5 Currency-linked scheduled yearly cover increases

- The scheduled yearly currency linked cover change rates can be:
  - R/GB Pound exchange rate as determined by us
  - R/US Dollar exchange rate as determined by us
  - R/Euro exchange as determined by us
  - Together with linking it to the relevant exchange rate, the owner will also have the option of changing the cover on a yearly basis at 0%, 5%, 10%, relevant inflation as determined by us. For example UK inflation for R/GBP exchange rate.

- The maximum yearly increase will be capped at 30%, reviewable depending on level of indexes.
- The minimum yearly increase will be capped at 0%, reviewable depending on level of indexes.
- Cover can increase or decrease based on the movement of the specified currency.
- The type of cover selected will define the options available.
- The currency value will be captured at the date the cover issues and will change on a yearly basis.
- With every currency-linked cover change, premiums will change to reflect the new level of cover (irrespective of the premium pattern selected).

2.7.2.6 Fixed-rate and inflation-linked scheduled yearly cover increase with compulsory yearly premium increases

- Premiums increase every year by the compulsory yearly premium increase rate plus the cost of the additional cover bought by the scheduled yearly cover increase.
- The premiums will increase at a rate in excess of the compulsory yearly premium increases rate.
- This pattern offers a cheaper initial premium, but one that gets more expensive with time.
- Scheduled yearly cover increases can be refused (but compulsory yearly premium increases cant be). Premiums will then increase at the compulsory yearly premium increase rate selected.
- If cover increases are refused for three consecutive years, it will be removed but compulsory yearly premium increases will still be applied.

2.7.2.7 Currency-linked scheduled yearly cover increases with compulsory yearly premium increases

- Premiums change every year by the compulsory yearly premium increase rate plus or minus the cost of the additional or reduction in cover as a result of the currency it's linked to.
- The owner pays yearly increasing premiums for the additional cover amount (where cover increases). This means that if the owner adds currency-linked cover changes with compulsory yearly premium increases, the premiums will increase at a rate in excess of the compulsory yearly premium increase rate selected to buy the additional cover (if cover increases).
- Currency-linked cover changes can be refused (but not compulsory yearly premium increases). Premiums will then increase at the compulsory yearly premium increase rate selected.
- If currency-linked cover changes are refused for three consecutive years, it will be removed but compulsory yearly premium increases will still be applied.

2.7.2.8 Increase dates for scheduled and compulsory increases

- Any increase date can be selected on condition that selected date coincides with a premium due date based on the premium frequency (i.e. 12 possible increase dates for a premium frequency of monthly, only the cover anniversary is available on the yearly frequency).
- Where the 11/12 monthly frequency has been selected, the scheduled yearly cover increase/compulsory yearly premium increase date can't be the same as the selected premium skip month.
- If scheduled yearly cover increases are selected with the compulsory yearly premium increases, the increases may be scheduled to occur on the same date or separate dates.
- If the increase date isn't on the cover anniversary the first increase must be within the first 12 months.
- If no date is selected, it will default to the cover anniversary date.
- It would usually be in the owner's best interest to schedule all increases to take place on the same date, resulting in a one-off increase each year rather than many increases.

2.8 COOL-OFF PERIOD

This is the period after buying a product or the period after a contract change has been implemented on a product during which the owner may cancel the contract.

- A request to cancel must reach us in writing within 31 days of receiving the contract or, in the case of existing cover changes, within 31 days of the first premium due date after the cover change.
- New cover may be cancelled within this period, unless an insured event has taken place or a cover amount has been claimed or paid.
- On cancellation, a portion of the premiums paid may be refunded to the owner. A portion is retained to pay for the costs associated with the sale through to the cancellation of the cover.
- On cancellation of a new business contract during the cool-off period, the owner forfeits the right to claim on the cover.

2.9 CESSIONS

A cession is a transaction whereby one party (the cedent) agrees to transfer their rights/obligations to another person or legal entity (the cessionary). Benefits may be ceded to another person or legal entity by way of a security cession or an outright cession.

2.9.1 Outright cessions

- Outright cessions changes the ownership of the contract where the owner cedes all or a portion of their rights to the cessionary.
- A full outright cession is the removal of an owner and replacing them with a new or existing owner.
- A partial outright cession is when no owner is removed, only additional owners are added.

THE FOLLOWING PRODUCTS ALLOW OUTRIGHT CESSIONS

- Life Cover
- Life Income Cover
- Accidental Death Cover
- Family Funeral Cover
- Extended Family Funeral Cover
- Disability Income Cover
- Functional Impairment Income Cover
- Disability Cover
- Functional Impairment Cover
- Physical Impairment Cover
- Accidental Disability and Death Cover
- Severe Illness Cover
- Retrenchment Cover
- Future Life Cover
- Business Life Cover
- Business Expenses Cover

- Outright cessions are not allowed in the following cases:
  - Last Survivor Cover
  - If the protection need/reason for cover is 'liquidity in estate'.
  - Where the owner used their age and specified retirement age as the premium term.
- The cedent won't have any rights to any claims on the insured persons after an outright cession.

Example: Outright cession

John buys Severe Illness Cover for his son whilst he is attending university. Once his son starts working, John can cede the Severe Illness Cover as an outright cession to his son. His son will then become the new owner and can start his own Old Mutual Protect contract by adding other cover to meet his financial needs.

2.9.2 Security cessions

- A security cession allows for proportions of a product to be ceded to another person or entity.
- Security cessions limit the ability of the owner to make changes to the cover. This means that the owner will need to obtain written permission from the cessionary to make changes to the cover for example increasing or reducing the cover amounts.
- Claims we received while the cover is ceded as security will be paid in full to the cessionary. The cessionary will return any overpaid proceeds back to us and then we will pay the beneficiaries or estate.

THE FOLLOWING PRODUCTS ALLOW SECURITY CESSIONS:

- Life Cover
- Life Income Cover
- Last Survivor Cover
- Accidental Death Cover
- Disability Income Cover
- Functional Impairment Income Cover
- Disability Cover
- Functional Impairment Cover
- Physical Impairment Cover
- Accidental Disability and Death Cover
- Severe Illness Cover
- Retrenchment Cover
- Future Life Cover
- Business Life Cover
- Business Expenses Cover

- Security cessions are not allowed on:
  - Extended Family Funeral Cover
  - Family Funeral Cover
- There is no capital gains tax on second-hand risk contracts, because at the date of the cession the value of the contract (base cost for capital gains tax purposes) is nil.

Example: Security cession

James buys Life Cover after taking out a mortgage bond with a bank. He then cedes this cover to the bank as a security cession for collateral on his bond. When the loan has been repaid, the cession will be cancelled.

2.10 BENEFIT TERM

2.10.1 Whole-life cover

Premiums have been calculated to provide cover until the insured person dies.

2.10.2 Term cover

- The minimum term is five years.
- The maximum term is subject to the specified end age.
- Cover stops at the end of the term but the owner can select to convert the term cover.
- Premiums are calculated to provide cover until the end of the benefit term that is selected i.e. starting at the insured person's entry age and ending at the age specified.

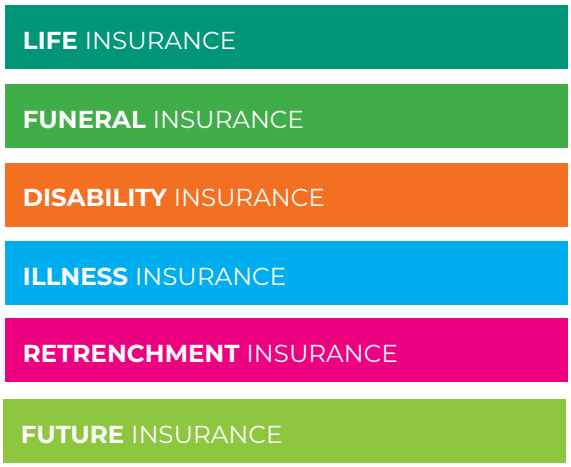
2.11 EXCLUSIONS

- General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that is generally excluded.
- Specific exclusions apply at a benefit level and are specified in the terms and conditions of the owner's contract.

3. PERSONAL PROTECTION

It's sensible financial management for customers to protect themselves and their loved ones against life's uncertainties. Investing in personal protection will ensure that customers and their families can continue to enjoy the lifestyle they've worked hard to achieve.

There are six personal protection needs:



Most of the Old Mutual Protect Products can have premium protection benefits attached to them as well as the Cashback feature.

3.1 PREMIUM PROTECTION

Premium protection benefits can't exist on their own and must be added to specific cover. It waives the premium of the cover it's attached to. 'Waives the premium' means that the cover continues while no premiums are payable. See Premium Protection events for more detail.

There are four premium protection benefits:

- Premium Protection Death
- Premium Protection Disability or
- Premium Protection Functional Impairment
- Premium Protection Retrenchment

The insured person for all premium protection benefits added to cover must be the same, except for Last Survivor Cover. See Last Survivor Cover for specific rules.

The insured person on Premium Protection Retrenchment has to be the same as the insured person on the cover it's attached to.

The insured person on the premium protection can't be the same as the insured person under the cover it's attached to if:

- Premium Protection Death is selected. For example, an owner can't buy Life Cover with John as the insured person and add Premium Protection Death with John as the insured person.
- Premium Protection Disability or Premium Protection Functional Impairment is added to Disability Cover or Functional Impairment Cover. For example, an owner can't buy Disability Cover with Anne as the insured person and add Premium Protection Disability or Premium Protection Functional Impairment with Anne as the insured person.

The owner would have to choose between Premium Protection Disability or Premium Protection Functional Impairment as they cannot have more than one attached to his/her cover.

This means that, except for Last Survivor Cover, at most two premium protection benefits can be added, as adding Premium Protection Death will preclude the addition of Premium Protection Retrenchment and vice versa.

For Last Survivor Cover at most three premium protection benefits can be added – Premium Protection Death, Premium Protection Retrenchment, and one of either Premium Protection Disability or Premium Protection Functional Impairment.

How does the cover amount or premium on the contract change while we are waiving its premiums?

The premium will increase each year with the compulsory yearly increase chosen and we'll waive the increased premium.

If currency-linked scheduled yearly cover increases were selected, the cover amount and premium will still increase yearly, but

- the percentage cover increase is limited to the inflation rate as set by us (currently capped at 10%) and
- we'll waive the increased premium.

If, at the end of a guarantee term the premium would have increased while we are waiving the contract's premiums, we'll decrease the cover amount and continue to waive the premium that applies at that time. If the premium would have decreased, we'll decrease the premium and continue to waive the decreased premium.

3.1.1 Premium Protection Death

Premium Protection Death waives the contract's premiums and ensures that cover continues when the insured person on the Premium Protection Death dies. It can be added with Premium Protection Disability, Premium Protection Functional Impairment or, for Last Survivor Cover, with Premium Protection Retrenchment.

PREMIUM PROTECTION DEATH CAN BE ADDED TO	
· Life Cover · Life Income Cover · Last Survivor Cover · Accidental Death Cover · Disability Cover · Functional Impairment Cover	· Physical Impairment Cover · Accidental Disability and Death Cove · Severe Illness Cover · Retrenchment Cover · Future Life Cover

3.1.1.1 Premium Protection Death product features

TYPE OF COVER	ADD-ON BENEFIT
Eligible lives	· All lives are eligible, subject to entry age limits and underwriting. · The insured person for Premium Protection Death can't be the same as the insured person of the cover it's attached to (except for Last Survivor Cover).
Relationship to owner	There must be an insurable interest if the owner and insured person aren't the same person.
Maximum number of insured persons	One
Entry age limits	**Minimum:** 15 next birthday **Maximum:** 75 next birthday
Premium frequency	Takes on the premium frequency of the cover it's attached to.
Premium term	Takes on the premium term of the cover it's attached to, subject to the benefit term.
Compulsory yearly premium increase	The premium increase will depend on the change in premium of the cover it's attached to.
Guarantee term	1 year
Cover amount limits	None (subject to financial underwriting)

Benefit term	The premium term of the cover it's attached to, subject to a maximum term of the contract anniversary immediately preceding the insured person on Premium Protection Death's 80th birthday. · If attached to term or whole life cover with a premium term equal to the benefit term, the benefit term will be the shorter of: – benefit term, or – 81 next birthday minus the insured person on Premium Protection Death's age next birthday at cover start date. · If attached to term or whole-life cover with a premium term to retirement, then the benefit term will be the shorter of: – the owner's retirement age minus age next birthday at cover start date, or – 81 next birthday minus the insured person on Premium Protection Death's age next birthday at cover start date.
Cover end age	81 next birthday
Scheduled yearly cover increase	The cover increase will depend on the change in premium of the cover it's attached to.
Underwriting method	· No medical tests, only questions · Medical tests, questions or both
Underwriting credit	If the insured person completed 'medical tests, questions or both' for an amount less than the upper limit of a particular underwriting band, they could qualify for: · Single underwriting credit · Comprehensive underwriting credit

3.1.1.2 Waiving of premiums

- Premium Protection Death waives the premiums of the attached cover and add-ons.
- Premiums will continue to be waived for the term of Premium Protection Death.
- At the end of the term, cover under Premium Protection Death stops and the premiums of the cover, add-ons, benefits and other features will once again become payable.

Example

Jane is the owner of Severe Illness Cover while her husband Johan is the insured person. Jane adds Premium Protection Death to Severe Illness Cover with her as the insured person. When Jane dies, premiums for Severe Illness Cover will be waived and Johan will continue to be protected under Severe Illness Cover.

Waiving of premiums stop on the earliest of the following:

- The benefit's cover end date.
- If the contract is cancelled.
- If the benefit is removed from the contract.

3.1.1.3 Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that is generally excluded.

We won't pay if the insured person's death is caused by:

- unrest, war or terrorist activity,
- radioactivity or nuclear explosion,
- the insured person provoking, committing or attempting to commit a crime for example murder, assault, housebreaking, theft, robbery, the forceful detention of another person or any similar crime or
- suicide within the first two years from the cover start date.

3.1.1.4 Premium Protection Death stops on the earliest of the following:

- The end of the benefit term.
- If the benefit lapses.
- If the contract is cancelled.
- If the benefit is removed from the contract.
- If one of the insured persons on Last Survivor Cover dies, and the other person is the insured person on Premium Protection Death.

3.1.2 Premium Protection Disability

Premium Protection Disability waives the contract's premiums and ensures that cover continues when the insured person under the Premium Protection Disability becomes occupationally disabled or functionally impaired after the cover started and if the waiting period is met. It can be with Premium Protection Death or Premium Protection Retrenchment. Premium Protection Disability can't be added to the cover if Premium Protection Functional Impairment already exists.

PREMIUM PROTECTION DISABILITY CAN BE ATTACHED TO

- Life Cover
- Life Income Cover
- Last Survivor Cover
- Accidental Death Cover
- Disability Cover
- Functional Impairment Cover
- Physical Impairment Cover
- Accidental Disability and Death Cover
- Severe Illness Cover
- Retrenchment Cover
- Future Life Cover

3.1.2.1 Premium Protection Disability product features

TYPE OF COVER	ADD-ON BENEFIT
Eligible lives	· All occupation classes · Certain occupations won't be eligible for cover
Relationship to owner	If the owner isn't the same person as the insured person insurable interest must exist between the owner and the insured person.
Maximum number of insured persons	One
Entry age limits	**Minimum:** 15 next birthday **Maximum:** 60 next birthday
Premium frequency	Takes on the premium frequency of the cover it's attached to.
Premium term	Takes on the premium term of the cover it's attached to, subject to the benefit term.
Compulsory yearly premium increase	The premium increase will depend on the change in premium of the cover it's attached to.
Guarantee term	1 year
Cover amount limits	None (subject to financial underwriting)
Benefit term	The premium term of the cover it's attached to, subject to a maximum term contract anniversary immediately preceding the insured person on Premium Protection Disability's 65th birthday. · If attached to term or whole life cover with a premium term equal to the benefit term, the benefit term will be the shorter of: – benefit term, or – 66 next birthday minus the insured person on Premium Protection Disability's age next birthday at cover start date. · If attached to term or whole-life cover with a premium term to retirement, the benefit term will be the shorter of: – owner's retirement age minus age next birthday at cover start date, or – 66 next birthday minus the insured person on Premium Protection Disability's age next birthday at cover start date.
Cover end age	66 next birthday

Scheduled yearly cover increase	The cover increase will depend on the change in premium of the cover it's attached to.
Underwriting method	No medical tests, only questions Medical tests, questions or both
Underwriting credit	If the insured person completed 'medical tests, questions or both' for an amount less than the upper limit of a particular underwriting band, they could qualify for: · Single underwriting credit · Comprehensive underwriting credit

3.1.2.2 Definitions

- **Occupationally disabled** means that the insured person is, in part or completely and despite following reasonable medical advice and adequate medical treatment, unable to perform the main duties of their occupation or another occupation for which they are reasonably suited, because of a sickness or injury.

  Should the insured person stop being engaged in their occupation due to retirement (and doesn't thereafter become re-engaged in any occupation), no benefit will be payable if the insured person becomes disabled. Claims received after the earlier of the above dates will only be assessed against the Functional Impairment definitions.

- **Reasonably suited** means an occupation that the insured person could reasonably do after re-skilling and taking into account their education, training, experience and employment history.

- **Functionally impaired** means that the insured person has suffered and met the requirements of a qualifying functional impairment.

- **Reasonable medical advice** means the medical opinion provided by a health professional that the insured person can reasonably be expected to follow to improve or preserve their health. This may include investigations, recommendations, lifestyle adjustments and treatment options based on the best available information and appropriate to the condition, the health professional's knowledge and scope of practice.

- **Adequate medical treatment** means the best possible treatment that a person can reasonably be expected to undergo and includes the use of simple external assistive devices for example hearing aids, glasses, contact lenses, a walking stick or a Zimmer frame but doesn't include the use of complex external assistive devices for example a wheelchair or leg prosthesis. The general meaning of the terms 'simple external assistive devices' and 'complex external assistive devices' isn't limited by the specific examples provided.

3.1.2.3 Waiting period

- The waiting period is six months.
- A waiting period is the number of consecutive days or months for which the insured person's occupational disability or functional impairment must have continued before we'll start waiving the contract's premiums.
- It starts on the date of the occupational disability or functional impairment as confirmed by Old Mutual's Medical Officer.

- Premiums must continue to be paid during the waiting period and while we decide if the claim is valid. If we've received any premiums after the end of the waiting period, we'll refund those premiums. We won't pay interest on this refund.
- If the contract is cancelled before the waiting period ends, we won't start waiving the contract's premiums.
- We can't apply the waiting period if the insured person was occupationally disabled or functionally impaired, recovers and then becomes occupationally disabled or functionally impaired from a related event within six months after their recovery. If we don't apply the waiting period, we'll start waiving the contract's premiums from the date of the occupational disability or functional impairment.
- Old Mutual's Medical Officer, supported by published medical evidence, determines if events are related. Typically this means that they stem from the same incident (for example a certain car accident) or condition (for example cancer) or from complications or treatment following the same incident or condition.

Example

Frank is diagnosed with chronic gastrointestinal disease on 1 January 2019. The waiting period starts on 1 January and ends at midnight on 30 June 2019. We'll start waiving the contract's premiums from 1 July 2019.

Example: Related event and the waiting period only applies once

Sally is diagnosed with chronic gastrointestinal disease and is functionally impaired. She is functionally impaired for the six-month waiting period, so we'll start waiving the contract's premiums from month seven. She recovers twelve months after her diagnosis and we stop waiving the contract's premiums. Two months later she's diagnosed with chronic liver disease and is again functionally impaired. Because we consider chronic liver and gastrointestinal diseases to be related functional impairments and because her second functional impairment happened within six months of her recovery from the first functional impairment, another six-month waiting period will not apply and we'll start waiving the contract's premiums immediately.

Example: Unrelated event and the waiting period is applied again

Sally is diagnosed with chronic gastrointestinal disease and is functionally impaired. She is functionally impaired for the six-month waiting period, so we'll start waiving the contract's premiums from month seven. She recovers twelve months after her diagnosis and we stop waiving the contract's premiums. Two months later she's diagnosed with hypertension and is again functionally impaired. Because chronic gastrointestinal disease is unrelated to hypertension and despite the short time between her recovery from the first functional impairment and her diagnosis with the second, we'll apply another six-month waiting period and will start waiving the contract's premiums only from month seven.

3.1.2.4 Waiving of premiums

- Premium Protection Disability waives the premiums of the cover and add-ons it's attached to while the insured person under Premium Protection Disability is disabled as defined.
- The premiums will begin to be waived following the expiry of the waiting period or when the claim is approved, whichever is the later.
- Premiums will continue to be waived until the insured person recovers from their disability or the Premium Protection Disability term ends.
- On recovery from the disability, Premium Protection Disability stops and the premiums of the cover, add-ons, benefits and other features will once again become payable.

Example

Peter has Life Cover with a Severe Illness Cover add-on. He takes out Premium Protection Disability on his Life Cover. If Peter becomes disabled, his premiums on Life Cover and the Severe Illness Cover add-on will be waived.

Double disability can occur when Premium Protection Disability is added to cover in conjunction with a partial cover add-on. For example, Life Cover with Disability Cover add-on that pays out 50% of the cover amount of the Life Cover. If the event causing the Disability Cover payout is also the Premium Protection Disability event, Premium Protection Disability will waive the remaining reduced premium, hence double disability occurs.

Example

Karen has R800 000 Life Cover with a Disability Cover add-on, including a Partial Functional Impairment Benefit, that pays out 50% of the cover amount of the Life Cover. She adds Premium Protection Disability to her Life Cover (waiving premiums on both Life Cover and Disability Cover add-on), where she's the insured person.

Example: Partial disability

Karen has R800 000 Life Cover and R400 000 Disability Cover. She gets diagnosed with chronic respiratory failure and meets the 50% functional impairment definition. She has a 50% claim on the Disability Cover and will get paid R200 000 (50% x R800 000 = R400 000 of the Disability Cover amount. Applying the 50% partial payout percentage to this = R200 000). She can't claim on Premium Protection Disability as she doesn't meet the 100% functional impairment definition, and must therefore continue to pay her premiums.

Example: Full disability

Karen has R800 000 Life Cover and R400 000 Disability Cover. She gets diagnosed with chronic respiratory failure and meets the 100% functional impairment definition. In this case, she will get paid R400 000 (50% x R800 000 = R400 00 is the Disability Cover amount. Applying the 100% payout percentage to this = R400 000). Her Disability Cover add-on falls away as she has claimed for the full cover amount. She can, however, claim on her Premium Protection Disability as she meets the 100% functional impairment definition, and premium on the remaining R400 000 Life Cover will therefore be waived.

Waiving of premiums stop on the earliest of the following:

- The benefit's cover end date.
- If the insured person recovers from their occupational disability or functional impairment.
- If the insured person fails to meet our requirements for following reasonable medical advice or adequate medical treatment and regular evaluation of their occupational disability or functional impairment or to undergo re-skilling for an occupation for which they are reasonably suited.
- When we've waived the contract's premiums for 24 months in total while the insured person was unable to perform the main duties of their occupation from related events.
- When the insured person dies.
- If the insured person no longer qualifies for the benefit because of changes to their circumstances.
- If the contract is cancelled.

- If this benefit is removed from the contract.
- When the insured person's occupational disability cover stops while we are waiving the contract's premiums because of occupational disability.

If we've stopped waiving the contract's premiums after 24 months in total because the insured person was unable to perform the main duties of their occupation from related events, we'll re-evaluate the claim. If we determine that the insured person is unable to perform the main duties of another occupation for which they are reasonably suited or is functionally impaired, we'll continue to waive the contract's premiums until one of the reasons listed above, causes us to stop. When we stop waiving the contract's premiums the benefit will continue until the cover end date and the owner can claim in future for occupational disability or functional impairment.

We'll determine the number of the contract's premiums to waive in line with the period of time the insured person is occupationally disabled or functionally impaired which may not exceed the average recommended period of recovery according to the latest edition of The Medical Disability Adviser: Workplace Guidelines for Disability Duration, by Presley Reed, M.D., or its replacement as determined by us. We'll consider waiving further contract premiums if the treating doctor can provide us with sufficient medical motivation in the form of specialist reports and/or test results. Any supporting medical proof that we need will be at the owner's own cost.

Example: Start paying premiums again after we stop waiving premiums

Jane takes out Life Cover where Johan, her husband, is the insured person. The term of that benefit's whole-life. Jane also takes out a Premium Protection Disability benefit on her life. Jane takes out this benefit when she's 45 years old. The term of the Premium Protection Disability benefit will be 20 years because the maximum end age for this benefit is 65. If Jane were to become functionally impaired two years after taking out her contract, we'll waive the contract's premiums for 18 years, until the Premium Protection Disability benefit stops waiving the premium. Thereafter, Jane will need to start paying the contract's premiums.

3.1.2.5 Changes to circumstances of the insured person on Premium Protection Disability

The owner must inform us if:

- The insured person starts participating recurrently in any risky activities which may expose the insured person to a higher than average risk of accident or injury.
- The insured person makes a change to their occupational circumstances:
  - occupation or any detail of their occupation,
  - industry,
  - duty split,
  - employment type or
  - starts/stops a second occupation or changes the number of hours per week that they work.
- The insured person's health/medical status changes (they recover or their condition improves) while we are waiving the contract's premium.
- The insured person dies.

3.1.2.6 Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that is generally excluded.

We won't pay if:

- the owner fails to meet our requirement to tell us about changes to the circumstances of the insured person (See changes to the circumstances of the insured person),
- the insured person refuses to follow reasonable medical advice or adequate medical treatment or to undergo re-skilling for an occupation for which they are reasonably suited
- the insured person's occupational disability or functional impairment is caused by:
  - unrest, war or terrorist activity,
  - radioactivity or nuclear explosion,
  - them provoking, committing or attempting to commit a crime for example murder, assault, housebreaking, theft, robbery, the forceful detention of another person or any similar crime or
  - self-inflicted injury.

We won't waive the premium if:

- the insured person's occupational disability or functional impairment is before the cover start date,
- we don't recognise the insured person's occupational disability or functional impairment or
- the waiting period isn't met.

We won't recognise the insured person's occupational disability:

- If they are able to do more than 75% of the main duties of their occupation.

We won't recognise the insured person's functional impairment if they suffer a functional impairment that:

- isn't on the list of functional impairments or
- doesn't meet all the qualifying requirements of that functional impairment.

3.1.2.7 Premium Protection Disability stops on the earliest of the following:

- When the insured person dies.
- The end of the benefit term.
- If the benefit lapses.
- If the insured person no longer qualifies for the cover because of changes to their circumstances.
- If the contract is cancelled.
- If the benefit is removed from the contract.

In addition to the above, occupational disability cover stops on the earliest of:

- The date the insured person retires.
- The insured person's 65th birthday.

3.1.3 Premium Protection Functional Impairment

Premium Protection Functional Impairment waives the contract's premiums and ensures that the cover continues when the insured person becomes functionally impaired after the cover started and if the waiting period is met. It can be added with Premium Protection Death or Premium Protection Retrenchment. Premium Protection Functional Impairment can't be added to the cover if Premium Protection Disability already exists.

PREMIUM PROTECTION FUNCTIONAL IMPAIRMENT CAN BE ATTACHED TO	
· Life Cover	· Physical Impairment Cover
· Life Income Cover	· Accidental Disability and Death Cover
· Last Survivor Cover	· Severe Illness Cover
· Accidental Death Cover	· Retrenchment Cover
· Disability Cover	· Future Life Cover
· Functional Impairment Cover	

3.1.3.1 Premium Protection Functional Impairment product features

TYPE OF COVER	ADD-ON BENEFIT
Eligible lives	· All occupation classes · Certain occupations won't be eligible for cover
Relationship to owner	There must be an insurable interest if the owner and insured person aren't the same person.
Maximum number of insured persons	One
Entry age limits	**Minimum:** 15 next birthday **Maximum:** 60 next birthday
Premium frequency	Takes on the premium frequency of the cover it's attached to.
Premium term	Takes on the premium term of the cover it's attached to, subject to the benefit term.
Compulsory yearly premium increase	The premium increase will depend on the change in premium of the cover it's attached to.
Guarantee term	1 year

Benefit term	The premium term of the cover it's attached to, subject to a maximum term of the contract anniversary immediately preceding the insured person on Premium Protection Functional Impairment's 65th birthday. · If attached to term or whole life cover with a premium term equal to the benefit term, then the benefit term will be the shorter of: – benefit term, or – 66 next birthday minus the insured person on Premium Protection Functional Impairment's age next birthday at cover start date.
	· If attached to term or whole-life cover with a premium term to retirement, then the benefit term will be the shorter of: – owner's retirement age minus current age next birthday at cover start date, or – 66 next birthday minus the insured person on Premium Protection Functional Impairment's age next birthday at cover start date.
Cover end age	66 next birthday
Scheduled yearly cover increase	The cover increase will depend on the change in premium of the cover it's attached to.
Underwriting method	· No medical tests, only questions · Medical tests, questions or both
Underwriting credit	If the insured person completed 'medical tests, questions or both' for an amount less than the upper limit of a particular underwriting band, they could qualify for: · Single underwriting credit · Comprehensive underwriting credit

3.1.3.2 Definitions

· **Functionally impaired** means that the insured person has suffered and met the requirements of a qualifying functional impairment.

· **Reasonable medical advice** means the medical opinion provided by a health professional that the insured person can reasonably be expected to follow to improve or preserve their health. This may include investigations, recommendations, lifestyle adjustments and treatment options based on the best available information and appropriate to the condition, the health professional's knowledge and scope of practice.

- **Adequate medical treatment** means the best possible treatment that a person can reasonably be expected to undergo and includes the use of simple external assistive devices, for example hearing aids, glasses, contact lenses, a walking stick or a Zimmer frame but doesn't include the use of complex external assistive devices, for example a wheelchair or leg prosthesis. The general meaning of the terms "simple external assistive devices" and "complex external assistive devices" isn't limited by the specific examples provided.

3.1.3.3 Waiting period

- The waiting period is six months.
- A waiting period is the number of consecutive days or months for which the insured person's functional impairment must have continued before we'll start waiving the contract's premiums.
- It starts on the date of the functional impairment as confirmed by Old Mutual's Medical Officer.
- Premiums must continue to be paid during the waiting period and while we decide whether the claim is valid. If we've received any premiums after the end of the waiting period, we'll refund those premiums. We won't pay interest on this refund.
- If the contract is cancelled before the waiting period ends, we won't start waiving the contract's premiums.
- We may not apply the waiting period if the insured person was functionally impaired, recover and then becomes functionally impaired from a related event within six months after their recovery. If we don't apply the waiting period, we'll start waiving the contract's premiums from the date of the functional impairment.
- Old Mutual's Medical Officer, supported by published medical evidence, determines if events are related. Typically this means that they stem from the same incident (for example a certain car accident) or condition (for example cancer) or from complications or treatment following the same incident or condition.

Example

Frank is diagnosed with chronic gastrointestinal disease on 1 January 2019. The waiting period starts on 1 January and ends at midnight on 30 June 2019. We'll start waiving the contract's premiums from 1 July 2019.

Example: Related event and the waiting period only applies once

Sally is diagnosed with chronic gastrointestinal disease and is functionally impaired. She's functionally impaired for the six-month waiting period so we'll start waiving the contract's premiums from month seven. She recovers twelve months after her diagnosis and we stop waiving the contract's premiums. Two months later she's diagnosed with chronic liver disease and is again functionally impaired. Because we consider chronic liver and gastrointestinal diseases to be related functional impairments and because her second functional impairment happened within six months of her recovery from the first functional impairment, another six-month waiting period will not apply and we'll start waiving the contract's premiums immediately.

Example: Unrelated event and the waiting period is applied again

Sally is diagnosed with chronic gastrointestinal disease and is functionally impaired. She's functionally impaired for the six-month waiting period so we'll start waiving the contract's premiums from month seven. She recovers twelve months after her diagnosis and we stop waiving the contract's premiums. Two months later she's diagnosed with hypertension and is again functionally impaired. Because chronic gastrointestinal disease is unrelated to hypertension and despite the short time between her recovery from the first functional impairment and her diagnosis with the second, we'll apply another six-month waiting period and will start waiving the contract's premiums only from month seven.

3.1.3.4 Waiving of premiums

- Premium Protection Functional Impairment waives the premiums of the cover and add-on it's attached to, while the insured person under the Premium Protection Functional Impairment benefit is functionally impaired as defined.
- The premiums will begin to be waived following the expiry of the waiting period or when the claim is admitted, whichever is the later.
- Premiums will continue to be waived until the Premium Protection Functional Impairment term ends.
- At the end of the term for Premium Protection Functional Impairment, the premiums of the cover, add-ons and other benefits and features will once again become payable.

Example

Alan has Life Cover with a Severe Illness Cover add-on. He takes out Premium Protection Functional Impairment on his Life Cover. If Alan becomes functionally impaired, his premiums on Life Cover and the Severe Illness Cover add-on will be waived if he is still functionally impaired after the six-month waiting period.

Double functional impairment can occur when Premium Protection Functional Impairment is added to cover in conjunction with a partial cover add-on. For example, Life Cover with Functional Impairment Cover add-on that pays out 50% of the cover amount of the Life Cover. If the event causing the Functional Impairment Cover payout is also the Premium Protection Functional Impairment event, Premium Protection Functional Impairment will waive the remaining reduced premium, hence double functional impairment occurs.

Example

Karen has R800 000 Life Cover with a Functional Impairment Cover add-on, including a Partial Functional Impairment Benefit that pays out 50% of the cover amount of the Life Cover. She adds Premium Protection Functional Impairment to her Life Cover (waiving premiums on both Life Cover and Functional Impairment Cover add-on), where she's the insured person.

Example: Partial functional impairment

Karen has R800 000 Life Cover with a Functional Impairment Cover add-on and gets diagnosed with chronic respiratory failure. She meets the 50% functional impairment definition. In this case, she will get paid R200 000 (50% x R800 000 = R400 000 of the Functional Impairment Cover amount. Applying the 50% partial payout percentage to this = R200 000). She can't claim on Premium Protection Functional Impairment as she doesn't meet the 100% functional impairment definition, and must therefore continue to pay her premiums.

Example: Full functional impairment

Karen has R800 000 Life Cover with a Functional Impairment Cover add-on and gets diagnosed with chronic respiratory failure. She meets the 100% functional impairment definition. In this case, she will get paid R400 000 (50% x R800 000 = R400 00) is the Functional Impairment Cover amount. Applying the 100% payout percentage to this = R400 000). Her Functional Impairment Cover add-on falls away as she has claimed for the full cover amount. She can, however, claim on her Premium Protection Functional Impairment since as she meets the 100% functional impairment definition, and premium on the remaining R400 000 Life Cover will therefore be waived.

Waiving of premiums stop on the earliest of the following:

- The benefit end date.
- If the insured person recovers from their functional impairment.
- If the insured person fails to meet our requirements for following reasonable medical advice or adequate medical treatment and regular evaluation of their functional impairment.
- When the insured person dies.
- If the insured person no longer qualifies for the benefit because of changes to their circumstances.
- If the contract is cancelled.
- If the benefit is removed from the contract.

We'll determine the number of the premiums to waive, in line with the period of time the insured person is functionally impaired which may not exceed the average recommended period of recovery according to the latest edition of The Medical Disability Adviser: Workplace Guidelines for Disability Duration, by Presley Reed, M.D., or its replacement as determined by us. We'll consider waiving further contract premiums if the treating doctor can provide us with sufficient medical motivation in the form of specialist reports and/or test results. Any supporting medical proof that we need will be at the owner's own cost.

Example: Start paying premiums again after we stop waiving premiums

Jane takes out Life Cover where Johan, her husband, is the insured person. The term of that benefit is for life. Jane also takes out a Premium Protection Functional Impairment benefit on her life. Jane takes out this benefit when she's 45 years old. The term of the Premium Protection Functional Impairment benefit will be 20 years because the maximum end age for this benefit is 65. If Jane were to become functionally impaired two years after taking out her contract, we'll waive the contract's premiums for 18 years, until the Premium Protection Functional Impairment benefit stops waiving the premiums. Thereafter, Jane will need to start paying the premiums on the contract.

3.1.3.5 Changes to circumstances of the insured person on Premium Protection Functional Impairment

The owner must inform us if:

- The insured person start participating recurrently in any risky activities which may expose the insured person to a higher than average risk of accident or injury.
- The insured person makes a change to their occupational circumstances:
  - occupation or any detail of their occupation,
  - industry or
  - starts/stops a second occupation or changes the number of hours per week that they work.
- The insured person's health/medical status changes (they recover or their condition improves) while we are waiving the contract's premiums.
- The insured person dies.

3.1.3.6 Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that is generally excluded.

We won't pay if:

- the owner fails to meet our requirement to tell us about changes to the circumstances of the insured person (See changes to the circumstances of the insured person),

- the insured person refuses to follow reasonable medical advice or adequate medical treatment or
- the insured person's functional impairment is caused by:
  - unrest, war or terrorist activity,
  - radioactivity or nuclear explosion,
  - them provoking, committing or attempting to commit a crime for example murder, assault, housebreaking, theft, robbery, the forceful detention of another person or any similar crime or
  - self-inflicted injury.

We won't waive the premium if:

- the insured person's functional impairment is before the cover start date.
- we don't recognise the insured person's functional impairment.
- the waiting period isn't met.

We won't recognise the insured person's functional impairment if they suffer a functional impairment:

- that's not on the list of functional impairments
- that doesn't meet all the requirements that the functional impairment must meet to qualify.

3.1.3.7 Premium Protection Functional Impairment stops on the earliest of the following:

- When the insured person dies.
- The end of the benefit term.
- If the benefit lapses.
- If the insured person no longer qualifies for the cover because of changes to their circumstances.
- If the contract is cancelled.
- If the benefit is removed from the contract.

3.1.4 Premium Protection Retrenchment

Premium Protection Retrenchment waives the contract's premiums and ensures that the cover continues for a maximum of 12 months at a time when the insured person is retrenched after the cover started and if the waiting period and exclusion period requirements have been met. An owner can claim a maximum of three times on Premium Protection Retrenchment. It can be added on its own or together with Premium Protection Disability or Premium Protection Functional Impairment.

PREMIUM PROTECTION RETRENCHMENT CAN BE ATTACHED TO	
• Life Cover	• Functional Impairment Cover
• Life Income Cover	• Physical Impairment Cover
• Last Survivor Cover	• Accidental Disability and Death Cover
• Accidental Death Cover	• Severe Illness Cover
• Disability Cover	• Future Life Cover

3.1.4.1 Premium Protection Retrenchment product features

TYPE OF COVER	ADD-ON BENEFIT
Eligible lives	· Employed lives for selected occupations, subject to entry age limits and underwriting. · At the date of application the insured person must have been continuously employed in a permanent full-time job for at least two years, of which at least one year must have been with their existing employer. · The following insured persons won't qualify for Retrenchment Cover: contract workers, part-time workers, temporary workers, casual workers, seasonal workers, self-employed, sole proprietor, business partner, unemployed, employed in a family business where they are a member of the family, or employed where the employer, branch, office or business is outside South Africa or Namibia. · Insured persons working in the following industries won't qualify for Retrenchment Cover: mining, fishing, building, sports, taxi, debt collecting, civil service, state-owned enterprise, or in an industry associated with any of the above.
Premium term	Takes on the premium term of the cover it's attached to, subject to the benefit term.
Compulsory yearly premium increase	The premium increase will depend on the change in premium of the cover it's attached to.
Guarantee term	1 year
Cover amount limits	None (subject to financial underwriting)
Relationship to owner	There must be an insurable interest if the owner and insured person aren't the same person.
Maximum number of insured persons	One
Entry age limits	**Minimum:** 18 next birthday **Maximum:** 60 next birthday
Premium frequency	Takes on the premium frequency of the cover it's attached to.

Benefit term	The premium term of the cover it's attached to, subject to a maximum term of the contract anniversary immediately preceding the insured person on Premium Protection Retrenchment's 65th birthday. · If attached to term or whole life cover with a premium term equal to the benefit term, the benefit term will be the shorter of: – benefit term, or – 66 next birthday minus the insured person on Premium Protection Retrenchment's age next birthday on cover start date. · If attached to term or whole-life cover with a premium term to retirement, the benefit term will be the shorter of: – owner's retirement age minus current age next birthday on contract start date, or – 66 next birthday minus the insured person on Premium Protection Retrenchment's age next birthday on contract start date.
Cover end age	66 next birthday
Scheduled yearly cover increase	The cover increase will depend on the change in premium of the cover it's attached to.
Underwriting method	Medical tests, questions or both
Underwriting credit	None

3.1.4.2 Definitions

· **Retrenched** means that the insured person stops practising their occupation because their employment is terminated by their employer because or in anticipation of, business conditions or decisions that result in staff reduction.

The insured person isn't retrenched if:

– they retire,
– they resign or chose voluntary retrenchment,
– they are dismissed,
– their fixed-term employment contract comes to an end or
– they are medically boarded because of a nervous breakdown, stress, burnout, disability or sickness.

· **Employment and employed** means a contractual relationship between two parties in terms of which an employer pays an employee to perform a job, service or task.

· **Government action** means regulatory actions taken by a government to affect or interfere with decisions made by individuals, groups, or organisations regarding social and economic matters.

3.1.4.3 Exclusion period

- No claims will be paid within 12 months of the cover start date.
- This exclusion will restart with effect from the date of any cover increase, other than as a result of scheduled yearly cover increases, but will only apply to the increased portion of cover.
- The insured person must have been in continuous full time employment for 12 months before they can have a subsequent valid claim on retrenchment. They don't need to be employed by the same employer, they only need to be continuously employed during this period.

3.1.4.4 Waiting period

- A waiting period is the number of consecutive days or months during which the insured person doesn't become employed before we'll start waiving the contract's premiums.
- It starts on the date of retrenchment as confirmed by us and ends one calendar month later.
- Premiums must continue to be paid during the waiting period and while we decide whether the claim is valid. If we've received any premiums after the end of the waiting period, we'll refund those premiums. We won't pay interest on this refund.
- At the end of the term for Premium Protection Retrenchment, the premiums of the cover, add-ons and other benefits and features will once again become payable.
- If the contract is cancelled before the waiting period ends, we won't start waiving the contract's premiums.

Example

The date of Frank's retrenchment is 1 January 2016. The one-month waiting period would end at midnight on 31 January 2020. If the premium is due on the 1st of the month, we'll start waiving the contract's premiums on 1 February 2020.

Example: Start paying premiums again after we stop waiving premiums

Johan takes out Disability Cover where he is the insured person. He also takes out a Premium Protection Retrenchment benefit. Johan is retrenched for two years. We'll waive his contract's premiums for 12 months because we'll only waive the contract's premiums for up to 12 months for each claim. After this, Johan will need to start paying the contract's premiums again.

Waiving of premiums stop on the earliest of the following:

- The benefit cover end date.
- If the insured person becomes employed.
- When we've waived the last premium that the insured person qualifies for.
- When the insured person dies.
- If the insured person no longer qualifies for the benefit because of changes to their circumstances.
- If the contract is cancelled.
- If this benefit is removed from the contract.

3.1.4.5 Changes to circumstances of the insured person on Premium Protection Retrenchment

The owner/insured person must inform us if:

- They make a change to their occupational circumstances:
  - occupation or any detail of their occupation,
  - industry or
  - employment type.
- They start/stop a second occupation or changes the number of hours per week that they work.
- They become:
  - a company director,
  - a business partner,
  - an employee of a company that has its head office based outside South Africa or Namibia, or
  - employed in a family business where they are a member of the family.
- The insured person dies.

3.1.4.6 Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that is generally excluded.

We won't pay if:

- the owner fails to meet our requirement to tell us about changes to the circumstances of the insured person (See changes to the circumstances of the insured person),
- the insured person is retrenched as a result of government action.

We won't waive the premium:

- If the insured person receives notice of retrenchment at any time before the cover start date.
- If the insured person is retrenched or receives notice of retrenchment within 12 months from the cover start date.
- After three valid claims.
- If the insured person:
  - wasn't continuously employed for 12 months or
  - didn't qualify for this benefit at any time during the 12 months before they were retrenched again.
- If the waiting period isn't met.

3.1.4.7 Premium Protection Retrenchment stops on the earliest of the following:

- After three valid claims.
- When the insured person dies.
- The end of the benefit term.
- If the benefit lapses.
- If the insured person no longer qualifies for the cover because of changes to their circumstances.
- If the contract is cancelled.
- If the benefit is removed from the contract.

3.2 PREMIUM PROTECTION EVENTS

3.2.1 Premium Protection Disability and Premium Protection Functional Impairment

CARDIOVASCULAR	
Arrhythmia	The diagnosis of an arrhythmia by a medical specialist. **With evidence of the following, despite adequate medical treatment:** • Shortness of breath so severe that symptoms are present at rest (NYHA, Class IV), and • Symptoms of palpitations and syncope or dizziness correlating with ECG evidence of serious arrhythmia are present daily.
Congestive cardiac failure	The diagnosis of congestive cardiac failure by a specialist cardiologist or physician as a result of coronary artery disease or valvular heart disease or diseases of the aorta or pericardial disease. **With evidence of the following:** • Ejection fraction consistently less than 40% after adequate medical treatment, and shortness of breath so severe that symptoms are present during less than ordinary activity or at rest (NYHA Class lll - IV), or • Awaiting cardiac transplantation.
Hypertension	The diagnosis of uncontrolled hypertension confirmed by a medical specialist. **With evidence of diastolic pressure greater than or equal to 110 mmHg on adequate treatment and complicated by 2 or more of the following:** • Stage 4 Kidney dysfunction • Cerebrovascular incident (excluding transient ischaemic attacks) confirmed by neuroimaging • Echocardiogram evidence of LVH (septal wall thickness to posterior LV wall thickness 1.3:1) • Grade IV retinopathy • Congestive cardiac failure with evidence of an ejection fraction consistently less than 45% after adequate medical treatment, and marked limitation in activity due to symptoms, even during ordinary or less than ordinary activity e.g. walking short distances (NYHA Class ll - III).
Peripheral arterial disease	The diagnosis of peripheral arterial disease of the lower limbs by a vascular surgeon. **With evidence of no recordable pulse on Doppler readings, and 1 of the following:** • Severe Vascular Ulceration, or • Gangrene secondary to peripheral arterial disease.
RESPIRATORY	
Chronic respiratory failure	The diagnosis of a chronic respiratory failure by a pulmonologist. **With persistent evidence of at least 1 of the following, despite adequate medical treatment:** • Impaired airflow with FEV1 less than or equal to 40%, or • FVC less than or equal to 50%, or • DLCO of less than or equal to 40%.
Pulmonary arterial hypertension	The diagnosis of Pulmonary Arterial Hypertension by a medical specialist. **With evidence of a Systolic Pulmonary Artery Pressure greater than 70 mmHg and complicated by at least 1 of the following:** • Right sided heart failure, or • Shortness of breath so severe that symptoms are present at rest (NYHA Class IV).

GASTROINTESTINAL	
Ano-rectal impairment	Faecal incontinence • **With evidence of complete faecal incontinence despite adequate medical and/ or surgical treatment by a gastroenterologist or equivalent specialist.**
Chronic gastrointestinal disease	The diagnosis of a chronic gastrointestinal disease by a gastroenterologist or equivalent specialist, as a result of a medical condition. **With evidence of the following:** • Medical findings confirming organic disease, and • Significant unintentional weight loss resulting in a BMI of less than 15 or 25% weight loss below the lower limit of the normal range for the individual, and • Symptoms uncontrolled by medical or surgical treatment. Psychiatric conditions are excluded.
Chronic liver failure	The diagnosis of chronic end-stage liver failure, with a Child Pugh classification of Class C, by a gastroenterologist or equivalent specialist.
UROGENITAL	
Bladder impairment	The diagnosis of a bladder impairment despite adequate surgical and medical treatment by a nephrologist or urologist. **With evidence of 1 of the following:** • No detectable reflex or voluntary urine control as a result of organic pathology, resulting in urinary incontinence, or • Total bladder resection, or • Chronic disorders of the bladder and its structures that require a permanent indwelling catheter.
Chronic kidney failure	The diagnosis of chronic renal failure despite adequate medical treatment by a nephrologist or urologist. **With evidence of 1 of the following:** • End-stage renal disease with an estimated GFR less than 24ml/min, or • Creatinine clearance of less than 28 ml per minute, or • Renal function deterioration that requires life-long peritoneal dialysis or lifelong haemodialysis.
CENTRAL NERVOUS SYSTEM	
Impaired consciousness	The diagnosis of a coma of a specified severity by a neurologist or neurosurgeon. Medically induced comas are excluded. **With evidence of the following for 14 days or more:** • A decreased level of consciousness, with a Glasgow Coma Scale of less than 9, and • Requiring total medical support including intubation and assisted ventilation.
Aphasia	The diagnosis of aphasia by a neurologist or neurosurgeon. **With evidence of the following:** A total inability to express oneself or communicate (through speech, writing, or signs), or to comprehend spoken or written language, due to injury or disease of the brain, and • Deficits in the formal aspects of language such as naming, word choice, comprehension, spelling and syntax, and • Objective medical findings supporting the diagnosis of aphasia. Psychiatric conditions are excluded.

Cranial Nerve VII	The diagnosis of facial nerve paralysis confirmed by a neurologist or neurosurgeon. **With persistent evidence of the following:** • Slight or no movement of the face, and • An inability to actively close the eyelids, and • Slight or no movement of the mouth.
Cranial Nerve VIII	The diagnosis of Vestibulocochlear nerve paralysis confirmed by a neurologist or neurosurgeon. **With evidence of the following:** • Nerve damage with severe imbalance resulting in limitation of Activities of Daily Living such that the insured person is unable to perform 3 of the Basic Activities of Daily Living or 4 of the Advanced Activities of Daily Living.
Cranial Nerves IX, X, XII	The diagnosis of Cranial Nerve IX, X, XII paralysis confirmed by a neurologist or neurosurgeon. **With evidence of the following:** • An inability to swallow or process oral secretions without choking, and • Need for external suctioning device, and • Medical findings confirming organic disease.
Epilepsy	The diagnosis of epilepsy by a neurologist or neurosurgeon supported by objective medical findings and resistant to optimal therapy as confirmed by drug serum-level testing. **With evidence of the following:** • 3 or more generalised seizures per week for at least 3 consecutive months, and • An inability to perform 3 of the Basic Activities of Daily Living or 4 of the Advanced Activities of Daily Living.
Hemiplegia	The total loss of the functioning of one side of the body due to an injury or disease of the brain as confirmed by a neurologist or neurosurgeon and correlating with objective medical findings.
Dementia (incl. Alzheimer's Disease)	The diagnosis of dementia by a neurologist, physician or neurosurgeon **With evidence of the following:** • A diminished intellectual ability (may include personality changes and episodes of confusion), and • A score of 2 under the 5 point Clinical Dementia Rating scale, and • Needs constant supervision.
Paraplegia/ Diplegia	The total loss of the functioning of both legs or both arms due to an injury or disease of the brain or spinal cord. This must be confirmed by a neurologist or neurosurgeon and correlate with objective medical findings.
Quadriplegia	The total loss of the functioning of both legs and both arms due to an injury or disease of the brain or spinal cord. This must be confirmed by a neurologist or neurosurgeon and correlate with objective medical findings.

CANCER	
Cancer	The diagnosis of an advanced stage of cancer as confirmed by an oncologist with supporting documentation. **With evidence of the following:** • Diagnosis of at least a Stage III cancer, and the insured person is unable to perform 2 of the Basic Activities of Daily Living or 3 of the Advanced Activities of Daily Living, or • Stage IV cancer, or • Cancer which has resulted in organ failure will be assessed under the affected organ. Organ failure will only be assessed under the following definitions: Congestive cardiac failure or Chronic respiratory failure or Chronic liver failure or Chronic kidney failure or Organic brain disorders/dementia
SENSES	
Loss of sight	Confirmed diagnosis of bilateral loss of sight by an ophthalmologist. The loss of sight cannot be improved through refractive correction or medication. **With evidence of 1 of the following:** • A reading of 6/60 or worse (or equivalent measure on a non-metric scale) in each eye after best correction, or • Severe proliferative diabetic retinopathy, or • Grade IV hypertensive retinopathy, or • Permanent Hemianopia in both eyes, or • A visual field loss to a 10° radius in the better eye. Loss of sight due to cataracts is excluded, unless there is evidence of failed cataract surgery or contraindications to cataract surgery.
Loss of hearing	Total loss of hearing in both ears as confirmed by an ear, nose and throat surgeon. **With evidence of the following:** • Audiometry measurements, done with the use of hearing aids, with an average loss of greater than 87dB.
Loss of speech	The total loss of the ability to produce intelligible and audible speech due to injury or disease, as confirmed by an ear, nose and throat surgeon, neurologist or neurosurgeon. • Objective medical evidence of an ear, nose and throat disorder causing the impairment must be provided. Loss of speech due to psychiatric causes are excluded.
ENDOCRINE	
Endocrine disorders	The diagnosis of an endocrine disorder, which despite adequate medical and surgical treatment, has resulted in organ failure, as confirmed by a medical specialist. Organ failure will only be assessed under the following definitions: Congestive cardiac failure or Chronic respiratory failure or Chronic liver failure or Chronic kidney failure or Organic brain disorders/dementia

PSYCHIATRIC	
Psychiatric disorder	The diagnosis of a psychiatric disorder, as confirmed by a specialist psychiatrist. Resulting in continuous institutionalisation and **With evidence of the following:** • persistent GAF score of 40 or less certified under the DSM IV classification, or • persistent WHODAS average domain score of 4 certified under the DSM 5 classification
TRAUMA	
Facial Disorders or Disfigurement	Total facial disfigurement as confirmed by a maxillofacial specialist or related specialist. There should be destruction or loss of skin, bone, or muscles that requires reconstructive surgery.
Major Burns	The diagnosis of third degree burns (full thickness burns) by a plastic surgeon or trauma specialist.
	With evidence of at least: • 30% of total body surface affected as measured on the Lund and Browder Chart or equivalent scale, or • more than 50% of the combined surface area of the bilateral upper limbs affected including involvement of at least 60% of combined surface area of the palms of both hands; and restriction of joint mobility of at least two of the following: 3 fingers; wrist or elbow.
HAEMATOLOGY	
Clotting disorders	The diagnosis of a clotting disorder, which despite adequate medical and surgical treatment, has resulted in organ failure, as confirmed by a medical specialist. **Organ failure will only be assessed under the following definitions:** Congestive Cardiac Failure or Chronic respiratory failure or Chronic liver failure or Chronic kidney failure or Organic Brain Disorders/ Dementia
Red blood cell disorders	The diagnosis of severe chronic anaemia by a physician or haematologist. **With evidence of the following:** • Hb persistently less than 8g/dL, and • Requiring 2-3U of blood every 2 weeks.
White blood cell disorders	The diagnosis of a severe white blood cell disorder by a physician or haematologist. **With evidence of 1 of the following:** • An absolute neutrophil count of less than 250, resulting in at least 3 hospitalisations per year for acute bacterial infections, or • Lymphoma or leukaemia requiring at least 3 chemotherapy regimens per year.

MUSCULOSKELETAL	
Chronic spinal column conditions	• A history of chronic pain syndrome due to a chronic spinal condition for a duration of at least two years. It must be treated by a multidisciplinary pain management team with at least three of the four requirements listed below, which must be confirmed by an orthopaedic or neurosurgeon. All these criteria must be present in the same region, as defined below, for a valid claim to be paid, or • Confirmed diagnosis of cauda equina syndrome resulting in bowel or bladder dysfunction. Spinal Regions: The neck and lower back are part of the spine. The spinal regions are: • Cervical region (C1-C7). • Thoracic region (T1-T12) and • Lumbosacral region (L1-S1). The C7 to T1 joint will be classified in the cervical region, and the T12 to L1 joint in the thoracolumbar region.
Chronic spinal column conditions	List of four requirements: 1. 50% or more compression of a vertebral body or multiple level compression fractures giving rise to kyphotic deformity. 2. Clinically significant radiculopathy (motor and sensory deficit or muscle atrophy and clinical signs of nerve tension and radiological evidence at the same site as clinically found. NB – We will not accept radiological signs of nerve compression without clinical evidence of neurological involvement as proof of functional impairment. 3. Alteration of motion segment integrity confirming instability with neurological deficit. 4. Multiple back or cervical operations (i.e. two or more on separate occasions within a period of 5 years) comprising laminectomy, discectomy or fusion, or a combination thereof.
Combination of loss of use of an upper and lower limb	The total loss of use of an upper and a lower limb appendage as defined below: • a foot at the transverse tarsal joint (Chopart's joint), • a leg at or above the ankle joint up to the hip joint, • a hand (at the metacarpophalangeal joint), • an arm at or above the wrist joint up to the shoulder joint, as confirmed by an orthopeadic or neurosurgeon.
Loss of use of both hands or arms	The total loss of use of: • both hands at the metacarpophalangeal joints, or • both arms at or above the wrist joint up to the shoulder joint, or • one hand at the metacarpophalangeal joint and one arm at or above the wrist joint up to the shoulder joint, as confirmed by an orthopaedic or neurosurgeon.
Loss of use of both feet or legs	The total loss of use of: • both legs at or above the ankle joint up to the hip joint, or • both feet at the transverse tarsal joint (Chopart's joint), or • one foot at the transverse tarsal joint (Chopart's joint) and one leg at or above the ankle joint up to the hip joint, as confirmed by an orthopaedic or neurosurgeon.

HIV/AIDS	

AIDS	The clinical manifestation of AIDS/Stage 4 HIV infection, as confirmed by a medical specialist.
	
	With evidence of the following:
	• Positive HIV antibody test (or other recognised test for the presence of AIDS, acceptable to
	• Old Mutual), and CD4 cell count of less than 200 despite compliance with anti-retroviral treatment as per latest National Guidelines, and either:
	  • The presence of 3 or more of the following 5 conditions:
	1. Weight loss of more than 10% body weight in less than 6 months
	2. Shingles
	3. Oral thrush
	4. Chronic diarrhoea
	5. Active tuberculosis
	
	Or:
	  • The diagnosis of one or more of the following 8 diseases:
	1. Kaposi's sarcoma,
	2. Candidiasis of oesophagus, trachea, bronchi or lungs,
	3. Oral hairy leukoplakia,
	4. Pneumocystis carinii pneumonia,
	5. Extra pulmonary Cryptococcus,
	6. Cytomegalo virus infection of an internal organ other than the liver,
	7. Disseminated atypical mycobacteriosis,
	8. Visceral leischmaniasis

ACTIVITIES OF DAILY LIVING

Any illness, condition or event that results in the insured person being unable to perform 3 **of the Basic Activities of Daily Living** or **4 of the Advanced Activities of Daily Living** as specified below.

Old Mutual's Medical Officer must confirm that:

- The insured person has undergone adequate medical treatment and has reached an adequate level of functioning that can reasonably be expected of a person suffering from the illness, condition or event, and
- The insured person does not qualify, as a result of suffering from an illness, condition or event, for the payment of the cover amount for any other listed Functional Impairment under this benefit.
- Where applicable, the activities listed below must be performed with simple external assistive devices (e.g. walking stick, Zimmer frame), but without complex external assistive devices (e.g. wheelchair, leg prosthesis).
- The general meaning of the terms 'simple external assistive devices' and 'complex external assistive devices' is not limited by the specific examples quoted or the class or type of the examples quoted.

BASIC ACTIVITIES OF DAILY LIVING	
Activity	**Description**
Bathing	The ability to wash/bathe oneself independently
Transferring	The ability to move oneself from a bed to a chair or from a bed to a toilet independently
Dressing	The ability to take off and put on one's clothes independently
Eating	The ability to feed oneself independently. This does not include the making of food
Toileting	The ability to use a toilet and cleanse oneself thereafter, independently
Locomotion on a level surface	The ability to walk on a flat surface, independently

ADVANCED ACTIVITIES OF DAILY LIVING	
Activity	**Description**
Driving a car	The ability to open a car door, change gears or use a steering wheel
Medical care	The ability to prepare and take the correct medication
Money management	The ability to do one's own banking and to make rational financial decisions
Communicative activities	The ability to communicate either verbally or written
Shopping	The ability to choose and lift groceries from shelves as well as carry them in bags
Food preparation	The ability to prepare food for cooking as well as using kitchen utensils
Housework	The ability to clean a house or iron clothing
Community ambulation with or without assistive device, but not requiring a mobility device	The ability to walk around in public places using only a walking stick if necessary

3.3 CASHBACK

Cashback is a feature that can't exist on its own and can be attached to Old Mutual Protect products.

- The owner will always be the cashback recipient. If there are multiple owners, only one can be selected as the recipient.
- Cashback will only accrue if the owner has cashback attached to their cover.
- The cashback feature will take on all the attributes of the product it's attached to such as premium frequency, premium payment method, premium payer etc.

Cashback can be added to all benefits except:

- Business Life Cover
- Business Expenses Cover

3.3.1 How cashback is calculated

- Cashback is calculated at 15% of total premiums that the owner has successfully paid to us for the product that it's added to, over a period of 60 months since the previous cashback anniversary date.
- Where the premium has been waived due to a requested premium holiday or a claim, these premiums won't be used in the calculation of the cashback.
- Any premium that is reversed or refunded won't be used in the calculation of the cashback.

3.3.2 How flexible is cashback?

- Owners can cancel the cashback feature at any time. Whatever has been accrued towards the cashback will be paid at a future cashback date, provided the cover to which it's attached is in force at the cashback payment date.
- If the cover is cancelled for any particular reason, any accrued cashbacks will be lost.
- Contract changes may adjust cashback terms. For example, if the premium on the cover to which the cashback is attached changes, the premium charged for the cashback will change.
- Where a contract lapsed and subsequently was restarted, the cashback value accrued to date would continue and be paid at the payment date of the cashback, provided the contract is in force at that time. During the period when the contract had lapsed, no cashbacks accrued due to no premiums having been paid. Cashback only accrues while the contract is active and premiums are being are paid.

3.3.3 Payment date of cashback

- The cashback will be paid on every fifth cashback anniversary and the contract must be active at that point.
- Where a successful claim results in a contract terminating, the cashback accrued will be lost.
- If the payment date of the cashback was during the period when the contract had lapsed and the contract subsequently revives, the accrued cashback until that payment date of cashback will be paid once the contract is active again. However cashback will only be calculated based on the premiums that we received.

3.3.4 Cashback guarantee term

- The guarantee term is the term during which we guarantee that the premium of the cashback will remain unchanged except in the circumstances indicated below, assuming that no changes are made by the owner to the product to which the cashback is attached.
- Premiums will change during the guaranteed term if:
  - **Compulsory yearly premium increases** (fixed rate or age-linked compulsory yearly premium increases) are selected – premiums will increase by the compulsory yearly premium increase rate every year on the cashback premium itself as well as due to the impact of the compulsory yearly premium increases on the premiums of the cover to which the cashback is attached.
  - **Scheduled yearly cover increases are selected** – premiums for the cover will increase to pay for the extra layers of cover every time a scheduled yearly cover increase is exercised which will inherently increase the cashback premium as a by-product of the cashback being attached to the cover.
  - **Changes are made by the owner** (e.g. voluntary cover increase), or changes occur in the insured person's rating factors (e.g. occupation)-The impact to cover will have a second-order impact on the cashback premium which derives its cost from the cover premium.

LIFE INSURANCE

OLD MUTUAL PROTECT LIFE INSURANCE

Life insurance is a contract between an owner and an insurer, where the insurer promises to pay a designated beneficiary a sum of money in exchange for a premium when the insured person dies during the benefit term. The insurance amount can be paid as a single amount or monthly amounts.

Within each type of cover various add-ons, benefits and other features can be attached to enhance the cover, depending on the customer's needs.

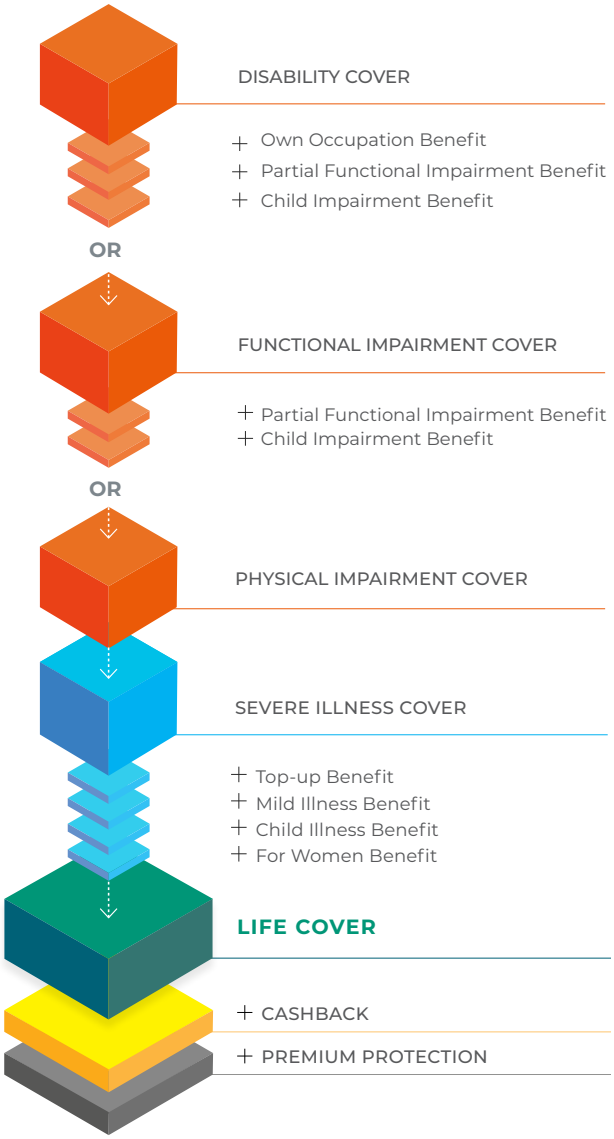
We offer the following cover under Old Mutual Protect Life Insurance:

- Life Cover
- Life Income Cover
- Last Survivor Cover
- Accidental Death Cover

4. LIFE COVER

Life Cover pays the cover amount as a single amount when the insured person dies or becomes terminally ill.

4.1 Life Cover overview



Life Cover is designed for customers with the following needs:

- Want to protect themselves or their families against financial consequences of death or terminal illness.
- Want to be able to adjust their cover as their needs change.
- Want to pay off a bond if any of the above events happen.
- Are looking for cover over a specific length of time.
- Want to mitigate the expected inheritance/estate duty tax.

4.2 Life cover Product features

TYPE OF COVER	COVER THAT PAYS OUT A SINGLE AMOUNT
Eligible lives	All lives are eligible, subject to entry age limits and underwriting.
Relationship to owner	There must be an insurable interest if the owner and insured person aren't the same person.
Maximum number of insured persons	One
Entry age limits	**Minimum:** 15 next birthday **Maximum**: 80 next birthday
Premium frequency	Monthly Monthly with the option to skip one premium a year Yearly
Premium term	Benefit term or Retirement (minimum premium term of 10 years)
Compulsory yearly premium increase	0% fixed rate 5% fixed rate Age-linked
Guarantee term	5 years 10 years 15 years
Cover amount limits	**Minimum**: R100 000 **Maximum**: · Employed: None (subject to salary) · Home executives: R4 000 000 (subject to three times yearly salary of the spouse/partner for cover above R2 500 000) · Students: R1 000 000 · Unemployed: R650 000
Benefit term	Whole-life Term (minimum of 5 years)

Cover end age	Whole-life 100 next birthday for term cover
Scheduled yearly cover increase	0% fixed rate 5% fixed rate 10% fixed rate Inflation-linked: CPI + 0%, 1%, 2%, 3%, -1%, -2% Currency-linked: · R/GB Pound exchange rate + 0%, 5%, 10%, UK inflation · R/US Dollar exchange rate + 0%, 5%, 10%, Dollar inflation · R/EUR exchange rate 0%, 5%, 10%, Euro inflation
Underwriting method	· No medical tests, only questions · Medical tests, questions or both
Underwriting credit	If the insured person completed 'medical tests, questions or both' for an amount less than the upper limit of a particular underwriting band, they could qualify for: · Single underwriting credit · Comprehensive underwriting credit

4.3 Automatic features

Terminal illness

If the insured person is diagnosed with a medical condition which, at the discretion of Old Mutual's Medical Officer will result in death within 12 months, the owner may request the payment of a terminal illness benefit. The amount of the terminal illness benefit is the full cover amount of Life Cover at the time of claim and a successful claim will result in the Life Cover stopping. The terminal illness payout isn't available in the last year of the benefit term if term cover was selected.

Terminal illness benefit stops on the earliest of the following:

- When the insured person dies.
- On the benefit end date.
- If the benefit lapses.
- If the contract is cancelled.
- 12 months before the benefit end date, if term cover was selected.

4.4 Add-ons

Cover

A maximum of two cover add-ons may be attached to enhance the Life Cover with a combination of the following:

- Disability Cover or Functional Impairment Cover or Physical Impairment Cover

  and/or

- Severe Illness Cover

The insured person on the cover add-on must be the same as the insured person on the Life Cover.

See the respective sections for more details.

Premium protection

A maximum of two premium protection benefits may be selected with a combination of the following:

- **Premium Protection Death**

  The insured person on Premium Protection Death must be different from the insured person on the cover.

- **Premium Protection Retrenchment**

  The insured person on Premium Protection Retrenchment must be the same as the insured person on the cover.

- **Premium Protection Disability or Premium Protection Functional Impairment**

  The insured person on Premium Protection Disability or Premium Protection Functional Impairment doesn't have to be the same as the insured person on the cover.

Adding Premium Protection Death will preclude the addition of Premium Protection Retrenchment and vice versa. See Premium Protection for more details.

Cashback

See Cashback for more details.

Linked Cover

See Retrenchment Cover for more details.

4.5 Conversion option

A term cover conversion option is available on this product when the product reaches the end of its term. See Changing the contract.

4.6 Claiming Life Cover

- The single amount payable will be the same as the cover amount at the date of the claim.
- All premiums received after the approved claim event will be refunded.
- Scheduled yearly cover increases will not be taken into account if it's applied after the claim event date but before we approve the payout.
- Life Cover with no cover add-on:

  On the death or terminal illness of the insured person, the full cover amount for the Life Cover will be paid as a single amount.

  Example
  Julian has R1 000 000 Life Cover on Lydia's life. On her death, Julian submits a claim and will receive a single amount of R1 000 000.

  Life Cover with one cover add-on:

  On the death or terminal illness of the insured person, the full cover amount of the Life Cover will be paid as a single amount. However, while the insured person is alive and the cover remains on books, any of the events covered under the add-on can result in a claim. A claim on any of these events will reduce the cover amount of the cover add-on, the cover amount of the Life Cover and any linked cover.

  Example
  Xander has R1 000 000 Life Cover on Jackie's life with a R500 000 Severe Illness Cover add-on. Jackie suffers a heart attack assessed at a 75% severity, with a claim payout of R375 000. Both the Severe Illness Cover add-on and the Life Cover will reduce by R375 000. After the claim payout, the cover amount for the Life Cover will be R625 000 with Severe Illness Cover add-on of R125 000.

Life Cover with two cover add-ons:
On the death or terminal illness of the insured person, the full cover amount of the Life Cover will be paid as a single amount. However, while the insured person is alive and the cover remains on books, any of the events covered under either of the cover add-ons can result in a claim. A claim on any of these events will reduce the cover amount of the respective add-on, the cover amount of Life Cover and any linked cover.

Example
Camilla has R1 000 000 Life Cover on Colin's life with a R500 000 Severe Illness Cover add-on and R500 000 Disability Cover add-on. Colin suffers an injury and is assessed to be permanently disabled under the reasonable occupational definition and is paid out the full cover amount of R500 000 as a single amount. The Disability Cover reduces to R0 and stops and Life Cover will reduce by R500 000 while Severe Illness Cover add-on will be unaffected. The Life Cover will then be equal to R500 000 with Severe Illness Cover add-on of R500 000.

The claim payout on one cover add-on won't impact the cover amount on the other cover add-on unless the claim payout causes the cover amount of the Life Cover to reduce lower than the cover amount of the cover add-on. In this instance the cover amount of the cover add-on will reduce to be equal to the cover amount of the Life Cover.

Example
Demi has R1 000 000 Life Cover on Leanne's life with a R700 000 Severe Illness Cover add-on and R1 000 000 Physical Impairment Cover add-on. Leanne suffers a stroke with a 100% severity and is paid out the full cover amount of R700 000 as a single amount. The Severe Illness Cover add-on reduces to R0 and ceases and Life Cover reduces by R700 000. As the remaining cover on Life Cover (R300 000) is less than the R1 000 000, the cover amount of the Physical Impairment Cover add-on will be adjusted downward to equal the R300 000 cover amount of the Life Cover with an Physical Impairment Cover add-on of R300 000.

4.7 Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that is generally excluded.

We won't pay if:

- the insured person commits suicide within the first two years from the cover start date. A suicide is a self injury resulting in death, where, in our opinion, the insured person had the intention to take their own life. It includes so-called assisted suicide where another person helped them to take their own life.

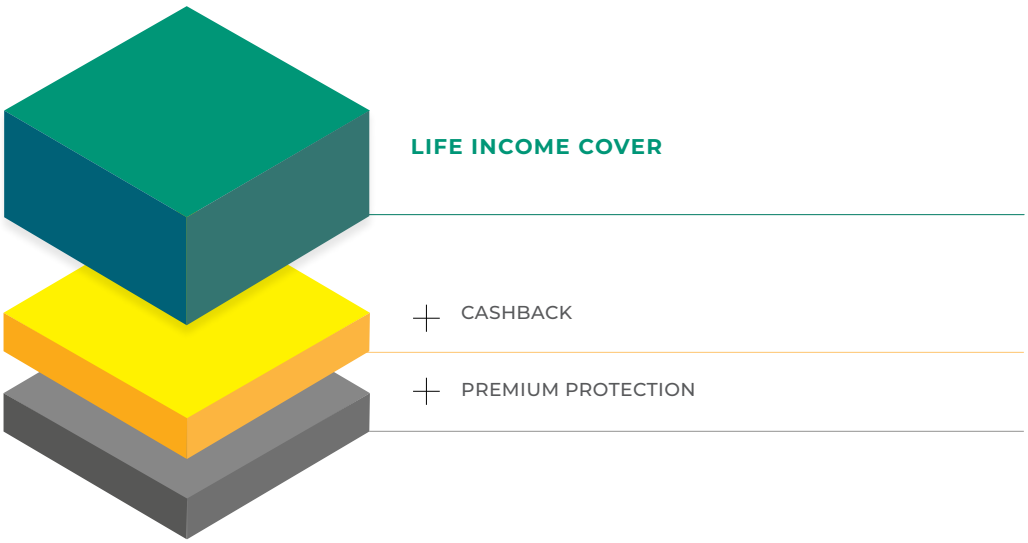
4.8 Life Cover stops on the earliest of the following:

- When the insured person dies
- On the cover end date
- If the cover lapses
- If the contract is cancelled.

5. LIFE INCOME COVER

Life Income Cover pays monthly payments when the insured person dies. The income is guaranteed for at least five years or to the end of the selected term.

5.1 Life Income Cover overview



Life Income Cover is designed for customers with the following needs:

- Want to protect themselves or their families against financial consequences of death.
- Want to be able to adjust their cover as their needs change.
- Want to provide for their dependents to pay off debt on a regular basis.
- Want to provide dependents with regular maintenance payments.
- Other needs that require a regular income to dependents on the death of the insured person.

5.2 Life Income Cover product features

TYPE OF COVER	COVER THAT PAYS MONTHLY AMOUNTS
Eligible lives	All lives are eligible, subject to entry age limits and underwriting.
Relationship to owner	There must be an insurable interest if the owner and insured person aren't the same person.
Maximum number of insured persons	One
Entry age limits	**Minimum:** 18 next birthday **Maximum**: 80 next birthday
Premium frequency	Monthly Monthly with the option to skip one premium a year Yearly
Premium term	Benefit term or Retirement (minimum premium term of 10 years)
Compulsory yearly premium increase	0% fixed rate 5% fixed rate Age-linked
Guarantee term	5 years
Cover amount limits	**Minimum**: R3 000 **Maximum**: None (subject to salary)
Benefit term	Term (minimum of 5 years)
Cover end age	100 next birthday
Scheduled yearly cover increase	0% fixed rate 5% fixed rate 10% fixed rate Inflation-linked: CPI + 0%, 1%, 2%, 3%, -1%, -2% Scheduled yearly cover increases will continue to apply while in claim status
Underwriting method	· No medical tests, only questions · Medical tests, questions or both
Underwriting credit	If the insured person completed 'medical tests, questions or both' for an amount less than the upper limit of a particular underwriting band, they could qualify for: · Single underwriting credit · Comprehensive underwriting credit

5.3 Add-ons

Premium protection

A maximum of two premium protection add-ons may be selected with a combination of the following:

- **Premium Protection Death**

  The insured person on Premium Protection Death must be different from the insured person on the cover.

- **Premium Protection Retrenchment**

  The insured person on Premium Protection Retrenchment must be the same as the insured person on the cover.

- **Premium Protection Disability or Premium Protection Functional Impairment**

  The insured person on Premium Protection Disability or Premium Protection Functional Impairment doesn't have to be the same as the insured person on the cover.

Adding Premium Protection Death will preclude the addition of Premium Protection Retrenchment and vice versa. See Premium Protection for more details.

Cashback

See Cashback for more details.

Linked cover

See Retrenchment Cover for more details.

5.4 Conversion option

A term cover conversion option is available on this product when the product reaches the end of its term.

5.5 Claiming Life Income Cover

- All premiums received after the date of claim event are refunded once the assessor confirms the insured person has died.
- Only one beneficiary may be nominated to whom the claim will be paid.
- Where the beneficiary isn't alive at time of insured person's death:
  - The owner can appoint a new beneficiary

    or
  - Where the owner is the insured person, the estate may nominate a new beneficiary for income payments or a single amount can be paid to the estate.
- Where the beneficiary dies while a claim is in payment, a single amount will be paid to the beneficiary's estate.

Example: The person receiving the monthly payment dies

While Betty is receiving the monthly payments on the Life Income Cover, she dies. At the time of her death, the insured person still qualified for another 12 monthly payments. We'll pay the present value of these 12 monthly payments to Betty's estate as a single amount.

- Claims will be paid out net of any premiums owing on the cover at the claim event date.
- The cover amount for the insured person can be claimed when they die.
- Each monthly payment is equal to the cover amount that applies on the date that we make the monthly payment.
- Monthly payments will be from the end of the calendar month in which the claim event occurred to the end of the term of the cover.

Example
Peyton has R10 000 per month Life Income Cover and she dies on 10 December 2032. We're notified of her death on 16 February 2033. The first monthly payment will pay out on 28 February 2033. On this date we'll pay a single amount retrospectively for the months since the date on which the even occurred, i.e. for December 2032, January 2033 and February 2033 inclusive. On 28 February 2033, we'll pay out a single amount of R30 000. From March onwards a monthly payment will continue to be made until the end of the benefit term.

- Life Income Cover payments are guaranteed for five years. Where the claim event occurs within five years of the Life Income Cover end date, the claim payment will continue after the end date until the end of the month, five years after the claim event date.

Example: The insured person dies less than five years before the cover end date
Brandon is the insured person on the Life Income Cover which has a cover end date of 31 March 2035. He dies on 15 March 2032. Because Brandon died less than five years before the cover end date, we'll pay 60 monthly payments. Even though the cover end date was 31 March 2035, the 60th and last monthly payment would have been made on 31 March 2037.

- In-claim escalation will apply to the claim payout provided scheduled yearly cover increases are active on the Life Income Cover before the claim event date. The scheduled yearly cover increases will apply as per the pre-claim event scheduled annual cover increase date and increase pattern, subject to normal scheduled yearly cover increase rules. No premium is applicable on the application of the scheduled yearly cover increase while the Life Income Cover is in payment.

Example
Shakirah dies on 18 July 2022. When she dies she had a 10% fixed rate scheduled yearly cover increase active on her contract scheduled for 1 October every year. The cover end date of her product is 31 November 2029. At the time of death her cover amount was R10 000 per month. On 31 July 2022 her contract will pay R10 000 and will pay monthly payments of R10 000 until September 2022.

In October the scheduled yearly cover increase will take place increasing the monthly payment for each month until September 2023 to R11 000. In October 2023 the scheduled yearly cover increase will again take place increasing the monthly payment due for the following year to R12 100 until September 2024. The scheduled yearly cover increases will continue to apply until the end of the term.

Monthly payments stop at the earliest of the following:

- When we've made the last monthly payment.

or

- When the person who receives the monthly payments dies. In this event, we'll pay the present value of the rest of the monthly payments as a single amount into their estate.

5.6 Exclusions

- General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that's generally excluded.

We won't pay if:

- the insured person commits suicide within the first two years from the cover start date. A suicide is a self injury resulting in death, where, in our opinion, the insured person had the intention to take their own life. It includes so-called assisted suicide where another person helped them to take their own life.

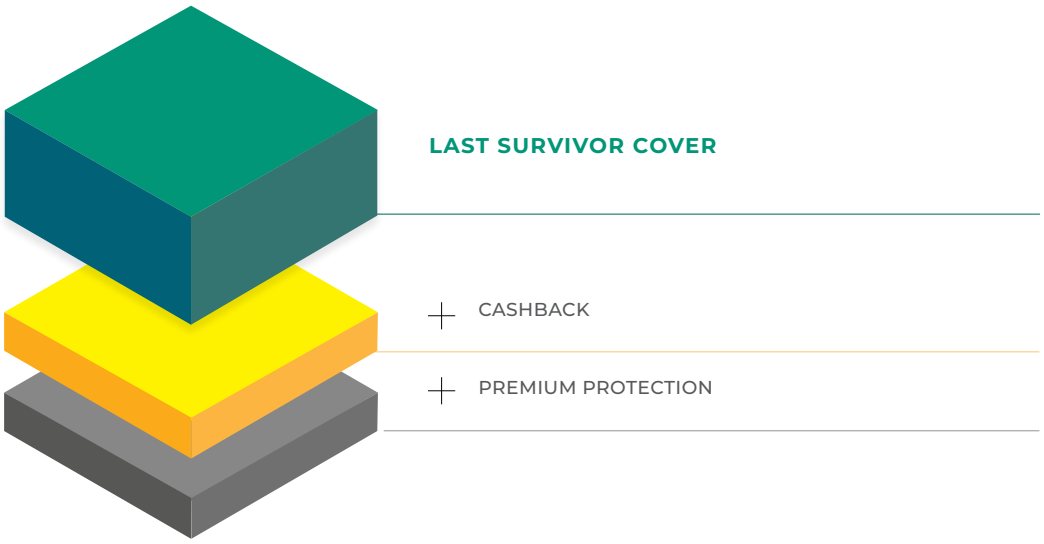
5.7 Life Income Cover stops on the earliest of the following:

- When the insured person dies.
- If the cover amount is paid when the insured person becomes terminally ill.
- On the cover end date.
- If the cover lapses.
- If the contract is cancelled.

6. LAST SURVIVOR COVER

Last Survivor Cover allows for two insured persons and pays a single amount when the last surviving insured person dies.

6.1 Last Survivor Cover overview



Last Survivor Cover is designed for customers with the following needs:

- Want to protect themselves or their families against financial consequences of death of the last surviving spouse.
- Want to be able to adjust their cover as their needs change.
- Want to mitigate the expected inheritance/estate duty tax.

6.2 Last Survivor Cover product features

TYPE OF COVER	LAST SURVIVOR COVER PAYS A SINGLE AMOUNT ON THE DEATH OF THE LAST INSURED PERSON
Eligible lives	Eligibility is subject to underwriting and age limits. Two lives must be covered at a time.
Relationship to owner	The insured person must be the same as the owner and each of the insured persons must meet the definition of spouse/partner with respect to the other insured person on the cover.
Maximum number of insured persons	Two
Entry age limits	**Minimum:** 15 next birthday **Maximum**: 80 next birthday
Premium frequency	Monthly Monthly with the option to skip one premium a year Yearly
Premium term	Benefit term or Retirement (minimum premium term of 10 years)
Compulsory yearly premium increase	0% fixed rate 5% fixed rate
Guarantee term	5 years 10 years 15 years
Cover amount limits	**Minimum**: R100 000 **Maximum**: None (subject to financial underwriting): The maximum cover amount, relative to salary, is specified in the underwriting section of this guide.
Benefit term	Whole-life
Cover end age	Whole-life of the last survivor
Scheduled yearly cover increase	0% fixed rate 5% fixed rate 10% fixed rate Inflation-linked: CPI + 0%, 1%, 2%, 3%, -1%, -2% Currency-linked: · R/GB Pound exchange rate + 0%, 5%, 10%, UK inflation · R/US Dollar exchange rate + 0%, 5%, 10%, Dollar inflation · R/EUR exchange rate 0%, 5%, 10%, Euro inflation · Scheduled yearly cover increases continue after the first death.

Underwriting method	· No medical tests, only questions · Medical tests, questions or both
Underwriting credit	If the insured person completed 'medical test, questions or both' for an amount less than the upper limit of a particular underwriting band, they could qualify for: · Single underwriting credit · Comprehensive underwriting credit

6.3 Automatic features

Terminal illness

- Is only applicable on the second insured person once the first insured person has died.
- If the last surviving insured person is diagnosed with a medical condition which, at the discretion of Old Mutual's Medical Officer will result in death within 12 months, the surviving insured person may request the payment of a terminal illness benefit.
- The amount of the terminal illness benefit is the full cover amount of the Last Survivor Cover at the time of claim and a successful claim will result in the Last Survivor Cover ending.

Terminal illness benefit stops on the earliest of the following:

- When the last insured person dies.
- If the cover lapses.
- If the contract is cancelled.

6.4 Add-ons

Premium protection

A maximum of three premium protection add-ons may be selected with a combination of the following:

- Premium Protection Death
- Premium Protection Retrenchment
- Premium Protection Disability or Premium Protection Functional Impairment

The insured person on all the Premium Protection benefits within a product must be the same and must be one of the two insured persons on the Last Survivor Cover.
If one of the insured persons of Last Survivor Cover dies, and the other insured person is the insured person on Premium Protection Death, Premium Protection Death must terminate. See Premium Protection for more details.

Cashback

See Cashback for more details.

6.5 Claiming Last Survivor Cover

The cover amount can be claimed when the last insured persons dies or becomes terminally ill. We'll pay the cover amount that applies on the date of death or terminal illness as confirmed by an Old Mutual's Medical Officer, whichever is applicable.

Example

Delilah and Kieran take out R2 000 000 Last Survivor Cover on their own lives in June 2018. On the death of Kieran in April 2044, Delilah notifies us of Kieran's death. At this stage no claim is payable. On October 2066 Delilah dies. A claim of the full cover amount of R2 000 000 becomes payable on her death.

Beneficiaries

- A beneficiary may not be nominated.
- The beneficiaries will be the same as the owner/insured person and will be split 50% under each insured person. The claim will pay into the estate of the last surviving owner.

Notification of first death

- Notification of the first death of one of the insured persons under Last Survivor Cover must reach us within 24 months of the date of death.
- If scheduled yearly cover increases are active on the cover before the death of the first insured person, scheduled yearly cover increases will continue to apply.
- Adding or changing the scheduled yearly cover increase pattern or increasing the guarantee term after the death of the first insured person won't be allowed.
- No voluntary cover increases are allowed after the death of the first insured person.

6.6 Changes to the circumstances of the insured person on Last Survivor Cover

We must be notified of the death of the first insured person.

6.7 Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that is generally excluded.

We won't pay if:

- the insured persons commits suicide within the first two years from the cover start date. A suicide is a self injury resulting in death, where, in our opinion, the insured person had the intention to take their own life. It includes "assisted suicide" where another person helped them to take their own life.

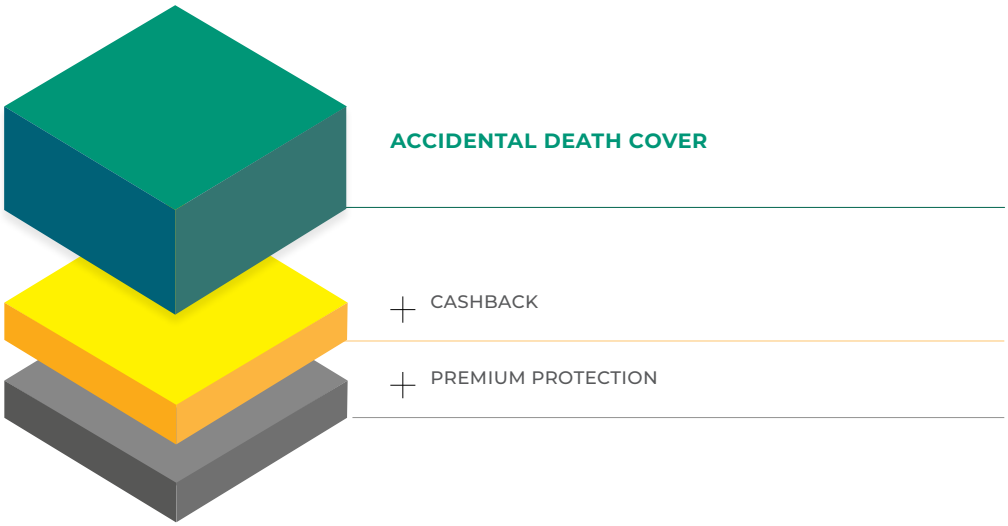
6.8 Last Survivor Cover stops on the earliest of the following:

- When we pay the cover amount for terminal illness or death of the last of the insured persons.
- If the first of the insured persons' death or terminal illness is:
  - before the cover start date or
  - because of an excluded event, activity or condition.
- On the cover end date.
- If the cover lapses.
- If the contract is cancelled.

7. ACCIDENTAL DEATH COVER

Accidental Death Cover pays the cover amount as a single amount when the insured person dies due to an accident.

7.1 Accidental Death Cover overview



Accidental Death Cover is designed for customers with the following needs:

- Want to protect themselves or their families against financial consequences of death as a result of an accident.
- If the insured person had been denied life cover due to health reasons.
- Want to supplement existing life cover to provide extra cover.

7.2 Accidental Death Cover product features

TYPE OF COVER	ACCIDENTAL DEATH COVER PAYS A SINGLE AMOUNT ON ACCIDENTAL DEATH OF THE INSURED PERSON
Eligible lives	All lives are eligible, subject to entry age limits and underwriting.
Relationship to owner	There must be an insurable interest if the owner and insured person aren't the same person.
Maximum number of insured persons	One
Entry age limits	**Minimum:** 15 next birthday **Maximum**: 60 next birthday
Premium frequency	Monthly Monthly with the option to skip one premium a year Yearly
Premium term	Benefit term or Retirement (minimum premium term of 10 years)

Compulsory yearly premium increase	0% fixed rate 5% fixed rate Age-linked
Guarantee term	5 years 10 years 15 years
Cover amount limits	**Minimum**: R100 000 **Maximum**: · Employed lives and home executives: R2 000 000 · Students and unemployed: R650 000
Benefit term	Term (minimum of 5 years)
Cover end age	65 next birthday
Scheduled yearly cover increase	0% fixed rate 5% fixed rate 10% fixed rate Inflation-linked: CPI + 0%, 1%, 2%, 3%, -1%, -2% Currency-linked: · R/GB Pound exchange rate + 0%, 5%, 10%, UK inflation · R/US Dollar exchange rate + 0%, 5%, 10%, Dollar inflation · R/EUR exchange rate 0%, 5%, 10%, Euro inflation
Underwriting method	Only the lifestyle questions are needed. However, the underwriting method selected on the quote will be "medical tests, questions or both" to apply for cover amounts above R1 000 000.

7.3 Add-ons

Premium protection

A maximum of two premium protection add-ons may be selected with a combination of the following:

- **Premium Protection Death**

  The insured person on Premium Protection Death must be different from the insured person on the cover.

- **Premium Protection Retrenchment**

  The insured person on Premium Protection Retrenchment must be the same as the insured person on the cover.

- **Premium Protection Disability or Premium Protection Functional Impairment**

  The insured person on Premium Protection Disability or Premium Protection Functional Impairment doesn't have to be the same as the insured person on the cover.

Adding Premium Protection Death will preclude the addition of Premium Protection Retrenchment and vice versa. See Premium Protection for more details.

Cashback
See Cashback for more details.

Linked cover
See Retrenchment Cover for more details.

7.4 Claiming Accidental Death Cover

The cover amount for the insured person can be claimed when they die because of an accident. The cover amount that applies on the date of death will be paid.

An accident is an unexpected and visible event of external origin that causes traumatic bodily injury and is not traceable, even indirectly, to the insured person's state of mental or physical health before the event. It isn't an accident if the insured person contracts a disease.

Example

- Paul is a healthy person who takes out Accidental Death Cover. A taxi drives into him and he is killed. We'll consider the claim because death was caused by an accident.
- Brian has heart problems. A taxi drives into him and he is killed. Once again, we will consider the claim, because death was caused by an accident and was unrelated to his heart problems.
- Joe is bitten by a dog and bleeds to death. His death is an accident because his death was because of an unexpected and visible event of external origin.
- Jack is bitten by a mosquito and contracts malaria and dies. His death isn't an accident because he contracted a disease.

7.5 Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that's generally excluded.

We won't pay if:

- the insured person's death is caused by anything other than an accident,
- the insured person's death is caused by:
  - unrest (example: riot, civil commotion, insurrection and rebellion, war or terrorist activity),
  - radioactivity or nuclear explosion,
  - them provoking, committing or attempting to commit a crime for example murder, assault, housebreaking, theft, robbery, the forceful detention of another person or any similar crime,
  - extreme climbing (soloing), ice climbing or extreme altitude climbing (above 5 000 meters) or
  - cave diving, internal exploration of underwater wrecks or diving at depths greater than 40 meters, motorised racing, boxing, kick boxing and mixed martial arts, BASE jumping, cluster ballooning, parachuting, sky surfing and sky diving participation in piloting an aircraft.

7.6 Accidental Death Cover stops on the earliest of the following:

- When the insured person dies
- On the cover end date
- If the cover lapses
- If the contract is cancelled.

FUNERAL INSURANCE

8. OLD MUTUAL PROTECT FUNERAL INSURANCE

Funeral Insurance pays the cover amount as a single or monthly amount when the insured person dies. We aim to pay out the single amount within 24 hours if requirements are met.

8.1 Funeral insurance Overview

Old Mutual Protect offers two funeral products:

- Family Funeral Cover
- Extended Family Funeral Cover

Each product has automatic features included and various add-ons, benefits and other features can also be attached to enhance the cover, depending on the customer's needs.

Funeral insurance is designed for customers with the following needs:

- Want flexible payment options
- Want a money back guarantee
- Would like to enjoy premium holidays
- Want an easy underwriting process
- Lower the amount of cover and premium according to their needs
- Want to cover extended members of their family
- Would like funeral cover that aims to pay a single amount within 24 hours.

Cessions

- Outright cessions are allowed
- Security cessions aren't allowed

Definitions

Suicide is a self-injury resulting in death, where, in our opinion, the insured person had the intention to take their own life. It includes so-called assisted suicide where another person helped them to take their own life.

Accident is an unexpected and visible event of external origin that causes traumatic bodily injury and isn't traceable, even indirectly, to the insured person's state of mental or physical health before the event. It isn't an accident if the insured person contracts a disease.

Stillborn: The biological mother must have been at least 26 weeks pregnant for the child to qualify as stillborn.

8.2 Family Funeral Cover

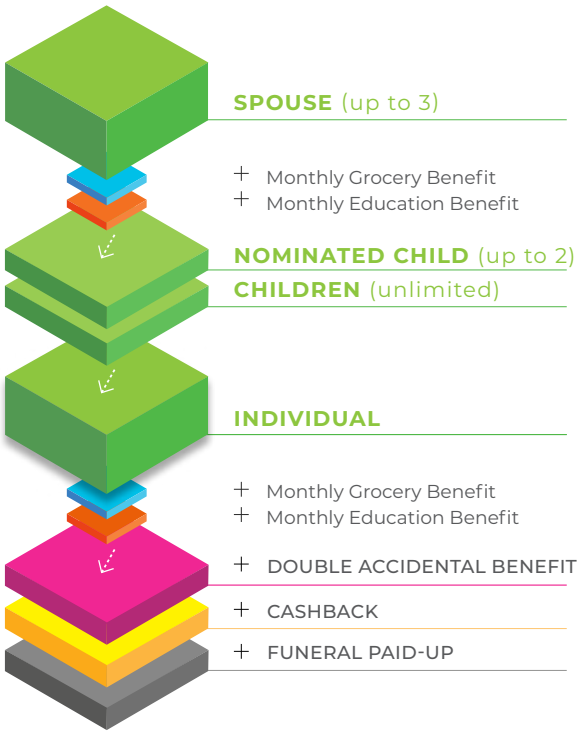
Family Funeral Cover allows the owner to cover themselves, up to three spouse/partner(s), an unlimited number of children as well as up to two nominated children.

- The cover pays a single amount when the insured person dies. Where applicable, monthly payments will also be made on the death of the insured person under Individual and Spouse/Partner cover.
- Spouse/Partner cover can be purchased without the owner having to own any other protection products.
- Individual cover is required in order to add cover for children or nominated children.
- Each nominated child is required to have cover in their own name.
- Different cover amounts can be selected per insured person, subject to the product limits.
- If the maximum number of insured persons is reached, it will be possible to cancel cover for one insured person and specify cover for a different person if there hasn't been a claim on the insured person who is being replaced.

  Example
  It is possible to add and remove spouses/partners so that there is up to three at a time under a Family Funeral Cover, given that there hasn't been a claim on the Spouse/Partner Cover. It's not possible to claim more than three times for a spouse/partner.

- Cover may start earlier than six months from the cover start date if, at application, the owner indicated that Family Funeral Cover was taken out to replace another policy that was designed to cover funeral expenses and was cancelled (including because it has lapsed or its term had ended) within the two months before the cover start date.
- Cover will not start earlier than six months from the cover start date.
  - if cover under the previous policy has not ended when the insured person dies, or
  - on the increased portion of cover, if you applied for more cover than you had under the previous policy.

8.2.1 Family Funeral Cover overview



8.2.2 Family Funeral Cover product features

FAMILY FUNERAL COVER	INDIVIDUAL	SPOUSE/ PARTNER	CHILDREN	NOMINATED CHILD
Type of cover	Cover payable as a: · Single amount or · Single amount and monthly amounts	Cover payable as a: · Single amount or · Single amount and monthly amounts	Cover payable as a single amount	Cover payable as a single amount
Eligible lives	All lives are eligible, subject to entry age limits and underwriting.			
Relationship to owner	Self	Insured person must be the spouse/partner(s) of the owner.	Biological, legally adopted, step children or grandchildren of the owner or their spouse/partner.	A child who · doesn't qualify for cover under the Children benefit, and · lives with and is dependent on the insured person on the Individual benefit.
Maximum number of insured persons	One	Three	Unlimited	Two
Entry age limits	**Minimum:** 15 next birthday **Maximum:** 80 next birthday	**Minimum:** 15 next birthday **Maximum:** 80 next birthday	**Minimum:** automatically from age one next birthday **Maximum: Unmarried** 21 next birthday **Minimum: Unmarried full-time student** 26 next birthday **Total mentally/ physically dependent** - Can be covered indefinitely	**Minimum:** one next birthday **Maximum:** 18 next birthday

Cover end age	None	None	**Unmarried:** 22 next birthday **Unmarried full-time student** - 27 next birthday **Total mentally/ physically dependent** - Can be covered indefinitely	25 next birthday
Premium frequency	Monthly Monthly with the option to skip one premium a year Yearly			
Premium term	Benefit term unless Funeral Paid-up is attached			
Compulsory yearly premium increase	0% fixed rate 5% fixed rate			
Guarantee term	1 year 5 years			
Cover amount limits	**Single amount** **Minimum:** R5 000 **Maximum:** R100 000 **Monthly amounts** 12 monthly installment options for **Monthly Education/Monthly Grocery Benefits** if selected: · R1 000 per month · R1 500 per month · R2 000 per month Only one of each installment benefit can be attached for each insured person.	**Minimum:** R5 000 **Maximum:** R50 000 (Legislative age - related limits will apply at claim stage) Cover amount selected can't be more than the cover on the owner's individual cover.	**Minimum:** R5 000 **Maximum:** R50 000 (Legislative age - related limits will apply at claim stage) Cover amount selected can't be more than the cover on the owner's individual cover.
Benefit term	Whole-life	Whole-life	Term, set equal to the length of time until the policy anniversary where the nominated child reaches the cover end age (25 next birthday).	

Scheduled yearly cover increase	0% fixed rate 5% fixed rate 10% fixed rate Inflation-linked: CPI + 0%, 1%, 2%, 3%, -1%, -2% Currency-linked: · R/GB Pound exchange rate + 0%, 5%, 10%, UK inflation · R/US Dollar exchange rate + 0%, 5%, 10%, Dollar inflation · R/EUR exchange rate 0%, 5%, 10%, Euro inflation
Underwriting method	No medical tests or questions: for cover amounts R5 000 – R50 000. No medical tests, only questions: for cover amounts R50 001 – R100 000. Cover amounts quoted exclude Monthly Grocery Benefit and Monthly Education Benefit amounts.

8.2.3 Definitions

Spouse/partner is the person, at the time that the cover is bought, to whom the insured person on the Individual cover is married or with whom they're in a relationship similar to marriage that's intended to be permanent.

Child is a legally adopted, stepchild, biological or grandchild of the insured person under the Individual cover, or their spouse/partner at the time of their death and is:

- unmarried and younger than 22 next birthday or
- unmarried and a full-time student younger than 27 next birthday or
- totally dependent on the insured person under the Individual Funeral cover or their spouse/partner because of a physical or mental disability.

Nominated child is a child who:

- doesn't qualify for cover under Children cover, and
- lives with and is dependent on the insured person on the Individual cover.

Stepchild: To qualify for cover under this benefit, a stepchild's biological or legally adoptive parent must, at any time after the birth of the stepchild have been married to the insured person under the Individual benefit cover or their spouse/partner. For the purposes of this definition, married means a marriage (including a customary marriage) or union recognised under South African law.

8.2.4 Automatic features

- Early Accidental Cover (on certain cover only)
- Unlimited stillbirth cover (Stillbirth cover is only for Individual and Spouse/Partner cover)
- Premium holiday
- Money back guarantee

8.2.5 Add-ons

- Funeral Paid-up
- Double Accidental Benefit
- Cashback
- Monthly Grocery Benefit
- Monthly Education Benefit

8.2.6 Conversion option

Conversion options are available if an insured child no longer qualifies for cover under the Children or Nominated Child cover.

If an owner still wants to cover a child that no longer qualifies for cover under the Children cover or Nominated Child cover, they would need to apply for other funeral cover (for example Other Family cover under the Extended Family Funeral Cover). A separate premium will be payable for this cover.

The owner may apply for other funeral cover within 90 days after the child no longer qualifies for cover under the Children or Nominated Child cover if:

- the premiums are up to date at the time,
- the cover amount on the new cover is the same as on the Children or Nominated Child cover, and
- all our requirements at the time are met (for example underwriting and completing an application).

8.2.7 Claiming Family Funeral Cover

- Individual, Spouse/Partner, Children, and Nominated Child cover may be claimed independently of one another.
- The money back guarantee will apply if the insured person dies before the cover start date or if claims aren't paid due to exclusion or suicide exclusion period being active from the start of the contract. The money back guarantee will not apply if any portion of the Family Funeral Cover is paid.
- The payout at claim stage will be doubled, if the Double Accidental Benefit is attached to the cover and death was due to an accident after the start date. For non-accidental claims, only the cover amount stated on the contract at the claim event date will pay out.

Individual and Spouse/Partner cover

Cover will be paid when the insured person dies as:

- a single amount, and
- if applicable, monthly amounts for either or both of a Monthly Education Benefit and Monthly Grocery Benefit will be payable over 12 consecutive months. Each monthly payment will be made on the last day of the month.

Child and Nominated Child funeral cover

- Cover will be paid as a single amount when the insured person dies, limited to legislative maximums at claim stage.
- Multiple claims on the Children benefit is allowed. Each claim will be for the full cover amount as listed on the cover, limited to legislative maximums at claim stage.

The legislative maximum amount that can be paid at claim stage is currently set at:

AGE NEXT BIRTHDAY AT TIME OF THEIR DEATH	LEGISLATIVE MAXIMUM
<=6	R20 000
>6 and <=14	R50 000
>14	No limit

- Cover can be issued in excess of the legislative maximums for a child, but at claims stage the maximum legislative amount will be enforced and premiums won't be refunded.

8.2.8 Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that's generally excluded.

- Six-month non-accidental death exclusion for cover that issued with no medical tests or questions.
- Six-month suicide exclusion.

Claims which are not paid due to the six-month non-accidental death exclusion and six-month suicide exclusion are subject to the money back guarantee. The money back guarantee will not apply if any portion of the cover is paid. See Money back guarantee for more details.

8.2.9 Family Funeral Cover stops

Individual and Spouse/Partner cover stops on the earliest of the following:

- When the insured person dies.
- If the cover lapses.
- If the contract is cancelled or this benefit is removed.

Children cover stops on the earliest of the following:

- When the insured person dies. Cover for the individual child stops, but can still continue for other children.
- If the cover lapses.
- If the Individual cover which this cover is attached to lapses or gets cancelled.
- If the contract is cancelled or if Children cover is removed.
- If the child no longer qualifies for cover under the benefit (for example they turn 22 next birthday and are not a full-time student). Cover for the individual child stops, but can still continue for other children.

Nominated Child cover stops on the earliest of the following:

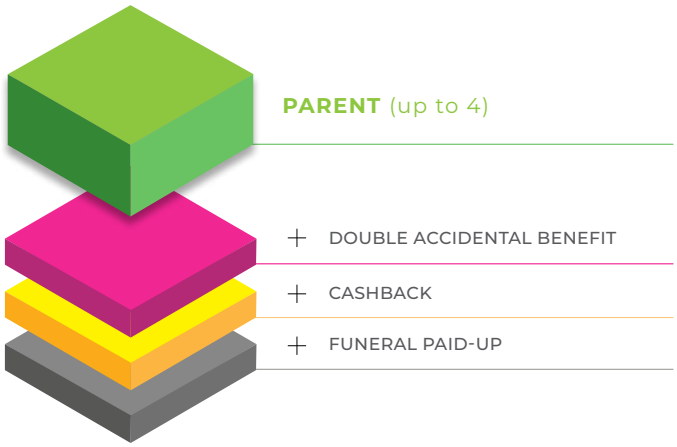
- When the insured person dies.
- At the end of the term.
- If the cover lapses.
- If the Individual cover which this cover is attached to lapses or gets cancelled.
- If the contract is cancelled or if Nominated Child cover is removed.

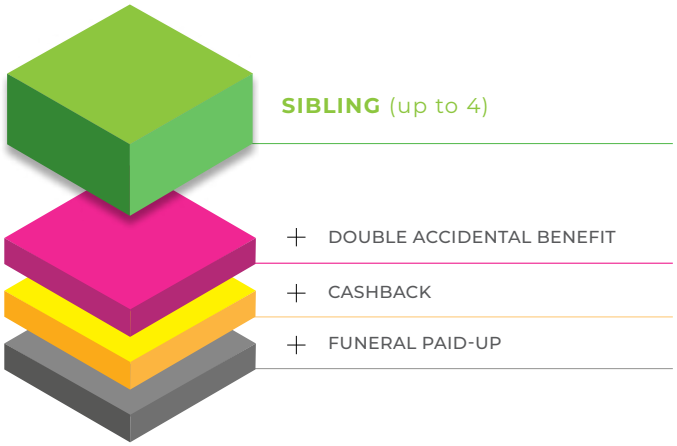
8.3. Extended Family Funeral Cover

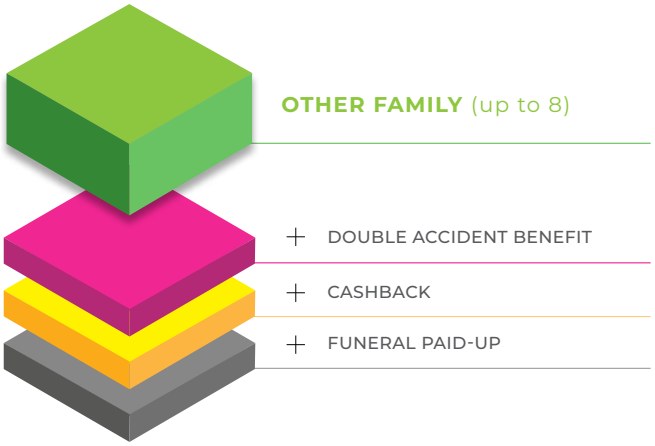
Extended Family Funeral allows owners to cover non-core family members. Each family member is covered under a separate contract with a maximum number of lives which can be covered under each cover type.
There are three available types of cover:

- Parent
- Sibling
- Other family

8.3.1 Extended Family Funeral Cover overview







8.3.2 Parent Cover

- The cover pays a single amount when the insured person dies.
- This cover can be purchased without the owner having to own any other protection products.
- If the maximum number of four insured persons is reached, it will be possible to cancel cover for one insured person and specify cover for a different person if there hasn't been a claim on the insured person who is being replaced.

8.3.2.1 Parent Cover product features

TYPE OF COVER	COVER THAT PAYS A SINGLE AMOUNT
Eligible lives	Parent as defined
Relationship to owner	· Mother/father · Mother/father-in-law · Adoptive mother/father · Adoptive mother/father-in-law · Step mother/father · Step mother/father-in-law
Maximum number of insured persons	Four
Premium frequency	Monthly Monthly with the option to skip one premium a year Yearly
Premium term	Benefit term unless Funeral Paid-up is attached
Compulsory yearly premium increases	0% fixed rate 5% fixed rate
Guarantee term	1 year 5 years
Cover amount limits	**Minimum:** R5 000 **Maximum:** R50 000
Benefit term	Whole-life
Cover end age	None
Scheduled yearly cover increases	0% fixed rate 5% fixed rate 10% fixed rate Inflation-linked: CPI + 0%, 1%, 2%, 3%, -1%, -2% Currency-linked: · R/GB Pound exchange rate + 0%, 5%, 10%, UK inflation · R/US Dollar exchange rate + 0%, 5%, 10%, Dollar inflation · R/EUR exchange rate 0%, 5%, 10%, Euro inflation
Underwriting method	No medical tests or questions

8.3.2.2 Definitions

Spouse/partner is the person to whom the owner, at the time that the cover is bought, is married or with whom they are in a relationship similar to marriage that's intended to be permanent.

Stepfather/mother: To qualify for cover, a stepfather/mother must, at any time after the birth of the step-child, have been married to the stepchild's biological or legally adoptive parent. For the purposes of this definition, stepchild includes the owner at the time the cover was bought and their spouse/partner and married means a marriage (including a customary marriage) or union recognised under South African law.

8.3.2.3 Automatic features

- Money back guarantee
- Premium holiday

8.3.2.4 Add-ons

The following add-ons are allowed on Extended Family Funeral Parent Cover:

- Funeral Paid-up
- Double Accidental Benefit
- Cashback

8.3.2.5 Claiming Parent cover

- Cover will be paid as a single amount when the insured person dies.
- Claims which are not paid due to the six-month non-accidental death exclusion and six-month suicide exclusion are subject to the money back guarantee. The money back guarantee will not apply if any portion of the cover is paid. See Money back guarantee for more details.
- The payout at claim stage will be doubled, if the Double Accidental Benefit is attached to the cover and death was due to an accident after the start date. For non-accidental claims, only the cover amount stated on the contract at the claim event date will pay out.

8.3.2.6 Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that's generally excluded.

- Six-month non-accidental death exclusion for cover that issued with no medical tests or questions.
- Six-month suicide exclusion.

8.3.2.7 Parent cover stops on the earliest of the following:

- When the insured person dies
- If the cover lapses
- If the contract is cancelled or this benefit is removed.

8.3.3 Sibling Cover

- The cover pays a single amount when the insured person dies.
- This cover can be purchased without the owner having to own any other protection products.
- If the maximum number of four insured persons is reached, it will be possible to cancel cover for one insured person and specify cover for a different person if there hasn't been a claim on the insured person who is being replaced.

8.3.3.1 Sibling Cover product features

TYPE OF COVER	COVER THAT PAYS A SINGLE AMOUNT ON DEATH
Eligible lives	Sibling as defined
Relationship to owner	Biological brother or sister
Maximum number of insured persons	Four
Entry age limits	**Minimum:** 1 next birthday **Maximum:** 85 next birthday
Premium frequency	Monthly Monthly with the option to skip one premium a year Yearly
Premium term	Benefit term unless Funeral Paid-up is attached
Compulsory yearly annual premium increase	0% fixed rate 5% fixed rate
Guarantee term	1 year 5 years
Cover amount limits	**Minimum:** R5 000 **Maximum:** R50 000 (Legislative age-related limits will apply at claim stage)
Benefit term	Whole-life
Cover end age	None
Scheduled yearly cover increase	0% fixed rate 5% fixed rate 10% fixed rate Inflation-linked: CPI + 0%, 1%, 2%, 3%, -1%, -2% Currency-linked: · R/GB Pound exchange rate + 0%, 5%, 10%, UK inflation · R/US Dollar exchange rate + 0%, 5%, 10%, Dollar inflation · R/EUR exchange rate 0%, 5%, 10%, Euro inflation
Underwriting method	No medical tests or questions

8.3.3.2 Automatic features

- Money back guarantee
- Premium holiday

8.3.3.3 Add-ons

The following add-ons are allowed on Sibling cover:

- Funeral Paid-up
- Double Accidental Benefit
- Cashback

8.3.3.4 Claiming Sibling cover

- Cover will be paid as a single amount when the insured person dies. If the sibling is a minor, the amount paid will be limited to legislative maximums at claim stage.
- The legislative maximum amount that can be paid at claim stage is currently set at:

AGE NEXT BIRTHDAY AT TIME OF THEIR DEATH	LEGISLATIVE MAXIMUM
<=6	R20 000
>6 and <=14	R50 000
>14	No limit

- Cover can be issued in excess of the legislative maximums for a child, but at claims stage the maximum legislative amount will be enforced and premiums won't be refunded.
- Claims which are not paid due to the six-month non-accidental death exclusion and six-month suicide exclusion are subject to the money back guarantee. The money back guarantee will not apply if any portion of the cover is paid. See Money back guarantee for more details.
- The payout at claim stage will be doubled, if the Double Accidental Benefit is attached to the cover and death was due to an accident after the start date. For non-accidental claims, only the cover amount stated on the contract at the claim event date will pay out.

8.3.3.5 Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that's generally excluded.

- Six-month non-accidental death exclusion.
- Six-month suicide exclusion.
- Claims which aren't paid due to the six month non-accidental death or the two year suicide exclusion are subject to the money back guarantee.
- The non-accidental death exclusion period will be automatically waived if no medical tests or questions are needed and the cover is added using a limited underwriting option.

8.3.3.6 Sibling cover stops on the earliest of the following:

- When the insured person dies
- If the cover lapses
- If the contract is cancelled or this benefit is removed.

8.3.4 Other Family Cover

- The cover pays a single amount when the insured person dies.
- This cover can be purchased without the owner having to own any other protection products.
- If the maximum number of insured person are reached, it will be possible to cancel cover for one insured person and specify cover for a different person if there hasn't been a claim on the insured person who is being replaced.
- An owner is allowed to cover a maximum of eight other family across all Other Family contracts. This number may be exceeded with the owner's own (biological/legally adopted/step/grand) children who no longer qualify to be covered under the Children cover or Nominated Child cover (a maximum of two nominated children can be covered across the Nominated Child and Other Family cover), provided the owner can prove the child is financially dependent on them (for example a mentally disabled child).
- The owner has up to three months after cover expires to transfer children from Children cover and/or Nominated Child cover to Other Family cover to prevent a break in cover. If done during this period, no new exclusion periods will apply.

8.3.4.1 Relationship to insured person

The insured person must be related to the owner or owner's spouse/partner in one of the following ways:

INSURED PERSONS	DESCRIPTION	RELATIVE OF THE OWNER	RELATIVE OF THE OWNER'S SPOUSE/ PARTNER
Aunt/uncle	Biological siblings of the biological parents of the owner or owner's spouse/partner.	✔	✔
Brother/sister	Biological, step or legally adopted siblings of the owner or owner's spouse/partner.	✔	✔
Brother-in-law/sister-in-law	Spouse/partner of biological, step or legally adopted siblings of the owner or owner's spouse/partner.	✔	✔
Son/daughter	Biological or legally adopted child of the owner or owner's spouse/partner.	✔	✔
Son-in-law/ daughter-in-law	Spouse/partner of the owner's biological or legally adopted child. This spouse/partner isn't the biological or legally adopted child of the owner.	✔	✔
Grandfather/ grandmother	Biological parent of a biological parent of the owner or owner's spouse/partner.	✔	✔
Stepfather/stepmother	Spouse/partner of the owner or owner's spouse's/ partner's biological parent. This spouse/partner isn't the biological parent of the owner or owner's spouse/partner.	✔	✔

Father/mother	Biological parent of the owner or owner's spouse/partner.	✔	✔
Legally adoptive father/mother	Legally adopted parent of the owner or owner's spouse/partner.	✔	✔
Ex-husband/ex-wife	Ex-spouse/ex-partner of the owner, with whom the owner was previously married or had a relationship similar to a marriage.	✔	✘
Cousins	Biological or legally adopted child of the aunt/uncle of the owner or owner's spouse/partner.	✔	✔
Stepson/stepdaughter	Biological child of the owner's spouse/partner. This child isn't the biological child of the owner.	✔	✘
Niece/nephew	Biological or traditionally adopted children of the brother/sister of the owner or owner's spouse/partner.	✔	✔
Children	Biological, legally adopted, step or grandchildren of the owner or the owner's spouse/partner who no longer qualify for cover under Children cover or Nominated Child cover, but are still financially dependent on the owner.	✔	✔
Spouse/partner	Person to whom the owner, at the time that this benefit is bought, is married or with whom he/she is in a relationship similar to marriage that is intended to be permanent.	✔	✘

8.3.4.2 Other Family Cover product features

TYPE OF COVER	SINGLE AMOUNT PAID OUT ON DEATH
Eligible lives	Other family members as defined
Relationship to owner	As defined in table above
Maximum number of insured persons	Eight
Entry age limits	**Minimum:** 1 next birthday **Maximum**: 85 next birthday
Premium frequency	Monthly Monthly with the option to skip one premium a year Yearly
Premium term	Benefit term unless Funeral Paid-up is attached
Compulsory yearly annual premium increase	0% fixed rate 5% fixed rate
Guarantee term	1 year 5 years
Cover amount limits	**Minimum**: R5 000 **Maximum**: R50 000 (Legislative age-related limits will apply at claim stage)
Benefit term	Whole-life
Cover end age	None
Scheduled yearly cover increase	0% fixed rate 5% fixed rate 10% fixed rate Inflation-linked: CPI + 0%, 1%, 2%, 3%, -1%, -2% Currency-linked: · R/GB Pound exchange rate + 0%, 5%, 10%, UK inflation · R/US Dollar exchange rate + 0%, 5%, 10%, Dollar inflation · R/EUR exchange rate 0%, 5%, 10%, Euro inflation
Underwriting method	No medical tests or questions

8.3.4.3 Definitions

Spouse/partner is the person to whom the owner, at the time that this benefit is bought, is married or with whom they're in a relationship similar to marriage that is intended to be permanent.

A **child** is, at the time that this benefit is bought, a legally adopted, stepchild, biological child or grandchild of the owner or their spouse/partner.

A **nominated child** is, at the time that this benefit is bought, a child who lives with and is dependent on the owner.

Stepchild: a stepchild's biological or legally adoptive parent must, at any time after the birth of the stepchild, have been married to the owner or to the owner's spouse/partner. For the purposes of this definition, owner means the owner at the time this benefit was bought and married means a marriage (including a customary marriage) or union recognised under South African law.

Stepfather/mother: a stepfather/mother must, at any time after the birth of the stepchild, have been married to the stepchild's biological or legally adoptive parent. For the purposes of this definition, stepchild includes the owner at the time this benefit was bought and their spouse/partner and married means a marriage (including a customary marriage) or union recognised under South African law.

Stepbrother/sister: a stepbrother/sister's biological or legally adoptive parent must, at any time, have been married to the biological or legally adoptive parent of the owner or to the biological or legally adoptive parent of the owner's spouse/partner. For the purposes of this definition, owner means the owner at the time this benefit was bought and married means a marriage (including a customary marriage) or union recognised under South African law.

8.3.4.4 Automatic features

- Money back guarantee
- Premium holiday

8.3.4.5 Add-ons

The following add-ons are allowed on Family Funeral Cover:

- Funeral Paid-up
- Double Accidental Benefit
- Cashback

8.3.4.6 Claiming Other Family cover

- Cover will be paid as a single amount when the insured person dies. If the insured person is a minor at the time of his/her death, the amount paid will be limited to legislative maximums at claim stage.

The legislative maximum amount that can be paid at claim stage is currently set at:

AGE NEXT BIRTHDAY AT TIME OF THEIR DEATH	LEGISLATIVE MAXIMUM
<=6	R20 000
>6 and <=14	R50 000
>14	No limit

- Cover can be issued in excess of the legislative maximums for a child, but at claims stage the maximum legislative amount will be enforced and premiums won't be refunded.
- Claims which are not paid due to the six-month non-accidental death exclusion and six-month suicide exclusion are subject to the money back guarantee. The money back guarantee will not apply if any portion of the cover is paid. See Money back guarantee for more details.
- The payout at claim stage will be doubled, if the Double Accidental Benefit is attached to the cover and death was due to an accident after the start date. For non-accidental claims, only the cover amount stated on the contract at the claim event date will pay out.

8.3.4.7 Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that's generally excluded.

- Six-month non-accidental death exclusion.
- Six-month suicide exclusion.
- Claims which aren't paid due to the six-month non-accidental death exclusion and the two-year suicide exclusion are subject to the money back guarantee.
- The non-accidental death exclusion period will be automatically waived if no medical tests or questions are needed and the cover is added using a limited underwriting option.

8.3.4.8 Other Family cover stops on the earliest of the following:

- When the insured person dies.
- If the cover lapses.
- If the contract is cancelled or this benefit is removed.

8.4 Automatic features

- Early Accidental cover
- Unlimited stillbirth cover
- Premium holidays
- Money back guarantee

8.4.1 EARLY ACCIDENTAL COVER

Early Accidental cover is only available to insured persons under Family Funeral Individual cover and Spouse/Partner cover who have done 'no medicals, questions only' for cover amounts over R50 000. Early accidental insurance provides cover against accidental death (excluding suicide) from the contract start date to the cover start date on a new contract.

- The cover amount applicable will be paid out including monthly amounts if selected.
- If the Double Accidental Benefit is an active feature on the contract, it won't be applicable to an Early Accidental cover claim.
- Early Accidental cover applies only to new cover issued and isn't applicable on any increases to the cover.

Example

Helen decides to take out R70 000 Individual cover with the Double Accidental Benefit on 1 January 2000. She decides that she would also like to receive monthly amounts for Monthly Education Benefit of R1 000 per month. Her cover start date is 15 February 2000.

She has an accidental death on 10 January 2000. Since Helen took out cover for R70 000 she would have been be required to undergo underwriting with 'no medicals, questions only'. The start date of her cover would be 16 January 2000 i.e. the later of 1 January 2000 and 15 February 2000 less 30 days. The Early Accidental cover period for Helen runs from 1 January 2000 – 16 January 2000. The amount to be paid on death would be R70 000 with an Monthly Education Benefit of R1 000.

There is no doubling of the cover due as the Double Accidental Benefit isn't applicable on Early Accidental cover claims.

Claiming Early Accidental cover

- Early Accidental cover will be limited across all contracts to which the insured person is attached irrespective of whether the owner differs.
- Only one claim is allowed.
- Claims are paid on death due to an accident.
- A claim must be submitted within three months of the claim event.
- Claim payout is subject to the minimum of the cover amount to which the Early Accidental cover is attached, and the maximum payout applicable under Early Accidental Insurance.

8.4.2 UNLIMITED COVER FOR STILLBIRTHS

Unlimited stillbirth cover for Family Funeral Individual and Spouse/Partner cover. The payout of a stillborn claim will have no impact on the cover amount.
The claim amount for a stillborn is limited to the smaller of:

- 25% of the cover amount on the Individual and/or Spouse/Partner cover or
- R3 000.

We won't pay if:

- The stillbirth was caused by the owner or the biological mother's negligence or intentional harm.

Claiming for stillbirths

- Unlimited stillbirth claims are allowed under Individual and Spouse/Partner cover. Proof that the child was the insured person's biological child will be required.
- Money back guarantee isn't applicable to stillbirths.
- If the biological child of the insured person on this cover or their spouse/partner is stillborn after the cover started, we'll also pay the smaller of:
  - 25% of the cover amount and
  - R3 000.
- We'll never pay more than R3 000 per stillborn even if both biological parents claim for the stillborn. The legislative limits don't apply to stillbirth.

Example

Anakin takes out R15 000 Individual cover, R10 000 Spouse/Partner cover on 1 January 2019. At application date, his spouse was one month pregnant. Unfortunately, there was a miscarriage in the eighth month after the exclusion period has stopped. Since both are the biological parents of the child, the total stillbirth claim will be for:

Min (R15 000 x 25% + R10 000 x 25%, R3 000) = Min (R6 250, R3 000) = R3 000

8.4.3 PREMIUM HOLIDAY

Premium holiday is a feature that allows the owner to miss up to six premiums during times of financial difficulty such as retrenchment, unemployment, maternity leave and study leave. This feature is only applicable to Old Mutual Protect Funeral products with a monthly premium frequency. A maximum of six premiums can be skipped altogether on a contract.

8.4.3.1 Automatic premium holidays

These are available from the first premium due date, accruing one each contract year in advance to a total of six, i.e.:

- The owner will accrue one automatic premium holiday immediately when the contract starts and premium holidays will continue accumulating each year for six years to a maximum of six premiums.
- These holidays accrue at the beginning of each contract year. Every unused premium holiday will be carried over until the beginning of the sixth year, after which none will be earned.

Example

Patrick's first monthly premium was due on 1 January 2010. By 4 February 2015, we haven't received his premium for February 2015. At this point he has six premium holidays (one automatic each for 1 January 2010, 2011, 2012, 2013, 2014 and 2015) and he has never used a requested premium holiday. Since Patrick qualifies for an automatic premium holiday, we'll automatically use one for the missed February 2015 premium and he'll then have five premium holidays left. If we also don't receive Patrick's premium for March 2015, we'll again use an automatic premium holiday and he'll have four premium holidays left.

8.4.3.2 Requested premium holidays

The owner can request up to four premium holidays after six premiums have been received and accelerate the usage the premium holidays whether they've accrued yet or not. This will reduce the total number of premium holidays available. The four requested premium holidays may be used together or separately provided there are still requested premium holidays available.

- If a premium is missed (including the first premium), we'll first check for available premium holidays and
- automatically use the premium holidays. The contract will enter the grace period once the premium holidays are depleted.
- The contract will lapse if the missed premium isn't paid before the end of the grace period or if a second premium is missed, whichever happens first.

Example

Sian's first monthly premium was due on 1 January 2010. On 27 February 2015, she asks to use her four requested premium holidays. At this point, Sian has four requested premium holidays available since we've received her sixth premium on 1 June 2010. But Sian has already used five automatic premium holidays. Since she qualifies for no more than six premium holidays in total and has already used five, she can only use one more requested premium holiday. She can use this requested premium holiday for the premium that would have been due on 1 April, because at time of the request, 27 February, we had already requested the premium for 1 March. When she has used the requested premium holiday, she would have completely used her premium holidays.

8.4.3.3 Premium holiday can be used more than once

- The owner may pay some or all of the missed premiums to make use of the equivalent number of premium holidays again in the future. Premium holidays are repaid at the amount of the original premium due.
- If a premium holiday is repaid, it doesn't reinstate the ability to request another premium holiday. The premium holiday paid back will only be used as automatic premium holidays to cover future missed premiums.
- Any compulsory yearly premium increases/scheduled yearly cover increases applicable during a month on which a premium holiday is being used will still have the increases applied to the contract on the increase due date. At the end of the premium holiday period, the premium payable by the owner will reflect all of these increases. The increased premium will be recorded as per the increase date and will apply when repaying the premium holidays' premiums missed in the future.
- Where an automatic premium holiday has been used, this won't count towards the receipt of the six premiums and entitlement to the requested premium holidays will shift till six premiums have been received.

8.5.4 MONEY BACK GUARANTEE

The money back guarantee provides a single payout where no claim is payable due to an exclusion period and/or suicide exclusion being active on the benefit at the time of the claim event.

- The amount paid is the smaller of all premiums we received under the contract:
  - before the insured person's death, less any previously paid money back guarantees, and
  - between the cover start date of the benefit and the insured person's death.

This ensures that the benefit still provides some value on the death of the insured person.

THE MONEY BACK GUARANTEE APPLIES TO THE FOLLOWING FUNERAL INSURANCE PRODUCTS

- Family Funeral Cover
  - Individual
  - Spouse/Partner
  - Children
  - Nominated Child
- Extended Family Funeral Cover
  - Parent
  - Sibling
  - Other Family

Claiming money back guarantee

A money back guarantee is payable if:

- The cover being claimed on was issued under either of the following underwriting options, as long as the exclusion period or exclusion is applicable:
  - no medical tests or questions
  - no medicals tests, questions only.
- Premiums have been received on the contract and only after the first premium due on the contract has been received. A premium holiday doesn't count towards a premium received.

The payout of money back guarantee will:

- be paid to the beneficiary (ies) as listed on the contract
- cause the underlying cover to stop, except where the payout is on the Children cover. Children may claim multiple times on the money back guarantee subject to the over-arching cover payout principles.

Example

John takes out R25 000 Individual funeral cover with a premium of R100 on 3 January 2020, with no medical tests or questions. Three months later, he takes out Spouse/Partner cover for Sally for less than R20 000 with no medical tests or questions and the new revised premium is R150.

At this time, three premiums had been paid. After four months from the application date of the contract, John has a non-accidental death and at the time of his death four premiums had been paid. The revised premium after John's death is R50.

After seven months from the application date of the contract, his spouse dies a non-accidental death and at the time of her death seven premiums had been paid. At the time of John's non-accidental death, which occurred during the exclusion period, four premiums had been received. Consequently, the last four premiums before his death will be refunded. Calculated money back guarantee at John's non-accidental death = R100 + R100 + R100 + R150 = R450. There were no previous money back guarantee payouts before John's death.

Actual payout at John's non-accidental death = min (R450, R450 – R0) = R450. John's beneficiary will receive a death claim benefit of R450.

Calculated money back guarantee at Sally's non-accidental death = R100 + R100 + R100 + R150 + R50 + R50 + R50 = R600. Previous money back guarantee payouts before Sally's death is R450. Actual payout at Sally's non-accidental death = min (R150 + R50 + R50 + R50, R600 – R450) = R150. Sally's beneficiary will receive R150.

Money back guarantee won't be paid:

- If there was a claim paid on any portion of cover is paid
- on stillborn claims
- where there's no initial exclusion period and/or suicide period on an active benefit
- on the additional slice of a cover from a voluntary cover increase, even if an exclusion period and/or suicide exclusion is applied to the additional cover.
- where there is no claim 'payable' on the Funeral paid-up benefit due to the Funeral paid-up exclusion period.

Example

John, the owner, decides to take out R40 000 Family Funeral Spouse/Partner Cover on 1 January 2020. In addition to this benefit, he takes out a Funeral Paid-up benefit. The total premium for this policy is R300. On 1 July 2020, John has a non-accidental death. At the time of his death, seven premiums had been received (a premium holiday was used). John's non-accidental death occurred outside the non-accidental death exclusion period and hence the cover amount, of R40 000, will be paid to John's beneficiary. John's non-accidental death occurred during the 12-month non-accidental exclusion period for the Funeral Paid-up benefit. Consequently, the Funeral Paid-up benefit will not be triggered but will terminate. The Money Back Guarantee will not provide a payout where there is no claim 'payable' on the Funeral Paid-up benefit and hence there will be no Money Back Guarantee pay-out for the Funeral Paid-up benefit.

8.5 ADD-ONS

- Funeral Paid-up
- Double Accidental Benefit
- Cashback
- Monthly Grocery Benefit
- Monthly Education Benefit

8.5.1 FUNERAL PAID-UP

The Funeral Paid-up benefit will waive the premiums on the cover and add-ons (including the Funeral Paid-up benefit) it's attached to after the death, disability or retirement of the insured person under the Funeral Paid-up benefit. When this happens, the contract will become paid-up and the scheduled yearly cover increases will stop on the entire product to which the Funeral Paid-up is attached.

- The Funeral Paid-up benefit may only be attached to: Family Funeral Cover and Extended Family Funeral Cover.
- Only one Funeral Paid-up can be attached to a product.
- The Funeral Paid-up Benefit will take on the term of the cover it's attached to.
- The insured person on the Funeral Paid-up must be the same as the insured person on the attached cover.

8.5.1.1 Definitions

Disability is defined as the insured person being physically impaired, i.e. the insured person is physically impaired if they suffer a defined physical impairment condition provided that such impairment is permanent and irreversible, as confirmed by Old Mutual's Medical Officer, and the insured person meets the survival period requirement.

Retirement is the contract anniversary where the insured person on Funeral Paid-up reaches 65 next birthday. On this anniversary, the entire contract to which Funeral Paid-up is added will go paid up, unless it's paid up earlier due to either death or disability.

Survival period is the consecutive number of days or months the insured person must survive after becoming physically impaired before we'll make the contract paid up. It starts on the date of the physical impairment as confirmed by Old Mutual's Medical Officer. The survival period for Funeral Paid-up is 10 days. Premiums must be paid during the survival period and while we decide if the claim is valid. If the contract is cancelled before the survival period stops, we won't make the contract paid up.

8.5.1.2 Funeral Paid-up product features

TYPE OF PRODUCT	ADD-ON BENEFIT
Eligible lives	All lives are eligible, subject to entry age limits and underwriting. The insured person for Funeral Paid-up can't be the insured person on the Extended Family Funeral Cover.
Relationship to owner	The owner must be the same as the insured person.
Maximum number of insured persons	One
Entry age limits	**Minimum:** 15 next birthday **Maximum:** 55 next birthday
Premium frequency	Inherits the premium frequency on the product to which it's attached.
Premium term	Inherits the premium term on the product to which it's attached.
Compulsory yearly premium increases	Inherits the premium pattern on the product to which it's attached. If the cover has compulsory yearly premium increases, the premium which is being waived will increase as per the compulsory yearly premium increases.
Guarantee term	1 year If a premium review occurs while the Funeral Paid-up benefit is in payment, a premium increase will result in cover decreasing and a premium decrease will result in the waived premium decreasing. In both cases, premiums will continue to be waived.
Benefit term	Whole-life
Cover end age	None
Scheduled yearly cover increases	Inherits the scheduled yearly cover increases of the cover it's attached to. Scheduled yearly cover increases will terminate once the contract becomes paid up.
Survival period	10 days (only applicable to disability)
Underwriting method	No medical tests or questions

8.5.1.3 Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that's generally excluded.

- Two-year suicide exclusion.
- One-year non-accidental death and disability exclusion applies if there were no medical tests or questions. Death or disability due to an accident will still result in the contract going paid up during this exclusion period.

This exclusion period will be waived:

- where the Funeral Paid-up benefit is attached to existing Family Funeral Cover which has an Individual benefit, where no medicals were done but questions were answered, provided the insured person on the Funeral Paid-up is the same insured person on the Individual benefit, or
- where the Funeral Paid-up benefit exists on Family Funeral Cover where an Individual benefit with no medicals required but questions are to be answered, is added and the insured person on both Funeral Paid-up benefit and the Individual benefit is the same, or
- where, for the same insured person, Funeral Paid-up benefit co-exists on Family Funeral Cover with an Individual benefit which has a cover increase which moves it into the cover bracket that would require questions to be answered.

8.5.1.4 Funeral Paid-up benefit stops on the earliest of the following:

- If the benefit lapses
- If no more regular premiums are due on the protected benefit(s)
- If the contract is cancelled or this benefit is removed.

8.5.1.5 Funeral Paid-up events

MUSCULOSKELETAL DISORDERS	
Combination of loss of use of an upper and lower limb	The total and permanent loss of use of an upper and a lower limb appendage as defined below: • a foot at the transverse tarsal joint (Chopart's joint), • a leg at or above the ankle joint up to the hip joint, • a hand (at the metacarpophalangeal joint), • an arm at or above the wrist joint up to the shoulder joint, as confirmed by an orthopaedic or neurosurgeon.
Loss of use of both feet or legs	The total and permanent loss of use of: • both legs at or above the ankle joint up to the hip joint, or • both feet at the transverse tarsal joint (Chopart's joint), or • one foot at the transverse tarsal joint (Chopart's joint) and one leg at or above the ankle joint up to the hip joint, as confirmed by an orthopaedic or neurosurgeon.
Loss of use of one leg	The total and permanent loss of use of one leg, at or above the ankle joint up to the hip joint, as confirmed by an orthopaedic or neurosurgeon.
Loss of use of one foot	The total and permanent loss of use of one foot at the transverse tarsal joint (Chopart's joint), as confirmed by an orthopaedic or neurosurgeon.

Loss of use of both hands or arms	The total and permanent loss of use of: • both hands at the metacarpophalangeal joints, or • both arms at or above the wrist joint up to the shoulder joint, or • one hand at the metacarpophalangeal joint and one arm at or above the wrist joint up to the shoulder joint, as confirmed by an orthopaedic or neurosurgeon.
Loss of use of one arm	The total and permanent loss of use of one arm at or above the wrist joint up to the shoulder joint, as confirmed by an orthopaedic or neurosurgeon.
Loss of use of one hand	The total and permanent loss of use of one hand at the metacarpophalangeal joint involving more than 3 fingers, one of which includes either the thumb or the index finger, as confirmed by an orthopaedic or neurosurgeon.
SENSES	
Loss of hearing	Total and permanent loss of hearing in both ears as confirmed by an ear, nose and throat surgeon. With evidence of the following: • Audiometry measurements, done with the use of hearing aids, with an average loss of greater than 87dB.
Loss of speech	The total and permanent loss of the ability to produce intelligible and audible speech due to injury or disease, as confirmed by an ear, nose and throat surgeon, neurologist or neurosurgeon. • Objective medical evidence of an ear, nose and throat disorder causing the impairment must be provided. Loss of speech due to psychiatric causes are excluded.
Loss of sight	Confirmed diagnosis of total and permanent bilateral loss of sight by an ophthalmologist. The loss of sight cannot be improved through refractive correction or medication. With evidence of 1 of the following: • A reading of 6/60 or worse (or equivalent measure on a non-metric scale) in each eye after best correction, or • Severe proliferative diabetic retinopathy, or • Grade IV hypertensive retinopathy, or • Permanent Hemianopia in both eyes, or • A visual field loss to a 10° radius in the better eye. Loss of sight due to cataracts is excluded, unless there is evidence of failed cataract surgery or contraindications to cataract surgery.

8.5.2 DOUBLE ACCIDENTAL BENEFIT

The Double Accidental Benefit will double the cover amount at the time of the insured person's death, if the death is due to an accident.

- The Double Accidental Benefit may only be attached to: Family Funeral Cover and Extended Family Funeral Cover.
- Only one Double Accidental Benefit can be attached to a product.
- The Double Accidental Benefit will take on the term of the cover it's attached to.
- The cover amount is not doubled:
  - if the insured person's death or the accident is before this benefit's cover start date, or
  - on the Monthly Grocery Benefit or the Monthly Education Benefit, or
  - on stillborn claims.

8.5.3 Monthly Education Benefit and Monthly Grocery Benefit

The owner can select to add both, neither or at least one of the following benefits to a Family Funeral Individual and/or Spouse/Partner cover:

- Monthly Education Benefit
- Monthly Grocery Benefit

The monthly cover amount options are:

- R1 000 per month
- R1 500 per month
- R2 000 per month

- When the insured person dies, this benefit pays the Monthly Education Benefit and/or Monthly Grocery Benefit's cover amount starting from the end of the month of death, for 12 consecutive months.
- Monthly Education Benefit and Monthly Grocery Benefits will enjoy the same cover increases of the cover they're attached to. No cover increases will apply once the claim is in payment.
- The Double Accidental Benefit won't apply to the Monthly Education Benefit and Monthly Grocery Benefit.

Example

Kerwin has R40 000 Individual funeral cover which started on 1 April 2020 and a Monthly Education Benefit of R1 000. He dies on the 15 January 2029. The R40 000 will pay as a single amount while the first monthly amount of the Monthly Education Benefit will become payable on the 31 January 2029. This monthly amount will continue to be payable until 31 December 2029.

- The Monthly Education Benefit and Monthly Grocery Benefit's cover amount will only be paid once our requirements have been met, and if the claim is valid on the Individual cover or Spouse/Partner covr and the insured person's death is after this cover start date.
- The payment day is the last day of the month. If any payment day isn't a working day, we'll make the monthly amount on the next working day.
- If there was at least one payment day between the date of the insured person's death and the date our requirements are met, we'll pay a single amount equal to the number of monthly amounts

since the date of the insured person's death and up to the date our requirements are met and we'll make the next monthly amount on the next payment day.

- If there was no payment day between the date of the insured person's death and the date our requirements are met, we'll make the first monthly amount on the payment day immediately after the date our requirements are met.

Example: All our requirements are met after at least one payment day has passed

Jackson has R50 000 Spouse/Partner cover and a Monthly Education Benefit of R1 000 per month. He dies on 30 May. All our requirements are met on 2 June of the same year. We'll make a single payment of R51 000 (R50 000 + R1 000) because the requirements were only met after the first payment day had passed. The next monthly amount of R1 000 for the Monthly Education Benefit will be made on 30 June.

Example: All our requirements are met but no payment day has passed

Jeffrey has R50 000 Spouse/Partner cover and a Monthly Education Benefit of R1 000 per month. He dies on 15 May. All our requirements are met on the following day. We make a single payment of R50 000 on the Spouse/Partner cover and the first monthly amount of R1 000 for the Monthly Education Benefit will be made on 31 May.

8.5.3.1 Monthly Education Benefit and Monthly Grocery Benefits stops on the earliest of the following:

- When the insured person dies and we make the last monthly payment
- If the cover lapses
- If the contract is cancelled or this benefit is removed.

DISABILITY INSURANCE

9. OLD MUTUAL PROTECT DISABILITY INSURANCE

Disability Insurance consists of six different products that can either pay a single amount or a monthly amount and can be tailored to the needs of the customer. It provides protection against temporary or permanent disability or impairment. The choice of the products will depend on whether the insured person is employed or not and whether their occupation is eligible for the product. Students, housewives, unemployed persons and those not eligible for Disability products will have the option of taking out Functional Impairment products, which cover a defined list of functional impairment events.

Below is an overview of the Old Mutual Protect Disability Insurance offers with their optional add-ons, benefits and other features.

9.1 DISABILITY MONTHLY AMOUNTS

The following products pay a monthly amount. The owner can select one cover type per contract depending on their need and the qualifying occupation of the insured person.

	DISABILITY INCOME COVER	FUNCTIONAL IMPAIRMENT INCOME COVER	BUSINESS EXPENSES
Benefits and other features to enhance cover	· Income Extender Benefit · Sickness Benefit · Family Support Benefit	· Family Support Benefit	· None
Add-ons	· Cashback	· Cashback	· None

9.2 DISABILITY SINGLE AMOUNT

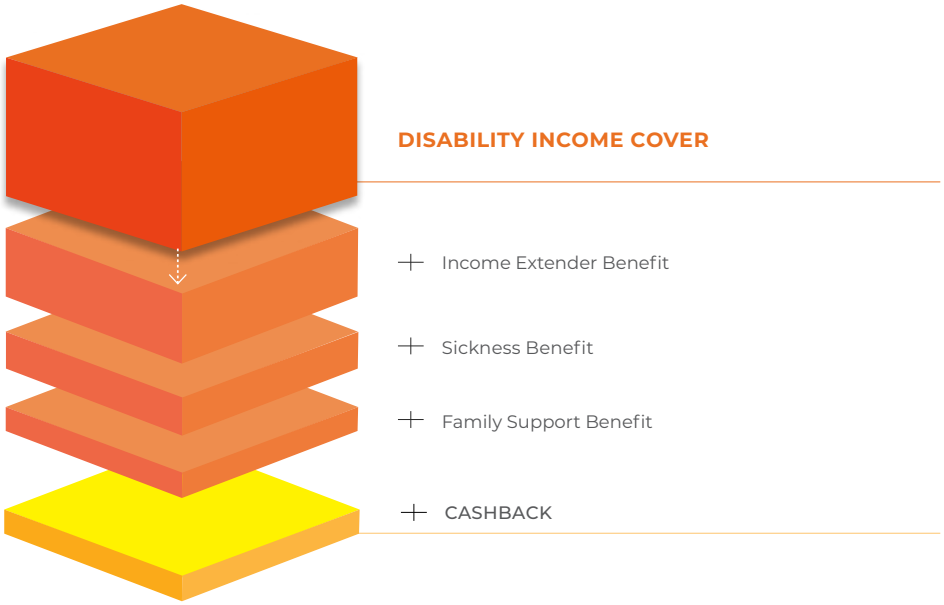
There are four products that pay as a single amount. The owner can select one cover type per contract depending on their need and the qualifying occupation of the insured person.

	DISABILITY COVER	FUNCTIONAL IMPAIRMENT COVER	PHYSICAL IMPAIRMENT COVER	ACCIDENTAL DISABILITY AND DEATH COVER
Benefits and other features to enhance cover	· Own Occupation Benefit · Partial Functional Impairment Benefit · Child Impairment Benefit	· Partial Functional Impairment Benefit · Child Impairment Benefit	· None	· None

Add-ons	· Premium Protection Death · Premium Protection Disability or Premium Protection Functional Impairment · Premium Protection Retrenchment · Cashback

10. DISABILITY INCOME COVER

10.1 Disability Income Cover overview



Disability Income Cover is designed for customers with the following needs:

- Don't want to depend on parents or children to financially assist if they should become disabled or functionally impaired.
- Don't have any or sufficient disability income on their employee benefits.
- Need a monthly income to pay expenses if they are unable to work.
- Need ongoing financial assistance to pay for rehabilitation cost or alternative treatment if they are unable to work.

10.2 Disability Income Cover product features

TYPE OF COVER	COVER THAT PAYS A MONTHLY AMOUNT
Eligible lives	· Specified occupations as determined by our underwriters. · Unemployed persons won't be eligible for cover. Eligible lives are subject to underwriting and age limits.
Relationship to owner	There must be an insurable interest if the owner and insured person aren't the same person.
Maximum number of insured persons	One
Entry age limits	**Minimum:** 18 next birthday **Maximum:** 60 next birthday
Premium frequency	Monthly No premium skipping is allowed
Premium term	Benefit term
Compulsory yearly premium increase	· 0% fixed rate · 5% fixed rate · Age-linked
Guarantee term	· 1 year · 5 years
Cover amount limits	**Minimum:** R6 000 per month **Maximum:** The total cover can't exceed the smaller of 100% of average net of tax monthly earning and R60 000 per month for whole-life cover R250 000 per month for term cover
Waiting period	The insured person has a choice of one of the following waiting periods: · 7 days · 1 month · 3 months · 6 months · 12 months · 24 months
Benefit term	· Whole-life · Term (minimum of 5 years) All claims will be assessed against functional impairment definitions if the insured person is no longer engaged in an occupation because they retired (and doesn't become re-engaged in any occupation) or reaches 70 next birthday, whichever is the earlier.

Cover end age	· Whole-life · Term (70 next birthday)
Scheduled yearly cover increase	· 0% fixed rate · 5% fixed rate · Inflation-linked: CPI + 0%, 1%, 2%, 3%, -1%, -2%
Underwriting method	· No medical tests, only questions · Medical tests, questions or both
Underwriting credit	If the insured person completed 'medical tests, questions or both' for an amount less than the upper limit of a particular underwriting band, they could qualify for: · Single underwriting credit · Comprehensive underwriting credit

10.3 Definitions

Occupationally disabled means that the insured person is, in part or completely and despite following reasonable medical advice and adequate medical treatment, unable to perform the main duties of their stated occupation because of a sickness or injury.

Functionally impaired means that the insured person has suffered and meets the requirements of a qualifying functional impairment, despite following reasonable medical advice and adequate medical treatment.

Reasonable medical advice means the medical opinion provided by a health professional that the insured person can reasonably be expected to follow to improve or preserve their health. This may include investigations, recommendations, lifestyle adjustments and treatment options based on the best available information and appropriate to the condition, the health professional's knowledge and scope of practice.

Adequate medical treatment means the best possible treatment that a person can reasonably be expected to undergo and includes the use of simple external assistive devices for example hearing aids, glasses, contact lenses, a walking stick or a Zimmer frame but doesn't include the use of complex external assistive devices for example a wheelchair or leg prosthesis. The general meaning of the terms 'simple external assistive devices' and 'complex external assistive devices' isn't limited by the specific examples provided.

Fracture means damage to the continuity of a bone. Not all fractures qualify for cover under this product, for example hairline fractures or fractures of the toe.

Related claims

Old Mutual's Medical Officer, supported by published medical evidence, determines if events are related. Typically this means that they stem from the same incident (for example a certain car accident) or condition (for example cancer) or from complications or treatment following the same incident or condition.

10.4 BENEFITS AND OTHER FEATURES

The owner can select all, neither or at least one of the following monthly amount benefits:

- Income Extender Benefit
- Sickness Income Benefit
- Family Support Benefit

These can be added when the cover is purchased or at a later date before the insured person reaches 60 next birthday. They can't be added while a claim is in process for Disability Income Cover or on any of the attached benefits and other features. Underwriting might be required premiums might be adjusted if added at a later stage.

10.5 Add-ons

Cashback

See Cashback for more details.

Linked Cover

See Retrenchment Cover for more details.

10.6 Claiming Disability Income Cover

The cover amount for the insured person can be claimed when they become occupationally disabled or functionally impaired and the waiting period is met. Payments for a fracture are also available on Disability Income with a seven-day or a one-month waiting period.

10.6.1 Occupational disability

The cover amount for the insured person can be claimed when they become occupationally disabled, and the waiting period is met.

- Each monthly payment is equal to a percentage of the cover amount that applies on the payment day.
- For occupational disability, the percentage of the cover amount depends on:
  - the insured person's ability, as determined by us, to continue doing some of the material and substantial duties of their occupation,
  - the average monthly income the insured person was earning from their occupation immediately before they became occupationally disabled which we may adjust over time by the inflation rate set by us,
  - the average monthly income that we determine the insured person being able to earn from their occupation while being occupationally disabled and
  - the average monthly income the insured person receives from any other source while they are occupationally disabled. Examples of any other source include income earned from:
    - another occupation, and
    - any income payments received from:
      - their employer,

  - any product provider (examples of a product provider include us and other insurers. It doesn't include payments received from the road accident fund or for the specific purpose of covering continuing business expenses).

- The percentage of the cover amount that's paid for occupational disability may change over time as the insured person's condition worsens or improves or their average monthly income changes.

10.6.2 Functional impairment

The cover amount for the insured person can be claimed when they become functionally impaired and the waiting period is met.

- Each monthly payment is equal to a percentage of the cover amount that applies on the payment day.
- For functional impairment, the percentage of the cover amount depends on:
  - the severity of the functional impairment and
  - the average monthly income the insured person was earning from their occupation immediately before they became functionally impaired and
  - the average monthly income the insured person receives from any other source while they are functionally impaired.
- Examples of any other source include income earned from:
  - another occupation, and
  - any income payments received from:
    - their employer,
    - any product provider (examples of a product provider include us and other insurers. It doesn't include payments received from the road accident fund or for the specific purpose of covering continuing business expenses).
- The percentage of the cover amount that's paid for functional impairment may change over time as the insured person's condition worsens or improves.

10.6.3 Fractures

- We'll pay 100% if the insured person meets the requirements of one of the defined fracture claim events for which we specify the number of monthly payments applicable and the waiting period has to be met.
- Payments for fractures are only applicable for income benefits with a seven-day or one-month waiting period.
- If the insured person suffers more than one fracture simultaneously, or suffers other fractures during the payment period for a prior fracture, we'll only pay the number of monthly payments applicable to the fracture with the longest payment period for which the insured person qualifies.
- If we're already making payments for a functional impairment or occupational disability claim, there can't also be a claim for a fracture.
- The insured person can claim on multiple separate incidences, provided we're not already making payments for a functional impairment or an occupational disability.

Example: Single fracture with a seven-day waiting period

Dr Sam is a cardiovascular surgeon with a seven-day waiting period on his Disability Income Cover. He was in an accident which resulted in a fracture of his leg between the knee and foot. As a result of the fracture he's unable to perform surgeries as he can't stand in the operating theatre. Dr Sam will receive two monthly payments.

Example: Simultaneous fractures with a seven-day waiting period

Mark has a seven-day waiting period on his Disability Income Cover. He was in an accident which resulted in a complete fracture of the collar bone and a fracture of the shoulder blade simultaneously. Mark will receive the number of monthly payments applicable to the fracture with the longest payment period for which he qualifies for, which will be two monthly payments.

Example: Other fractures during the payment period of a prior fracture

Mark has a seven-day waiting period on his Disability Income Cover. He was in an accident which resulted in a fracture of the shoulder blade. As a result, Mark will receive two monthly payments as a fracture payout. In the month before his second monthly payment he falls, resulting in a complete fracture of the shaft of the thigh bone. This qualifies him for three monthly payments. Since he's already claiming for a previous fracture, Mark will only receive the number of monthly payments applicable to the fracture with the longest payment period for which he qualifies. He'll only receive an additional two monthly payments (total of three monthly payments).

10.6.4 Waiting period

- A waiting period is the number of consecutive days or months for which the insured person's occupational disability or functional impairment must have continued, or from the date of the fracture that must have passed before we'll start the monthly payments. There will be no monthly payments in the waiting period.
- It starts on the date of the occupational disability, functional impairment or the fracture as confirmed by Old Mutual's Medical Officer.
- Premiums must continue to be paid during the waiting period.
- The waiting period can be increased or decreased after start of the contract, subject to the following:
  - Premiums will change to reflect the new waiting period
  - Additional underwriting will apply where the waiting period is decreased.
- If the seven-day waiting period is selected and the occupational disability or functional impairment was directly or indirectly caused by a condition below, a one-month waiting period will apply:
  - cosmetic surgery or procedures, unless reconstructive in nature, following an accident or illness which happened after the cover start date,
  - fertility treatments to facilitate pregnancy,
  - non-surgical treatment to cure impotence or to improve potency,
  - uncomplicated pregnancy,
  - uncomplicated birth including caesarean sections,
  - any spinal conditions unless,
    - diagnosed by a specialist orthopaedic or neurosurgeon ,
    - supported by medical evidence of spinal pathology and
    - for which they were hospitalised for at least 24 hours
  - any mechanical musculoskeletal disorder primarily causing pain, decreased range of motion or loss of sensation unless
    - diagnosed by a specialist orthopaedic or neurosurgeon and
    - for which they were hospitalised for at least 24 hours

- all psychiatric disorders unless diagnosed by a psychiatrist and for which they were hospitalised for at least 24 hours,
- headaches and migraines unless diagnosed by a neurologist and for which they were hospitalised for at least 24 hours,
- the common cold (coryza), rhinitis, sinusitis, influenza, bronchitis, pharyngitis, laryngitis, pneumonia or any combination of these, unless they were hospitalised for at least 24 hours,
- any functional pain disorders including:
  - chronic fatigue syndrome,
  - fibromyalgia,
  - myalgic encephalopathy (yuppie flu),

    unless diagnosed by a specialist orthopaedic or neurosurgeon or rheumatologist and for which they were hospitalised for at least seven days.

10.6.5 Payment rules

- The monthly payments for a valid claim will start after the end of the waiting period.
- The payment day is the day of the month on which the owner chooses to receive the monthly payments. When the owner of the contract claims, they can choose the payment day. If the owner doesn't choose a day of the month, the payment day will be the last day of the month.
- If the insured person is occupationally disabled or functionally impaired for part of a month when the monthly payment is payable, we'll pay a proportion of the monthly payment that would have applied for that month.
- If all our requirements are met before the waiting period has passed, we'll pay the first monthly payment on the payment day immediately after the end of the waiting period to cover the time after the end of the waiting period and up to the date of the first monthly payment.
- If all our requirements are met after the waiting period has passed and:
  - if there was at least one payment day between the end of the waiting period and the date our requirements are met, we'll pay:
    - a single amount to cover the time after the end of the waiting period and up to the payment day immediately before or on the date our requirements are met and
    - the first monthly payment on the payment day immediately after the date our requirements are met to cover the time after the payment day immediately before or on the date our requirements are met and up to the date of the first monthly payment
  - if there was no payment day between the end of the waiting period and the date our requirements are met, we'll pay the first monthly payment on the payment day immediately after the date our requirements are met to cover the time after the end of the waiting period and up to the date of the first monthly payment.
- We won't pay interest on any of these amounts:
  - If the contract is cancelled before the waiting period ends, we won't start the monthly payments.
  - In payment escalation: If a scheduled yearly cover increases option was chosen, this will continue to apply even though claim payments are being made.
  - If the insured person qualified for more than one claim at the same time, once we stop making payments for the claim that resulted in the highest percentage of the cover amount, we'll continue to make monthly payments at a lower percentage of the cover amount if the insured person still qualifies for monthly payments under another claim.
  - If the monthly payments stop and cover continues, premium payments must restart.

10.6.6 Number of monthly payments

- Maximum number of payments:
  - We'll make up to 24 full monthly payments for occupational disability and functional impairment for related events.
  - The owner can claim more than once if:
    - for related events, we haven't made 24 full monthly payments on this cover together with the Sickness Income Benefit or the Income Extender Benefit, if it was chosen, or
    - the incident or condition that caused the occupational disability or functional impairment is completely unrelated to the reason for previous claims. We'll make up to 24 full monthly payments in this case.
- A full monthly payment is 100% of the cover amount. Where the monthly payment is less than 100% of the cover amount, this will increase the number of payments available such that a maximum of 24 full monthly payments is made.

Example
Jenna suffers from chronic liver failure at the highest severity and receives six full monthly payments (or 100% of the cover amount) for her functional impairment. She recovers but is later diagnosed with chronic gastrointestinal disease at the highest severity. Because Old Mutual's Medical Officer considered her chronic liver failure and chronic gastrointestinal disease as related, she'll only qualify for up to 18 more full monthly payments for this functional impairment. If she's later diagnosed with a functional impairment that's unrelated to chronic liver failure and chronic gastrointestinal disease, she can qualify for up to 24 full monthly payments.

Example
Jenna suffers from hypertension and qualifies for 50% of the cover amount. She may receive up to 48 monthly payments of 50% of the cover amount.
Chris loses his sight in one of his eyes and qualifies for 25% of the cover amount. He may receive up to 96 monthly payments of 25% of the cover amount.

- For occupational disability, we'll determine the number of monthly payments that we make in line with the period of time the insured person is occupationally disabled which may not exceed the average recommended period of recovery according to the latest edition of The Medical Disability Advisor: Workplace Guidelines for Disability Duration, by Presley Reed, M.D., or its replacement as determined by us. We'll consider making further payments if the treating doctor can provide us with sufficient medical motivation in the form of specialist reports or test results. Any supporting medical proof that we need will be at the owner's cost.
- For functional impairment, we'll determine the number of monthly payments that we make in line with the period of time the insured person continuously meets all the requirements of the functional impairment, as evidenced by sufficient specialist reports or test results from the treating doctor. Any supporting medical proof that we need will be at the owner's cost. The number of monthly payments we make for fractures is specified.

10.6.7 Premiums in claim

- Premiums must continue to be paid during the waiting period and while we decide if the claim is valid but the premiums are no longer due when we start the monthly payments.
- Premiums are payable again if the monthly claim payments stop and cover continues.

10.6.8 Linked claims

- For benefits with a seven-day or one-month waiting period, the waiting period on a subsequent related claim event may be waived if:
  - the insured person had been continuously occupationally disabled/functionally impaired for at least one month on the previous valid claim and
  - the claim event date on the subsequent related claim is within three months after recovery date of that previous valid claim.
- For benefits with a three-month, six-month, 12-months and 24-months waiting period, the waiting period on a subsequent related claim event may be waived if:
  - the claim event date on the subsequent related claim is within a period equal to the length of the waiting period after recovery date of the previous valid claim.
- Cover won't be paid between the date of recovery and the date of the subsequent claim event.

Example

Stan has Disability Income Cover with a one-month waiting period. He becomes occupationally disabled, and after the waiting period he receives monthly payments. Six months later Stan recovers, his monthly payments are stopped and he goes back to work. Two months after his recovery he's occupationally disabled for a second time. Stan won't have to go through the waiting period of one month and will once again receive monthly payments.

10.6.9 Enhanced in payment escalation

- In payment escalation: If a scheduled yearly cover increases option was chosen, this will continue to apply even though monthly claim payments are being made.
- Enhanced in payment escalation:
  - If the insured person's occupation is one of our qualifying occupations, the chosen scheduled yearly cover increases will be doubled while payments are being made under this cover.
  - If double the chosen scheduled yearly cover increases is more than 20%, the cover amount won't increase by more than 20%.
  - The enhanced in payment scheduled yearly cover increases stops and only the scheduled yearly cover increases will continue if:
    - five enhanced in payment scheduled yearly cover increases has been applied, or
    - the insured person turns 35

    whichever happens first.
- Enhanced in payment escalation won't apply if there are no scheduled yearly cover increases options chosen or scheduled yearly cover increases are no longer applicable on the benefit based on the rules around scheduled yearly cover increases.
- Where the owner discloses (as per the contract) any change of occupation from one that qualifies for the enhanced in payment escalation to one that doesn't, this will result in the entire cover being restructured such that the enhanced in payment escalation won't apply on the new restructured cover (and vice versa).
- In some cases, once the claim stops, the resulting cover amount may potentially be higher than the average net monthly income of the insured person when they recover and on return to work due to the enhanced in payment escalation rate. It's the owner's responsibility to ensure that the cover amount isn't greater than their average net monthly income and adjust their cover amount if necessary.

Example: Limitation to five enhanced in payment scheduled yearly cover increases

Bill is a lawyer and has R10 000 Disability Income Cover with a scheduled yearly cover increase of 5% with a scheduled yearly cover increase date on the contract anniversary. He's age 23 at the point of purchase. On his first contract anniversary date (age 24), he becomes occupationally disabled, and after the waiting period he receives monthly payments of R10 500. Since Bill's occupation qualifies him for an enhanced in payment escalation, on the second contract anniversary, Bill's cover amount is increased by 5% x 2 = 10%. His cover continues to increase by 10% at each contract anniversary until and including the sixth contract anniversary i.e. from age 25 next birthday till age 29. However, the enhanced in payment escalation will only apply for a minimum of five scheduled yearly cover increases or till the insured person turns 35. On his seventh and subsequent contract anniversaries, his cover will only increase by 5% while he's still claiming.

Example: Minimum enhanced scheduled yearly cover increases where claimant turns 35

Bill is a lawyer and has R10 000 Disability Income Cover with a scheduled yearly cover increase of 5% with a scheduled yearly cover increase date on the contract anniversary. He's age 30 at the point of purchase. On his first contract anniversary date (age 31, he becomes occupationally disabled, and after the waiting period he receives monthly payments of R10 500.
Since Bill's occupation qualifies him for an enhanced in payment escalation.

- On the second contract anniversary (age 32), Bill's cover amount is increased by 5% x 2 = 10%
- On the third contract anniversary (age 33), Bill's cover amount is increased by 5% x 2 = 10%
- On the fourth contract anniversary (age 34), Bill's cover amount is increased by 5% x 2 = 10%
- On the fifth contract anniversary (age 35), Bill's cover amount will only be increased by 5% as the enhanced in payment escalation will only apply for a minimum of five scheduled yearly cover increases or till the insured person turns 35.

10.7 Taxation

Under current revenue practice, premiums for income replacement benefits aren't tax deductible and the income benefit payment is tax free. As such, we limit the cover amount for income benefits by up to 100% of the insured person's average net monthly income to prevent them from being over insured.

The monthly payments stop on the earliest of the following:

- When the insured person dies.
- At the end of the term, if term cover was selected.
- If the maximum number of payments have been reached for related events if no Income Extender Benefit is selected.
- If we no longer recognise the insured person's functional impairment or occupational disability.
- If the insured person fails to meet our requirements for following reasonable medical advice or adequate medical treatment.
- If the insured person fails to meet our requirements for regular evaluation of their occupational disability or functional impairment.
- If the insured person no longer qualifies for this benefit because of changes to their circumstances unless the Sickness Income Benefit is attached, in which case the benefit stops:
  - 12 months after the insured person changed their occupational circumstances so that they don't continuously qualify for this benefit during these 12 months

  - immediately if the insured person no longer qualifies for the benefit because of changes to their circumstances other than their occupational circumstances.

- If the contract is cancelled.
- When the insured person's occupational disability cover stops while we're making monthly payments because of an occupational disability. If the monthly payments for occupational disability has stopped because the insured person's occupational disability cover has stopped, we'll re-evaluate the claim. If the insured person is functionally impaired, we'll start making monthly payments for functional impairment until the monthly payments stop for one of the other reasons listed above. If not, we'll stop making monthly payments under occupational disability but the cover will continue until the cover end date and future claims for functional impairment or fractures can be made.

10.8 Changes to the circumstances of the insured person on Disability Income Cover (including benefits and other features)

The owner must inform us if the:

- insured person starts participating recurrently in any risky activities which may expose them to a higher than average risk of accident or injury
- insured person makes a change to their occupational circumstances:
  - occupation or any detail of their occupation
  - industry
  - duty split
  - employment type
  - starts/stops a second occupation or changes the number of hours per week that they work
- insured person's income decreases
- insured person's income increases while we're making payments
- insured person's health/medical status changes (they recover or their condition improves) while we're making payments
- if the insured person dies.

10.9 Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that's generally excluded.

We won't pay if:

  - the owner fails to tell us about changes to the circumstances of the insured person (See changes to the circumstances of the insured person),
  - the insured person refuses to follow reasonable medical advice or adequate medical treatment,
  - the insured person's occupational disability, functional impairment or fracture is caused by:
    - unrest (for example: riot, civil commotion, insurrection and rebellion, war or terrorist activity),
    - radioactivity or nuclear explosion,
    - them provoking, committing or attempting to commit a crime for example murder, assault, housebreaking, theft, robbery, the forceful detention of another person or any similar crime,
    - self-inflicted injury.

- the insured person's occupational disability, functional impairment or fracture is before this benefit's cover start date,
- we don't recognise the insured person's occupational disability, functional impairment or fracture,
- the insured person's occupational disability, functional impairment or fracture is because of an excluded event, activity or condition or
- the waiting period isn't met.

We won't recognise the insured person's:

- **occupational disability if:**
  - they don't qualify for at least 25% of the cover amount or
  - they are able to do more than 75% of the main duties of their occupation.
- **functional impairment:**
  - that's not on the list of functional impairments,
  - at the severity that the contract doesn't cover or
  - that doesn't meet all the requirements that the functional impairment must meet to qualify.
- **fracture if:**
  - they suffer a fracture that's not on the list of fractures covered or
  - a waiting period longer than one month was chosen.

10.10 Disability Income Cover stops on the earliest of the following:

- When the insured person dies.
- At the end of the term, if term cover was selected.
- If the insured person no longer qualifies for this cover because of changes to their circumstances, unless the Sickness Income Benefit is added, in which case the cover stops:
  - 12 months after the insured person changed their occupational circumstances so that the insured person doesn't continuously qualify for this benefit during these 12 months
  - immediately if the insured person no longer qualifies for the benefit because of changes to their circumstances other than their occupational circumstances.
- If the insured person refuses to follow reasonable medical advice or adequate medical treatment.
- If the cover lapses.
- If the contract is cancelled.

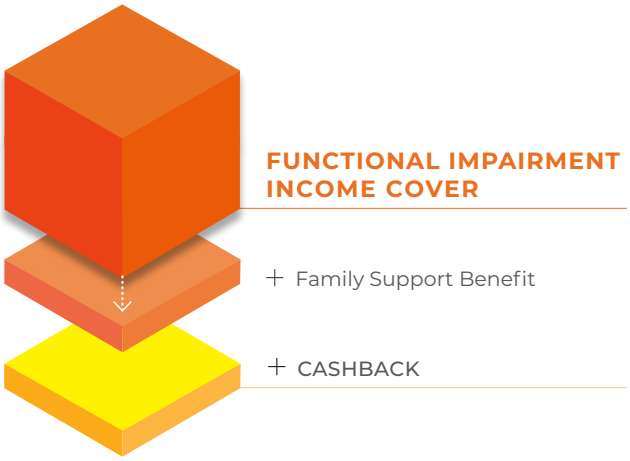
In addition to the above, occupational disability cover stops on the earliest of:

- The date the insured person retires.
- On the insured person's 69th birthday.

11. FUNCTIONAL IMPAIRMENT INCOME COVER

Functional Impairment Income Cover pays a monthly amount of up to 100% of the cover amount if the insured person becomes functionally impaired, and the waiting period is met. Payments for a fracture are also available on the Functional Impairment Income cover with a one-month waiting period.

11.1 Functional Impairment Income Cover overview



Functional Impairment Income Cover is designed for customers with the following needs:

- Don't want to depend on parents or children to financially assist if they should become functionally impaired.
- Don't have any functional impairment cover on their employee benefits.
- Need a monthly income to pay expenses.
- Need ongoing financial assistance to pay for rehabilitation costs or alternative treatment.

11.2 Functional Impairment Income Cover product features

TYPE OF COVER	COVER THAT PAYS MONTHLY AMOUNTS
Eligible lives	· Specified occupations as determined by our underwriters. · Cover will also be available to home executives and students. · Lives that are unemployed at entry won't be eligible for cover. Eligible lives are subject to underwriting and age limits.
Relationship to owner	There must be an insurable interest if the owner and insured person aren't the same person.
Maximum number of insured persons	One
Entry age limits	**Minimum:** 18 next birthday **Maximum:** 65 next birthday

Premium frequency	Monthly No premium skipping is allowed
Premium term	Benefit term
Compulsory yearly premium increase	· 0% fixed rate · 5% fixed rate · Age-linked
Guarantee term	· 1 year · 5 years
Cover amount limits	**Minimum:** R3 000 per month **Maximum:** The total cover can't exceed the smaller of 100% of average net of tax monthly earnings and · R60 000 per month for whole-life cover · R250 000 per month for term cover Maximum of R15 000 per month for home executives and students.
Waiting period	The insured person has a choice of one of the following waiting periods: · 1 month · 3 months · 6 months · 12 months · 24 months
Benefit term	· Whole-life · Term (minimum of 5 years)
Cover end age	· Whole-life · Term (70 next birthday)
Scheduled yearly cover increase	· 0% fixed rate · 5% fixed rate · Inflation-linked: CPI + 0%, 1%, 2%, 3%, -1%, -2%
Underwriting option	· Medical tests, questions or both · No medical tests, only questions
Underwriting credit	If the insured person completed 'medical tests, questions or both' for an amount less than the upper limit of a particular underwriting band, they could qualify for: · Single underwriting credit · Comprehensive underwriting credit

11.3 Definitions

Functionally impaired means that the insured person has suffered and meets the requirements of a qualifying functional impairment, despite following reasonable medical advice and adequate medical treatment.

Reasonable medical advice means the medical opinion provided by a health professional that the insured person can reasonably be expected to follow to improve or preserve their health. This may include investigations, recommendations, lifestyle adjustments and treatment options based on the best available information and appropriate to the condition, the health professional's knowledge and scope of practice.

Adequate medical treatment means the best possible treatment that a person can reasonably be expected to undergo and includes the use of simple external assistive devices for example hearing aids, glasses, contact lenses, a walking stick or a Zimmer frame but doesn't include the use of complex external assistive devices for example a wheelchair or leg prosthesis. The general meaning of the terms 'simple external assistive devices' and 'complex external assistive devices' isn't limited by the specific examples provided.

Fracture means damage to the continuity of a bone. Not all fractures qualify for benefits under this product, for example hairline fractures or fractures of the toe.

Related claim: Old Mutual's Medical Officer, supported by published medical evidence, determines if events are related. Typically this means that they stem from the same incident (for example a certain car accident) or condition (for example cancer) or from complications or treatment following the same incident or condition.

11.4 Benefits and other features

The owner can select all, neither or at least one of the following monthly amount benefits:

- Family Support Benefit.

These can be added when the cover is purchased or at a later date before the insured person reaches 60 next birthday. They can't be added while a claim is in process for Functional Impairment Income Cover or on any of the attached benefits and other features. Underwriting might be required and premiums will be adjusted if added at a later stage.

11.5 Add-ons

Cashback

See Cashback for more details.

Linked Cover

See Retrenchment Cover for more details.

11.6 Claiming Functional Impairment Income Cover

The cover amount for the insured person can be claimed when they become functionally impaired, and the waiting period is met. Payments for a fracture are also available on Functional Impairment Income cover with a one-month waiting period.

11.6.1 Functional Impairment

- The cover amount for the insured person can be claimed when they become functionally impaired, and the waiting period is met.
- Each monthly payment is equal to a percentage of the cover amount that applies on the payment day.
- For functional impairment, the percentage of the cover amount depends on:
  - the severity of the functional impairment, as indicated in the list of functional impairments,
  - the average monthly income the insured person was earning from their occupation immediately before they became functionally impaired, and
  - the average monthly income the insured person receives from any other source while they are functionally impaired. Examples of any other source include income earned from:
    - another occupation, and
    - any income payments received from:
      - their employer,
      - any product provider. Examples of a product provider include us and other insurers. It doesn't include payments received from the road accident fund or for the specific purpose of covering continuing business expenses.
- The percentage of the cover amount that's paid for functional impairment may change over time as the insured person's condition worsens or improves.

11.6.2 Fractures

- We'll pay 100% if the insured person meets the requirements of one of our defined fracture claim events for which we specify the number of monthly payments applicable, and the waiting period is met.
- Payments for fractures are only applicable for income benefits with a one month waiting period.
- If the insured person suffers more than one fracture simultaneously, or suffers other fractures during the payment period for a prior fracture, we'll only pay the number of monthly payments applicable to the fracture with the longest payment period for which the insured person qualifies.
- If we're already making payments for a functional impairment, there can't also be a claim for a fracture.
- The insured person can claim on multiple separate incidences, provided we aren't already making payments for a functional impairment.

Example: Single fracture with a one-month waiting period

Dr Sam is cardiovascular surgeon with a one month waiting period on his Functional Impairment Income Cover. He was in an accident which resulted in a fracture of his leg between the knee and foot. As a result of the fracture he's unable to perform surgeries as he cannot stand in the operating theatre. Dr Sam will receive one monthly payment.

Example: Simultaneous fractures with a one-month waiting period

Mark has a one-month waiting period on his Functional Impairment Income Cover. He was in an accident which resulted in a complete fracture of the pelvis and a fracture of the shoulder blade simultaneously. Mark will receive the number of monthly payments applicable to the fracture with the longest payment period for which he qualifies which is two monthly payments.

Example: Other fractures during the payment period of a prior fracture

Mark has a one-month waiting period on his Functional Impairment Income Cover. He was in an accident which resulted in a fracture of the shoulder blade. As a result, Mark will receive one monthly payment as a fracture payout.

Before his first monthly payment, he falls, resulting in a complete fracture of the shaft of the thigh bone. This qualifies him for two monthly payments. Since he's already claiming for a previous fracture, Mark will only receive the number of monthly payments applicable to the fracture with the longest payment period for which he qualifies. He'll only receive an additional one monthly payments (total of two monthly payments).

11.6.3 Waiting period

- A waiting period is the number of consecutive days or months for which the insured person's functional impairment must have continued, or from the date of the fracture that must have passed before we'll start the monthly payments. There will be no monthly payments in the waiting period.
- It starts on the date of the functional impairment or the fracture as confirmed by Old Mutual's Medical Officer.
- Premiums must continue to be paid during the waiting period.
- The waiting period can be increased or decreased after start of the contract, subject to the following:
  - Premiums will change to reflect the new waiting period.
  - Additional underwriting will apply where the waiting period is decreased.

11.6.4 Payment rules

- The monthly payments for a valid claim will start after the end of the waiting period.
- The payment day is the day of the month on which the owner has chosen to receive the monthly payments. When the owner of the contract claims, they can choose the payment day. If the owner doesn't choose a day of the month, the payment day will be the last day of the month.
- If the insured person is functionally impaired for part of a month when the monthly payment is payable, we'll pay a proportion of the monthly payment that would have applied for that month.
- If all our requirements are met before the waiting period has passed, we'll pay the first monthly payment on the payment day immediately after the end of the waiting period to cover the time after the end of the waiting period and up to the date of the first monthly payment.
- If all our requirements are met after the waiting period has passed and:
  - if there was at least one payment day between the end of the waiting period and the date our requirements are met, we'll pay:
    - a single amount to cover the time after the end of the waiting period and up to the payment day immediately before or on the date our requirements are met and
    - the first monthly payment on the payment day immediately after the date our requirements are met to cover the time after the payment day immediately before or on the date our requirements are met and up to the date of the first monthly payment.

  - If there was no payment day between the end of the waiting period and the date our requirements are met, we will pay the first monthly payment on the payment day immediately after the date our requirements are met to cover the time after the end of the waiting period and up to the date of the first monthly payment.

- We won't pay interest on any of these amounts:

  - In claim escalation: If a scheduled yearly cover increase option was chosen, this will continue to apply even though claim payments are being made.
  - If the insured person qualified for more than one claim at the same time, once we stop making payments for the claim that resulted in the highest percentage of the cover amount, we'll continue to make monthly payments at a lower percentage of the cover amount if the insured person still qualifies for monthly payments under another claim.
  - If the monthly payments stop and cover continues, premium payments must restart.

11.6.5 Number of monthly payments

- For functional impairment, we'll determine the number of monthly payments that we make in line with the period of time the insured person continuously meets all the requirements of the functional impairment, as evidenced by sufficient specialist reports or test results from the treating doctor. Any supporting medical proof that we need will be at the owner's cost.
- The number of monthly payments we make for fractures is specified.

11.6.6 Premiums in claim

- Premiums must continue to be paid during the waiting period and while we decide if the claim is valid but the premiums are no longer due when we start the monthly payments.
- Premiums are payable again if the monthly claim payments stop and cover continues.

11.6.7 Linked claims

- For cover with a one-month waiting period, the waiting period on a subsequent related claim event may be waived if:
  - the claim event date on the subsequent related claim is within three months after the recovery date of that previous valid claims (for which the insured person was continuously impaired for 1 month),
- For benefits with a three-month, six- month, 12-month and 24-month waiting period, the waiting period on a subsequent related claim event may be waived if:
  - the claim event date on the subsequent related claim is within a period equal to the length of the waiting period after the recovery date of the previous valid claim.
- Cover won't be paid between the date of recovery and the date of the subsequent claim event.

Example

Stan has Functional Impairment Income Cover with a one-month waiting period. He becomes functionally impaired, and after the waiting period he receives monthly benefit payments. Six months later Stan recovers and his monthly payments are stopped. Two months after his recovery he's functionally impaired from a condition that's related to his previous claim. Stan won't have to go through the waiting period of one month and will once again receive monthly benefit payments.

11.6.8 Enhanced in payment escalation

- In payment escalation: If a scheduled yearly cover increase option was selected, this will continue to apply even though claim payments are being made.
- Enhanced in payment escalation:
  - If the insured person's occupation is one of our qualifying occupations, the chosen scheduled yearly cover increases will be doubled while payments are being made under this benefit.
  - If double the chosen scheduled yearly cover increases is more than 20%, the cover amount won't increase by more than 20%.
  - The enhanced in payment scheduled yearly cover increases stops and only the scheduled yearly cover increases will continue if:
    - we've already applied five enhanced in payment scheduled yearly cover increases or
    - the insured person turns 35

    whichever happens first.
- Enhanced in payment escalation won't apply if there are no scheduled yearly cover increases options chosen or scheduled yearly cover increases are no longer applicable on the benefit based on the rules around scheduled yearly cover increases.
- Where the insured person discloses (as per the contract) any change of occupation from one that qualifies for the enhanced in payment escalation to one that doesn't, this will result in the entire cover being restructured such that the enhanced in payment escalation won't apply on the new restructured cover (and vice versa).
- In some cases, once the claim stops, the resulting cover amount may potentially be higher than the average net monthly income of the insured person when they recover and on return to work due to the enhanced in payment escalation. It's the owner's responsibility to ensure that the cover amount isn't greater than the insured person's average net monthly income and adjust the cover amount if necessary.

Example: Limitation to five enhanced in payment scheduled yearly cover increases

Bill is a lawyer and buys R10 000 Functional Impairment Income Cover with a scheduled yearly cover increase of 5% with a scheduled yearly cover increase date on the contract anniversary. He's 23 at the point of purchase. On his first contract anniversary date (age 24), he becomes functionally impaired, and after the waiting period he receives monthly benefit payments of R10 500. Since Bill's occupation qualifies him for an enhanced in payment escalation, on the second contract anniversary, Bill's cover amount is increased by 5% x 2 = 10%. His cover continues to increase by 10% at each benefit anniversary, so that only five enhanced in payment increases is applied The enhanced in payment escalation will only apply for a minimum of five scheduled yearly cover increases or until the insured person turns 35. On his seventh and subsequent contract anniversaries, his cover will only increase by 5% while he's still claiming.

Example: Minimum enhanced scheduled yearly cover increases where insured person turns 35

Bill is a lawyer and buys R10 000 Functional Impairment Income Cover with a scheduled yearly cover increase of 5% with a scheduled yearly cover increase date on the contract anniversary. He's 30 at the point of purchase. On his first contract anniversary date (age 31), he becomes functionally impaired, and after the waiting period he receives monthly cover payments of R10 500.

- Since Bill's occupation qualifies him for an enhanced in payment escalation:
  - On the second benefit anniversary (age 32), Bill's cover amount is increased by 5% x 2 = 10%
  - On the third benefit anniversary (age 33), Bill's cover amount is increased by 5% x 2 = 10%
  - On the fourth benefit anniversary (age 34), Bill's cover amount is increased by 5% x 2 = 10%
  - On the fifth benefit anniversary (age 35), Bill's cover amount will only be increased by 5% as the enhanced in payment escalation will only apply for a minimum of five scheduled yearly cover increases or until the insured person turns 35.

11.7 Taxation

Under current revenue practice, premiums for income replacement benefits aren't tax deductible and the income benefit payment is tax free. As such, we limit the cover amount for income benefits by up to 100% of the insured person's average net monthly income to prevent them from being over insured.

The monthly payments stop on the earliest of the following:

- When the insured person dies.
- At the end of the term, if term cover was selected.
- If we no longer recognise the insured person's functional impairment.
- If the insured person fails to meet our requirements for following reasonable medical advice or adequate medical treatment.
- If the insured person fails to meet our requirements for regular evaluation of their functional impairment.
- When we've made the last monthly payment that the insured person qualifies for (explained under 'Number of monthly payments').
- If the insured person no longer qualifies for the cover because of changes to their circumstances. (See changes to the circumstances of the insured person).
- If the contract is cancelled.

11.8 Changes to the circumstances of the insured person on Functional Impairment Income Cover

The owner must inform us if the:

- insured person starts participating recurrently in any risky activities which may expose them to a higher than average risk of accident or injury.
- insured person's health/medical status changes (they recover or their condition improves) while we're making payments.
- the insured person dies.

11.9 Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that's generally excluded.

We won't pay if:

- the owner fails to meet the requirement to tell us about changes to the circumstances of the insured person (See changes to the circumstances of the insured person),
- the insured person refuses to follow reasonable medical advice or adequate medical treatment,
- the insured person's functional impairment or fracture is caused by:
  - unrest (for example: riot, civil commotion, insurrection and rebellion, war or terrorist activity),
  - radioactivity or nuclear explosion,
  - them provoking, committing or attempting to commit a crime for example murder, assault, housebreaking, theft, robbery, the forceful detention of another person or any similar crime or
  - self-inflicted injury.
- the insured person's functional impairment or fracture is before the cover start date of this cover,

- we don't recognise the insured person's functional impairment or fracture,
- the insured person's functional impairment or fracture is because of an excluded event, activity or condition or
- if the waiting period isn't met.

We won't recognise the insured person's:

- **functional impairment:**
  - that isn't on the list of functional impairments,
  - at the severity that the contract doesn't cover or
  - that doesn't meet all the requirements that the functional impairment must meet to qualify.
- **fracture if:**
  - they suffer a fracture that isn't on the list of fractures that the contract cover or
  - a waiting period of longer than one month was selected.

11.10 Functional Impairment Income Cover stops on the earliest of the following:

- When the insured person dies.
- At the end of the term, if term cover was selected.
- If the insured person fails to meet our requirements for following reasonable medical advice or adequate medical treatment.
- If the cover lapses.
- If the contract is cancelled.
- If the insured person no longer qualifies for the cover because of changes to their circumstances.

12. BENEFITS AND OTHER FEATURES (MONTHLY AMOUNTS)

12.1 INCOME EXTENDER BENEFIT

The Income Extender Benefit can't exist on its own and can be attached to the Disability Income Cover. It increases the number of monthly payments for occupational disability and functional impairment from the maximum of 24 full monthly payments on related events on Disability Income Cover.

12.1.1 Claiming Income Extender Benefit

Same as under Disability Income Cover.

12.1.1.1 Waiting period

Same as under Disability Income Cover.

12.1.1.2 Payment rules

Same as under Disability Income Cover.

12.1.1.3 Number of monthly payments

The Disability Income Cover pays up to 24 full monthly payments on related events. We may pay more than once for unrelated events. The Income Extender Benefit increases the number of monthly payments for occupational disability and functional impairment. Instead of making up to 24 full monthly payments on related events, because of the Income Extender Benefit, we'll only stop making monthly payments on the earliest of the events listed under the section below referencing when the monthly payments stops.

For occupational disability:

- We'll determine the number of monthly payments that we make in line with the period of time the insured person is occupationally disabled. This may not exceed the average recommended period of recovery according to the latest edition of The Medical Disability Adviser: Workplace Guidelines for Disability Duration, by Presley Reed, M.D., or its replacement as determined by us.
- We'll consider making further payments if the treating doctor can provide us with sufficient medical motivation in the form of specialist reports or test results.

For functional impairment:

- We'll determine the number of monthly payments that we make in line with the period of time the insured person continuously meets all the requirements of the functional impairment, as evidenced by sufficient specialist reports or test results from the treating doctor.

Any supporting medical proof that we need will be at the owner's cost.

Example: Disability Income Cover only

Shamiela is a flight attendant age 35 with R13 000 per month Disability Income Cover. She chose a 20-year cover term. This means she'll be covered until age 55. After nine years (age 44) Shamiela is diagnosed with permanent and irreversible advanced Stage IV cancer and is unable to perform certain daily activities. She meets the requirements for 100% payout under the functional impairment definition for cancer. After the waiting period has passed and provided she's met all our requirements, she'll receive a monthly payment of R13 000 for a maximum of 24 months as Disability Income Cover pays out a maximum of 24 full monthly payments for related events.

Example: Disability Income Cover with the Income Extender Benefit (term cover)

Shamiela is a flight attendant age 35 with R13 000 Disability Income Cover and the Income Extender Benefit. She chose a 20-year cover term. This means she'll be covered until age 55. After nine years (age 44) Shamiela is diagnosed with permanent and irreversible advanced Stage IV cancer and is unable to perform certain daily activities. She meets the requirements for 100% payout under the functional impairment definition for cancer. After the waiting period has passed and provided she's met all our requirements, she'll receive a monthly payment of R13 000 until the remainder of her term (until age 55) unless the monthly payments stop because of any other claim reason (listed under the section below referencing when the monthly payments stops) that occurs earlier e.g. death or if she recovers.

Example: Disability Income Cover with the Income Extender Benefit (whole-life cover)

Shamiela is a flight attendant age 35 with R13 000 Disability Income Cover and the Income Extender Benefit. She chose whole-life cover in this instance. After nine years (age 44) Shamiela is diagnosed with permanent and irreversible with advanced Stage IV cancer and is unable to perform certain daily activities. She meets the requirements for 100% payout under the functional impairment definition for cancer. After the waiting period has passed and provided she's met all our requirements, she'll receive a monthly payment of R13 000 unless the monthly payments stop because of any other reason (listed under the section below referencing when the monthly payments stops) that occurs earlier e.g. death or if she recovers.

12.1.1.4 Premiums in claim

Same as under Disability Income Cover.

12.1.1.5 Linked claims

Same as under Disability Income Cover.

12.1.1.6 Enhanced in payment escalation

Same as under Disability Income Cover.

12.1.2 Taxation

Same as under Disability Income Cover.

Monthly payments stop on the earliest of the following:

- At the end of the term, if term cover was selected.
- When the insured person dies.
- If we no longer recognise the insured person's functional impairment or occupational disability (explained under excluded events, activities or conditions).
- If the insured person fails to meet our requirements for following reasonable medical advice or adequate medical treatment.
- If the insured person fails to meet our requirements for regular evaluation of their occupational disability or functional impairment.
- The insured person no longer qualifies for this cover because of changes to their circumstances.
- The contract is cancelled.
- When we've made the last payment that the insured person qualifies for.
- When their occupational disability cover stops while we're making monthly payments because of occupational disability. If the monthly payments for occupational disability has stopped because the insured person's occupational disability cover has stopped, we'll re-evaluate the claim. If the insured person is functionally impaired, we'll start making monthly payments for functional impairment until the monthly payments stop for one of the other reasons listed above. If not, we'll stop making monthly payments under occupational disability but the cover will continue until the cover end date and future claims for functional impairment or fractures can be made.

12.1.3 Exclusions

Same as under Disability Income Cover.

12.1.4 Income Extender Benefit stops on the earliest of the following:

Same as under Disability Income Cover.

- In addition, cover under this benefit stops if it is removed from your contract.

12.2 SICKNESS BENEFIT

The Sickness Benefit can't exist on its own and can be attached to Disability Income Cover if a seven-day or one-month waiting period is selected on the Disability Income Cover. It pays monthly amounts if the insured person is booked off by a doctor as a result of a sickness or injury for the full duration of the waiting period. Once in claim the benefit payout isn't dependent on whether the insured person is earning an income or not. This benefit together with Disability Income Cover adds the definition of being booked off sick with the aim of allowing for a quicker payout. If the insured person doesn't qualify for a claim under this benefit, they may still be assessed to see if they meet the definitions to claim under the Disability Income Cover.

The Sickness Benefit can only be added to the Disability Income Cover with waiting periods of:

- 7 day
- 1 month

The Sickness Benefit will not be allowed on Disability Income Cover where a waiting period of 3 month, 6 month, 12 month or 24 months has been selected on the Disability Income Cover.

12.2.1 Eligible lives

- Eligible lives are subject to underwriting and age limits.
- Insured persons with specified preferred occupations as determined by our underwriters.
- Lives that are unemployed at entry won't be eligible for cover.

12.2.2 Benefit term

Term (minimum of 5 years).

12.2.3 Benefit end age

Earliest of:

- the end of the term if term cover was selected on Disability Income Cover.
- age 70 next birthday.

12.2.4 Definitions

Booked off sick: We'll consider the insured person as booked off if, at the time they were booked off, they were:

- practising their occupation.
- on approved leave or
- on a period of special consideration.

Approved leave is the period of annual leave, maternity leave or family responsibility leave in line with the Basic Conditions of Employment Act (or its replacement) or as per the employer's leave contract where entitled to full pay, if these periods are longer.

Special consideration includes the time when the insured person:

- isn't practicing their occupation or
- has been granted leave as an extension to approved leave by their employer or
- has been granted unpaid leave by their employer.

Special consideration on its own or together with approved leave can't be more than 12 months.

Occupation is the occupation as stated on the contract under the insured person's occupation.

Related: Old Mutual's Medical Officer, supported by published medical evidence, determines if events are related. Typically this means that they stem from the same incident (for example a certain car accident) or condition (for example cancer) or from complications or treatment following the same incident or condition.

12.2.5 Claiming Sickness Benefit

- The cover amount for the insured person can be claimed when they are continuously booked off by a doctor for the full duration of the selected waiting period.
- Each monthly payment is equal to a percentage of the cover amount that applies on the payment day.
- The percentage of the cover amount payable for the Sickness Benefit depends on whether the insured person has been continuously booked off for their full day or part of the day:

BOOKED OFF FOR	% OF THE COVER AMOUNT PAYABLE
Full day	100%
Part of the day	50%

- The percentage of the cover amount that's paid may change over time as the insured person's condition worsens or improves.
- If the insured person is continuously booked off for part of a month when the monthly payment is payable, we'll pay a proportion of the monthly payment that would have applied for that month.
- If the insured person qualifies for a claim on this benefit and on the Disability Income Cover at the same time, we'll only pay the claim on this benefit.

12.2.5.1 Waiting period

- The waiting period is the same as that selected on the Disability Income Cover it's attached to. The Sickness Benefit may only be attached to a Disability Income Cover that has a seven-day or one-month waiting period.
- A waiting period is the number of consecutive days or months for which the insured person must have been booked off and that must have passed before we'll start the monthly payments.
- It starts on the first day that the insured person is booked off.
- Premiums must continue to be paid during the waiting period and one more premium must be paid after the waiting period has ended.
- If the seven-day waiting period is selected and the insured person is booked off because of a condition below, a one-month waiting period will apply:
  - non-surgical treatment to cure impotence or to improve potency
  - uncomplicated pregnancy

- uncomplicated birth including caesarean sections
- any spinal conditions unless
  - diagnosed by a specialist orthopaedic or neurosurgeon and
  - supported by medical evidence of spinal pathology
- any mechanical musculoskeletal disorder primarily causing pain, decreased range of motion or loss of sensation unless
  - diagnosed by a specialist orthopaedic or neurosurgeon and
  - for which they were hospitalised for at least 24 hours
- all psychiatric disorders unless
  - diagnosed by a psychiatrist and for which they were hospitalised for at least 24 hours or
  - diagnosed by a psychiatrist as a chronic condition for which consultation with the psychiatrist and treatment is required for more than six months
- headaches and migraines unless diagnosed by a neurologist and for which they were hospitalised for at least 24 hours or
- any functional pain disorders including
  - chronic fatigue syndrome
  - fibromyalgia or
  - myalgic encephalopathy (yuppie flu)

  unless diagnosed by a specialist orthopaedic or neurosurgeon or rheumatologist and they were hospitalised for at least seven days.

- There will be no monthly payments for the waiting period, unless a day 1 or day 15 payment applies.
- Day 1 payment: If the seven-day waiting period is selected and if the insured person is:
  - continuously booked off for their full day for the duration of the chosen waiting period and
  - not booked off because of any of the conditions listed above, a payment will accrue from day 1 (retrospectively).
- Day 15 payment: If the one-month waiting period is selected and if the insured person is:
  - continuously booked off for their full day for the duration of the chosen waiting period
  - has been hospitalised for at least 48 consecutive hours during this period and
  - not booked off because of any of the conditions listed above, a payment will accrue from day 15 (retrospectively).

12.2.5.2 Payment rules

Same as under Disability Income Cover.

12.2.5.3 Number of monthly payments

- Maximum number of benefit payments:
  - We'll make up to 24 full monthly payments if the insured person is booked off due to sickness or injury for related events. The owner can claim more than once if:
    - for related events, we haven't made 24 full monthly payments for this benefit together with the Disability Income Cover or Income Extender Benefit, if selected or

  - the incident or condition that caused the event is completely unrelated to the reason for previous claims. We'll make up to 24 full monthly payments in this case
- If the insured person is booked off due to sickness or injury during a time of special consideration, we'll make up to 12 full monthly payments if we haven't made 24 full monthly payments for related events for this benefit together with the Disability Income Cover. The owner can claim more than once during the same time of special consideration if:
  - for related events, we haven't made 12 full monthly payments or
  - the incident or condition that caused the event is completely unrelated to the reason for previous claims. We'll make up to 12 full monthly payments in this case.

- A full monthly payment is 100% of the cover amount. Where the monthly payment is less than 100% of the cover amount, this will increase the number of payments available such that a maximum of 24 full monthly payments is made.
- We'll determine the number of monthly payments that we make in line with the period of time the insured person is booked off due to sickness or injury. This may not exceed the average recommended period of recovery according to the latest edition of The Medical Disability Adviser: Workplace Guidelines for Disability Duration, by Presley Reed, M.D., or its replacement as determined by us. We'll consider making further payments if the treating doctor can provide us with sufficient medical motivation in the form of specialist reports or test results. Any supporting medical proof that we need will be at the owner's cost.
- Where the Income Extender Benefit is attached, after we've made the last monthly payment that the insured person qualifies for under the Sickness Benefit as explained above, the monthly payments for the Sickness Benefit stops and we'll re-evaluate the claim under the occupational disability or functional impairment definitions. If the insured person qualifies under either of these definitions, we'll start making monthly payments under the Income Extender Benefit.

12.2.5.4 Premiums in claim

- Premiums must continue to be paid during the waiting period and one more premium must be paid after the waiting period has ended. Premiums must also be paid while we decide if the claim is valid, but the premiums are no longer due when we start the monthly payments.
- Premiums are payable again if the monthly claim payments stop and cover continues.

12.2.5.5 Linked claims

- The waiting period on a subsequent related claim event may be waived if:
  - the insured person had been continuously booked off for one month on the previous valid claim and
  - the claim event date on the subsequent related claim is within three months after recovery date of that previous valid claim.
- Cover won't be paid between the date of recovery and the date of the subsequent claim event.

The monthly payments stop on the earliest of the following:

- When the benefit set of 24 payments for related claims ends (for claims where the insured person is booked off at a time when they were practising their occupation or was on approved leave).
- When the benefit set of 12 payments for related claims ends (for claims where the insured person is booked off at a time when they were on a period of special consideration).

- When the insured person dies.
- At the end of the term.
- When the insured person is no longer booked off or returns to work.
- If the insured person fails to meet our requirements for following reasonable medical advice or adequate medical treatment.
- If the insured person fails to meet our requirements for regular evaluation of their sickness or injury.
- Twelve months after the insured person changed their occupational circumstances so that they don't continuously qualify for this benefit during these twelve months.
- If the insured person no longer qualifies for the benefit because of changes to their circumstances other than their occupational circumstances.
- If the contract is cancelled.

12.2.6 Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that's generally excluded.

We won't pay if:

- the owner fails to meet our requirement to tell us about changes to the circumstances of the insured person (See changes to the circumstances of the insured person),
- the owner claims more than one year after the date that the insured person recovered from a sickness or injury,
- the insured person refuses to follow reasonable medical advice or adequate medical treatment,
- the insured person is booked off because of:
  - unrest (for example: riot, civil commotion, insurrection and rebellion, war or terrorist activity),
  - radioactivity or nuclear explosion,
  - them provoking, committing or attempting to commit a crime for example murder, assault, housebreaking, theft, robbery, the forceful detention of another person or any similar crime,
  - self-inflicted injury or
  - cosmetic surgery or procedures, unless reconstructive in nature because of a sickness or injury suffered after the cover start date.
- the insured person has been booked off before the cover start date,
- the insured person has been booked off because of an excluded event, activity or condition or
- the waiting period isn't met.

12.2.7 Sickness Benefit stops on the earliest of the following:

- At the end of the term.
- When the insured person dies.
- If the cover lapses.
- On the date of retirement of the insured person, if this is earlier than the selected term.
- On the insured person's 69th birthday.
- If the insured person refuses to follow reasonable medical advice or adequate medical treatment.
- If the benefit is removed from the contract.
- Twelve months after the insured person changed any of their occupational circumstances so that they don't continuously qualify for this benefit during these 12 months.
- If the insured person no longer qualifies for the benefit because of changes to their circumstances other than their occupational circumstances.
- If the contract is cancelled.

12.3 FAMILY SUPPORT BENEFIT

This can be added when the cover is purchased or at a later date before the insured person reaches 60 next birthday. This benefit can't be added while a claim is in process for the cover it's attached to, which can be either Functional Impairment Income or Disability Income Cover.

The Family Support Benefit can't exist on its own and can be attached to either Functional Impairment Income or Disability Income Cover.

The Family Support Benefit includes the following:

- Spouse/Partner and Child Benefit.
- Maternity/Paternity Benefit.

12.3.1 SPOUSE/PARTNER AND CHILD BENEFIT

This benefit aims to provide cover when the insured person may incur additional costs if their:

- spouse/partner dies or needs their care because of a severe illness.
- child needs their care because of a severe illness, and the survival period is met.

12.3.1.2 Eligible lives

- Male or female lives who have bought Functional Impairment Income or Disability Income Cover together with the Family Support Benefit.
- Biological, legally adopted or step child of the insured person are included.

12.3.1.3 Age limits

Benefit is only available until:

- Insured person: 65 next birthday.
- Spouse/partner: 65 next birthday.
- Child: 19 next birthday.

12.3.1.4 Definitions

Spouse/partner is the person to whom the insured person is married or with whom they are in a relationship similar to marriage that's intended to be permanent.

Child must be the insured person's biological, step or legally adopted child. To qualify for cover under this benefit, a stepchild's biological or legally adoptive parent must, at any time after the birth of the stepchild, have been married to the insured person. For the purposes of this definition, married means a marriage (including a customary marriage) or union recognised under South African law.

12.3.1.5 Claiming Spouse/Partner and Child Benefit

- It pays up to three monthly payments if the insured person's:
  - spouse/partner dies or needs their care because of a severe illness. Severe illness means that the spouse/partner suffers and meets the requirements of a qualifying severe illness as confirmed by Old Mutual's Medical Officer.
  - child needs their care because of a severe illness, and the child meets the survival period. Severe illness means that the child suffers and meets the requirements of a qualifying severe illness as confirmed by Old Mutual's Medical Officer.
- We'll pay 100% of the cover amount of the benefit's its attached to, that's applicable on the date that we make the monthly payment.

- Each monthly payment is limited to R100 000.
- A maximum of three claims can be admitted during the term of the benefit.
- A maximum of one claim can be admitted during the term of the benefit for a spouse/partner's death or severe illness.
- A maximum of two claims can be admitted during the term of the benefit for a child severe illness with a further maximum of one claim per child.
- Where there are multiple valid claims (subject to the above maximums) at the same time under this benefit, we'll pay the claims simultaneously.
- A valid Spouse/Partner and Child Benefit claim will be payable even if we're making monthly payments under the Functional Impairment Income or Disability Income Cover or on any attached benefits and vice versa.
- The cover on the Functional Impairment Income or Disability Income Cover (including any of the attached benefits) won't be reduced by a claim on the Spouse/Partner Benefit and Child Benefit.
- The monthly payments for valid claims will start on the payment day, once our requirements are met.
- If our requirements are met after the payment day, we'll pay a single amount to cover the time after the date of the severe illness or the spouse/partner's death and up to the start of the monthly payments.
- We won't pay interest on any of these amounts.
- The owner will be responsible for the cost of medical proof when a claim is submitted.

Example: Death of spouse/partner and one child severe illness claim

David has R50 000 Functional Impairment Income Cover with the Family Support Benefit. David has a wife, Lisa and two children, Cathy and Mark. Lisa and Mark were in a car accident and Lisa dies, Mark suffers severe burns but also loses his sight. Mark's conditions meets two of the child severe illness definitions. So the benefit payment for each month for the next three months would be: R50 000 under the first claim (spouse/partner's death). Despite the fact that Mark meets two of the child severe illness definitions, the benefit is limited to one claim per child and David will receive R50 000 under the second claim. David will be able to claim once more if Cathy were to meet one of the severe illness definitions in future.

Example: Death of a spouse/partner and two child severe illness claims

David has R50 000 Functional Impairment Cover with the Family Support Benefit. David has a wife, Lisa and two children, Cathy and Mark. Lisa and both the children were in a car accident and Lisa dies, Mark suffers severe burns and Cathy loses her sight. Both Mark and Cathy's conditions meet the definition under the child severe illness benefit. So the benefit payment for each month for the next three months would be the sum of:

- R50 000 under the first claim (spouse/partner's death) and
- R50 000 under the second claim (Child Severe Illness on Mark) and
- R50 000 under the third claim (Child Severe Illness on Cathy)
- He has made the maximum of three claims, and the Spouse/Partner and Child Benefit stops.

Survival period

Only applies to a Child Benefit event:

We'll admit a claim only if the child survived the claim event for 10 days from the date of the event.

Premiums in claim

While we make the monthly payments, premiums don't need to be paid (premiums on the benefit that the Family Support Benefit is attached to).

Monthly payments stop on the earliest of the following:

- When the insured person dies.
- When we've made three monthly payments.
- On the Family Support Benefit's cover end date.
- If the contract is cancelled.
- On the insured person's 64th birthday.
- If the Family Support Benefit is removed from the contract.

If the monthly payments stop and cover continues, premiums must be restarted.

13.3.1.6 Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that's generally excluded.

We won't pay if:

- if the claim is directly or indirectly caused by an event, activity or condition that's excluded.
- the spouse/partner's death or the severe illness is before the Family Support Benefit's cover start date,
- we don't recognise the severe illness,
- the claim under Spouse/Partner and Child Benefit is because of an excluded event, activity or condition,
- the owner fails to meet our requirement to tell us about changes to the circumstances of the insured person (See changes to the circumstances of the insured person).
- the claim is because of:
  - unrest (for example: riot, civil commotion, insurrection and rebellion, war or terrorist activity),
  - radioactivity or nuclear explosion,
  - the spouse/partner or child provoking, committing or attempting to commit a crime for example murder, assault, housebreaking, theft, robbery, the forceful detention of another person or any similar crime,
  - a self-inflicted injury.
- the spouse/partner's death is because of anything other than an accident within six months of Family Support Benefit's start date or
- the severe illness is within six months of the Family Support Benefit's start date,
- the spouse/partner's death is because of suicide in the first two years from Family Support Benefit's start date,
- the claim is because of any conditions with which:
  - the spouse/partner or child was diagnosed before the Family Support Benefit's start date,
  - the child was diagnosed before they became the insured person's legally adopted or stepchild,
  - the spouse/partner was diagnosed before they became the insured person's spouse/partner,
- the claim was directly or indirectly caused by the use of alcohol, poison, drugs or non-prescribed medication,
- the claim was as a result of a crime the owner committed against them or
- the child doesn't live for at least 10 days from the date of the severe illness.

We won't recognise the severe illness if the spouse/partner or child suffers a severe illness:

- that isn't on the list of severe illnesses,
- at the severity that the contract doesn't cover or
- that don't meet all the requirements that the severe illness must meet to qualify.

12.3.1.7 Spouse/Partner and Child Benefit stops on the earliest of the following:

- When the insured person dies.
- On the Family Support Benefit's cover end date.
- If the cover lapses.
- If the contract is cancelled.
- Once we've paid three valid claims under Spouse/Partner and Child Benefit.
- On the insured person's 64th birthday.
- Cover for a spouse/partner stops on their 64th birthday.
- Cover for a child stops on their 18th birthday.
- If the Family Support Benefit is removed from the contract.

12.3.2 MATERNITY/PATERNITY BENEFIT

It pays a single amount when an insured event happens.

An insured event is when the:

- biological child of the insured person is born or stillborn or
- biological child of the spouse of the insured person is born or stillborn or
- insured person legally adopts a child younger than three.

12.3.2.1 Eligible lives

Insured persons who have Functional Impairment Income or Disability Income with the Family Support Benefit.

12.3.2.2 Definitions

Child is a biological, legally adopted or step child of the insured person.
Stillbirth: The biological mother of the child must have been at least 26 weeks pregnant for the child to qualify as stillborn.

12.3.2.3 Claiming Maternity/Paternity Benefit

- We'll pay the cover amount of four times the monthly premium that was applicable at the insured event date, once our requirements have been met and if the claim is valid.
- For stillbirth claim events, we will pay the smaller of:
  - the cover amount of four times the monthly premium that was applicable at the insured event date and
  - the legal limit allowed for the death of unborn children, which is currently set at R20 000.
- A maximum of two events qualify for payments under the Maternity/Paternity benefit.

- A valid claim under this benefit will be payable even if we're making monthly payments under the benefit that its attached to or any of that benefit's optional features and vice versa.
- If two valid claim events occur at the same time, we'll pay for both.

Premiums in claim

This benefit pays a single amount therefore premiums won't be waived when claiming.

12.3.2.4 Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that's generally excluded.

We won't pay if:

- the insured event is before the Family Support Benefit's cover start date,
- the claim under Maternity/paternity support is because of an excluded event, activity or condition,
- the owner fails to tell us about changes to the circumstances of the insured person (See changes to the circumstances of the insured person) or
- the claim is because of:
  - unrest (for example: riot, civil commotion, insurrection and rebellion, war or terrorist activity),
  - radioactivity or nuclear explosion,
- the insured event happens within nine months from the Family Support Benefit's start date,
- the insured event was as a result of a crime the owner, the insured person or their spouse/partner committed against the biological mother or
- stillbirth was caused by the owner's, the insured person's or the biological mother's negligence or intentional harm.

12.3.2.5 Maternity/Paternity Benefit stops on the earliest of the following:

- When the insured person dies.
- On the Family Support Benefit's cover end date.
- If the cover lapses.
- If the contract is cancelled.
- Once we've paid two valid claims under Maternity/Paternity Benefit.
- If the Family Support Benefit is removed from the contract.

13. BUSINESS EXPENSES COVER

Provides monthly payments for a limited period of time if the insured person is unable to work due to illness or injury or suffers a qualifying functional impairment and meets the waiting period.

13.1 Business Expenses Cover overview

Business Expenses Cover is designed for customers with the following needs:

Business Expenses Cover under Old Mutual Protect Personal Insurance is designed for sole proprietors who need insurance to cover the contribution that they would have made to the allowable overhead expenses.

This benefit pays up to 100% of the cover amount monthly if the insured person becomes:

- occupationally disabled
- functionally impaired or
- suffers a fracture

after the cover started and if the waiting period is met.

Tax impacts

Income tax

Business Expenses Cover taxation

- Under current revenue practice, premiums for income replacement cover aren't tax deductible and the income cover payment is exempt from tax (tax free).
- For personal income tax purposes, where the owner, insured person and beneficiary aren't the same person, the tax exemption for income cover payments may be jeopardised.

Capital Gains Tax

No Capital Gains Tax is applicable on Business Expenses Cover.

Overlap of Buy and Sell Insurance, Keyperson Insurance and personal cover

Business Expenses Cover within Personal Insurance is designed for business owners who are sole proprietors. The owner can also be a keyperson in the business or a member of one-sided buy and sell agreement.

13.2 Business Expenses Cover product features

TYPE OF COVER	MONTHLY PAYMENTS MADE TO COVER BUSINESS EXPENSES ON THE DISABILITY OF THE INSURED LIFE
Eligible lives	Owners/Partners of a business. The insured person must: · be actively involved in the business and · have special skills, qualifications, knowledge or experience that would make it difficult to find another person to perform the insured person's business activities in time to prevent the business from suffering a significant drop in turnover in the event of the insured person's disability and · make a significant contribution to turnover (typically a contribution in excess of 25% is considered significant), subject to entry age limits and underwriting.
Relationship to owner	There must be an insurable interest if the owner and insured person aren't the same person.
Maximum number of insured persons	One
Entry age limits	**Minimum:** 18 next birthday **Maximum:** 60 next birthday
Premium frequency	Monthly
Compulsory yearly premium increase	· 0% fixed rate · 5% fixed rate · Age-linked

Guarantee term	· 1 year · 5 years
Cover amount limits	**Minimum:** R6 000 per month **Maximum:** The total cover can't exceed the smaller of 100% of average net monthly earnings and · R60 000 per month for whole-life cover · R250 000 per month for term cover
Benefit term	· Whole-life · Term (minimum of 5 years)
Cover end age	· Whole-life · Term (70 next birthday)
Scheduled yearly cover increase	· 0% fixed rate · 5% fixed rate · Inflation-linked: CPI + 0%, 1%, 2%, 3%, -1%, -2%
Waiting period	· 7 days · 1 month · 3 months Fractures are only covered if a waiting period of seven days or one month is selected.
Underwriting option	· Medical tests, questions or both · No medical tests, only questions (up to R10 000)
Underwriting credit	If the insured person completed 'Medical tests, questions or both' for an amount less than the upper limit of a particular underwriting band, they could qualify for: · Single underwriting credit · Comprehensive underwriting credit

13.3 Definitions

Occupationally disabled means that the insured person is, in part or completely and despite following reasonable medical advice and adequate medical treatment, unable to perform the main duties of their occupation, because of a sickness or injury.

Functionally impaired means that the insured person has suffered and meets the requirements of a qualifying functional impairment, despite following reasonable medical advice and adequate medical treatment.

Reasonable medical advice means the medical opinion provided by a health professional that the insured person can reasonably be expected to follow to improve or preserve their health. This may include investigations, recommendations, lifestyle adjustments and treatment options based on the best available information and appropriate to the condition, the health professional's knowledge and scope of practice.

Adequate medical treatment means the best possible treatment that a person can reasonably be expected to undergo and includes the use of simple external assistive devices for example hearing aids, glasses, contact

lenses, a walking stick or a Zimmer Frame but doesn't include the use of complex external assistive devices for example a wheelchair or leg prosthesis. The general meaning of the terms 'simple external assistive devices' and 'complex external assistive devices' isn't limited by the specific examples provided.

A fracture means damage to the continuity of a bone. Not all fractures qualify for benefits under this product, for example hairline fractures or fractures of the toe. See the list of qualifying fractures and how many payments each fracture qualifies for depending on the waiting period selected at the end of this guide.

Related claims: Old Mutual's Medical Officer, supported by published medical evidence, determines if events are related. Typically this means that they stem from the same incident (for example a certain car accident) or condition (for example cancer) or from complications or treatment following the same incident or condition.

13.4 Other role players

Personal

- Where the business is a sole proprietorship, the sole proprietor must be the owner.
- No beneficiaries may be nominated on this benefit.

Business

- Where the business is a sole proprietorship, the sole proprietor must be the owner.
- Where the business is a partnership, either one or all of the partners must be the owner. This means that someone who isn't a partner in the business may not be an owner.
- For all other forms of business, the business must be the owner.
- No beneficiaries may be nominated on this benefit. The owner must be the beneficiary in the case of all business entities.

13.5 Claiming Business Expenses Cover

The cover amount for the insured person can be claimed when they become occupationally disabled, functionally impaired or suffers a fracture, and the waiting period is met.

Occupational disability

The cover amount for the insured person can be claimed when they become occupationally disabled.

Each monthly payment is equal to a percentage of the cover amount that applies on the payment day.

For occupational disability, the percentage of the cover amount depends on:

- the insured person's ability as determined by us, to continue doing some of the material and substantial duties of their occupation,
- the part of the business expenses that the insured person continues to be responsible for while being occupationally disabled and
- any payments received from any product provider, Old Mutual or other insurers, for the specific purpose of covering continuing business expenses that the insured person is responsible for while they are occupationally disabled.

Example: Percentage of the cover amount payable on occupational disability

Jacob is a business owner and is responsible for all of his company's business expenses. The business expenses were R100 000 when he bought his Old Mutual Protect Business Expenses Cover so he bought cover for R100 000 and he chose a scheduled yearly cover increase of 10% to ensure that the cover amount increased each year. At his first scheduled cover increase date, we automatically changed Jacob's cover to R110 000. Jacob then became occupationally disabled and the business expenses he was responsible for, was only R105 000. We'll never pay more than R105 000. Jacob is unable to do any of the material and substantial duties of his occupation and we'll start paying R105 000 per month.

Functional Impairment

The cover amount for the insured person can be claimed when they become functionally impaired.

Each monthly payment is equal to a percentage of the cover amount that applies on the payment day.

- For functional impairment, the percentage of the cover amount depends on:
  - the severity of the functional impairment,
  - the part of the business expenses that the insured person continues to be responsible for while being functionally impaired and
  - any payments received from any product provider, including us, for the specific purpose of covering continuing business expenses that the insured person is responsible for while they are functionally impaired.
- If the insured person is occupationally disabled or functionally impaired for part of a month when the monthly payment is payable, we'll pay a proportion of the monthly payment that would have applied for that month.
- The percentage of the cover amount that's paid for occupational disability or functional impairment may change over time as the insured person's condition worsens or improves or the part of the business expenses that the insured person continues to be responsible for changes.
- If the insured person qualifies for more than one claim at the same time, we'll pay the claim that results in the highest percentage of the cover amount.

Fractures

If the insured person suffers a fracture, each monthly payment will be equal to 100% of the cover amount. We specify the number of monthly payments that we will make for fractures.
We won't pay for a fracture if a waiting period of longer than one month was selected or if the insured person suffers a fracture while we're already making monthly payments for occupational disability or functional impairment.

If the insured person suffers more than one fracture or suffers another fracture while we're making monthly payments for a previous one, we'll pay the number of monthly payments that applies to the one with the highest number of payments.

Example: Insured person suffers a fracture while receiving monthly payments for another fracture

Mark is the insured person under an Old Mutual Protect Business Expenses Cover contract that has a seven-day waiting period. He was in an accident and fractured his shoulder blade. Mark qualified for two monthly payments. Before receiving the second payment, he falls and fractures the shaft of his thigh bone. This qualifies him for three monthly payments, but because we're still making monthly payments for his previous fracture, we'll pay the number of monthly payments that applies to the fracture with the highest number of payments, which is the fracture to the shaft of the thigh bone. We'll make two more monthly payments (in total three monthly payments).

13.5.1 Waiting periods

- A waiting period is the number of consecutive days or months for which the insured person's occupational disability or functional impairment must have continued, or from the date of the fracture, that must have passed before we'll start the monthly payments.
- There will be no monthly payments in the waiting period.
- It starts on the date of the occupational disability, functional impairment or the fracture as confirmed by Old Mutual's Medical Officer.

- Premiums must continue to be paid during the waiting period. If the contract is cancelled before the waiting period ends, we won't start the monthly payments.
- The waiting period can be increased or decreased after start of the contract, subject to the following:
  - Premiums will change to reflect the new waiting period
  - Additional underwriting will apply where the waiting period is decreased.
- If the seven-day waiting period is selected and the occupational disability or functional impairment is directly or indirectly caused by a condition below, a one-month waiting period will apply:
  - cosmetic surgery or procedures, unless reconstructive in nature, following an accident or illness which happened after the cover start date
  - fertility treatments to facilitate pregnancy,
  - non-surgical treatment to cure impotence or to improve potency
  - uncomplicated pregnancy
  - uncomplicated birth including caesarean sections
  - any spinal conditions unless:
    - diagnosed by a specialist orthopaedic or neurosurgeon,
    - supported by medical evidence of spinal pathology and
    - for which they were hospitalised for at least 24 hours,
- any mechanical musculoskeletal disorder primarily causing pain, decreased range of motion or loss of sensation unless
  - diagnosed by a specialist orthopaedic or neurosurgeon and
  - for which they were hospitalised for at least 24 hours,
- all psychiatric disorders unless diagnosed by a psychiatrist and for which they were hospitalised for at least 24 hours
- headaches and migraines unless diagnosed by a neurologist and for which they were hospitalised for at least 24 hours
- the common cold (coryza), rhinitis, sinusitis, influenza, bronchitis, pharyngitis, laryngitis, pneumonia or any combination of these, unless they were hospitalised for at least 24 hours
- any functional pain disorders including
  - chronic fatigue syndrome,
  - fibromyalgia, or
  - myalgic encephalopathy (yuppie flu)

  unless diagnosed by a specialist orthopaedic or neurosurgeon or rheumatologist and for which they were hospitalised for at least seven days.

13.5.2 Monthly payments start

- The monthly payments for a valid claim will start after the end of the waiting period.
- The payment day is the day of the month on which the owner has chosen to receive the monthly payments. When the owner of the contract claims, they can choose the payment day. If the owner doesn't choose a day of the month, the payment day will be the last day of the month.
- If all our requirements are met before the waiting period has passed, we'll pay the first monthly payment on the payment day immediately after the end of the waiting period to cover the time after the end of the waiting period and up to the date of the first monthly payment.

If all our requirements are met after the waiting period has passed and:

- If there was at least one payment day between the end of the waiting period and the date our requirements are met, we'll pay:
  - a single amount to cover the time after the end of the waiting period and up to the payment day immediately before or on the date our requirements are met and
  - the first monthly payment on the payment day immediately after the date our requirements are met to cover the time after the payment day immediately before or on the date our requirements are met and up to the date of the first monthly payment.
- If there was no payment day between the end of the waiting period and the date our requirements are met, we'll pay the first monthly payment on the payment day immediately after the date our requirements are met to cover the time after the end of the waiting period and up to the date of the first monthly payment.

Example: All our requirements are only met after the waiting period and at least one payment day has passed

Jolene has R80 000 Business Expenses Cover and a one-month waiting period. She becomes functionally impaired on 1 May. The waiting period starts on 1 May and ends at midnight on 31 May. All our requirements are met on 15 July and she chose to receive the monthly payments at the end of the month. The first monthly payment of R80 000 will be made on 31 July because she chose to receive monthly payments at the end of the month. We'll make a single payment of R80 000 (for June) because our requirements were only met after the waiting period has passed.

Example: All our requirements are only met after the waiting period has passed but no payment day has passed

Jane has R80 000 Business Expenses Cover and a one month waiting period. She becomes functionally impaired on 1 May. The waiting period starts on 1 May and ends at midnight on 31 May. All our requirements are met on 21 June and she chose to receive the monthly payments at the end of the month. The first monthly payment of R80 000 (for June) will be made on 30 June because she chose to receive monthly payments at the end of the month. No single payment will be made because there was no payment day between the end of the waiting period and the date our requirements were met.

We won't pay interest on any of these amounts.
If the contract is cancelled before the waiting period ends, we won't start the monthly payments.

13.5.3 Payment rules

We'll make up to 24 full monthly payments for occupational disability and functional impairment for related events.

Multiple claims can be made if:

- for related events, we haven't made 24 full monthly payments or
- the incident or condition that caused the occupational disability or functional impairment is completely unrelated to the reason for previous claims. We'll make up to 24 full monthly payments in this case.

A full monthly payment is 100% of the cover amount. Where the monthly payment is less than 100% of the cover amount this will increase the number of payments available such that a maximum of 24 full monthly payments is made.

Example: How the monthly payments work on occupational disability and functional impairment

Jenna suffers from chronic liver failure at the highest severity and receives six full monthly payments (or 100% of the cover amount) for her functional impairment. She recovers but is later diagnosed with chronic gastrointestinal disease at the highest severity. Because Old Mutual's Medical Officer considered her chronic liver failure and chronic gastrointestinal disease as related, she'll only qualify for up to 18 more full monthly payments for this functional impairment. If she's later diagnosed with a functional impairment that's unrelated to chronic liver failure and chronic gastrointestinal disease, she can qualify for up to 24 full monthly payments.

Example: Number of monthly payments where insured person only qualifies for partial payments

Jenna suffers from hypertension and qualifies for 50% of the cover amount. She may receive up to 48 monthly payments of 50% of the cover amount.
Chris loses his sight in one of his eyes and qualifies for 25% of the cover amount. He may receive up to 96 monthly payments of 25% of the cover amount.

- For occupational disability, we'll determine the number of monthly payments that we make, in line with the period of time the insured person is occupationally disabled which may not exceed the average recommended period of recovery according to the latest edition of The Medical Disability Advisor: Workplace Guidelines for Disability Duration, by Presley Reed, M.D., or its replacement as determined by us. We'll consider making further payments if the treating doctor can provide us with sufficient medical motivation in the form of specialist reports or test results. Any supporting medical proof that we need will be at the owner's cost own cost.
- For functional impairment, we'll determine the number of monthly payments that we make, in line with the period of time the insured person continuously meets all the requirements of the functional impairment, as evidenced by sufficient specialist reports or test results from the treating doctor. Any supporting medical proof that we need will be at the owner's cost.
- In claim escalation: if a scheduled yearly cover increase option was selected, this will continue to apply even though claim payments are being made.

13.5.4 Premiums in claim

Premiums must continue to be paid during the waiting period and while we decide if the claim is valid but the premiums are no longer due when we start the monthly payments.

Premium are payable again if the monthly claim payments stop and cover continues.

13.5.5 Linked claims

- For benefits with a seven-day or one-month waiting period, the waiting period on a subsequent related claim event may be waived if:
  - the insured person had been continuously occupationally disabled/functionally impaired for at least one month on the previous valid claim and,
  - the claim event date on the subsequent related claim is within three months after recovery date of that previous valid claim.
- For benefits with a three-month waiting period, the waiting period on a subsequent related claim event may be waived if:
  - the claim event date on the subsequent related claim is within a period equal to the length of the waiting period after recovery date of the previous valid claim.
- Cover won't be paid between the date of recovery and the date of the subsequent claim event.
- If we decide not to apply the waiting period, we'll start the monthly payments from the date of the occupational disability or functional impairment.

Monthly payments stop on the earliest of the following:

- When the insured person dies.
- At the end of the term, if term cover was selected.
- If we no longer recognise the insured person's functional impairment or occupational disability.
- If the insured person fails to meet our requirements for following reasonable medical advice or adequate medical treatment.
- If the insured person fails to meet our requirements for regular evaluation of their occupational disability or functional impairment (We may need the insured person to prove that they still qualify for payments by undergoing regular evaluation.)
- When we've made the last monthly payment that the insured person qualifies for.
- If the insured person no longer qualifies for the benefit because of changes to their circumstances.
- If the contract is cancelled.
- When their occupational disability cover stops while we're making monthly payments because of occupational disability,

If the monthly payments for occupational disability has stopped because the insured person's occupational disability cover has stopped, we'll re-evaluate the claim. If the insured person is functionally impaired, we'll start making monthly payments for functional impairment until the monthly payments stop for one of the other reasons listed above. If not, we'll stop making monthly payments under occupational disability but the benefit will continue until the cover end date and a claim for functional impairment or a fracture can be made in the future.

If the insured person qualified for more than one claim at the same time, once we stop making payments for the claim that resulted in the highest percentage of the cover amount, we'll continue to make monthly payments at a lower percentage of the cover amount if the insured person still qualifies for monthly payments under another claim.

13.6 Changes to the circumstances of the insured person on Business Expenses Cover

The owner must inform us if the insured person:

- Starts participating recurrently in any risky activities which may expose them to a higher than average risk of injury.
- Makes a change with respect to their:
  - occupation
  - industry
  - duty split
  - employment status
  - starts/stops a second occupation or changes the number of hours per week that they work
- The insured person's part of the business expenses that they are responsible for decreases while we're making payments
- The insured person's health/medical status changes (they recover or their condition improves) while we're making payments.
- The insured person dies.

13.7 Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that's generally excluded.

We won't pay if:

- the owner fails to meet our requirement to tell us about changes to the circumstances of the insured person. (See Changes to the circumstances of the insured person.)
- the insured person refuses to follow reasonable medical advice or adequate medical treatment,
- the insured person's occupational disability, functional impairment or fracture is caused by:
  - unrest (for example: riot, civil commotion, insurrection and rebellion, war or terrorist activity,
  - radioactivity or nuclear explosion,
  - them provoking, committing or attempting to commit a crime for example murder, assault, housebreaking, theft, robbery, the forceful detention of another person or any similar crime or
  - self-inflicted injury.
- if the insured person's occupational disability, functional impairment or fracture is before the cover start date
- if we don't recognise the insured person's occupational disability, functional impairment or fracture
- if the insured person's occupational disability, functional impairment or fracture is because of an excluded event, activity or condition
- if the waiting period isn't met.

We won't recognise the insured person's:

- occupational disability if:
  - the insured person doesn't qualify for at least 25% of the cover amount or
  - the insured person is able to do more than 75% of the main duties of their occupation.
- functional impairment:
  - that's not on the list of functional impairments,
  - at the severity that the contract doesn't cover, or
  - that doesn't meet all the requirements that the functional impairment must meet to qualify.
- fracture if:
  - the insured person suffers a fracture that's not on the list of fractures that the contracts cover or
  - if a waiting period longer than one month is selected.

13.8 Business Expenses Cover stops on the earliest of the following:

- When the insured person dies.
- At the end of the term, if term cover was selected.
- If the insured person no longer qualifies for the benefit because of changes to their circumstances.
- If the insured person refuses to follow reasonable medical advice or adequate medical treatment.
- If the cover lapses.
- If the contract is cancelled.

In addition to the above, occupational disability cover stops on the earliest of:

- The date the insured person retires.
- On the insured persons 69th birthday.

13.9 BUSINESS EXPENSES COVER EVENTS

Business expenses are those monthly costs incurred in the day-to-day running of a business and is recognised by us.

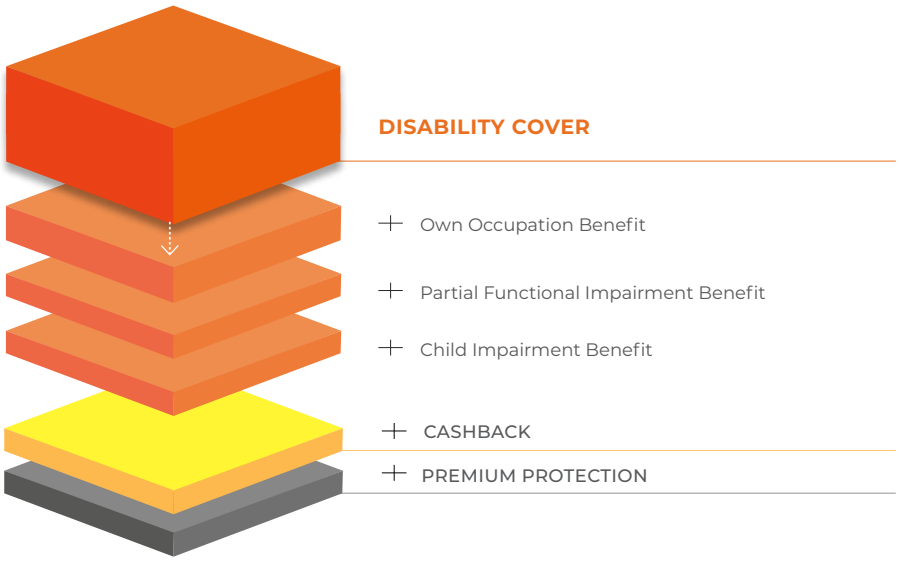
BUSINESS EXPENSES INCLUDED	BUSINESS EXPENSES EXCLUDED
The business expenses that we'll recognise are: · rent · interest portion of repayments on debt, for example, a mortgage bond or loan · property taxes · electricity, water and telephone · regular maintenance services · equipment leasing costs · insurance premiums · accounting fees · remuneration payable to staff who – don't directly impact on or contribute to turnover or – directly impact on or contribute to turnover but who are unable to do so because of the insured person's occupational disability, functional impairment or fracture.	The business expenses that we won't recognise are: · any provision, for example, for depreciation or bad debt · remuneration payable to the insured person · remuneration payable to staff who directly impact on or contribute to turnover but who are still able to do so despite the insured person's occupational disability, functional impairment or fracture. · cost of trading stock or merchandise · any expenses of a personal nature and not related to the business of the owner · any capital expenses · capital portion of repayments on debt, for example, a mortgage bond or loan or · expenses not related directly to the continued functioning of the business.

We'll assume that the part of the business expenses that the insured person is responsible for, expressed as a percentage, is the same as their contribution to the total monthly turnover.

Business Expenses Cover protects businesses against risk. As always, appropriate structuring and advice must be in place to effect a complete and tax-efficient solution.

14. DISABILITY COVER

14.1 Disability Cover overview



Disability Cover is designed for customers with the following needs:

- Want to protect themselves or their families against financial consequences of a permanent and irreversible occupational disability or functional impairment.
- Need to cover once-off expenses associated with a permanent and irreversible occupational disability or functional impairment.
- Want the option to cover the once-off expenses when their child suffers an impairment or congenital birth defect.
- Want to be able to adjust their cover as their needs change.

14.2 Building Disability Cover

- Disability Cover pays a single amount if the insured person is permanently and irreversibly:
  - unable to perform the main duties of their occupation or another occupation for which they are reasonably suited, because of a sickness or injury and the survival period is met or
  - becomes permanently and irreversibly functionally impaired and if the survival period is met.
- **Attaching the Own Occupation Benefit** allows payouts on occupational disability when the insured person is permanently and irreversibly unable to perform the main duties of their occupation because of a sickness or injury and if the survival period is met, regardless of whether they are able to do another occupation for which they are reasonably suited.
- **Attaching the Partial Functional Impairment Benefit** allows payouts on functional impairment at a percentage that will be less than 100% of the cover amount of Disability Cover when the insured person has permanently and irreversibly suffered any of the qualifying functional impairments and if the survival period is met. The percentage of the cover amount for Disability Cover depends on the severity of the functional impairment.
- **Attaching the Child Impairment Benefit** allows payouts of up to 10% of the cover amount, subject to a maximum of R500 000 on Disability Cover, if the child qualifies for an insured event as confirmed by Old Mutual's Medical Officer and if the survival period is met. The payment of a claim for Child Impairment Benefit doesn't reduce the cover amount on Disability Cover.

14.3 Disability Cover product features

TYPE OF COVER	COVER THAT PAYS A SINGLE AMOUNT CAN ALSO BE ATTACHED TO LIFE COVER
Eligible lives	· Specified occupations as determined by our underwriters. · Lives that are unemployed at entry won't be eligible for cover. Eligible lives are subject to underwriting and age limits.
Relationship to owner	There must be an insurable interest if the owner and insured person aren't the same person.
Maximum number of insured persons	One
Entry age limits	**Minimum:** 15 next birthday **Maximum:** 60 next birthday
Premium frequency	· Monthly · Monthly with the option to skip one premium · Yearly
Premium term	· Benefit term or · Retirement (minimum premium term of 10 years)
Compulsory yearly premium increase	· 0% fixed rate · 5% fixed rate · Age-linked
Guarantee term	· 5 years · 10 years
Cover amount limits	**Minimum:** R100 000 **Maximum:** · R6 000 000 for whole-life cover · R30 000 000 for term cover · Limited to the cover amount of Life Cover if selected as an add-on. · The maximum cover amount, relative to salary, is specified in the underwriting section. · All similar benefits will be considered when determining the specific maximum limit applicable to the insured person.

Benefit term	· Whole-life · Term (minimum of 5 years) All claims will be assessed against functional impairment definitions if the insured person is no longer engaged in an occupation because they retired (and doesn't become re-engaged in any occupation) or reaches 70 next birthday, whichever is the earlier.
Cover end age	· Whole-life · Term (70 next birthday)
Scheduled yearly cover increase	· 0% fixed rate · 5% fixed rate · 10% fixed rate · Inflation-linked: CPI + 0%, 1%, 2%, 3%, -1%, -2% · Currency-linked: – R/GB Pound exchange rate + 0%, 5%, 10%, UK inflation – R/US Dollar exchange rate + 0%, 5%, 10%, Dollar inflation – R/EUR exchange rate 0%, 5%, 10%, Euro inflation
Underwriting method	· No medical tests, only questions · Medical tests, questions or both
Underwriting credit	If the insured person completed 'medical tests, questions or both' for an amount less than the upper limit of a particular underwriting band, they could qualify for: · Single underwriting credit · Comprehensive underwriting credit

14.4 Definitions

Occupationally disabled means that the insured person is permanently and irreversibly unable to perform the main duties of their occupation or another occupation for which they are reasonably suited because of a sickness or injury.

Reasonably suited means an occupation that the insured person could reasonably do after re-skilling and taking into account their education, training, experience and employment history.

Functionally impaired means that the insured person has permanently and irreversibly suffered and met the requirements of a qualifying functional impairment.

Permanent and irreversible means that the insured person can't recover from the sickness or injury despite following reasonable medical advice, adequate medical treatment and having achieved maximum medical improvement as confirmed by Old Mutual's Medical Officer.

Reasonable medical advice means the medical opinion provided by a health professional that the insured person can reasonably be expected to follow to improve or preserve their health. This may include investigations, recommendations, lifestyle adjustments and treatment options based on the best available information and appropriate to the condition, the health professional's knowledge and scope of practice.

Adequate medical treatment means the best possible treatment that a person can reasonably be expected to undergo and includes the use of simple external assistive devices for example hearing aids, glasses, contact lenses, a walking stick or a Zimmer frame but doesn't include the use of complex external assistive devices for example a wheelchair or leg prosthesis. The general meaning of the terms 'simple external assistive devices' and 'complex external assistive devices' isn't limited by the specific examples provided.

Maximum medical improvement means that the insured person's condition can't be improved any further. It means that the insured person has fully recovered from their medical condition or that their medical condition has stabilised to the point that no major medical or emotional change can be expected despite continuing medical treatment or rehabilitative programmes.

14.5 Benefits and other features

A maximum of three benefits may be attached to Disability Cover either at new business stage or before age 60 next birthday, with a combination of the following:

- Own Occupation Benefit
- Partial Functional Impairment Benefit
- Child Impairment Benefit

The insured person on the attached benefit must be the same as the insured person on Disability Cover. Medicals and/or questions might be required whenever additional benefits are added at a later stage and premiums will be adjusted.

14.6 Add-ons

Premium Protection

A maximum of two premium protection add-ons may be added with a combination of the following:

- Premium Protection Death
  The insured person on Premium Protection Death must be different from the insured person on the Disability Cover.
- Premium Protection Retrenchment
  The insured person on Premium Protection Retrenchment must be the same as the insured person on the Disability Cover.
- Premium Protection Disability or Premium Protection Functional Impairment
  The insured person on Premium Protection Disability or Premium Protection Functional Impairment must be different from the insured person on Disability Cover.

This means that adding Premium Protection Death, Premium Protection Disability or Premium Protection Functional Impairment will preclude the addition of Premium Protection Retrenchment and vice versa.
See Premium Protection for more details.

Cashback

See Cashback for more details.

Linked cover

See Retrenchment Cover for more details.

14.7 Claiming Disability Cover

We'll pay 100% of the cover amount that applies on the date of the occupational disability or functional impairment as confirmed by Old Mutual's Medical Officer.

For functional impairments, the insured person will be assessed under qualifying functional impairment definitions at a severity of 100% only, with no payments for less severe functional impairments.

After we have paid a claim under this benefit, the cover under it will stop.

Survival period

- The survival period is 10 days.
- A survival period is the number of consecutive days or months the insured person must survive after becoming occupationally disabled or functionally impaired.
- It starts on the date of the occupational disability or functional impairment as confirmed by Old Mutual's Medical Officer.
- Premiums must continue to be paid during the survival period and while we decide if the claim is valid.
- If the contract is cancelled before the survival period ends, the cover amount won't be paid.

14.8 Changes to the circumstances of the insured person on Disability Cover

The owner must inform us if the insured person:

- starts participating recurrently in any risky activities which may expose them to a higher than average risk of accident or injury, or makes a change to their occupational circumstances:
  - occupation or any detail of their occupation
  - industry
  - duty split
  - employment type
  - starts/stops a second occupation or changes the number of hours per week that they work.

14.9 Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that's generally excluded.

We won't pay if:

- the owner fails to meet our requirement to tell us about changes to the circumstances of the insured person (See changes to the circumstances of the insured person).
- the insured person refuses to follow reasonable medical advice or adequate medical treatment or to undergo re-skilling for an occupation for which they are reasonably suited,
- the insured person's occupational disability or functional impairment is caused by:
  - unrest (for example: riot, civil commotion, insurrection and rebellion), war or terrorist activity,
  - radioactivity or nuclear explosion,

  - them provoking, committing or attempting to commit a crime for example murder, assault, housebreaking, theft, robbery, the forceful detention of another person or any similar crime or
  - self-inflicted injury.
- the insured person's occupational disability or functional impairment is before the cover start date,
- the insured person isn't occupationally disabled,
- we don't recognise the insured person's functional impairment,
- the insured person's occupational disability or functional impairment is because of an excluded event, activity or condition,
- the survival period isn't met.

We won't recognise the insured person's functional impairment:

- that isn't on the list of functional impairments,
- at the severity that the contract doesn't cover or
- that doesn't permanently and irreversibly meet all the requirements that the functional impairment must meet to qualify.

14.10 Disability Cover stops on the earliest of the following:

- When the insured person dies.
- At the end of the term, if term cover was selected.
- If the cover lapses.
- If 100% of the Disability Cover amount is paid.
- If the insured person no longer qualifies for the cover because of changes to their circumstances.
- If the contract is cancelled.
- If the cover is removed from the contract.

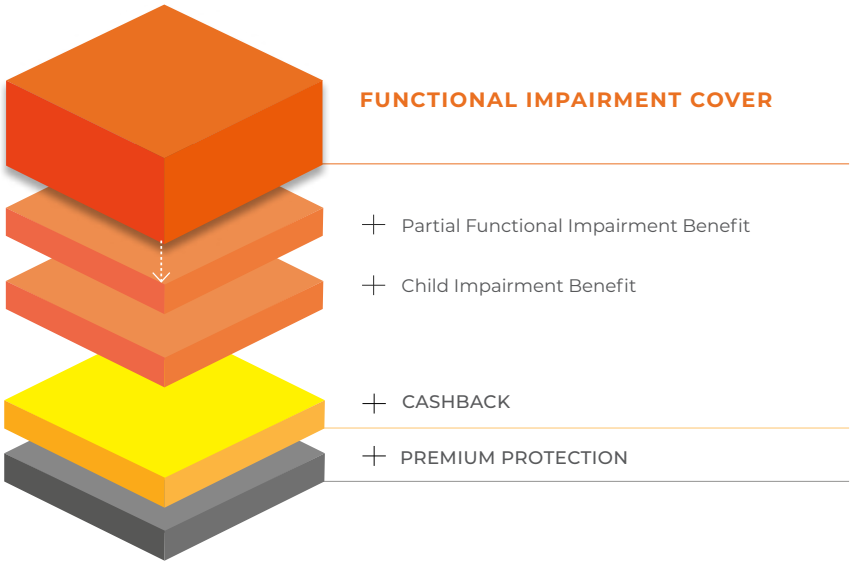
In addition to the above, occupational disability cover stops on the earliest of:

- the date the insured person retires.
- on the insured person's 69th birthday.

15. FUNCTIONAL IMPAIRMENT COVER

Functional Impairment Cover pays the cover amount as a single amount when the insured person becomes permanently and irreversibly functionally impaired and the survival period is met.

15.1 Functional Impairment Cover overview



Functional Impairment Cover is designed for customers with the following needs:

- Want to protect themselves or their families against financial consequences of a permanent and irreversible functional impairment.
- Need to cover once-off expenses associated with a permanent and irreversible functional impairment.
- Want the option to cover the once-off expenses when their child suffers a functional impairment or congenital birth defect.
- Want to be able to adjust their cover as their needs change.

15.2 Functional Impairment Cover product features

TYPE OF COVER	COVER THAT PAYS A SINGLE AMOUNT. CAN ALSO BE ATTACHED TO LIFE COVER.
Eligible lives	· Specified occupations as determined by our underwriters. · Cover will also be available to home executives, students and unemployed lives. Eligible lives are subject to underwriting and age limits.
Relationship to owner	There must be an insurable interest if the owner and insured person aren't the same person.
Maximum number of insured persons	One
Entry age limits	**Minimum:** 15 next birthday **Maximum:** 65 next birthday

Premium frequency	· Monthly · Monthly with the option to skip one premium · Yearly
Premium term	· Benefit term or · Retirement (minimum premium term of 10 years)
Compulsory yearly premium increase	· 0% fixed rate · 5% fixed rate · Age-linked
Guarantee term	· 5 years · 10 years
Cover amount limits	**Minimum:** R100 000 **Maximum:** · R6 000 000 for whole-life cover · R30 000 000 for term cover · R2 500 000 for home executives · R2 000 000 for students · R1 250 000 for unemployed · Limited to the cover amount of Life Cover if selected as an add-on. · The maximum cover amount, relative to salary, is specified in the underwriting section. · All similar benefits will be considered when determining the specific maximum limit applicable to the insured person.
Benefit term	· Whole-life · Term (minimum of 5 years)
Cover end age	· Whole-life · Term (70 next birthday)
Scheduled yearly cover increase	· 0% fixed rate · 5% fixed rate · 10% fixed rate · Inflation-linked: CPI + 0%, 1%, 2%, 3%, -1%, -2% · Currency-linked: – R/GB Pound exchange rate + 0%, 5%, 10%, UK inflation – R/US Dollar exchange rate + 0%, 5%, 10%, Dollar inflation – R/EUR exchange rate 0%, 5%, 10%, Euro inflation

Underwriting method	· No medical tests, only questions · Medical tests, questions or both
Underwriting credit	If the insured person completed 'medical tests, questions or both' for an amount less than the upper limit of a particular underwriting band, they could qualify for: · Single underwriting credit · Comprehensive underwriting credit

15.3 Definitions

Functionally impaired means that the insured person has permanently and irreversibly suffered and met the requirements of a qualifying functional impairment.

Permanent and irreversible means that the insured person can't recover from the sickness or injury despite following reasonable medical advice, adequate medical treatment and having achieved maximum medical improvement as confirmed by Old Mutual's Medical Officer.

Reasonable medical advice means the medical opinion provided by a health professional that the insured person can reasonably be expected to follow to improve or preserve their health. This may include investigations, recommendations, lifestyle adjustments and treatment options based on the best available information and appropriate to the condition, the health professional's knowledge and scope of practice.

Adequate medical treatment means the best possible treatment that a person can reasonably be expected to undergo and includes the use of simple external assistive devices for example hearing aids, glasses, contact lenses, a walking stick or a Zimmer frame but doesn't include the use of complex external assistive devices for example a wheelchair or leg prosthesis.

Maximum medical improvement means that the insured person's condition can't be improved any further. It means that the insured person has fully recovered from their medical condition or that their medical condition has stabilised to the point that no major medical or emotional change can be expected despite continuing medical treatment or rehabilitative programmes.

15.4 Claiming Functional Impairment Cover

- The cover amount can be claimed when the insured person becomes functionally impaired, and the survival period is met.
- We'll pay 100% of the cover amount that applies on the date of a qualifying functional impairment as confirmed by Old Mutual's Medical Officer.
- After a claim has been paid under this benefit, the cover under it stops.

Survival period

- The survival period is 10 days.
- A survival period is the number of consecutive days or months the insured person must survive after becoming functionally impaired before we'll pay the cover amount.
- It starts on the date of the functional impairment as confirmed by Old Mutual's Medical Officer.
- Premiums must continue to be paid during the survival period and while we decide if the claim is valid.
- If the contract is cancelled before the survival period ends, we won't pay the cover amount.

15.5 Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that's generally excluded.

We won't pay if:

- the owner fails to meet our requirement to tell us about changes to the circumstances of the insured person (See changes to the circumstances of the insured person),
- the insured person refuses to follow reasonable medical advice or adequate medical treatment,
- the insured person's functional impairment is caused by:
  - unrest (for example: riot, civil commotion, insurrection and rebellion, war or terrorist activity),
  - radioactivity or nuclear explosion,
  - the insured person provoking, committing or attempting to commit a crime for example murder, assault, housebreaking, theft, robbery, the forceful detention of another person or any similar crime or
  - self-inflicted injury.
- the insured person's functional impairment is before the cover start date,
- we don't recognise the insured person's functional impairment,
- the insured person's functional impairment is because of an excluded event, activity or condition or
- the survival period isn't met.

We won't recognise the insured person's functional impairment:

- that isn't on the list of functional impairments,
- at the severity that the contract doesn't cover or
- that doesn't permanently and irreversibly meet all the requirements that the functional impairment must meet to qualify.

15.6 Functional Impairment Cover stops on the earliest of the following:

- When the insured person dies.
- At the end of the term, if term cover was selected.
- If the cover lapses.
- If 100% of the Functional Impairment cover amount is paid.
- If the insured person no longer qualifies for the benefit because of changes to their circumstances.
- If the contract is cancelled.

16. BENEFITS AND OTHER FEATURES (SINGLE AMOUNTS)

16.1 OWN OCCUPATION BENEFIT

Own Occupation Benefit can't exist on its own and can only be attached to Disability Cover as an optional benefit. This benefit will have the same survival period as Disability Cover it's attached to. The benefit stops when the cover it's attached to stops.

- Disability Cover pays on occupational disability when the insured person is permanently and irreversibly unable to perform the main duties of their occupation or another occupation for which they are reasonably suited, because of a sickness or injury and if the survival period is met.
- Attaching the Own Occupation Benefit to Disability Cover will pay on occupational disability when the insured person is permanently and irreversibly unable to perform the main duties of their occupation because of a sickness or injury and if the survival period is met, regardless of whether they are able to do another occupation for which they are reasonably suited.

16.1.1 Definitions

Occupationally disabled: For the purposes of the Own Occupation Benefit, occupational disability means that the insured person is permanently and irreversibly unable to perform the main duties of their occupation because of a sickness or injury.

16.1.2 Claiming Own Occupation Benefit

- The cover amount for the insured person can be claimed when they become occupationally disabled and the survival period is met.
- We'll pay 100% of the cover amount that applies on the date of the occupational disability as confirmed by Old Mutual's Medical Officer.
- If the insured person qualifies for a claim on this benefit and on Disability Cover at the same time, we'll only pay the claim on this benefit.
- The cover under the Disability Cover and Own Occupation Benefit will stop if a claim is paid under Own Occupation Benefit.

Survival period

The survival period is 10 days.

16.1.3 Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that's generally excluded.

We won't pay if:

- the owner fails to meet our requirement to tell us about changes to the circumstances of the insured person (See changes to the circumstances of the insured person) or
- the insured person refuses to follow reasonable medical advice or adequate medical treatment,
- the insured person's occupational disability is caused by:
  - unrest (for example: riot, civil commotion, insurrection and rebellion), war or terrorist activity,

  - radioactivity or nuclear explosion,
  - them provoking, committing or attempting to commit a crime for example murder, assault, housebreaking, theft, robbery, the forceful detention of another person or any similar crime or
  - self-inflicted injury.
- the insured person's occupational disability is before the cover start date,
- the insured person isn't occupationally disabled,
- the insured person's occupational disability is because of an excluded event, activity or condition or
- the survival period isn't met.

16.1.4 Own Occupation Benefit stops

Same as under Disability Cover.

In addition, cover under the Own Occupation Benefit stops if it's removed from the contract.

16.2 PARTIAL FUNCTIONAL IMPAIRMENT BENEFIT

Partial Functional Impairment Benefit can't exist on its own and can be attached to Disability Cover. The survival period is the same as Disability Cover.

- Attaching Partial Functional Impairment Benefit to Disability Cover allows for payouts on functional impairment at a percentage that will be less than 100% of the cover amount of the Disability Cover it's attached to, when the insured person has permanently and irreversibly suffered any of the qualifying functional impairments and if the survival period is met. The percentage of the cover amount for Disability Cover depends on the severity of the functional impairment.

16.2.1 Claiming Partial Functional Impairment Benefit

We'll pay a percentage of Disability Cover amount that applies on the date of the functional impairment as confirmed by Old Mutual's Medical Officer. For a claim to be paid, the functional impairment must be on the list of functional impairments covered under the Partial Functional Impairment Benefit.

- It must be permanent and irreversible and must be at the severity listed.
- If the insured person qualifies for more than one claim at the same time, we'll pay the claim that results in the highest cover amount.
- Subsequent claims for the same functional impairment must be at a higher severity level than the previous claim.
- Each time a claim is paid under this benefit the cover amount for Disability Cover will decrease by the amount paid and the benefit will continue unless the amount paid was 100% of the cover amount of Disability Cover.

Example

Jack has R500 000 Disability Cover and a Partial Functional Impairment Benefit. Jack's house burns down and he suffers major burns and qualifies for a payment equal to 50% of the cover amount. Because Jack has the Partial Functional Impairment Benefit, we pay R250 000 (R500 000 * 50%), and the Disability cover decreases to R250 000 (R500 000 - R250 000).

Two months later, Jack suffers loss of hearing in one ear and qualifies for a payment equal to 25% of the cover amount. The cover amount at the date of the functional impairment was R250 000. We'll pay R62 500 (R250 000 * 25%) and Disability Cover will reduce to R187 500 (R250 000 – R62 500). One year later, Jack suffers loss of sight and qualifies for a payment equal to 100% of the cover amount. The cover amount at the date of the functional impairment was R206 250 (R187 500 + 10% scheduled yearly cover increase of R18 750). We pay R206 250 (R206 250 * 100%) and Disability Cover decreases to R0 and the cover stops.

Survival period

The survival period is 10 days.

16.2.2 Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that's generally excluded.

We won't pay if:

- the owner fails to meet our requirement to tell us about changes to the circumstances of the insured person (See changes to the circumstances of the insured person),
- the insured person refuses to follow reasonable medical advice or adequate medical treatment or
- the insured person's functional impairment is caused by:
  - unrest (for example: riot, civil commotion, insurrection and rebellion, war or terrorist activity),
  - radioactivity or nuclear explosion,
  - them provoking, committing or attempting to commit a crime for example murder, assault, housebreaking, theft, robbery, the forceful detention of another person or any similar crime or
  - self-inflicted injury.
- the insured person's functional impairment is before the cover start date,
- we don't recognise the insured person's functional impairment,
- the insured person's functional impairment is because of an excluded event, activity or condition or
- the survival period isn't met.

We won't recognise the insured person's functional impairment:

- that's not on the list of functional impairments,
- at the severity that the contract doesn't cover or
- that doesn't permanently and irreversibly meet all the requirements that the functional impairment must meet to qualify.

16.2.3 Partial Functional Impairment Benefit stops

Same as under Disability Cover.

In addition, cover under the Partial Functional Impairment benefit stops if it's removed from the contract.

16.3 CHILD IMPAIRMENT BENEFIT

The child Impairment Benefit can't exist on its own and can be attached to Disability Cover as an optional benefit.

This benefit pays up to 10% of the cover amount on the Disability Cover, subject to a specified maximum, if the child qualifies for an insured event (as defined below) as confirmed by Old Mutual's Medical Officer and if the survival period is met.

The payment of a claim for Child Impairment Benefit doesn't reduce the cover amount on the Disability Cover.

67.3.1 Definitions

Insured event means congenital birth defects of biological children and child impairments. The date of the insured event will be the date of birth for congenital birth defects or the date of child impairment as confirmed by Old Mutual's Medical Officer.

The **child** must be the biological, step or legally adopted child of the insured person on Disability Cover.

A **stepchild's** biological or legally adoptive parent must, at any time after the birth of the stepchild, have been married to the insured person. For the purposes of this definition, married means a marriage (including a customary marriage) or union recognised under South African law.

16.3.2 Claiming Child Impairment Benefit

- A percentage of the Child Impairment Benefit can be claimed when an insured event happens.
- The Child Impairment Benefit's cover amount is the smaller of 10% of Disability Cover on the date of the insured event and R500 000.
- The percentage of the cover amount depends on the severity of the insured event.
- The cover amount payable for a Child Impairment Benefit claim can be calculated as follows:
  - Calculate Child Impairment Benefit cover amount = the lesser of 10% x cover amount for Disability Cover or R500 000.
  - Child Impairment Benefit cover amount x event payout percentage.
- We'll pay a maximum of one claim per child for up to two children.
- If more than one insured event happens to the same child at the same time, we'll pay the claim that results in the highest cover amount.
- We'll never pay more than R500 000 per child across all Child Impairment Benefits across all Disability Covers for the same insured person.

Example: Multiple Child Impairment Benefits taken out for the same insured person and the over amount is limited to R500 000

Abulela is the owner and insured person under two Old Mutual Protect Disability Cover contracts, both with a Child Impairment Benefit. Disability Covers have a cover amount of R5 000 000 and R1 000 000 respectively. A year later, his child Zinhle meets the criteria for total loss of hearing, which qualifies for 100% of the cover amount under the Child Impairment Benefit.
Abulela's total cover is R6 000 000. If we considered the two contracts separately, there would be a claim for R500 000 [10% of R5 000 000] and R100 000 [10% of R1 000 000] or a total of R600 000 for Zinhle.

However, a maximum of R500 000 applies per child and per insured person across all Child Impairment Benefits and we'll pay a percentage of this amount based on the severity of the insured event. In this case, the insured event qualifies for 100%, so 100% x R500 000 = R500 000 will be paid.

Example: Multiple Child Impairment Benefits taken out for two different insured persons and the cover amount is limited to R500 000 for each insured person's Child Impairment Benefits

Abulela's wife, Ntombi, is also the owner and insured person under two Old Mutual Protect Disability Cover contracts with Child Impairment Benefit. Disability Cover have a cover amount of R2 000 000 and R2 500 000 respectively. Ntombi also claims for Zinhle's total loss of hearing. Ntombi's total cover is R4 500 000. If we considered her two contracts separately, she would be able to claim for R200 000 [10% of R2 000 000] and R250 000 [10% of R2 500 000] or a total of R450 000 for Zinhle. We'll pay a percentage, based on the severity of the insured event, of the R450 000. In this case, the insured event qualifies for 100% so 100% x R450 000 = R450 000 will be paid.

In total we paid R950 000 [R500 000 from Abulela's contracts and R450 000 from Ntombi's ones]. The claim for Zinhle will also stop her cover under both her parents' Child Impairment Benefits because we'll only pay one valid claim for her.

Survival period

- The survival period is 10 days.
- A survival period is the number of consecutive days or months the child must survive after the insured event happened before we'll pay the cover amount.
- It starts on the date of the insured event as confirmed by Old Mutual's Medical Officer.
- Premiums must continue to be paid during the survival period and while we decide if the claim is valid.
- If the contract is cancelled before the survival period ends, we won't pay the cover amount.

16.3.3 Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that's generally excluded.

We won't pay if:

- the owner fails to meet our requirement to tell us about changes to the circumstances of the insured person (See changes to the circumstances of the insured person),
- the claim for a child impairment is because of:
  - unrest (for example: riot, civil commotion, insurrection and rebellion, war or terrorist activity),
  - radioactivity or nuclear explosion,
  - self-inflicted injury.
  - the owner or the child provoking, committing or attempting to commit a crime for example murder, assault, housebreaking, theft, robbery, the forceful detention of another person or any similar crime or
  - the use of alcohol, poison, drugs or non-prescribed medication or
  - a condition that was diagnosed:
    - before or within six months after this benefit's start date or
    - before the child was legally adopted or became the stepchild of the insured person under the Disability Cover.

- the claim for a congenital birth defect was where the child was born before or within nine months after this benefit's start date or if it's because of:
  - unrest (for example: riot, civil commotion, insurrection and rebellion, war or terrorist activity),
  - radioactivity or nuclear explosion,
  - self-inflicted injury by the biological mother of the child,
  - the owner or the biological mother provoking, committing or attempting to commit a crime or
  - the use of alcohol, poison, drugs or non-prescribed medication by the biological mother of the child.

In addition to the above, we won't pay if:

- the insured event is before the cover start date,
- we don't recognise the insured event, because:
  - the event isn't on the list of congenital birth defects and child impairments,
  - the severity isn't covered by the benefit,
  - the event doesn't meet all the requirements to qualify,
- the insured event is because of an excluded event, activity or condition or
- the survival period isn't met.

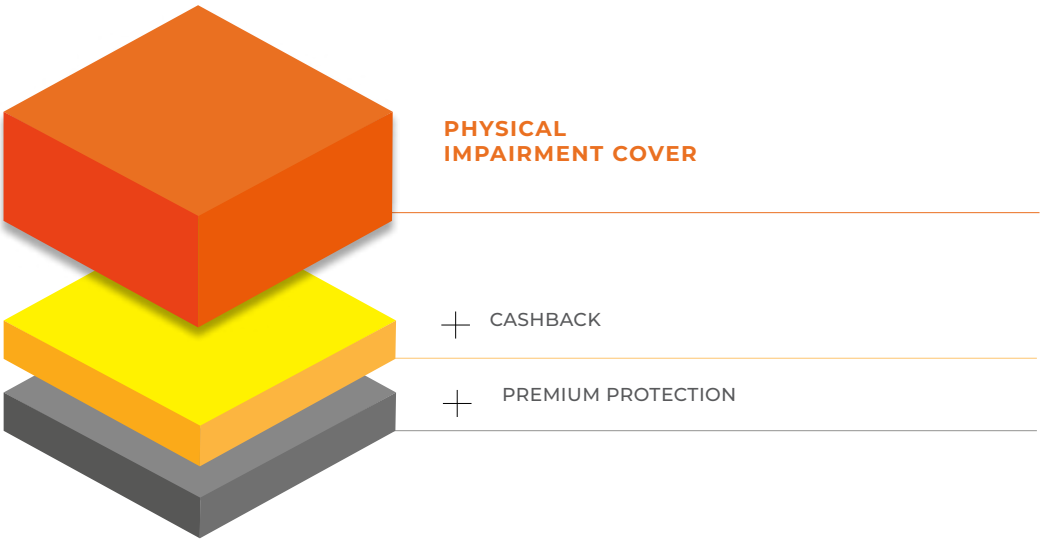
16.3.4 Child Impairment Benefit stops on the earliest of the following:

- At the end of the term, if term cover was selected.
- If the cover lapses.
- If the contract is cancelled.
- Once two valid claims have been paid under this benefit.
- If this benefit is removed from the contract.
- In addition to the above, cover for a child under this benefit stops on the earliest of the following:
  - At the child's 18th birthday.
  - Once we've paid one valid claim for the child.
  - Once we've paid R500 000 for the child across all Child Impairment Benefits across all Disability Cover for the same insured person.

17. PHYSICAL IMPAIRMENT COVER

Physical Impairment Cover pays a percentage of the cover amount as a single amount if the insured person becomes permanently and irreversibly physically impaired and survives the six-month survival period.

17.1 Physical Impairment Cover overview



Physical Impairment Cover is designed for customers with the following needs:

- Want to protect themselves or their families against financial consequences of a permanent and irreversible physical impairment.
- Need to cover once-off expenses associated with a permanent and irreversible physical impairment.
- Want to be able to adjust their cover as their needs change.
- Are looking for cover over a specific length of time.

17.2 Physical Impairment Cover product features

TYPE OF COVER	COVER THAT PAYS A SINGLE AMOUNT CAN ALSO BE ATTACHED TO LIFE COVER
Eligible lives	All lives are eligible, subject to underwriting and age limits. Cover is also available to home executives, students and unemployed persons.
Relationship to owner	There must be an insurable interest if the owner and insured person aren't the same person.
Maximum number of insured persons	One
Entry age limits	**Minimum:** 15 next birthday **Maximum:** 65 next birthday

Premium frequency	· Monthly · Monthly with the option to skip one premium · Yearly
Premium term	· Benefit term or · Retirement (minimum premium term of 10 years)
Compulsory yearly premium increase	· 0% fixed rate · 5% fixed rate · Age-linked
Guarantee term	· 5 years · 10 years
Cover amount limits	**Minimum:** R100 000 **Maximum**: R4 000 000 · Home executives: R2 500 000 · Students and unemployed: R1 250 000 · Limited to the cover amount of Life Cover if selected as an add-on. · The maximum cover amount, relative to salary, is specified in the underwriting section. · All similar benefits will be considered when determining the specific maximum limit applicable to the insured person.
Benefit term	· Whole-life · Term (minimum of 5 years)
Cover end age	· Whole-life · Term (70 next birthday)
Scheduled yearly cover increase	· 0% fixed rate · 5% fixed rate · 10% fixed rate · Inflation-linked: CPI + 0%, 1%, 2%, 3%, -1%, -2% · Currency-linked: – R/GB Pound exchange rate + 0%, 5%, 10%, UK inflation – R/US Dollar exchange rate + 0%, 5%, 10%, Dollar inflation – R/EUR exchange rate 0%, 5%, 10%, Euro inflation
Underwriting method	· No medical tests, only questions · Medical tests, questions or both

Underwriting credit	If the insured person completed 'medical tests, questions or both' for an amount less than the upper limit of a particular underwriting band, they could qualify for: · Single underwriting credit · Comprehensive underwriting credit

17.3 Definitions

Physically impaired means that the insured person has permanently and irreversibly suffered and met the requirements of a qualifying physical impairment.

Permanent and irreversible means that the insured person can't recover from the sickness or injury despite following reasonable medical advice, adequate medical treatment and having achieved maximum medical improvement as confirmed by Old Mutual's Medical Officer.

Reasonable medical advice means the medical opinion provided by a health professional that the insured person can reasonably be expected to follow to improve or preserve their health. This may include investigations, recommendations, lifestyle adjustments and treatment options based on the best available information and appropriate to the condition, the health professional's knowledge and scope of practice.

Adequate medical treatment means the best possible treatment that a person can reasonably be expected to undergo and includes the use of simple external assistive devices for example hearing aids, glasses, contact lenses, a walking stick or a Zimmer frame but doesn't include the use of complex external assistive devices for example a wheelchair or leg prosthesis.

Maximum medical improvement means that the insured person's condition can't be improved any further. It means that the insured person has fully recovered from their medical condition or that their medical condition has stabilised to the point that no major medical or emotional change can be expected despite continuing medical treatment or rehabilitative programmes.

17.4 Add-ons

Premium Protection

A maximum of two premium protection add-ons may be added with a combination of the following:

- Premium Protection Death
  The insured person on Premium Protection Death must be different from the insured person on the Physical Impairment Cover.
- Premium Protection Retrenchment
  The insured person on Premium Protection Retrenchment must be the same as the insured person on the Physical Impairment Cover.
- Premium Protection Disability or Premium Protection Functional Impairment
  The insured person on Premium Protection Disability or Premium Protection Functional Impairment must be different from the insured person on the Physical Impairment Cover.

This means that adding Premium Protection Death, Premium Protection Disability or Premium Protection Functional Impairment will preclude the addition of Premium Protection Retrenchment and vice versa. See Premium Protection for more details.

Cashback

See Cashback for more details.

Linked cover

See Retrenchment Cover for more details.

17.5 Claiming Physical Impairment Cover

- We'll pay a percentage of the cover amount that applies on the date of the physical impairment as confirmed by Old Mutual's Medical Officer.
- The percentage of the cover amount depends on the severity of the physical impairment.
- If the insured person qualifies for more than one claim at the same time, we'll pay the claim that results in the highest cover amount.
- A subsequent claim for the same physical impairment can only be made if it's more severe than was previously claimed for.
- Each time a claim is paid under this benefit, its cover amount will decrease by the amount paid and the benefit will continue unless the amount paid was 100% of the cover amount.

Example

Jack has R500 000 Physical Impairment Cover. Jack's house burns down and he suffers major burns and qualifies for a payment equal to 50% of the cover amount. We pay R250 000 (R500 000 * 50%) and we decrease Jack's Physical Impairment Cover to R250 000 (R500 000 – R250 000).

Two months later, Jack suffers loss of hearing in one ear and qualifies for a payment equal to 25% of the cover amount. The cover amount at the date of the physical impairment was R250 000. We pay R62 500 (R250 000 * 25%) and we decrease Jack's Physical Impairment Cover to R187 500 (R250 000 – R62 500)

One year later, Jack is permanently confined to a wheelchair and qualifies for a payment equal to 100% of the cover amount. The cover amount at the date of the physical impairment was R206 250 (R187 500 + 10% scheduled yearly cover increase of R18 750). We pay R206 250 (R206 250 * 100%) and we decrease Jack's Physical Impairment Cover to R0 and Jack's Physical Impairment Cover stops.

Survival period

- The survival period is six months.
- A survival period is the number of consecutive days or months the insured person must survive after becoming physically impaired before we'll pay the cover amount.
- It starts on the date of the physical impairment as confirmed by Old Mutual's Medical Officer.
- Premiums must continue to be paid during the survival period and while we decide if the claim is valid.
- If the contract is cancelled before the survival period ends, we won't pay the cover amount.

17.6 Changes to the circumstances of the insured person

The owner must inform us if the insured person starts participating recurrently in any risky activities which may expose them to a higher than average risk of accident or injury.

17.7 Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that's generally excluded.

We won't pay if:

- the owner fails to meet our requirement to tell us about changes to the circumstances of the insured person (See changes to the circumstances of the insured person),
- the insured person refuses to follow reasonable medical advice or adequate medical treatment,
- the insured person's physical impairment is caused by:
  - unrest (for example: riot, civil commotion, insurrection and rebellion, war or terrorist activity),
  - radioactivity or nuclear explosion,
  - them provoking, committing or attempting to commit a crime for example murder, assault, housebreaking, theft, robbery, the forceful detention of another person or any similar crime or
  - self-inflicted injury.
- the insured person's physical impairment is before the cover start date,
- we don't recognise the insured person's physical impairment,
- the insured person's physical impairment is because of an excluded event, activity or condition or
- the survival period isn't met.

We won't recognise the insured person's physical impairment:

- that isn't on the list of physical impairments,
- at the severity that the benefit doesn't cover,
- that doesn't permanently and irreversibly meet all the requirements that the physical impairment must meet to qualify.

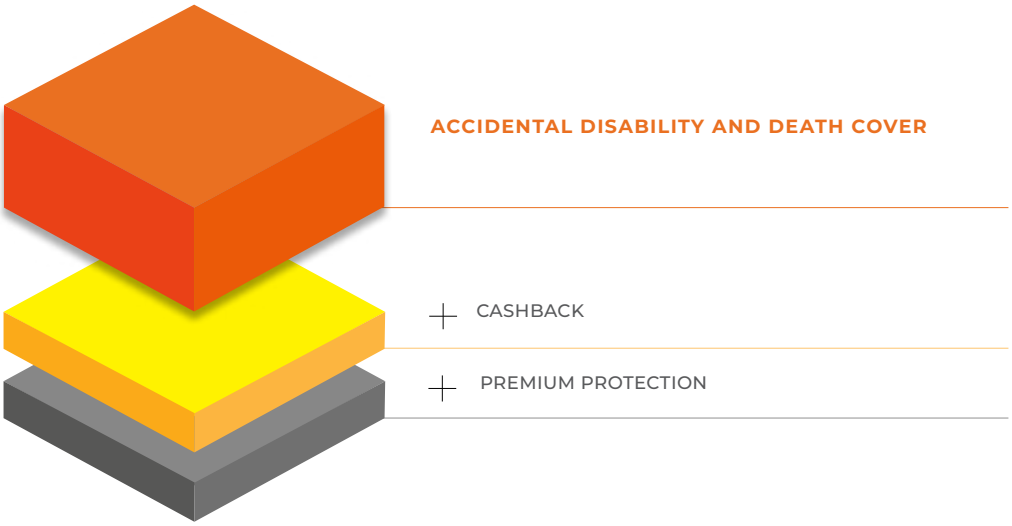
17.9 Physical Impairment Cover stops on the earliest of the following:

- When the insured person dies.
- At the end of the term, if term cover was selected.
- If the cover lapses.
- If 100% of the Physical Impairment cover amount is paid.
- If the insured person no longer qualifies for the benefit because of changes to their circumstances.
- If the contract is cancelled.

18. ACCIDENTAL DISABILITY AND DEATH COVER

Accidental Disability and Death Cover pays the cover amount as a single amount when the insured person dies because of an accident or becomes permanently and irreversibly occupationally disabled/physically impaired because of an accident and the survival period is met.

18.1 Accidental Disability and Death Cover overview



Accidental Disability and Death Cover is designed for customers with the following needs:

- Want to protect themselves or their families against financial consequences of death or disability because of an accident.
- Are medically unable to qualify for underwritten cover.
- Want additional cover during risky periods of the year, for example holidays.

18.2 Accidental Disability and Death Cover product features

TYPE OF COVER	COVER THAT PAYS A SINGLE AMOUNT
Eligible lives	· Specified occupations as determined by our underwriters. · Students, home executives and unemployed persons won't be eligible for cover at entry. Eligible lives are subject to underwriting and age limits.
Relationship to owner	There must be an insurable interest if the owner and insured person aren't the same person.
Maximum number of insured persons	One
Entry age limits	**Minimum:** 15 next birthday **Maximum:** 60 next birthday
Premium frequency	· Monthly · Monthly with the option to skip one premium · Yearly
Premium term	· Benefit term · or · Retirement (minimum premium term of 10 years)
Compulsory yearly premium increase	· 0% fixed rate · 5% fixed rate · Age-linked
Guarantee term	· 5 years · 10 years · 15 years
Cover amount limits	**Minimum:** R100 000 **Maximum:** R2 000 000 at the start of the cover
Benefit term	Term (minimum of 5 years)
Cover end age	Term (65 next birthday)
Scheduled yearly cover increase	· 0% fixed rate · 5% fixed rate · 10% fixed rate · Inflation-linked: CPI + 0%, 1%, 2%, 3%, -1%, -2% · Currency-linked: · R/GB Pound exchange rate + 0%, 5%, 10%, UK Inflation · R/US Dollar exchange rate + 0%, 5%, 10%, US Dollar Inflation · R/EUR exchange rate 0%, 5%, 10%, Euro Inflation
Underwriting method	Medical tests, questions or both

18.3 Definitions

An accident is an unexpected and visible event of external origin that causes traumatic bodily injury and isn't traceable, even indirectly, to the insured person's state of mental or physical health before the event. It's not an accident if the insured person contracts a disease.

Occupationally disabled means that the insured person is permanently and irreversibly unable to perform the main duties of their occupation or another occupation for which they are reasonably suited, because of an injury sustained in an accident.

Reasonably suited means an occupation that the insured person could reasonably do after re-skilling and taking into account their education, training, experience and employment history.

Physically impaired means that the insured person has permanently and irreversibly suffered and met the requirements of a qualifying physical impairment because of an accident.

Permanent and irreversible means that the insured person can't recover from the injury despite following reasonable medical advice, adequate medical treatment and having achieved maximum medical improvement as confirmed by Old Mutual's Medical Officer.

Reasonable medical advice means the medical opinion provided by a health professional that the insured person can reasonably be expected to follow to improve or preserve their health. This may include investigations, recommendations, lifestyle adjustments and treatment options based on the best available information and appropriate to the condition, the health professional's knowledge and scope of practice.

Adequate medical treatment means the best possible treatment that a person can reasonably be expected to undergo and includes the use of simple external assistive devices for example hearing aids, glasses, contact lenses, a walking stick or a Zimmer frame but doesn't include the use of complex external assistive devices for example a wheelchair or leg prosthesis.

Maximum medical improvement means that the insured person's condition can't be improved any further. It means that the insured person has fully recovered from his medical condition or that their medical condition has stabilised to the point that no major medical or emotional change can be expected despite continuing medical treatment or rehabilitative programmes.

18.4 Add-ons

Premium Protection

A maximum of two premium protection add-ons may be added with a combination of the following:

- Premium Protection Death
  The insured person on Premium Protection Death must be different from the insured person on the Accidental Disability and Death Cover.
- Premium Protection Retrenchment
  The insured person on Premium Protection Retrenchment must be the same as the insured person on the Accidental Disability and Death Cover.
- Premium Protection Disability or Premium Protection Functional Impairment.
  The insured person on Premium Protection Disability or Premium Protection Functional Impairment must be different from the insured person on the Accidental Disability and Death Cover.

This means that adding Premium Protection Death, Premium Protection Disability or Premium Protection Functional Impairment will preclude the addition of Premium Protection Retrenchment and vice versa.
See Premium Protection for more details.

Cashback

See Cashback for more details.

Linked cover

See Retrenchment Cover for more details.

18.5 Claiming Accidental Disability and Death Cover

- The cover amount for the insured person can be claimed when they die because of an accident, or become occupationally disabled/physically impaired because of an accident and if the survival period is met.
  - For death, we'll pay 100% of the cover amount that applies on the date of death.
  - For occupational disability, we'll pay 100% of the cover amount that applies on the date of occupational disability as confirmed by Old Mutual's Medical Officer.
  - For physical impairment, we'll pay a percentage of the cover amount that applies on the date of physical impairment as confirmed by Old Mutual's Medical Officer. The percentage of the cover amount depends on the severity of the physical impairment.
- If the insured person qualifies under both physical impairment and occupational disability, we'll pay the claim that results in the highest cover amount.
- A subsequent claim for the same physical impairment can only be made if it's more severe than was previously claimed for.
- Each time a claim is paid under this benefit, its cover amount will decrease by the amount paid and the benefit will continue unless the amount paid was 100% of the cover amount. The cover under this benefit stops after a death or occupational disability claim has been paid.

Survival period

- The survival period is 10 days.
- A survival period is the number of consecutive days the insured person must survive after becoming occupationally disabled or physically impaired before we'll pay the cover amount.
- It starts on the date of occupational disability or physical impairment as confirmed by Old Mutual's Medical Officer.
- Premiums must continue to be paid during the survival period and while we decide if the claim is valid. If the contract is cancelled before the survival period ends, we won't pay the cover amount.

18.6 Changes to the circumstances of the insured person

The owner must inform us if the insured person:

- starts participating recurrently in any risky activities which may expose them to a higher than average risk of accident or injury
- makes a change to their occupational circumstances:
  - occupation or any detail of their occupation,
  - industry,
  - duty split,
  - employment type or
  - starts/stops a second occupation or changes the number of hours per week that they work.

18.7 Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that's generally excluded.

We won't pay if:

- the insured person's death, occupational disability or physical impairment is caused by anything other than an accident,
- the owner fails to meet our requirement to tell us about changes to the circumstances of the insured person (See changes to the circumstances of the insured person),
- the insured person refuses to follow reasonable medical advice or adequate medical treatment or to undergo re-skilling for an occupation for which they are reasonably suited,
- the insured person's death, occupational disability or physical impairment is caused by:
  - unrest (for example: riot, civil commotion, insurrection and rebellion, war or terrorist activity),
  - radioactivity or nuclear explosion,
  - them provoking, committing or attempting to commit a crime for example murder, assault, housebreaking, theft, robbery, the forceful detention of another person or any similar crime,
  - self-inflicted injury.
- the insured person's death, occupational disability, physical impairment or the accident is before the cover start date,
- the insured person isn't occupationally disabled,
- we don't recognise the insured person's physical impairment,
- the insured person's death, occupational disability or physical impairment is because of an excluded event, activity or condition or
- for occupational disability or physical impairment, if the survival period isn't met.

We won't recognise the insured person's physical impairment if they suffer a physical impairment:

- that isn't on the list of physical impairments,
- at the severity that the contract doesn't cover or
- that doesn't permanently and irreversibly meet all the requirements that the physical impairment must meet to qualify.

18.8 Accidental Disability and Death Cover stops on the earliest of the following:

- If 100% of the cover amount is paid.
- On the cover end date.
- If the cover lapses.
- If the insured person no longer qualifies for the benefit because of changes to their circumstances.
- When the insured person dies.
- If the contract is cancelled.

In addition to the above, occupational disability cover stops on the earliest of:

- The date the insured person retires.
- The date they stop practicing any occupation.

19. DISABILITY INSURANCE EVENTS

19.1 FUNCTIONAL IMPAIRMENTS THAT QUALIFY UNDER DISABILITY INCOME COVER, FUNCTIONAL IMPAIRMENT INCOME COVER AND BUSINESS EXPENSES COVER

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
CARDIOVASCULAR		
Arrhythmia	The diagnosis of an arrhythmia by a medical specialist. **With evidence of the following, despite adequate medical treatment:** • Shortness of breath so severe that symptoms are present at rest (NYHA, Class IV), and • Symptoms of palpitations and syncope or dizziness correlating with ECG evidence of serious arrhythmia are present daily.	**100%**
	The diagnosis of an arrhythmia by a medical specialist. **With evidence of the following, despite adequate medical treatment:** • Marked limitation in activity due to symptoms, even during less-than-ordinary activity, e.g. walking short distances (NYHA Class III), and • Symptoms of palpitations and syncope or dizziness correlating with ECG evidence of serious arrhythmia are present frequently with at least 3 episodes per week.	**50%**
Congestive cardiac failure	The diagnosis of Congestive cardiac failure by a specialist cardiologist or physician as a result of coronary artery disease or valvular heart disease or diseases of the aorta or pericardial disease. **With evidence of the following:** • Ejection fraction (EF) consistently less than 40% after adequate medical treatment, and shortness of breath so severe that symptoms are present during less than ordinary activity or at rest (NYHA Class lll - IV), or • Awaiting cardiac transplantation.	**100%**
	The diagnosis of Congestive cardiac failure by a specialist cardiologist or physician as a result of coronary artery disease or valvular heart disease or diseases of the aorta or pericardial disease. **With evidence of the following:** • Ejection fraction (EF) consistently less than 45% after adequate medical treatment, and marked limitation in activity due to symptoms, even during ordinary or less than ordinary activity e.g. walking short distances (NYHA Class ll - III).	**50%**
Hypertension	The diagnosis of uncontrolled hypertension confirmed by a medical specialist. **With evidence of diastolic pressure greater than or equal to 110mmHg on adequate treatment and complicated by 2 or more of the following:** • Stage 4 Kidney dysfunction • Cerebrovascular incident (excluding transient ischaemic attacks) confirmed by neuroimaging • Echocardiogram evidence of LVH (septal wall • thickness to posterior LV wall thickness 1.3:1)	**100%**
	• Grade IV retinopathy • Congestive Cardiac Failure with evidence of an ejection fraction (EF) consistently less than 45% after adequate medical treatment, and marked limitation in activity due to symptoms, even during ordinary or less than ordinary activity e.g. walking short distances (NYHA Class ll - III).	**50%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
	The diagnosis of uncontrolled hypertension confirmed by a medical specialist. **With evidence of diastolic pressure greater than 105mmHg on adequate treatment and complicated by 1 of the following:** • Stage 3 Kidney dysfunction, or • Cerebrovascular incident (excluding transient ischaemic attacks) confirmed by neuroimaging, or • Grade III retinopathy.	
Peripheral arterial disease	The diagnosis of peripheral arterial disease of the lower limbs by a vascular surgeon. **With evidence of no recordable pulse on Doppler readings, and 1 of the following:** • Severe Vascular Ulceration, or • Gangrene secondary to peripheral arterial disease.	**100%**
	The diagnosis of peripheral arterial disease of the lower limbs by a vascular surgeon. **With evidence of the following:** • Abnormal diminished pulse on Doppler readings, and • Ankle-brachial index (ABI) < 0.9 and • Pain on exercise as a result of peripheral arterial disease with claudication on walking less than 500m.	**50%**
Peripheral venous disease	The diagnosis of veno-occlusive disease of the lower limbs by a vascular surgeon. **With evidence of the following:** • Severe deep and widespread vascular ulceration, and • Oedema of the lower limbs	**50%**
RESPIRATORY		
Chronic respiratory failure	The diagnosis of a chronic respiratory failure by a pulmonologist. **With persistent evidence of at least 1 of the following, despite adequate medical treatment:** • Impaired airflow with FEV1 less than or equal to 40%, or • FVC less than or equal to 50%, or • DLCO of less than or equal to 40%.	**100%**
	The diagnosis of a chronic respiratory failure by a pulmonologist. **With persistent evidence of at least 1 of the following, despite adequate medical treatment:** • Impaired airflow with FEV1 less than or equal to 50%, or • FVC less than or equal to 60%, or • DLCO of less than or equal to 50%.	**50%**
Pulmonary arterial hypertension	The diagnosis of pulmonary hypertension by a medical specialist. **With evidence of a Systolic Pulmonary Artery Pressure greater than 70mmHg and complicated by at least 1 of the following:** • Right sided heart failure, or • Shortness of breath so severe that symptoms are present at rest (NYHA Class IV).	**100%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
	The diagnosis of pulmonary hypertension by a medical specialist. **With evidence of a Systolic Pulmonary Artery Pressure of 40-70 mmHg and complicated by at least 1 of the following:** • Right sided heart failure, or • Marked limitation in activity due to symptoms, even during less-than-ordinary activity, e.g. walking short distances (NYHA Class III).	**50%**
GASTROINTESTINAL		
Ano-rectal impairment	Faecal incontinence With evidence of complete faecal incontinence despite adequate medical and/or surgical treatment by a gastroenterologist or equivalent specialist.	**100%**
	A stoma in situ created by a gastroenterologist or equivalent specialist due to a gastrointestinal disorder.	**50%**
Biliary tract disease	The diagnosis of a biliary tract disease by a liver specialist, gastroenterologist or equivalent medical specialist. **With evidence of the following:** • Persistent biliary tract obstruction with recurrent cholangitis, and • Persistent jaundice	**75%**
Chronic gastrointestinal disease	The diagnosis of a chronic gastrointestinal disease by a gastroenterologist or equivalent specialist, as a result of a medical condition. **With evidence of the following:** • Medical findings confirming organic disease, and • Significant unintentional weight loss resulting in a BMI of less than 15 or 25% weight loss below the lower limit of the normal range for the individual, and • Symptoms uncontrolled by medical or surgical treatment. Psychiatric conditions are excluded.	**100%**
	The diagnosis of a chronic gastrointestinal disease by a gastroenterologist or equivalent specialist, as a result of a medical condition. **With evidence of the following:** • Medical findings confirming organic disease, and • Significant unintentional weight loss resulting in a BMI between 15 and 16.1 or 20% weight loss below the lower limit of the normal range for the individual, and • Symptoms uncontrolled by medical or surgical treatment. Psychiatric conditions are excluded.	**75%**
	The diagnosis of a chronic gastrointestinal disease by a gastroenterologist or equivalent specialist, as a result of a medical condition. **With evidence of the following:** • Medical findings confirming organic disease, and • Significant unintentional weight loss resulting in a BMI between 16.2 and 17 or 15% weight loss below the lower limit of the normal range for the individual, and • Symptoms uncontrolled by medical or surgical treatment. Psychiatric conditions are excluded.	**50%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Chronic liver failure	The diagnosis of chronic end-stage liver failure, with a Child Pugh classification of Class C, by a gastroenterologist or equivalent specialist.	**100%**
	The diagnosis of progressive chronic liver disease, with a Child Pugh classification of Class B, by a gastroenterologist or equivalent specialist.	**50%**
Irreducible hernia	The diagnosis of an irreducible hernia, following unsuccessful surgical repair of the hernia, by a gastroenterologist or equivalent specialist. With evidence of bowel dysfunction which impacts on Activities of Daily Living, such that the insured person is unable to perform 2 of the Basic Activities of Daily Living and 2 of the Advanced Activities of Daily Living.	**50%**
UROGENITAL		
Bladder impairment	The diagnosis of a bladder impairment despite adequate surgical and medical treatment by a nephrologist or urologist. **With evidence of 1 of the following:** • No detectable reflex or voluntary urine control as a result of organic pathology, resulting in urinary incontinence, or • Total bladder resection, or • Chronic disorders of the bladder and its structures that require a permanent indwelling catheter.	**100%**
Chronic kidney failure	The diagnosis of chronic renal failure despite adequate medical treatment by a nephrologist or urologist. **With evidence of 1 of the following:** • End-stage renal disease with an estimated GFR less than 24ml/min, or • Creatinine clearance of less than 28 ml per minute, or • Renal function deterioration that requires life-long peritoneal dialysis or lifelong haemodialysis.	**100%**
	The diagnosis of chronic renal failure despite adequate medical treatment by a nephrologist or urologist. **With evidence of 1 of the following:** • Chronic renal disease with an estimated GFR between 24-40ml/min, or • Creatinine clearance of 28 to 42 ml per minute.	**50%**
CENTRAL NERVOUS SYSTEM		
Impaired consciousness	The diagnosis of a coma of a specified severity by a neurologist or neurosurgeon. Medically induced comas are excluded. **With evidence of the following for 14 days or more:** • A decreased level of consciousness, with a Glasgow Coma Scale of less than 9, and • Requiring total medical support including intubation and assisted ventilation.	**100%**
	The diagnosis of a coma of a specified severity by a neurologist or neurosurgeon. Medically induced comas are excluded. **With evidence of the following:** • Decreased level of consciousness, with a Glasgow Coma Scale of less than 9, which is constant and present for greater than 96hrs.	**50%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Aphasia	The diagnosis of aphasia by a neurologist or neurosurgeon. **With evidence of the following:** • A total inability to express oneself or communicate (through speech, writing, or signs), or to comprehend spoken or written language, due to injury or disease of the brain, and • Deficits in the formal aspects of language such as naming, word choice, comprehension, spelling and syntax, and • Objective medical findings supporting the diagnosis of aphasia. Psychiatric conditions are excluded.	**100%**
Cranial nerve V (Trigeminal Neuralgia)	The diagnosis of severe unilateral or bilateral facial neuralgic pain by a neurologist due to an affliction of the Trigeminal Nerve. **With evidence of the following:** • Resistance to pharmacological treatment, and • Has resulted in decompression surgery.	**50%**
Cranial nerve VII	The diagnosis of facial nerve paralysis confirmed by a neurologist or neurosurgeon. **With persistent evidence of the following:** • Slight or no movement of the face, and • An inability to actively close the eyelids, and • Slight or no movement of the mouth.	**100%**
	The diagnosis of facial nerve paralysis confirmed by a neurologist or neurosurgeon. **With persistent evidence of the following:** • Slight or no movement of one half of the face with asymmetry at rest, and • An inability to actively close the eyelid on the affected side, and • Slight or no movement of the mouth.	**50%**
Cranial nerve VIII	The diagnosis of Vestibulocochlear nerve paralysis confirmed by a neurologist or neurosurgeon. **With evidence of the following:** • Nerve damage with severe imbalance resulting in limitation of Activities of Daily Living such that the insured person is unable to perform 3 of the Basic Activities of Daily Living or 4 of the Advanced Activities of Daily Living.	**100%**
	The diagnosis of Vestibulocochlear nerve paralysis confirmed by a neurologist or neurosurgeon. **With evidence of the following:** • Nerve damage with moderately-severe imbalance resulting in limitation of Activities of Daily Living such that the insured person is unable to perform 2 of the Basic Activities of Daily Living and 2 of the Advanced Activities of Daily Living.	**50%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Cranial nerves IX, X, XII	The diagnosis of Cranial Nerve IX, X, XII paralysis confirmed by a neurologist or neurosurgeon. **With evidence of the following:** • An inability to swallow or process oral secretions without choking, and • Need for external suctioning device, and • Medical findings confirming organic disease.	**100%**
	The diagnosis of Cranial Nerve IX, X, XII paralysis confirmed by a neurologist or neurosurgeon. **With evidence of the following:** • Severe dysarthria or dysphagia, and • Nasal regurgitation, and • Aspiration of liquids or semi-solid foods, and • Medical findings confirming organic disease.	**50%**
Epilepsy	The diagnosis of epilepsy by a neurologist or neurosurgeon supported by objective medical findings and resistant to optimal therapy as confirmed by drug serum-level testing. **With evidence of the following:** • 3 or more generalised seizures per week for at least 3 consecutive months, and • An inability to perform 3 of the Basic Activities of Daily Living or 4 of the Advanced Activities of Daily Living.	**100%**
	The diagnosis of epilepsy by a neurologist or neurosurgeon supported by objective medical findings and resistant to optimal therapy as confirmed by drug serum-level testing. **With evidence of the following:** • 6 or more generalised seizures per month for at least 3 consecutive months, and • An inability to perform 2 of the Basic Activities of Daily Living and 2 of the Advanced Activities of Daily Living.	**50%**
Gait disorders/ poor motor coordination	The diagnosis of a cerebellar disorder by a neurologist or neurosurgeon correlating with objective medical findings. **With evidence of the following:** • Needs assistive devices or mechanical support for daily functions, or • An inability to perform 2 of the Basic Activities of Daily Living and 2 of the Advanced Activities of Daily Living, or • Documented previous falls and inability to stand, walk, stoop, squat, kneel, climb stairs, or • Inability to grasp and pincer grip and a complete loss of fine or gross motor coordination or grip strength.	**50%**
	The diagnosis of a cerebellar disorder by a neurologist or neurosurgeon. The diagnosis of a cerebellar disorder by a neurologist or neurosurgeon correlating with objective medical findings. **With evidence of the following:** • Difficulty with standing or maintaining a standing position, without assistive devices, and needs assistance with walking, or • Difficulty with fine or gross motor coordination or grip strength.	**25%**
Hemiplegia	The total loss of the functioning of one side of the body due to an injury or disease of the brain as confirmed by a neurologist or neurosurgeon and correlating with objective medical findings.	**100%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Dementia (incl. Alzheimer's Disease)	The diagnosis of dementia by a neurologist, physician or neurosurgeon **With evidence of the following:** • A diminished intellectual ability (may include personality changes and episodes of confusion), and • A score of 2 under the 5 point Clinical Dementia Rating scale, and • Needs constant supervision.	**100%**
	The diagnosis of dementia by a neurologist, physician or neurosurgeon **With evidence of the following:** • A diminished intellectual ability (may include a personality change and episodes of confusion), and • A score of 1 under the 5 point Clinical Dementia Rating scale, and • Needs some supervision with everyday duties.	**50%**
Paraplegia / diplegia	The total loss of the functioning of both legs or both arms due to an injury or disease of the brain or spinal cord. This must be confirmed by a neurologist or neurosurgeon and correlate with objective medical findings.	**100%**
Quadriplegia	The total loss of the functioning of both legs and both arms due to an injury or disease of the brain or spinal cord. This must be confirmed by a neurologist or neurosurgeon and correlate with objective medical findings.	**100%**
CANCER		
Cancer	The diagnosis of an advanced stage of cancer as confirmed by an oncologist with supporting documentation. **With evidence of the following:** • Diagnosis of at least a Stage III cancer, and the insured person is unable to perform 2 of the Basic Activities of Daily Living or 3 of the Advanced Activities of Daily Living, or • Stage IV cancer or • Cancer which has resulted in organ failure will be assessed under the affected organ.	**100%**
	Organ failure will only be assessed under the following definitions: • Congestive cardiac failure or • Chronic respiratory failure or • Chronic liver failure or • Chronic kidney failure or • Organic brain disorders/dementia	

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
SENSES		
Loss of sight	Confirmed diagnosis of bilateral loss of sight by an ophthalmologist. The loss of sight cannot be improved through refractive correction or medication. **With evidence of 1 of the following:** • A reading of 6/60 or worse (or equivalent measure on a non-metric scale) in each eye after best correction, or • Severe proliferative diabetic retinopathy, or • Grade IV hypertensive retinopathy, or • Permanent Hemianopia in both eyes, or • A visual field loss to a 10° radius in the better eye. Loss of sight due to cataracts is excluded, unless there is evidence of failed cataract surgery or contraindications to cataract surgery.	**100%**
	Confirmed diagnosis of bilateral loss of sight by an ophthalmologist. The loss of sight cannot be improved through refractive correction or medication. **With evidence of 1 of the following:** • A reading of 6/36 or worse (or equivalent measure on a non-metric scale) in each eye after best correction, or • Severe non-proliferative diabetic retinopathy, or • Grade III hypertensive retinopathy, or • A visual field loss to a 20° radius in the better eye. Loss of sight due to cataracts is excluded, unless there is evidence of failed cataract surgery or contraindications to cataract surgery.	**50%**
	Confirmed diagnosis of loss of sight in one eye by an ophthalmologist. The loss of sight cannot be improved through refractive correction or medication. **With evidence of the following:** • A reading of 6/60 or worse (or equivalent measure on a non-metric scale) in one eye after best correction, or • The diagnosis of a hemianopia in one eye, or • A visual field loss to a 10° radius. Loss of sight due to cataracts is excluded, unless there is evidence of failed cataract surgery or contraindications to cataract surgery.	**25%**
Loss of hearing	Total loss of hearing in both ears as confirmed by an ear, nose and throat surgeon. **With evidence of the following:** • Audiometry measurements, done with the use of hearing aids, with an average loss of greater than 87dB.	**100%**
	Total loss of hearing in both ears as confirmed by an ear, nose and throat surgeon. **With evidence of the following:** • Audiometry measurements, done with the use of hearing aids, averaging between 70-87dB.	**50%**
	Total loss of hearing in one ear as confirmed by an ear, nose and throat surgeon. **With evidence of the following:** • Audiometry measurements, done with the use of hearing aids, with an average loss of greater than 70dB.	**25%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Loss of speech	The total loss of the ability to produce intelligible and audible speech due to injury or disease, as confirmed by an ear, nose and throat surgeon, neurologist or neurosurgeon. • Objective medical evidence of an ear, nose and throat disorder causing the impairment must be provided. Loss of speech due to psychiatric causes are excluded.	**100%**
	The loss of 50% of speech, as confirmed by an ear, nose and throat surgeon, neurologist or neurosurgeon. Objective medical evidence of an ear, nose and throat disorder causing the impairment must be provided, with clinical evidence of 2 of the following requirements: • Audibility: while whisper may be present, there is no audible voice. • Intelligibility: while single words may be recognisable, most words are unintelligible. • Function: speech is impractically slow and laboured. Loss of speech due to psychiatric causes are excluded.	**50%**
ENDOCRINE		
Endocrine disorders	The diagnosis of an endocrine disorder, which despite adequate medical and surgical treatment, has resulted in organ failure, as confirmed by a medical specialist. **Organ failure will only be assessed under the following definitions:** • Congestive Cardiac Failure or • Chronic respiratory failure or • Chronic liver failure or • Chronic kidney failure or • Organic Brain Disorders/ Dementia	**100%**
PSYCHIATRIC		
Psychiatric disorder	The diagnosis of a psychiatric disorder, as confirmed by a specialist psychiatrist. **Resulting in continuous institutionalisation and with evidence of the following:** • persistent GAF score of 40 or less certified under the DSM IV classification, or • persistent WHODAS average domain score of 4 certified under the DSM 5 classification	**100%**
	The diagnosis of a psychiatric disorder, as confirmed by a specialist psychiatrist. **Requires constant supervision and with evidence of the following:** • persistent GAF score of 40 or less certified under the DSM IV classification, or • persistent WHODAS average domain score of 4 certified under the DSM 5 classification	**75%**
TRAUMA		
Facial disorders or disfigurement	Total facial disfigurement as confirmed by a maxillofacial specialist or related specialist. There should be destruction or loss of skin, bone, or muscles that requires reconstructive surgery.	**100%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Major burns	The diagnosis of third degree burns (full thickness burns) by a plastic surgeon or trauma specialist. **With evidence of at least:** • 30% of total body surface affected as measured on the Lund and Browder Chart or equivalent scale, or • more than 50% of the combined surface area of the bilateral upper limbs affected including involvement of at least 60% of combined surface area of the palms of both hands; and restriction of joint mobility of at least two of the following: 3 fingers, wrist or elbow.	**100%**
	The diagnosis of third degree burns (full thickness burns) by a plastic surgeon or trauma specialist. **With evidence of:** • at least 20% of total body surface affected as measured on the Lund and Browder Chart or equivalent scale, or • more than 50% of the combined surface area of the bilateral lower limbs including involvement of at least 60% of the combined surface area of the soles of both feet; or • more than 50% of the combined surface area of an upper and lower limb including involvement of at least 60% of the combined surface area of the sole of one foot and the palm of one hand.	**50%**
Inhalational burn	Inhalational burns resulting in a tracheostomy.	**50%**
HAEMATOLOGY		
Clotting disorders	The diagnosis of a clotting disorder, which despite adequate medical and surgical treatment, has resulted in organ failure, as confirmed by a medical specialist. **Organ failure will only be assessed under the following definitions:** • Congestive Cardiac Failure or • Chronic respiratory failure or • Chronic liver failure or • Chronic kidney failure or • Organic Brain Disorders/ Dementia	**100%**
Red blood cell disorders	The diagnosis of severe chronic anaemia by a physician or haematologist. **With evidence of the following:** • Hb persistently less than 8g/dL, and • Requiring 2-3U of blood every 2 weeks.	**100%**
	The diagnosis of severe chronic anaemia by a physician or haematologist. **With evidence of the following:** • Hb persistently less than 8g/dL, and • Requiring 2-3U of blood every 4-6 weeks.	**50%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
White blood cell disorders	The diagnosis of a severe white blood cell disorder by a physician or haematologist. **With evidence of 1 of the following:** • An absolute neutrophil count of less than 250, resulting in at least 3 hospitalisations per year for acute bacterial infections, or • Lymphoma or Leukaemia requiring at least 3 chemotherapy regimens per year.	**100%**
	The diagnosis of a severe white blood cell disorder by a physician or haematologist. **With evidence of 1 of the following:** • An absolute neutrophil count of between 250 and 500 , resulting in at least 2 hospitalisations per year for acute bacterial infections, or • Lymphoma or Leukaemia requiring at least 1 chemotherapy regimen per year.	**50%**
MUSCULOSKELETAL		
Chronic spinal column conditions	• A history of chronic pain syndrome due to a chronic spinal condition for a duration of at least two years. It must be treated by a multidisciplinary pain management team with at least three of the four requirements listed below, which must be confirmed by an orthopaedic or neurosurgeon. All these criteria must be present in the same region, as defined below, for a valid claim to be paid. OR • Confirmed diagnosis of Cauda equina syndrome resulting in bowel or bladder dysfunction.	**100%**
	• A history of chronic pain syndrome due to a chronic spinal condition for a duration of at least two years. It must be treated by a multidisciplinary pain management team with at least two of the four requirements listed below, which must be confirmed by an orthopaedic or neurosurgeon. All these criteria must be present in the same region, as defined below, for a valid claim to be paid.	**50%**
	• A history of chronic pain syndrome due to a chronic spinal condition for a duration of at least two years. It must be treated by a multidisciplinary pain management team with at least one of the four requirements listed below, which must be confirmed by an orthopaedic or neurosurgeon. All these criteria must be present in the same region, as defined below, for a valid claim to be paid.	**25%**
	Spinal Regions: The neck and lower back are part of the spine. The spinal regions are: • Cervical region (C1-C7). • Thoracic region (T1-T12) and • Lumbosacral region (L1-S1). The C7 to T1 joint will be classified in the cervical region, and the T12 to L1 joint in the thoracolumbar region. **List of four requirements:** 1. 50% or more compression of a vertebral body or multiple level compression fractures giving rise to kyphotic deformity. 2. Clinically significant radiculopathy (motor and sensory deficit or muscle atrophy and clinical signs of nerve tension and radiological evidence at the same site as clinically found. NB – We will not accept radiological signs of nerve compression without clinical evidence of neurological involvement as proof of functional impairment. 3. Alteration of motion segment integrity confirming instability with neurological deficit. 4. Multiple back or cervical operations (i.e. two or more on separate occasions within a period of 5 years) comprising laminectomy, discectomy or fusion, or a combination thereof.	

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Combination of loss of use of an upper and lower limb	**The total loss of use of an upper and a lower limb appendage as defined below:** • a foot at the transverse tarsal joint (Chopart's joint), • a leg at or above the ankle joint up to the hip joint, • a hand (at the metacarpophalangeal joint), • an arm at or above the wrist joint up to the shoulder joint, as confirmed by an orthopaedic or neurosurgeon.	**100%**
Loss of use of both hands or arms	**The total loss of use of:** • both hands at the metacarpophalangeal joints, or • both arms at or above the wrist joint up to the shoulder joint, or • one hand at the metacarpophalangeal joint and one arm at or above the wrist joint up to the shoulder joint, as confirmed by an orthopaedic or neurosurgeon.	**100%**
Loss of use of both feet or legs	**The total loss of use of:** • both legs at or above the ankle joint up to the hip joint, or • both feet at the transverse tarsal joint (Chopart's joint), or • one foot at the transverse tarsal joint (Chopart's joint) and one leg at or above the ankle joint up to the hip joint, as confirmed by an orthopaedic or neurosurgeon.	**100%**
Loss of use of one arm	The total loss of use of one arm at or above the wrist joint up to the shoulder joint, as confirmed by an orthopaedic or neurosurgeon.	**75%**
Loss of use of one hand	The total loss of use of one hand at the metacarpophalangeal joint involving more than 3 fingers, one of which includes either the thumb or the index finger, as confirmed by an orthopaedic or neurosurgeon.	**50%**
Loss of use of one thumb	The total loss of use of one thumb, as confirmed by an orthopaedic or neurosurgeon.	**25%**
Loss of use of one leg	The total loss of use of one leg, at or above the ankle joint up to the hip joint, as confirmed by an orthopaedic or neurosurgeon.	**75%**
Loss of use of one foot	The total loss of use of one foot at the transverse tarsal joint (Chopart's joint), as confirmed by an orthopaedic or neurosurgeon.	**50%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
HIV/AIDS		
AIDS	The clinical manifestation of AIDS/Stage 4 HIV infection, as confirmed by a medical specialist. **With evidence of the following:** Positive HIV antibody test (or other recognised test for the presence of AIDS, acceptable to Old Mutual), and CD4 cell count of less than 200 despite compliance with anti-retroviral treatment as per latest National Guidelines, and either: **The presence of 3 or more of the following 5 conditions:** Weight loss of more than 10% body weight in less than 6 months • Shingles • Oral thrush • Chronic diarrhoea • Active tuberculosis or: **The diagnosis of one or more of the following 8 diseases:** • Kaposi's sarcoma, • Candidiasis of oesophagus, trachea, bronchi or lungs, • Oral hairy leukoplakia, • Pneumocystis carinii pneumonia, • Extra pulmonary Cryptococcus, • Cytomegalo virus infection of an internal organ other than the liver, • Disseminated atypical mycobacteriosis, • Visceral leischmaniasis	**100%**
ACTIVITIES OF DAILY LIVING		
Any illness, condition or event that results in the insured person being unable to perform certain Basic Activities of Daily Living and / or Advanced Activities of Daily Living, as specified below. • An inability to perform 3 of the Basic Activities of Daily Living or 4 of the Advanced Activities of Daily Living. **Old Mutual's Medical Officer must confirm that:** • The insured person has undergone adequate medical treatment and has reached an adequate level of functioning that can reasonably be expected of a person suffering from the illness, condition or event, and • The insured person does not qualify, as a result of suffering from an illness, condition or event, for the payment of the cover amount for any other listed Functional Impairment under this benefit. Where applicable, the activities listed below must be performed with simple external assistive devices (e.g. walking stick, Zimmer frame), but without complex external assistive devices (e.g. wheelchair, leg prosthesis). • The general meaning of the terms 'simple external assistive devices' and 'complex external assistive devices' is not limited by the specific examples quoted or the class or type of the examples quoted.	**100%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
	Any illness, condition or event that results in the insured person being unable to perform certain Basic Activities of Daily Living and / or Advanced Activities of Daily Living, as specified below. • An inability to perform 2 of the Basic Activities of Daily Living and 2 of the Advanced Activities of Daily Living. **Old Mutual's Medical Officer must confirm that:** • The insured person has undergone adequate medical treatment and has reached an adequate level of functioning that can reasonably be expected of a person suffering from the illness, condition or event, and • The insured person does not qualify, as a result of suffering from an illness, condition or event, for the payment of the cover amount for any other listed Functional Impairment under this benefit. Where applicable, the activities listed below must be performed with simple external assistive devices (e.g. walking stick, Zimmer frame), but without complex external assistive devices (e.g. wheelchair, leg prosthesis). The general meaning of the terms 'simple external assistive devices' and 'complex external assistive devices' is not limited by the specific examples quoted or the class or type of the examples quoted.	**50%**

Activities of Daily Living under Disability Income Cover, Functional Impairment Income Cover and Business Expenses Cover.

BASIC ACTIVITIES OF DAILY LIVING	
Activity	**Description**
Bathing	The ability to wash/bathe oneself independently
Transferring	The ability to move oneself from a bed to a chair or from a bed to a toilet independently
Dressing	The ability to take off and put on one's clothes independently
Eating	The ability to feed oneself independently. This does not include the making of food
Toileting	The ability to use a toilet and cleanse oneself thereafter, independently
Locomotion on a level surface	The ability to walk on a flat surface, independently

ADVANCED ACTIVITIES OF DAILY LIVING	
Activity	**Description**
Driving a car	The ability to open a car door, change gears or use a steering wheel
Medical care	The ability to prepare and take the correct medication
Money management	The ability to do one's own banking and to make rational financial decisions
Communicative activities	The ability to communicate either verbally or written
Shopping	The ability to choose and lift groceries from shelves as well as carry them in bags
Food preparation	The ability to prepare food for cooking as well as using kitchen utensils
Housework	The ability to clean a house or iron clothing
Community ambulation with or without assistive device, but not requiring a mobility device	The ability to walk around in public places using only a walking stick if necessary

19.2 FRACTURES THAT QUALIFY UNDER DISABILITY INCOME COVER AND BUSINESS EXPENSES COVER

For fractures, the amount we pay depends on the waiting period selected.

Fracture	7-Day waiting period	1-Month waiting period	Other waiting periods
Collar bone (Clavicle)	1 month's income	No income	No income
Facial bones – Le Forte II	1 month's income	No income	No income
Forearm (Radius or ulna or both)	1 month's income	No income	No income
Bones of the hand (includes wrist and fingers) requiring plaster/fibreglass cast or surgery	1 month's income	No income	No income
Hind foot or ankle	1 month's income	No income	No income
Skull	1 month's income	No income	No income
Compression fracture of a vertebral body <10%	1 month's income	No income	No income
Two or less ribs	1 month's income	No income	No income
Three or more ribs	2 months' income	1 month's income	No income
Knee cap (patella)	2 months' income	1 month's income	No income
Leg - between the knee and foot (Tibia or fibula or both)	2 months' income	1 month's income	No income
Shoulder blade (scapula)	2 months' income	1 month's income	No income
Humerus	2 months' income	1 month's income	No income
Spinous processes or transverse processes of the spine	2 months' income	1 month's income	No income
Facial bones – Le Forte III	3 months' income	2 months' income	No income
Pelvis	3 month's income	2 months' income	No income
Compression fracture of a vertebral body ≥10%	3 months' income	2 months' income	No income
Dislocation fracture of the spine requiring surgery	3 months' income	2 months' income	No income
Depressed fracture of the skull requiring surgery	3 months' income	2 months' income	No income
Neck of femur (thigh bone)	3 months' income	2 months' income	No income
Shaft of femur (thigh bone)	3 months' income	2 months' income	No income

19.3 FRACTURES THAT QUALIFY UNDER FUNCTIONAL IMPAIRMENT INCOME COVER

Fracture	1-Month waiting period	Other waiting periods
Collar bone (Clavicle)	No income	No income
Facial bones – Le Forte II	No income	No income
Forearm (Radius or ulna or both)	No income	No income
Bones of the hand (includes wrist and fingers) requiring plaster/fibreglass cast or surgery	No income	No income
Hind foot or ankle	No income	No income
Skull	No income	No income
Compression fracture of a vertebral body <10%	No income	No income
Two or less ribs	No income	No income
Three or more ribs	1 Month's income	No income
Knee cap (patella)	1 Month's income	No income
Leg - between the knee and foot (Tibia or fibula or both)	1 Month's income	No income
Shoulder blade (scapula)	1 Month's income	No income
Humerus	1 Month's income	No income
Spinous processes or transverse processes of the spine	1 Month's income	No income
Facial bones – Le Forte III	2 Month's income	No income
Pelvis	2 Month's income	No income
Compression fracture of a vertebral body ≥10%	2 Month's income	No income
Dislocation fracture of the spine requiring surgery	2 Month's income	No income
Depressed fracture of the skull requiring surgery	2 Month's income	No income
Neck of femur (thigh bone)	2 Month's income	No income
Shaft of femur (thigh bone)	2 Month's income	No income

19.4 FAMILY SUPPORT BENEFIT SPOUSE/PARTNER EVENTS

This section should be read in conjunction with the ASISA SCIDEP Disclosures in the claims chapter.

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
CANCER		

Cancer	Confirmation of a malignant tumour diagnosed and characterised by the uncontrolled growth of malignant cells and invasion beyond the layer of cells in which it originated into a deeper layer of tissue. The term malignant tumour includes leukaemia, sarcoma and lymphoma.
	
	All cancers classified as Stage II by the American Joint Committee for Cancer are covered, where the following cancers are only covered as specified:
	• Prostate cancer is covered from Stage III
	• Malignant melanoma is covered from Stage II
	• WHO Grade II brain tumours are covered if neurological deficit is present
	• Blood cancers are covered at the stages specified below
	  • Chronic Lymphocytic Leukemia, from Stage II on the Rai classification
	  • Chronic Myeloid Leukemia
	  • Hodgkin's/Non Hodgkin's lymphoma from Stage II on the Ann Arbor classification
	  • Multiple Myeloma Stage from Stage I on the Durie-Salmon Scale
	
	Exclusions
	• All cancers which are histologically classified as any of the following:
	  • pre-malignant
	  • non-invasive
	  • cancer in situ
	  • having borderline malignancy
	  • tumours with low malignant potential
	• All prostate cancers, unless conforming to the specifications above
	• All skin cancers, except malignant melanoma as specified above
	• All blood cancers, unless as specified above
		100%

Hematopoietic stem cell (bone marrow) transplant	**One of the following:** • Undergoing a hematopoietic stem cell (bone marrow) transplant • Inclusion on a bone marrow transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure **Requirements for a claim to be considered:** • Confirmation by the treating specialist with supportive evidence	**100%**

CARDIOVASCULAR		

Heart attack	Confirmed diagnosis of a heart attack by the treating cardiologist characterised by death of heart muscle, due to inadequate blood supply.
	
	Requirements for a claim to be considered:
	• Raised cardiac biomarkers with at least one reading above the upper reference level
	• Two of the following must be present:
	  • compatible clinical symptoms
	  • new characteristic electrocardiography (ECG) changes indicative of myocardial ischaemia or myocardial infarction
	  • angiography showing critical occlusion of a coronary artery indicative of myocardial ischaemia or myocardial infarction
	  • evidence of hypokinesis on ECHO confirming the death of heart muscle tissue
	
	Exclusions
	• Other acute coronary syndromes (including but not limited to angina and unstable angina)
	• Coronary spasms
	• Elevations of troponin in the absence of overt ischemic heart diseases (e.g. myocarditis, apical ballooning, cardiac contusion, pulmonary embolism, drug toxicity)
		100%

Coronary artery bypass graft	The undergoing of surgery to correct the narrowing of, or blockage to, one or more coronary arteries by means of a bypass graft.	**100%**
Aortic surgery	The repair of a narrowing, obstruction, dissection or aneurysm of either the main thoracic or abdominal aorta, by means of any minimally invasive surgical technique. This includes keyhole or catheter techniques, or a mini-thoracoscopic/laparoscopic surgical procedure. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**100%**
Cardiomyopathy	Confirmed diagnosis of cardiomyopathy by the treating cardiologist. **Requirements for a claim to be considered:** • The cardiomyopathy results in permanent and irreversible cardiac impairment, evidenced by echocardiogram findings showing left ventricular ejection fraction (LVEF) of less than 50%, measured twice at least 3 months apart.	**100%**
Heart surgery	The correction of any structural abnormality of the heart, through surgically opening the chest cavity (thoracotomy or sternotomy). **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions:** • Any investigative procedure NOTE: Coronary artery bypass graft is covered as a separate severe illness	**100%**

Heart transplant	**One of the following:** • Undergoing a heart transplant • Inclusion on a heart transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure **Requirements for a claim to be considered:** • Confirmation by the treating specialist with supportive evidence	**100%**
CENTRAL NERVOUS SYSTEM		
Acquired intellectual or cognitive impairment	Confirmed diagnosis of a permanent acquired intellectual or cognitive impairment caused by an organic disease or injury. **Requirements for a claim to be considered:** • Confirmation by the treating neurologist or psychiatrist • Objective tests such as brain imaging demonstrating appropriate pathology • IQ must be less than 60 as measured by at least two independent psychiatrists using the appropriate Wechsler Intelligence Scale and at least one other internationally recognized equivalent neuropsychological test **Exclusions:** • All other mental, psychological and psychiatric conditions	**100%**
Brain surgery	Any condition for which the insured person has undergone open brain surgery. This must involve a craniotomy (where there is surgical removal of part of the bone from the skull to expose the brain). This includes depressed skull fracture requiring removal of bone or reconstruction of the skull. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions:** • Stereotactic or radiosurgery • Burr hole surgery • Any minimally invasive surgery such as keyhole or endovascular surgery	**100%**
Coma	Confirmed diagnosis of a coma by the treating neurologist or neurosurgeon. **Requirements for a claim to be considered:** • Decreased level of consciousness, with a Glasgow Coma Scale of 8 or less • The coma is constant and present for longer than 14 days **Exclusions:** • Medically induced comas • Comas due to the consumption of alcohol, drugs or medication not used as prescribed	**100%**
Paralysis	**The total and permanent loss of use of:** • A hand or hands at the level of the wrist joint and above, or • A foot or feet at the level of the ankle and above **Requirements for a claim to be considered:** • Permanence must be confirmed by the treating specialist • Supportive special investigations	**100%**

Stroke	Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in neurological deficit, confirmed by neuroimaging investigation and appropriate clinical findings by a specialist neurologist. Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months.
	
	Stroke as a result of traumatic injury to brain tissue or blood vessels is included.
	
	Requirements for a claim to be considered:
	
	• One of the following must be present:
	  • The inability to do 3 or more Advanced Activities of Daily Living, as defined below.
	  • A Whole Person Impairment (WPI) of 11%- 20%. WPI figures are calculated as per the latest version of the American Medical Association Guides to the Evaluation of Permanent Impairment
	
	Exclusions:
	
	• Transient ischaemic attack
	• Vascular disease affecting the eye or optic nerve
	• Migraine and vestibular disorders
		100%

Motor neurone disease	Confirmed diagnosis of motor neurone disease by the treating neurologist. **Requirements for a claim to be considered:** • There must be appropriate evidence, which could include nerve conduction studies (NCS) and electromyography (EMG)	**100%**
Dementia (incl. Alzheimer's Disease)	Confirmed diagnosis of Alzheimer's disease or any other type of dementia by the treating neurologist. **Requirements for a claim to be considered:** • The diagnosis meets the criteria of the latest Diagnostic and Statistical Manual of Mental Disorders (DSM) • Supportive imaging and neurological reports	**100%**
Parkinson's disease	Confirmed diagnosis of primary idiopathic Parkinson's disease by the treating neurologist. **Requirements for a claim to be considered:** The diagnosis must be confirmed by the presence of at least 2 cardinal symptoms of Parkinson's disease, which are: • Bradykinesia • Resting tremor • Muscle rigidity • Postural instability **Exclusions:** • Parkinsonian syndromes including but not limited to those caused by the consumption of alcohol, drugs or medication not used as prescribed • Secondary Parkinsonism • Essential tremor	**100%**
AUTOIMMUNE AND CONNECTIVE TISSUE		
Advanced rheumatoid arthritis	Confirmed diagnosis and treatment of rheumatoid arthritis by the treating rheumatologist. **Requirements for a claim to be considered:** • Serological markers to be positive • Despite adequate treatment for at least 6 months with disease modifying drugs including biologics, the disease remains unresponsive or poorly responsive • The insured person undergoes joint replacement, joint reconstruction or joint fixation **Exclusions:** • Reactive arthritis • Psoriatic arthritis	**100%**

UROGENITAL		
Chronic kidney failure	Confirmed diagnosis of chronic renal failure by the treating nephrologist or urologist. **Requirements for a claim to be considered:** One of the following must be present, despite adequate medical treatment: • End-stage renal disease with an estimated Glomerular Filtration Rate (GFR) less than 24ml/min • Renal function deterioration for which either peritoneal dialysis or haemodialysis has been instituted	**100%**
Kidney transplant	**One of the following:** • Undergoing a kidney transplant • Inclusion on a kidney transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure **Requirements for a claim to be considered:** • Confirmation by the treating specialist with supportive evidence	**100%**
GASTROINTESTINAL		
Chronic liver failure	Confirmed diagnosis of chronic end-stage liver disease by the treating gastroenterologist or equivalent specialist. **Requirements for a claim to be considered:** • Supportive clinical, laboratory and histological evidence • The liver failure must be classified as at least Child-Pugh Class C **Exclusions:** • Liver disease caused by the consumption of alcohol, drugs or medication not used as prescribed	**100%**
Liver transplant	**One of the following:** • Undergoing a liver transplant • Inclusion on a liver transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure **Requirements for a claim to be considered:** • Confirmation by the treating specialist with supportive evidence	**100%**
Pancreatectomy or pancreas transplant	**One of the following:** • Undergoing a complete pancreatectomy • Undergoing a complete pancreas transplant • Inclusion on a pancreas transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure **Requirements for a claim to be considered:** • Confirmation by the treating specialist with supportive evidence	**100%**
HIV/AIDS		
AIDS	Confirmed diagnosis of AIDS or Stage 4 HIV infection by the treating specialist. **Requirements for a claim to be considered:** • Positive HIV antibody test (or other recognised test for the presence of HIV, acceptable to Old Mutual) • CD4 count of persistently less than 200 cells/mm3 must be present, despite compliance with anti-retroviral treatment as per latest National Guidelines • At least one of the AIDS-defining conditions listed in the current World Health Organization's (WHO) clinical staging of HIV/AIDS	**100%**

RESPIRATORY		
Chronic respiratory failure	Confirmed diagnosis of a chronic respiratory disorder by the treating pulmonologist. **Requirements for a claim to be considered:** Any one of the below measurements taken on at least 3 occasions, at least 1 month apart • Impaired airflow with FEV1 (forced expiratory volume in the first second) of ≤40% predicted • FVC (forced vital capacity) of ≤40% predicted • DLCO (diffusing capacity of the lungs for carbon monoxide) of ≤40% predicted	**100%**
Prolonged mechanical ventilation	A severe physical injury or organic disease that results in an extended period of assisted mechanical ventilation. **Requirements for a claim to be considered:** One of the following must be present: • A severe physical injury that results in ICU admission for more than 14 full days, with assisted mechanical ventilation for more than 7 full days • Any organic disease that results in assisted mechanical ventilation of more than 30 consecutive days	**100%**
	NOTE: • A day is 24 hours • The life covered does not qualify for a payment for any other listed severe illness under this benefit • The survival period applies from the date the claim definition has been met	
Lung transplant	**One of the following:** • Undergoing a lung transplant (this includes the whole lung or a lobe of the lung) • Inclusion on a lung transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure **Requirements for a claim to be considered:** • Confirmation by the treating specialist with supportive evidence	**100%**
SENSES		
Loss of hearing	Confirmed diagnosis of loss of hearing in both ears by the treating ENT specialist. **Requirements for a claim to be considered:** • Average auditory threshold, measured at 500, 1000, 2000 and 3000 Hertz in the better ear using a pure tone audiogram, of between 90 or more decibels • This must be confirmed by audiometry conducted with hearing aids	**100%**
Loss of sight	Confirmed diagnosis of loss of sight by the treating ophthalmologist. The loss of sight can't be improved through refractive correction or medication. **Requirements for a claim to be considered:** One of the following must be present: • A reading of 6/60 or worse (or equivalent measure on a non-metric scale) in each eye , after best correction • A visual field loss to a 10° radius, after best correction • Severe proliferative diabetic retinopathy • Grade IV hypertensive retinopathy • Permanent hemianopia in both eyes	**100%**

	Exclusions: • Loss of sight due to cataracts, unless there is evidence of failed cataract surgery or contraindications to cataract surgery	
Loss of speech	Total permanent and irreversible loss of the ability to speak as a result of physical injury or disease as diagnosed by the treating ENT specialist, neurologist or neurosurgeon. **Requirements for a claim to be considered:** • The loss of speech has to be present for a continuous period of at least 6 months **Exclusions:** Loss of speech due to psychiatric causes	**100%**
TERMINAL ILLNESS		
Terminal illness	Confirmed diagnosis of a medical condition that is or has become incurable by a treating specialist. In the opinion of the treating specialist and as confirmed by Old Mutual's Medical Officer, the condition is likely to result in death within 12 months after the diagnosis.	**100%**
TRAUMA		
Accidental brain injury	Death of brain tissue due to traumatic injury as a result of an accident resulting in neurological deficit, confirmed by neuroimaging investigation and appropriate clinical findings by a specialist neurologist. Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months. **Requirements for a claim to be considered:** One of the following must be present: • A Whole Person Impairment (WPI) of 11%- 20%. WPI figures are calculated as per the latest version of the American Medical Association Guides to the Evaluation of Permanent Impairment **NOTE:** • An accident is an unexpected and visible event of external origin that causes traumatic bodily injury and is not traceable, even indirectly, to the child's state of mental or physical health before the event.	**100%**
Major burns	Confirmed diagnosis of external third degree burns (full thickness burns) by the treating plastic surgeon or trauma specialist. **Requirements for a claim to be considered** **One of the following must be present:** • At least 20% of total body surface affected, as measured on the Lund and Browder Chart or equivalent • 30% of the surface area of the face affected, which for the purposes of this definition includes the forehead and ears **Exclusions:** • Sunburn or sun exposure	**100%**
MUSCULOSKELETAL		
Amputation of limb	• Any organic disease or severe physical injury that results in the medically necessary, complete physical severance of: • A hand or hands at the level of the wrist joint or above, or • A foot or feet at the level of the ankle and above **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**100%**

BASIC ACTIVITIES OF DAILY LIVING	
Activity	**Description**
Bathing	The ability to wash/bathe oneself independently
Transferring	The ability to move oneself from a bed to a chair or from a bed to a toilet independently
Dressing	The ability to take off and put on one's clothes independently
Eating	The ability to feed oneself independently. This does not include the making of food
Toileting	The ability to use a toilet and cleanse oneself thereafter, independently
Locomotion on a level surface	The ability to walk on a flat surface, independently
Locomotion on an incline	The ability to walk up a gentle slope, or a flight of steps independently
ADVANCED ACTIVITIES OF DAILY LIVING	
Activity	**Description**
Driving a car	The ability to open a car door, change gears or use a steering wheel
Medical care	The ability to prepare and take the correct medication
Money management	The ability to do one's own banking and to make rational financial decisions
Communicative activities	The ability to communicate either verbally or written
Shopping	The ability to choose and lift groceries from shelves as well as carry them in bags
Food preparation	The ability to prepare food for cooking as well as using kitchen utensils
Housework	The ability to clean a house or iron clothing
Community ambulation with or without assistive device, but not requiring a mobility device	The ability to walk around in public places using only a walking stick if necessary
Moderate activities	Activities like moving a table, pushing a vacuum cleaner, bowling, golf
Vigorous activities	Able to partake in running, heavy lifting, sports

20.5 FAMILY SUPPORT BENEFIT CHILD EVENTS

This section should be read in conjunction with the ASISA SCIDEP Disclosures in the claims chapter.

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
CANCER		

Cancer	Confirmation of a malignant tumour diagnosed and characterised by the uncontrolled growth of malignant cells and invasion beyond the layer of cells in which it originated into a deeper layer of tissue. The term malignant tumour includes leukaemia, sarcoma and lymphoma.
	
	All cancers classified as Stage II by the American Joint Committee for Cancer are covered, where the following cancers are only covered as specified:
	
	• Prostate cancer is covered from Stage III
	• Malignant melanoma is covered from Stage II
	• WHO Grade II brain tumours are covered if neurological deficit is present
	• Blood cancers are covered at the stages specified below
	  • Chronic Lymphocytic Leukemia, from Stage II on the Rai classification
	  • Chronic Myeloid Leukemia
	  • Hodgkin's/Non Hodgkin's lymphoma from Stage II on the Ann Arbor classification
	  • Multiple Myeloma Stage from Stage I on the Durie-Salmon Scale
	
	Exclusions:
	
	• All cancers which are histologically classified as any of the following:
	  • pre-malignant
	  • non-invasive
	  • cancer in situ
	  • having borderline malignancy
	  • tumours with low malignant potential
	
	• All prostate cancers, unless conforming to the specifications above
	• All skin cancers, except malignant melanoma as specified above
	• All blood cancers, unless as specified above
		100%

Hematopoietic stem cell (bone marrow) transplant	**One of the following:** • Undergoing a hematopoietic stem cell (bone marrow) transplant • Inclusion on a bone marrow transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure **Requirements for a claim to be considered:** • Confirmation by the treating specialist with supportive evidence	**100%**

CARDIOVASCULAR		

Heart attack	Confirmed diagnosis of a heart attack by the treating cardiologist characterised by death of heart muscle, due to inadequate blood supply.
	
	Requirements for a claim to be considered:
	• Raised cardiac biomarkers with at least one reading above the upper reference level
	• Two of the following must be present:
	  • compatible clinical symptoms
	  • new characteristic electrocardiography (ECG) changes indicative of myocardial
	  • ischaemia or myocardial infarction
	  • angiography showing critical occlusion of a coronary artery indicative of myocardial
	  • ischaemia or myocardial infarction
	  • evidence of hypokinesis on ECHO confirming the death of heart muscle tissue
		100%

	Exclusions: • Other acute coronary syndromes (including but not limited to angina and unstable angina) • Coronary spasms • Elevations of troponin in the absence of overt ischemic heart diseases (e.g. myocarditis, apical ballooning, cardiac contusion, pulmonary embolism, drug toxicity)	
Coronary artery bypass graft	The undergoing of surgery to correct the narrowing of, or blockage to, one or more coronary arteries by means of a bypass graft.	**100%**
Aortic Surgery	The repair of a narrowing, obstruction, dissection or aneurysm of either the main thoracic or abdominal aorta, by means of any minimally invasive surgical technique. This includes keyhole or catheter techniques, or a mini-thoracoscopic/laparoscopic surgical procedure. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**100%**
Cardiomyopathy	Confirmed diagnosis of cardiomyopathy by the treating cardiologist. **Requirements for a claim to be considered:** • The cardiomyopathy results in permanent and irreversible cardiac impairment, evidenced by echocardiogram findings showing left ventricular ejection fraction (LVEF) of less than 50%, measured twice at least 3 months apart.	**100%**
Heart surgery	The correction of any structural abnormality of the heart, through surgically opening the chest cavity (thoracotomy or sternotomy). **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions:** • Any investigative procedure **NOTE:** Coronary artery bypass graft is covered as a separate severe illness	**100%**

Heart transplant	One of the following: • Undergoing a heart transplant • Inclusion on a heart transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure **Requirements for a claim to be considered:** • Confirmation by the treating specialist with supportive evidence	**100%**
CENTRAL NERVOUS SYSTEM		
Acquired intellectual or cognitive impairment	Confirmed diagnosis of a permanent acquired intellectual or cognitive impairment caused by an organic disease or injury. **Requirements for a claim to be considered:** • Confirmation by the treating neurologist or psychiatrist • Objective tests such as brain imaging demonstrating appropriate pathology • IQ must be less than 60 as measured by at least two independent psychiatrists using the appropriate Wechsler Intelligence Scale and at least one other internationally recognized equivalent neuropsychological test. **Exclusions:** • All other mental, psychological and psychiatric conditions	**100%**
Brain surgery	Any condition for which the insured person has undergone open brain surgery. This must involve a craniotomy (where there is surgical removal of part of the bone from the skull to expose the brain). This includes depressed skull fracture requiring removal of bone or reconstruction of the skull. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions:** • Stereotactic or radiosurgery • Burr hole surgery • Any minimally invasive surgery such as keyhole or endovascular surgery	**100%**
Coma	Confirmed diagnosis of a coma by the treating neurologist or neurosurgeon. **Requirements for a claim to be considered:** • Decreased level of consciousness, with a Glasgow Coma Scale of 8 or less • The coma is constant and present for longer than 14 days **Exclusions:** • Medically induced comas • Comas due to the consumption of alcohol, drugs or medication not used as prescribed	**100%**
Paralysis	The total and permanent loss of use of: • A hand or hands at the level of the wrist joint and above, or • A foot or feet at the level of the ankle and above **Requirements for a claim to be considered:** • Permanence must be confirmed by the treating specialist • Supportive special investigations	**100%**

BASIC ACTIVITIES OF DAILY LIVING	
Activity	**Description**
Bathing	The ability to wash/bathe oneself independently
Transferring	The ability to move oneself from a bed to a chair or from a bed to a toilet independently
Dressing	The ability to take off and put on one's clothes independently
Eating	The ability to feed oneself independently. This does not include the making of food
Toileting	The ability to use a toilet and cleanse oneself thereafter, independently
Locomotion on a level surface	The ability to walk on a flat surface, independently
Locomotion on an incline	The ability to walk up a gentle slope, or a flight of steps independently

ADVANCED ACTIVITIES OF DAILY LIVING	
Activity	**Description**
Driving a car	The ability to open a car door, change gears or use a steering wheel
Medical care	The ability to prepare and take the correct medication
Money management	The ability to do one's own banking and to make rational financial decisions
Communicative activities	The ability to communicate either verbally or written
Shopping	The ability to choose and lift groceries from shelves as well as carry them in bags
Food preparation	The ability to prepare food for cooking as well as using kitchen utensils
Housework	The ability to clean a house or iron clothing
Community ambulation with or without assistive device, but not requiring a mobility device	The ability to walk around in public places using only a walking stick if necessary
Moderate activities	Activities like moving a table, pushing a vacuum cleaner, bowling, golf
Vigorous activities	Able to partake in running, heavy lifting, sports

19.6 FUNCTIONAL IMPAIRMENTS THAT QUALIFY UNDER 100% PAYOUT UNDER DISABILITY COVER, FUNCTIONAL IMPAIRMENT COVER AND BUSINESS DISABILITY

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
CARDIOVASCULAR		
Arrhythmia	The diagnosis of an arrhythmia by a medical specialist. **With evidence of the following requirements which need to be permanent and irreversible, despite adequate medical treatment:** • Shortness of breath so severe that symptoms are present at rest (NYHA, Class IV), and • Symptoms of palpitations and syncope or dizziness correlating with ECG evidence of serious arrhythmia are present daily.	**100%**
Congestive cardiac failure	The diagnosis of Congestive cardiac failure by a specialist cardiologist or physician as a result of coronary artery disease or valvular heart disease or diseases of the aorta or pericardial disease. **With evidence of the following requirements which need to be permanent and irreversible:** • Ejection fraction (EF) consistently less than 40% after adequate medical treatment, and shortness of breath so severe that symptoms are present during less than ordinary activity or at rest (NYHA Class lll - IV), or • Awaiting cardiac transplantation.	**100%**
Hypertension	The diagnosis of uncontrolled hypertension confirmed by a medical specialist. **With evidence of diastolic pressure permanently greater than or equal to 110mmHg on adequate treatment and complicated by 2 or more of the following requirements which need to be permanent and irreversible**: • Stage 4 Kidney dysfunction • Cerebrovascular incident (excluding transient ischaemic attacks) confirmed by neuroimaging • Echocardiogram evidence of LVH (septal wall thickness to posterior LV wall thickness 1.3:1) • Grade IV retinopathy • Congestive Cardiac Failure with evidence of an ejection fraction (EF) consistently less than 45% after adequate medical treatment, and marked limitation in activity due to symptoms, even during ordinary or less than ordinary activity e.g. walking short distances (NYHA Class ll - III).	**100%**
Peripheral arterial disease	The diagnosis of peripheral arterial disease of the lower limbs by a vascular surgeon. **With evidence of a permanently absent pulse on Doppler readings, and 1 of the following requirements which need to be permanent and irreversible:** • Severe Vascular Ulceration, or • Gangrene secondary to peripheral arterial disease.	**100%**
RESPIRATORY		
Chronic respiratory failure	The diagnosis of a chronic respiratory failure by a pulmonologist. **With evidence of at least 1 of the following requirements which need to be permanent and irreversible:** • Impaired airflow with FEV1 less than or equal to 40%, or • FVC less than or equal to 50%, or • DLCO of less than or equal to 40%.	**100%**

Pulmonary arterial hypertension	The diagnosis of pulmonary hypertension by a medical specialist. **With evidence of a permanent Systolic Pulmonary Artery Pressure greater than 70mmHg and complicated by at least 1 of the following requirements which need to be permanent and irreversible:** • Right sided heart failure, or • Shortness of breath so severe that symptoms are present at rest (NYHA Class IV).	**100%**
GASTROINTESTINAL		
Ano-rectal impairment	Faecal incontinence **With evidence of complete faecal incontinence despite adequate medical and/or surgical treatment by a gastroenterologist or equivalent specialist.**	**100%**
Chronic gastrointestinal disease	The diagnosis of a chronic gastrointestinal disease by a gastroenterologist or equivalent specialist, as a result of a medical condition. **With evidence of the following requirements which need to be permanent and irreversible:** • Medical findings confirming organic disease, and • Significant unintentional weight loss resulting in a BMI of less than 15 or 25% weight loss below the lower limit of the normal range for the individual, and • Symptoms uncontrolled by medical or surgical treatment. Psychiatric conditions are excluded.	**100%**
Chronic Liver Failure	The diagnosis of permanent and irreversible chronic end-stage liver failure, with a Child Pugh classification of Class C, by a gastroenterologist or equivalent specialist.	**100%**
UROGENITAL		
Bladder Impairment	The diagnosis of a bladder impairment despite adequate surgical and medical treatment by a nephrologist or urologist. **With evidence of 1 of the following requirements which need to be permanent and irreversible:** • No detectable reflex or voluntary urine control as a result of organic pathology, resulting in urinary incontinence, or • Total bladder resection, or • Chronic disorders of the bladder and its structures that require a permanent indwelling catheter.	**100%**
Chronic Kidney Failure	The diagnosis of chronic renal failure despite adequate medical treatment by a nephrologist or urologist. **With evidence of 1 of the following requirements which need to be permanent and irreversible:** • End-stage renal disease with an estimated GFR less than 24ml/min, or • Creatinine clearance of less than 28 ml per minute, or • Renal function deterioration that requires life-long peritoneal dialysis or lifelong haemodialysis.	**100%**
CENTRAL NERVOUS SYSTEM		
Impaired consciousness	The diagnosis of a coma of a specified severity by a neurologist or neurosurgeon. Medically induced comas are excluded. **With evidence of the following for 14 days or more:** • A decreased level of consciousness, with a Glasgow Coma Scale of less than 9, and • Requiring total medical support including intubation and assisted ventilation.	**100%**
Aphasia	The diagnosis of aphasia by a neurologist or neurosurgeon. **With evidence of the following requirements which need to be permanent and irreversible:** • A total inability to express oneself or communicate (through speech, writing, or signs), or to comprehend spoken or written language, due to injury or disease of the brain, and • Deficits in the formal aspects of language such as naming, word choice, comprehension, spelling and syntax, and • Objective medical findings supporting the diagnosis of aphasia. Psychiatric conditions are excluded.	**100%**

Cranial Nerve VII	The diagnosis of facial nerve paralysis confirmed by a neurologist or neurosurgeon. **With evidence of the following requirements which need to be permanent and irreversible:** • Slight or no movement of the face, and • An inability to actively close the eyelids, and • Slight or no movement of the mouth.	**100%**
Cranial Nerve VIII	The diagnosis of Vestibulocochlear nerve paralysis confirmed by a neurologist or neurosurgeon. **With evidence of the following requirements which need to be permanent and irreversible:** • Nerve damage with severe imbalance resulting in limitation of Activities of Daily Living such that the insured person is permanently unable to perform 3 of the Basic Activities of Daily Living or 4 of the Advanced Activities of Daily Living.	**100%**
Cranial Nerves IX, X, XII	The diagnosis of Cranial Nerve IX, X, XII paralysis confirmed by a neurologist or neurosurgeon. **With evidence of the following requirements which need to be permanent and irreversible:** • An inability to swallow or process oral secretions without choking, and • Need for external suctioning device, and • Medical findings confirming organic disease.	**100%**
Epilepsy	The diagnosis of epilepsy by a neurologist or neurosurgeon supported by objective medical findings and resistant to optimal therapy as confirmed by drug serum-level testing. **With evidence of the following requirements which need to be permanent and irreversible:** • 3 or more generalised seizures per week, and • An inability to perform 3 of the Basic Activities of Daily Living or 4 of the Advanced Activities of Daily Living.	**100%**
Hemiplegia	The total and permanent loss of the functioning of one side of the body due to an injury or disease of the brain as confirmed by a neurologist or neurosurgeon and correlating with objective medical findings.	**100%**
Dementia (incl. Alzheimer's Disease)	The diagnosis of dementia by a neurologist, physician or neurosurgeon. **With evidence of the following requirements which need to be permanent and irreversible:** • A diminished intellectual ability (may include personality changes and episodes of confusion), and • A score of 2 under the 5 point Clinical Dementia Rating scale, and • Needs constant supervision.	**100%**
Paraplegia/ Diplegia	The total and permanent loss of the functioning of both legs or both arms due to an injury or disease of the brain or spinal cord. This must be confirmed by a neurologist or neurosurgeon and correlate with objective medical findings.	**100%**
Quadriplegia	The total and permanent loss of the functioning of both legs and both arms due to an injury or disease of the brain or spinal cord. This must be confirmed by a neurologist or neurosurgeon and correlate with objective medical findings.	**100%**

CANCER		
Cancer	The diagnosis of an advanced stage of cancer as confirmed by an oncologist with supporting documentation. **With evidence of the following requirements which need to be permanent and irreversible:** • Diagnosis of at least a Stage III cancer, and the insured person is unable to perform 2 of the Basic Activities of Daily Living or 3 of the Advanced Activities of Daily Living, or • Stage IV cancer or • Cancer which has resulted in organ failure will be assessed under the affected organ. **Organ failure will only be assessed under the following definitions:** • Congestive Cardiac Failure or • Chronic respiratory failure or • Chronic liver failure or • Chronic kidney failure or • Organic Brain Disorders/ Dementia	**100%**
SENSES		
Loss of sight	Confirmed diagnosis of total and permanent bilateral loss of sight by an ophthalmologist. The loss of sight cannot be improved through refractive correction or medication. **With evidence of 1 of the following:** • A reading of 6/60 or worse (or equivalent measure on a non-metric scale) in each eye after best correction, or • Severe proliferative diabetic retinopathy, or • Grade IV hypertensive retinopathy, or • Permanent Hemianopia in both eyes, or • A visual field loss to a 10° radius in the better eye. Loss of sight due to cataracts is excluded, unless there is evidence of failed cataract surgery or contraindications to cataract surgery.	**100%**
Loss of hearing	Total and permanent loss of hearing in both ears as confirmed by an ear, nose and throat surgeon. **With evidence of the following:** • Audiometry measurements, done with the use of hearing aids, with an average loss of greater than 87dB.	**100%**
Loss of speech	The total and permanent loss of the ability to produce intelligible and audible speech due to injury or disease, as confirmed by an ear, nose and throat surgeon, neurologist or neurosurgeon. • Objective medical evidence of an ear, nose and throat disorder causing the impairment must be provided. • Loss of speech due to psychiatric causes are excluded.	**100%**
ENDOCRINE		
Endocrine Disorders	The diagnosis of an endocrine disorder, which despite adequate medical and surgical treatment, has resulted in permanent organ failure, as confirmed by a medical specialist. **Organ failure will only be assessed under the following definitions:** • Congestive Cardiac Failure or • Chronic respiratory failure or • Chronic liver failure or • Chronic kidney failure or • Organic Brain Disorders/ Dementia	**100%**
PSYCHIATRIC		
Psychiatric Disorder	The diagnosis of a psychiatric disorder, as confirmed by a specialist psychiatrist. Resulting in permanent institutionalisation and **With evidence of the following:** • permanent GAF score of 40 or less certified under the DSM IV classification, or • permanent WHODAS average domain score of 4 certified under the DSM 5 classification	**100%**

TRAUMA		
Facial Disorders or Disfigurement	Total facial disfigurement as confirmed by a maxillofacial specialist or related specialist. There should be destruction or loss of skin, bone, or muscles that requires reconstructive surgery.	**100%**
Major Burns	The diagnosis of third degree burns (full thickness burns) by a plastic surgeon or trauma specialist. **With evidence of at least:** • 30% of total body surface affected as measured on the Lund and Browder Chart or equivalent scale, or • more than 50% of the combined surface area of the bilateral upper limbs affected including involvement of at least 60% of combined surface area of the palms of both hands; and restriction of joint mobility of at least two of the following: 3 fingers, wrist or elbow.	**100%**
HAEMATOLOGY		
Clotting Disorders	The diagnosis of a clotting disorder, which despite adequate medical and surgical treatment, has resulted in permanent organ failure, as confirmed by a medical specialist. **Organ failure will only be assessed under the following definitions:** • Congestive Cardiac Failure or • Chronic respiratory failure or • Chronic liver failure or • Chronic kidney failure or • Organic Brain Disorders/ Dementia	**100%**
Red Blood Cell Disorders	The diagnosis of severe chronic anaemia by a physician or haematologist. **With evidence of the following requirements which need to be permanent and irreversible:** • Hb less than 8g/dL, and • Requiring 2-3U of blood every 2 weeks.	**100%**
White Blood Cell Disorders	The diagnosis of a severe white blood cell disorder by a physician or haematologist. **With evidence of 1 of the following requirements which need to be permanent and irreversible:** • An absolute neutrophil count of less than 250, resulting in at least 3 hospitalisations per year for acute bacterial infections, or • Lymphoma or Leukaemia requiring at least 3 chemotherapy regimens per year.	**100%**

MUSCULOSKELETAL		
Chronic Spinal Column Conditions	• A history of chronic pain syndrome due to a chronic spinal condition for a duration of at least two years. It must be treated by a multidisciplinary pain management team with at least three of the four requirements listed below, which must be permanent and irreversible as confirmed by an orthopaedic or neurosurgeon. All these criteria must be present in the same region, as defined below, for a valid claim to be paid, or • Confirmed diagnosis of Cauda equina syndrome resulting in permanent and irreversible bowel or bladder dysfunction. **Spinal Regions:** The neck and lower back are part of the spine. The spinal regions are: • Cervical region (C1-C7). • Thoracic region (T1-T12) and • Lumbosacral region (L1-S1). The C7 to T1 joint will be classified in the cervical region, and the T12 to L1 joint in the thoracolumbar region.	**100%**
	List of four requirements: • 50% or more compression of a vertebral body or multiple level compression fractures giving rise to kyphotic deformity. • Clinically significant radiculopathy (motor and sensory deficit or muscle atrophy and clinical signs of nerve tension and radiological evidence at the same site as clinically found. NB – We will not accept radiological signs of nerve compression without clinical evidence of neurological involvement as proof of functional impairment. • Alteration of motion segment integrity confirming instability with neurological deficit. • Multiple back or cervical operations (i.e. two or more on separate occasions within a period of 5 years) comprising laminectomy, discectomy or fusion, or a combination thereof.	
Combination of loss of use of an upper and lower limb	**The total and permanent loss of use of an upper and a lower limb appendage as defined below:** • a foot at the transverse tarsal joint (Chopart's joint), • a leg at or above the ankle joint up to the hip joint, • a hand (at the metacarpophalangeal joint), • an arm at or above the wrist joint up to the shoulder joint, as confirmed by an orthopeadic or neurosurgeon.	**100%**
Loss of use of both hands or arms	**The total and permanent loss of use of:** • both hands at the metacarpophalangeal joints, or • both arms at or above the wrist joint up to the shoulder joint, or • one hand at the metacarpophalangeal joint and one arm at or above the wrist joint up to the shoulder joint, as confirmed by an orthopaedic or neurosurgeon.	**100%**
Loss of use of both feet or legs	**The total and permanent loss of use of:** • both legs at or above the ankle joint up to the hip joint, or • both feet at the transverse tarsal joint (Chopart's joint), or • one foot at the transverse tarsal joint (Chopart's joint) and one leg at or above the ankle joint up to the hip joint, as confirmed by an orthopaedic or neurosurgeon.	**100%**

HIV/AIDS		
AIDS	The clinical manifestation of AIDS/Stage 4 HIV infection, as confirmed by a medical specialist. **With evidence of the following:** • Positive HIV antibody test (or other recognised test for the presence of AIDS, acceptable to Old Mutual), and CD4 cell count of less than 200 despite compliance with anti-retroviral treatment as per latest National Guidelines, and either: **The presence of 3 or more of the following 5 conditions:** • Weight loss of more than 10% body weight in less than 6 months • Shingles • Oral thrush • Chronic diarrhoea • Active tuberculosis or: **The diagnosis of one or more of the following 8 diseases:** • Kaposi's sarcoma, • Candidiasis of oesophagus, trachea, bronchi or lungs, • Oral hairy leukoplakia, • Pneumocystis carinii pneumonia, • Extra pulmonary Cryptococcus, • Cytomegalo virus infection of an internal organ other than the liver, • Disseminated atypical mycobacteriosis, • Visceral leischmaniasis	**100%**
ACTIVITIES OF DAILY LIVING		
Activities of Daily Living	Any illness, condition or event that results in the insured person being permanently unable to perform certain Basic Activities of Daily Living and / or Advanced Activities of Daily Living, as specified below. • A permanent inability to perform 3 of the Basic Activities of Daily Living or 4 of the Advanced Activities of Daily Living. **Old Mutual's Medical Officer must confirm that:** • The insured person has undergone adequate medical treatment and has reached an adequate level of functioning that can reasonably be expected of a person suffering from the illness, condition or event, and • The insured person does not qualify, as a result of suffering from an illness, condition or event, for the payment of the cover amount for any other listed Functional Impairment under this benefit. Where applicable, the activities listed below must be performed with simple external assistive devices (e.g. walking stick, Zimmer frame), but without complex external assistive devices (e.g. wheelchair, leg prosthesis). • The general meaning of the terms 'simple external assistive devices' and 'complex external assistive devices' is not limited by the specific examples quoted or the class or type of the examples quoted.	**100%**

BASIC ACTIVITIES OF DAILY LIVING	
Activity	**Description**
Bathing	The ability to wash/bathe oneself independently
Transferring	The ability to move oneself from a bed to a chair or from a bed to a toilet independently
Dressing	The ability to take off and put on one's clothes independently
Eating	The ability to feed oneself independently. This does not include the making of food
Toileting	The ability to use a toilet and cleanse oneself thereafter, independently
Locomotion on a level surface	The ability to walk on a flat surface, independently

ADVANCED ACTIVITIES OF DAILY LIVING	
Activity	**Description**
Driving a car	The ability to open a car door, change gears or use a steering wheel or access public transport.
Medical care	The ability to prepare and take the correct medication
Money management	The ability to do one's own banking and to make rational financial decisions
Communicative activities	The ability to communicate either verbally or written
Shopping	The ability to choose and lift groceries from shelves as well as carry them in bags
Food preparation	The ability to prepare food for cooking as well as using kitchen utensils
Housework	The ability to clean a house or iron clothing
Community ambulation with or without assistive device, but not requiring a mobility device	The ability to walk around in public places using only a walking stick if necessary

19.7 PARTIAL FUNCTIONAL IMPAIRMENT BENEFIT EVENTS

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
CARDIOVASCULAR		
Arrhythmia	The diagnosis of an arrhythmia by a medical specialist. **With evidence of the following requirements which need to be permanent and irreversible, despite adequate medical treatment:** • Marked limitation in activity due to symptoms, even during less-than-ordinary activity, e.g. walking short distances (NYHA Class III), and • Symptoms of palpitations and syncope or dizziness correlating with ECG evidence of serious arrhythmia are present frequently with at least 3 episodes per week.	**50%**
Congestive Cardiac Failure	The diagnosis of Congestive cardiac failure by a specialist cardiologist or physician as a result of coronary artery disease or valvular heart disease or diseases of the aorta or pericardial disease. **With evidence of the following requirements which need to be permanent and irreversible:** • Ejection fraction (EF) consistently less than 45% after adequate medical treatment, and marked limitation in activity due to symptoms, even during ordinary or less than ordinary activity e.g. walking short distances (NYHA Class II - III).	**50%**
Hypertension	The diagnosis of uncontrolled hypertension confirmed by a medical specialist. **With evidence of diastolic pressure permanently greater than 105mmHg on adequate treatment and complicated by 1 of the following requirements which need to be permanent and irreversible:** • Stage 3 Kidney dysfunction, or • Cerebrovascular incident (excluding transient ischaemic attacks) confirmed by neuroimaging, or • Grade III retinopathy.	**50%**

Peripheral Arterial Disease	The diagnosis of peripheral arterial disease of the lower limbs by a vascular surgeon. **With evidence of the following requirements which need to be permanent and irreversible:** • Abnormal diminished pulse on Doppler readings, and • Ankle-brachial index (ABI) < 0.9 and • Pain on exercise as a result of peripheral arterial disease with claudication on walking less than 500m	**50%**
Peripheral Venous Disease	The diagnosis of veno-occlusive disease of the lower limbs by a vascular surgeon. **With evidence of the following requirements which need to be permanent and irreversible:** • Severe deep and widespread vascular ulceration, and • Oedema of the lower limbs	**50%**
RESPIRATORY		
Chronic Respiratory Failure	The diagnosis of a chronic respiratory failure by a pulmonologist. **With evidence of at least 1 of the following requirements which need to be permanent and irreversible:** • Impaired airflow with FEV1 less than or equal to 50%, or • FVC less than or equal to 60%, or • DLCO of less than or equal to 50%.	**50%**
Pulmonary Arterial Hypertension	The diagnosis of pulmonary hypertension by a medical specialist. **With evidence of a permanent Systolic Pulmonary Artery Pressure of 40-70 mmHg and complicated by at least 1 of the following requirements which need to be permanent and irreversible:** • Right sided heart failure, or • Marked limitation in activity due to symptoms, even during less-than-ordinary activity, e.g. walking short distances (NYHA Class III).	**50%**
GASTROINTESTINAL		
Ano-rectal impairment	A permanent and irreversible stoma created by a gastroenterologist or equivalent specialist due to a gastrointestinal disorder.	**50%**
Biliary Tract Disease	The diagnosis of a biliary tract disease by a liver specialist, gastroenterologist or equivalent medical specialist. **With evidence of the following requirements which need to be permanent and irreversible:** • Persistent biliary tract obstruction with recurrent cholangitis, and • Persistent jaundice	**75%**
Chronic Gastrointestinal Disease	The diagnosis of a chronic gastrointestinal disease by a gastroenterologist or equivalent specialist, as a result of a medical condition. **With evidence of the following requirements which need to be permanent and irreversible:** • Medical findings confirming organic disease, and • Significant unintentional weight loss resulting in a BMI between 15 and 16.1 or 20% weight loss below the lower limit of the normal range for the individual, and • Symptoms uncontrolled by medical or surgical treatment. Psychiatric conditions are excluded.	**75%**
	The diagnosis of a chronic gastrointestinal disease by a gastroenterologist or equivalent specialist, as a result of a medical condition. **With evidence of the following requirements which need to be permanent and irreversible:** • Medical findings confirming organic disease, and • Significant unintentional weight loss resulting in a BMI between 16.2 and 17 or 15% weight loss below the lower limit of the normal range for the individual, and • Symptoms uncontrolled by medical or surgical treatment. Psychiatric conditions are excluded.	**50%**
Chronic Liver Failure	The diagnosis of permanent and irreversible chronic liver disease, with a Child Pugh classification of Class B, by a gastroenterologist or equivalent specialist.	**50%**

Irreducible Hernia	The diagnosis of an irreducible hernia, following unsuccessful surgical repair of the hernia, by a gastroenterologist or equivalent specialist. **With evidence of the following requirements which need to be permanent and irreversible:** • Bowel dysfunction which impacts on Activities of Daily Living, such that the insured person is permanently unable to perform 2 of the Basic Activities of Daily Living and 2 of the Advanced Activities of Daily Living.	**50%**
UROGENITAL		
Chronic Kidney Failure	The diagnosis of chronic renal failure despite adequate medical treatment by a nephrologist or urologist. **With evidence of 1 of the following requirements which need to be permanent and irreversible:** • Chronic renal disease with an estimated GFR between 24-40ml/min, or • Creatinine clearance of 28 to 42 ml per minute.	**50%**
CENTRAL NERVOUS SYSTEM		
Impaired consciousness	The diagnosis of a coma of a specified severity by a neurologist or neurosurgeon. Medically induced comas are excluded. **With evidence of the following:** • Decreased level of consciousness, with a Glasgow Coma Scale of less than 9, which is constant and present for greater than 96hrs.	**50%**
Cranial Nerve V (Trigeminal Neuralgia)	The diagnosis of severe unilateral or bilateral facial neuralgic pain by a neurologist due to an affliction of the Trigeminal Nerve. **With evidence of the following requirements which need to be permanent and irreversible:** • Resistance to pharmacological treatment, and • Has resulted in decompression surgery.	**50%**
Cranial Nerve VII	The diagnosis of facial nerve paralysis confirmed by a neurologist or neurosurgeon. **With evidence of the following requirements which need to be permanent and irreversible:** • Slight or no movement of one half of the face with asymmetry at rest, and • An inability to actively close the eyelid on the affected side, and • Slight or no movement of the mouth.	**50%**
Cranial Nerve VIII	The diagnosis of Vestibulocochlear nerve paralysis confirmed by a neurologist or neurosurgeon. **With evidence of the following requirements which need to be permanent and irreversible:** • Nerve damage with moderately-severe imbalance resulting in limitation of Activities of Daily Living such that the insured person is permanently unable to perform 2 of the Basic Activities of Daily Living and 2 of the Advanced Activities of Daily Living.	**50%**
Cranial Nerves IX, X, XII	The diagnosis of Cranial Nerve IX, X, XII paralysis confirmed by a neurologist or neurosurgeon. **With evidence of the following requirements which need to be permanent and irreversible:** • Severe dysarthria or dysphagia, and • Nasal regurgitation, and • Aspiration of liquids or semi-solid foods, and • Medical findings confirming organic disease.	**50%**

Epilepsy	The diagnosis of epilepsy by a neurologist or neurosurgeon supported by objective medical findings and resistant to optimal therapy as confirmed by drug serum-level testing. **With evidence of the following requirements which need to be permanent and irreversible:** • 6 or more generalised seizures per month, and • An inability to perform 2 of the Basic Activities of Daily Living and 2 of the Advanced Activities of Daily Living.	**50%**
Gait disorders/ Poor motor coordination	The diagnosis of a cerebellar disorder by a neurologist or neurosurgeon correlating with objective medical findings. **With evidence of the following requirements which need to be permanent and irreversible:** • Needs assistive devices or mechanical support for daily functions, or • An inability to perform 2 of the Basic Activities of Daily Living and 2 of the Advanced Activities of Daily Living, or • Documented previous falls and inability to stand, walk, stoop, squat, kneel, climb stairs, or • Inability to grasp and pincer grip and a complete loss of fine or gross motor coordination or grip strength.	**50%**
	The diagnosis of a cerebellar disorder by a neurologist or neurosurgeon correlating with objective medical findings. **With evidence of the following requirements which need to be permanent and irreversible:** • Difficulty with standing or maintaining a standing position, without assistive devices, and needs assistance with walking, or • Difficulty with fine or gross motor coordination or grip strength.	**25%**
Dementia (including Alzheimer's Disease)	The diagnosis of dementia by a neurologist, physician or neurosurgeon. **With evidence of the following requirements which need to be permanent and irreversible:** • A diminished intellectual ability (may include a personality change and episodes of confusion), and • A score of 1 under the 5 point Clinical Dementia Rating scale, and • Needs some supervision with everyday duties.	**50%**
SENSES		
Loss of sight	Confirmed diagnosis of total and permanent bilateral loss of sight by an ophthalmologist. The loss of sight cannot be improved through refractive correction or medication. **With evidence of 1 of the following:** • A reading of 6/36 or worse (or equivalent measure on a non-metric scale) in each eye after best correction, or • Severe non-proliferative diabetic retinopathy, or • Grade III hypertensive retinopathy, or • A visual field loss to a 20° radius in the better eye. Loss of sight due to cataracts is excluded, unless there is evidence of failed cataract surgery or contraindications to cataract surgery.	**50%**
	Confirmed diagnosis of total and permanent loss of sight in one eye by an ophthalmologist. The loss of sight cannot be improved through refractive correction or medication. **With evidence of the following:** • A reading of 6/60 or worse (or equivalent measure on a non-metric scale) in one eye after best correction, or • The diagnosis of a hemianopia in one eye, or • A visual field loss to a 10° radius. • Loss of sight due to cataracts is excluded, unless there is evidence of failed cataract surgery or contraindications to cataract surgery.	**25%**

Loss of hearing	Total and permanent loss of hearing in both ears as confirmed by an ear, nose and throat surgeon. **With evidence of the following:** • Audiometry measurements, done with the use of hearing aids, averaging between 70-87dB.	**50%**
	Total and permanent loss of hearing in one ear as confirmed by an ear, nose and throat surgeon. **With evidence of the following:** • Audiometry measurements, done with the use of hearing aids, with an average loss of greater than 70dB.	**25%**
Loss of speech	The permanent loss of 50% of speech, as confirmed by an ear, nose and throat surgeon, neurologist or neurosurgeon. **Objective medical evidence of an ear, nose and throat disorder causing the impairment must be provided, with clinical evidence of 2 of the following requirements which need to be permanent and irreversible:** • Audibility: while whisper may be present, there is no audible voice. • Intelligibility: while single words may be recognisable, most words are unintelligible. • Function: speech is impractically slow and laboured. Loss of speech due to psychiatric causes are excluded.	**50%**
PSYCHIATRIC		
Psychiatric Disorder	The diagnosis of a psychiatric disorder, as confirmed by a specialist psychiatrist. Requires constant supervision on a permanent basis and **With evidence of the following:** • permanent GAF score of 40 or less certified under the DSM IV classification, or • permanent WHODAS average domain score of 4 certified under the DSM 5 classification	**75%**
TRAUMA		
Major Burns	The diagnosis of third degree burns (full thickness burns) by a plastic surgeon or trauma specialist. **With evidence of:** • at least 20% of total body surface affected as measured on the Lund and Browder Chart or equivalent scale, or • more than 50% of the combined surface area of the bilateral lower limbs including involvement of at least 60% of the combined surface area of the soles of both feet; or • more than 50% of the combined surface area of an upper and lower limb including involvement of at least 60% of the combined surface area of the sole of one foot and the palm of one hand	**50%**
Inhalational Burn	Inhalational burns resulting in a permanent tracheostomy.	**50%**
HAEMATOLOGY		
Red Blood Cell Disorders	The diagnosis of severe chronic anaemia by a physician or haematologist. **With evidence of the following requirements which need to be permanent and irreversible:** • Hb less than 8g/dL, and • Requiring 2-3U of blood every 4-6 weeks.	**50%**
White Blood Cell Disorders	The diagnosis of a severe white blood cell disorder by a physician or haematologist. **With evidence of 1 of the following requirements which need to be permanent and irreversible:** • An absolute neutrophil count of between 250 and 500 , resulting in at least 2 hospitalisations per year for acute bacterial infections, or • Lymphoma or Leukaemia requiring at least 1 chemotherapy regimen per year.	**50%**

MUSCULOSKELETAL		
Chronic Spinal Column Conditions	• A history of chronic pain syndrome due to a chronic spinal condition for a duration of at least two years. It must be treated by a multidisciplinary pain management team with at least two of the four requirements listed below, which must be permanent and irreversible as confirmed by an orthopaedic or neurosurgeon . All these criteria must be present in the same region, as defined below, for a valid claim to be paid. **Spinal Regions:** The neck and lower back are part of the spine. The spinal regions are: • Cervical region (C1-C7). • Thoracic region (T1-T12) and • Lumbosacral region (L1-S1). The C7 to T1 joint will be classified in the cervical region, and the T12 to L1 joint in the thoracolumbar region. **List of four requirements:** • 50% or more compression of a vertebral body or multiple level compression fractures giving rise to kyphotic deformity. • Clinically significant radiculopathy (motor and sensory deficit or muscle atrophy and clinical signs of nerve tension and radiological evidence at the same site as clinically found. NB – We will not accept radiological signs of nerve compression without clinical evidence of neurological involvement as proof of functional impairment. • Alteration of motion segment integrity confirming instability with neurological deficit. • Multiple back or cervical operations (i.e. two or more on separate occasions within a period of 5 years) comprising laminectomy, discectomy or fusion, or a combination thereof.	**50%**
	• A history of chronic pain syndrome due to a chronic spinal condition for a duration of at least two years. It must be treated by a multidisciplinary pain management team with at least one of the four requirements listed below, which must be permanent and irreversible as confirmed by an orthopaedic or neurosurgeon. All these criteria must be present in the same region, as defined below, for a valid claim to be paid. **Spinal Regions:** The neck and lower back are part of the spine. The spinal regions are: • Cervical region (C1-C7). • Thoracic region (T1-T12) and • Lumbosacral region (L1-S1). The C7 to T1 joint will be classified in the cervical region, and the T12 to L1 joint in the thoracolumbar region. **List of four requirements:** • 50% or more compression of a vertebral body or multiple level compression fractures giving rise to kyphotic deformity. • Clinically significant radiculopathy (motor and sensory deficit or muscle atrophy and clinical signs of nerve tension and radiological evidence at the same site as clinically found. NB – We will not accept radiological signs of nerve compression without clinical evidence of neurological involvement as proof of functional impairment. • Alteration of motion segment integrity confirming instability with neurological deficit. • Multiple back or cervical operations (i.e. two or more on separate occasions within a period of 5 years) comprising laminectomy, discectomy or fusion, or a combination thereof.	**25%**
Loss of use of one arm	The total and permanent loss of use of one arm at or above the wrist joint up to the shoulder joint, as confirmed by an orthopaedic or neurosurgeon.	**75%**
Loss of use of one hand	The total and permanent loss of use of one hand at the metacarpophalangeal joint involving more than 3 fingers, one of which includes either the thumb or the index finger, as confirmed by an orthopaedic or neurosurgeon.	**50%**
Loss of use of one thumb	The total and permanent loss of use of one thumb, as confirmed by an orthopaedic or neurosurgeon.	**25%**
Loss of use of one leg	The total and permanent loss of use of one leg, at or above the ankle joint up to the hip joint, as confirmed by an orthopaedic or neurosurgeon.	**75%**
Loss of use of one foot	The total and permanent loss of use of one foot at the transverse tarsal joint (Chopart's joint), as confirmed by an orthopaedic or neurosurgeon.	**50%**

ACTIVITIES OF DAILY LIVING		
Activities of Daily Living	Any illness, condition or event that results in the insured person being permanently unable to perform certain Basic Activities of Daily Living and / or Advanced Activities of Daily Living, as specified below. • A permanent inability to perform 2 of the Basic Activities of Daily Living and 2 of the Advanced Activities of Daily Living. **Old Mutual's Medical Officer must confirm that:** • The insured person has undergone adequate medical treatment and has reached an adequate level of functioning that can reasonably be expected of a person suffering from the illness, condition or event, and • The insured person does not qualify, as a result of suffering from an illness, condition or event, for the payment of the cover amount for any other listed Functional Impairment under this benefit. Where applicable, the activities listed below must be performed with simple external assistive devices (e.g. walking stick, Zimmer frame), but without complex external assistive devices (e.g. wheelchair, leg prosthesis). • The general meaning of the terms 'simple external assistive devices' and 'complex external assistive devices' is not limited by the specific examples quoted or the class or type of the examples quoted.	**50%**

BASIC ACTIVITIES OF DAILY LIVING	
Activity	**Description**
Bathing	The ability to wash/bathe oneself independently
Transferring	The ability to move oneself from a bed to a chair or from a bed to a toilet independently
Dressing	The ability to take off and put on one's clothes independently
Eating	The ability to feed oneself independently. This does not include the making of food
Toileting	The ability to use a toilet and cleanse oneself thereafter, independently
Locomotion on a level surface	The ability to walk on a flat surface, independently

ADVANCED ACTIVITIES OF DAILY LIVING	
Activity	**Description**
Driving a car	The ability to open a car door, change gears or use a steering wheel or access public transport.
Medical care	The ability to prepare and take the correct medication
Money management	The ability to do one's own banking and to make rational financial decisions
Communicative activities	The ability to communicate either verbally or written
Shopping	The ability to choose and lift groceries from shelves as well as carry them in bags
Food preparation	The ability to prepare food for cooking as well as using kitchen utensils
Housework	The ability to clean a house or iron clothing
Community ambulation with or without assistive device, but not requiring a mobility device	The ability to walk around in public places using only a walking stick if necessary

19.8 CHILD IMPAIRMENT BENEFIT EVENTS

19.8.1 Congenital Birth Defects

BODY SYSTEMS	REQUIREMENTS TO QUALIFY	%
Achondroplasia	The undergoing of surgery to treat complications of achondroplasia. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**50%**
Anal atresia	The undergoing of surgery to correct anal atresia. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**50%**
Biliary Atresia	Confirmed diagnosis of biliary atresia by the treating specialist. **Requirements for a claim to be considered:** • Supportive imaging and blood tests	**50%**
Brain and skull disorders	Confirmed diagnosis of one of the following disorders by the treating specialist: • Microcephaly • Hydrocephaly • Craniostenosis • Craniosynostosis **Requirements for a claim to be considered:** • Supportive imaging and blood tests • The disorder results in severe neurological deficit.	**100%**
Cerebral Palsy	Confirmed diagnosis of cerebral palsy by the treating specialist. **Requirements for a claim to be considered:** One of the following must be present for at least 6 months: • Spastic diplegia • Spastic hemiplegia • Spastic quadriplegia	**100%**
Choanal atresia	The undergoing of surgery to correct choanal atresia. **Requirements for a claim to be considered:** • The complications have resulted in at least two surgical interventions, on two separate occasions, other than for diagnostic purposes • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**50%**
Cleft lip and complete cleft palate	Confirmed diagnosis of cleft lip and complete cleft palate (hard and soft palate) by the treating specialist.	**50%**

Clubbed feet (Talipes)	The undergoing of surgery to correct bilateral clubbed feet. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**50%**
	The undergoing of surgery to correct a clubbed foot. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**25%**
Congenital blindness	Confirmed diagnosis of total visual loss in both eyes at birth, by the treating specialist. **Requirements for a claim to be considered:** • Supportive clinical evidence	**100%**
	Confirmed diagnosis of total visual loss in one eye at birth, by the treating specialist. **Requirements for a claim to be considered:** • Supportive clinical evidence	**50%**
Congenital deafness	Confirmed diagnosis of total hearing loss in both ears at birth by the treating specialist. **Requirements for a claim to be considered:** • Supportive clinical evidence using the Automated Otoacoustic Emission test or the Automated Auditory Brainstem Response test (or equivalent measure).	**100%**
	Confirmed diagnosis of total hearing loss in one ear at birth by the treating specialist. **Requirements for a claim to be considered:** • Supportive clinical evidence using the Automated Otoacoustic Emission test or the Automated Auditory Brainstem Response test (or equivalent measure).	**50%**
Congenital heart disease	The correction of any congenital structural abnormality of the heart, through surgically opening the chest cavity (thoracotomy or sternotomy). **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions:** • Any investigative procedure	**100%**
	The correction of any congenital structural abnormality of the heart, through any minimally invasive surgery. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions:** • Any investigative procedure • Patent ductus arteriosus	**50%**

Congenital hip dislocation	The undergoing of surgery to correct congenital bilateral hip dislocation. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**50%**
	The undergoing of surgery to correct congenital unilateral hip dislocation. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**25%**
Cystic fibrosis	Confirmed diagnosis of cystic fibrosis by the treating specialist. **Requirements for a claim to be considered:** • A diagnostic sweat test • Pulmonary complications (e.g. recurrent pneumonia, suppurative lung disease, lung abscesses) confirmed by radiological investigations	**100%**
Down Syndrome	Confirmed diagnosis of Down syndrome by the treating specialist. **Requirements for a claim to be considered:** • Supportive genetic tests	**100%**
Duchenne Syndrome or Congenital Myotonic Dystrophy	Confirmed diagnosis of one of the following by the treating specialist: • Duchenne muscular dystrophy • Congenital myotonic muscular dystrophy (MMD 1) **Requirements for a claim to be considered:** For Duchenne muscular dystrophy: • Evidence of clinical symptoms • Raised creatine kinase • Muscle biopsy with abnormal levels of dystrophin protein For Congenital myotonic muscular dystrophy: • Supportive genetic tests	**100%**
Haemophilia	Confirmed diagnosis of haemophilia by the treating haematologist. **Requirements for a claim to be considered:** • Despite adequate treatment for at least 6 consecutive months, both of the following are present: • 1% of the normal clotting factor in the blood At least four units of blood or blood products has been transfused per month for at least 3 consecutive months	**50%**
Hirschsprung's disease	Confirmed diagnosis of Hirschprung's disease by the treating specialist. **Requirements for a claim to be considered:** • Full-thickness rectal biopsy	**50%**
Hydrocephalus	The surgical insertion of a shunt to treat congenital hydrocephalus. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**50%**

Hypospadias	The undergoing of surgery to treat hypospadias in a male child. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**50%**
Inborn metabolic disorders	Confirmed diagnosis of one of the following inborn errors of metabolism by the treating specialist: • Gaucher's disease • Glycogen storage disease • Tay Sachs Disease • Mucopolysaccharidosis Requirements for a claim to be considered: • Supportive laboratory tests	**100%**
Autosomal recessive polycystic kidney disease	Confirmed diagnosis of autosomal recessive polycystic kidney disease by the treating specialist. Requirements for a claim to be considered: • Supportive genetic tests	**100%**
Klinefelter's syndrome	Confirmed diagnosis of Klinefelter's syndrome by the treating specialist. Requirements for a claim to be considered: • Supportive genetic tests	**25%**
Necrotising enterocolitis	The undergoing of surgery to treat necrotising enterocolitis. Requirements for a claim to be considered: • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**50%**
Neuro-develop-mental disorders	Confirmed diagnosis of one of the following developmental disorders of the by the treating specialist: • Symptomatic Rett syndrome with a MECP2 mutation • Symptomatic fragile X syndrome with a FMR1 mutation • Symptomatic tuberous sclerosis with a TSC2 mutation • Symptomatic neurofibromatosis Requirements for a claim to be considered: • Supportive genetic tests • Supportive clinical evidence	**100%**
Myelomening-ocele	Confirmed diagnosis of myelomeningocele by the treating specialist. Requirements for a claim to be considered: • Supportive imaging and blood tests	**100%**
Tracheooesoph-ageal Fistula or Oesophageal Atresia	Confirmed diagnosis of a tracheo-oesophageal fistula or oesophageal atresia by the treating specialist. Requirements for a claim to be considered: • Supportive imaging and blood tests • Pulmonary complications (e.g. recurrent pneumonia, suppurative lung disease, lung abcesses) confirmed by radiological investigations	**50%**

19.8.2 Child Impairments

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
CENTRAL NERVOUS SYSTEM		
Paraplegia, hemiplegia or quadriplegia	Total and permanent paralysis of 2 or more limbs from any cause.	**100%**
SENSES		
Loss of Hearing	The total and permanent loss of hearing of greater than 70dB in both ears as diagnosed by an Ear, Nose and Throat Specialist. The measurements are done with the use of hearing aids for the assessment of hearing impairment.	**100%**
Loss of Sight	Confirmed diagnosis of total and permanent bilateral loss of sight by an ophthalmologist. The loss of sight cannot be improved through refractive correction or medication. With evidence of 1 of the following: • A reading of 6/60 or worse (or equivalent measure on a non-metric scale) in each eye after best correction, or • A visual field loss to a 10° radius in the better eye. Loss of sight due to cataracts is excluded.	**100%**
Loss of Speech	The total and permanent loss of the ability to produce intelligible and audible speech due to injury or disease, as confirmed by an ear, nose and throat surgeon, neurologist or neurosurgeon. • Objective medical evidence of an ear, nose and throat disorder causing the impairment must be provided. Loss of speech due to psychiatric causes are excluded.	**100%**
TRAUMA		
Major Burns	The diagnosis of third degree burns (full thickness burns) by a plastic surgeon or trauma specialist. With evidence of: • at least 20% of total body surface affected as measured on the Lund and Browder Chart or equivalent scale, or • more than 50% of the combined surface area of the bilateral lower limbs including involvement of at least 60% of the combined surface area of the soles of both feet; or • more than 50% of the combined surface area of an upper and lower limb including involvement of at least 60% of the combined surface area of the sole of one foot and the palm of one hand.	**100%**

Accidental brain damage	Permanent impairment of intellectual capacity as a result of brain damage sustained in an accident, as defined. Confirmation of intellectual impairment by neuropsychological testing. Note: An accident is an unexpected and visible event of external origin that causes traumatic bodily injury and is not traceable, even indirectly, to the child's state of mental or physical health before the event.	**100%**
Trauma	An accident resulting in severe physical injury. With evidence of the following: • Requires mechanical ventilation in an intensive care unit for at least 48 hours , and • Results in permanent neurological deficit. Note: An accident is an unexpected and visible event of external origin that causes traumatic bodily injury and is not traceable, even indirectly, to the child's state of mental or physical health before the event.	**100%**
	An accident resulting in severe physical injury, requiring mechanical ventilation in an intensive care unit for at least 96 hours. Note: An accident is an unexpected and visible event of external origin that causes traumatic bodily injury and is not traceable, even indirectly, to the child's state of mental or physical health before the event.	**50%**
CANCER		
Cancer	The diagnosis of an advanced stage of cancer as confirmed by an oncologist with supporting documentation. With evidence of the following: • Diagnosis of at least a Stage III cancer, and the child is permanently confined to a bed or a wheelchair, or • Stage IV cancer	**100%**
Terminal Illness	The diagnosis of a medical condition which, according to Old Mutual's Medical Officer, will result in death within 12 months. The claim must be received within this 12 month period.	**100%**
ACTIVITIES OF DAILY LIVING		
Permanent confinement to a bed or a wheelchair	Permanent confinement to a bed or a wheelchair, as confirmed by the treating specialist due to an organic disease or injury.	**100%**

19.9 PHYSICAL IMPAIRMENT COVER AND ACCIDENTAL DISABILITY AND DEATH COVER

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
MUSCULOSKELETAL DISORDERS		
Combination of loss of use of an upper and lower limb	**The total and permanent loss of use of an upper and a lower limb appendage as defined below:** • a foot at the transverse tarsal joint (Chopart's joint), • a leg at or above the ankle joint up to the hip joint, • a hand (at the metacarpophalangeal joint) • an arm at or above the wrist joint up to the shoulder joint, as confirmed by an orthopeadic or neurosurgeon.	**100%**
Loss of use of both feet or legs	**The total and permanent loss of use of:** • both legs at or above the ankle joint up to the hip joint, or • both feet at the tranverse tarsal joint (Chopart's joint), or • one foot at the tranverse tarsal joint (Chopart's joint) and one leg at or above the ankle joint up to the hip joint, as confirmed by an orthopaedic or neurosurgeon.	**100%**
Loss of use of one leg	The total and permanent loss of use of one leg, at or above the ankle joint up to the hip joint, as confirmed by an orthopaedic or neurosurgeon.	**75%**
Loss of use of one foot	The total and permanent loss of use of one foot at the tranverse tarsal joint (Chopart's joint), as confirmed by an orthopaedic or neurosurgeon.	**50%**
Loss of use of both hands or arms	**The total and permanent loss of use of:** • both hands at the metacarpophalangeal joints, or • both arms at or above the wrist joint up to the shoulder joint, or • one hand at the metacarpophalangeal joint and one arm at or above the wrist joint up to the shoulder joint, as confirmed by an orthopaedic or neurosurgeon.	**100%**
Loss of use of one arm	The total and permanent loss of use of one arm at or above the wrist joint up to the shoulder joint, as confirmed by an orthopaedic or neurosurgeon.	**75%**
Loss of use of one hand	The total and permanent loss of use of one hand at the metacarpophalangeal joint involving more than 3 fingers, one of which includes either the thumb or the index finger, as confirmed by an orthopaedic or neurosurgeon.	**50%**
SENSES		
Loss of hearing	Total and permanent loss of hearing in both ears as confirmed by an ear, nose and throat surgeon. **With evidence of the following:** • Audiometry measurements, done with the use of hearing aids, with an average loss of greater than 87dB.	**100%**
	Total and permanent loss of hearing in one ear as confirmed by an ear, nose and throat surgeon. **With evidence of the following:** • Audiometry measurements, done with the use of hearing aids, with an average loss of greater than 70dB.	**25%**
Loss of speech	The total and permanent loss of the ability to produce intelligible and audible speech due to injury or disease, as confirmed by an ear, nose and throat surgeon, neurologist or neurosurgeon. • Objective medical evidence of an ear, nose and throat disorder causing the impairment must be provided. Loss of speech due to psychiatric causes are excluded.	**100%**

Loss of sight	Confirmed diagnosis of total and permanent bilateral loss of sight by an ophthalmologist. The loss of sight cannot be improved through refractive correction or medication. **With evidence of 1 of the following:** • A reading of 6/60 or worse (or equivalent measure on a non-metric scale) in each eye after best correction, or • Severe proliferative diabetic retinopathy, or • Grade IV hypertensive retinopathy, or • Permanent Hemianopia in both eyes, or • A visual field loss to a 10° radius in the better eye. Loss of sight due to cataracts is excluded, unless there is evidence of failed cataract surgery or contraindications to cataract surgery.	**100%**
	Confirmed diagnosis of total and permanent loss of sight in one eye by an ophthalmologist. The loss of sight cannot be improved through refractive correction or medication. **With evidence of the following:** • A reading of 6/60 or worse (or equivalent measure on a non-metric scale) in one eye after best correction, or • The diagnosis of a hemianopia in one eye, or • A visual field loss to a 10° radius. Loss of sight due to cataracts is excluded, unless there is evidence of failed cataract surgery or contraindications to cataract surgery.	**25%**
TRAUMA		
Major Burns	The diagnosis of third degree burns (full thickness burns) by a plastic surgeon or trauma specialist. **With evidence of at least:** • 30% of total body surface affected as measured on the Lund and Browder Chart or equivalent scale, or • more than 50% of the combined surface area of the bilateral upper limbs affected including involvement of at least 60% of combined surface area of the palms of both hands; and restriction of joint mobility of at least two of the following: 3 fingers; wrist or elbow;	**100%**
	The diagnosis of third degree burns (full thickness burns) by a plastic surgeon or trauma specialist. **With evidence of:** • at least 20% of total body surface affected as measured on the Lund and Browder Chart or equivalent scale, or • more than 50% of the combined surface area of the bilateral lower limbs including involvement of at least 60% of the combined surface area of the soles of both feet; or • more than 50% of the combined surface area of an upper and lower limb including involvement of at least 60% of the combined surface area of the sole of one foot and the palm of one hand	**50%**
Facial Disorders or Disfigurement	Total facial disfigurement as confirmed by a maxillofacial specialist or related specialist. There should be destruction or loss of skin, bone, or muscles that requires reconstructive surgery.	**100%**
ACTIVITIES OF DAILY LIVING		
Permanent confinement to bed or wheelchair	Permanent confinement to a bed or wheelchair as confirmed by the treating specialist due to an organic disease or injury.	**100%**

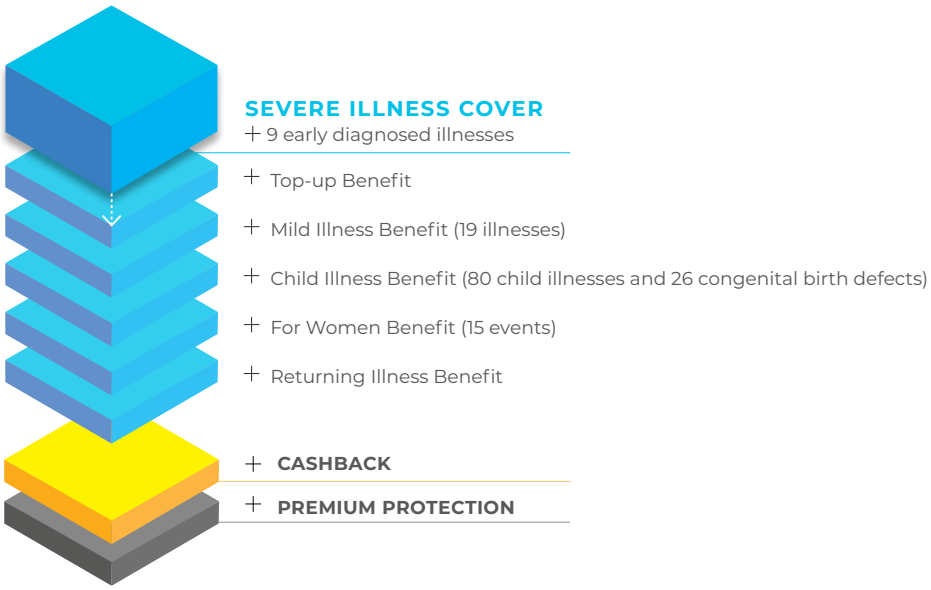
ILLNESS INSURANCE

20. OLD MUTUAL PROTECT ILLNESS INSURANCE

Severe Illness Cover pays a percentage of the cover amount as a single amount if the insured person suffers a severe illness and the relevant survival period is met. Severe Illness Cover includes cover for a comprehensive list of severe illnesses and automatically includes features such as Cancer Enhancer and cover for Early Diagnosed Illnesses. Cover isn't dependent on occupation and the customer can add cover for children and female-specific illnesses.

Severe Illness Cover is severity based. This means that each claim will be assessed and the severity level will determine the percentage of cover paid. See the events descriptions under the claims section.

20.1 Severe Illness Cover overview



Severe Illness Cover is designed for customers with the following needs:

- Want to protect themselves or their families against the financial consequences of severe illnesses.
- Want to be able to adjust their cover as their needs change.
- Would like to add or remove benefits and features according to their individual needs.

20.2 Severe Illness Cover product features

TYPE OF PRODUCT	SEVERE ILLNESS COVER SEVERE ILLNESS COVER ADD-ON
Eligible lives	All lives are eligible, subject to entry age limits and underwriting.
Relationship to owner	There must be an insurable interest if the owner and insured person aren't the same person.
Maximum number of insured persons	One
Entry age limits	**Minimum:** 15 next birthday **Maximum:** 70 next birthday
Premium frequency	Monthly Monthly with the option to skip one premium Yearly
Premium term	Benefit term Retirement (minimum premium term of 10 years)
Compulsory yearly premium increase	0% fixed rate 5% fixed rate Age-linked
Guarantee term	5 years 10 years
Cover amount limits	**Minimum:** R100 000 **Maximum:** · Employed: R6 000 000 (subject to underwriting) · Home executives: R2 000 000 · Students: R2 000 000 · Unemployed: R1 250 000 If sold as an add-on, the cover must be equal to or less than the Life Cover amount.
Benefit term	Whole-life Term (minimum of 5 years)
Cover end age	Whole-life 100 next birthday for term cover

Scheduled yearly cover increase	0% fixed rate 5% fixed rate 10% fixed rate Inflation-linked: CPI + 0%, 1%, 2%, 3%, -1%, -2% Currency-linked: · R/GB Pound + 0%, 5%, 10%, UK inflation · R/US Dollar + 0%, 5%, 10%, US inflation · R/Euro + 0%, 5%, 10%, Euro Inflation
Survival period	· 10 days
Underwriting method	· No medical tests, only questions · Medical tests, questions or both
Underwriting credit	If the insured person completed 'Medical tests, questions or both' for an amount less than the upper limit of a particular underwriting band, they could qualify for: · Single underwriting credit · Comprehensive underwriting credit

20.3 Automatic features

- Early Diagnosed Illnesses
- Cancer Enhancer

20.4 Add-ons

Premium protection

A maximum of two premium protection benefits may be selected with a combination of the following:

- Premium Protection Death

  The insured person on Premium Protection Death must be different from the insured person on Severe Illness Cover.
- Premium Protection Disability or Premium Protection Functional Impairment

  The insured person on Premium Protection Disability or Premium Protection Functional Impairment doesn't have to be the same as the insured person on the Severe Illness Cover.
- Premium Protection Retrenchment

  The insured person on Premium Protection Retrenchment must be the same as the insured person on Severe Illness Cover.

Adding Premium Protection Death will preclude the addition of Premium Protection Retrenchment and vice versa. See Premium Protection for more details.

Cashback

See Cashback for more details.

20.5 Claiming Severe Illness Cover

20.5.1 Subsequent claims

Severe Illness Cover on its own

Subsequent claims can be considered either to be:

- Related
  - Automatically related claims for the same event (the event must have progressed and therefore can't be at a lower or equal severity than a previous claim).
  - A new event related to a previous claim event that will be considered as related
  - A new event related to a previous claim event that may be considered as related
- Unrelated
  - Unrelated to an event that has been previously claimed for
  - An event that's specified on the related illness list as related to a previous claim event but deemed to be unrelated by us.

Claims that are related and that may be related will be listed in the Severe Illness Cover events.

Severe Illness Cover attached to Life Cover

For Severe Illness Cover add-on, you will always be able to qualify for subsequent claims irrespective of whether it's considered related or not (provided that there is sufficient cover left and it's not a progressive claim). A progressive claim at the same or lower severity won't be valid. The cover amount reduces after each claim. The premium will also reduce after every claim.

The payout will be determined as:

Cover amount under consideration x severity %

This formula applies to Severe Illness events, Early Diagnosed Illness events and payouts under the Cancer Enhancer. Note that for Early Diagnosed Illness events, there is a cap of R100 000 per payout that applies to the above formula.

Example

Viyalka has R1 000 000 Life Cover with R1 000 000 Severe Illness Cover add-on. She's diagnosed with cancer at severity level D (25%). She receives a tiered payout of R250 000 (R1 000 000 x 25%). Following the payout, her cover reduces to R1 000 000 - R250 000 = R750 000. Her cancer progresses to severity C (50%). She will only be able to claim for the remaining cover of R750 000 x 50% = R375 000. Viyalka's remaining cover amount is now R750 000 - R375 000 = R375 000.

20.5.2 Related claims

If a claim is considered related to any previous claims, the total payout for that group of claims on related illnesses will always be capped at 100% of the cover amount.

The actual payout for each claim will depend on the severity level of the event.

- **Automatically related claims for the same event**

  Subsequent related claims for the same event are considered a progressive claim. A successful progressive claim must be at a higher severity. A maximum of 100% of the cover amount will be paid in total for all related events.

Example

Sibusiso has R1 000 000 Severe Illness Cover with no optional benefits and features. He meets the medical criteria to claim for the event heart attack at severity level C (50%). He receives a tiered payout of R500 000 (R1 000 000 x 50%).

Subsequent claims for the event heart attack are considered automatically related and will be progressive claims. Thus, valid claims can only be at higher severity levels (i.e. severity levels A and B). He won't have a valid claim at severity levels C and D. Even though six months later, he meets the medical criteria for heart attack at severity level D (25%), he won't have a valid claim.

A year later he meets the medical criteria to claim under heart attack at severity level A (100%). He will only be able to claim for the remaining cover of R1 000 000 x min [100%; (100% - 50%)] = R500 000. In total, Sibusiso has received a maximum 100% of his cover amount (R1 000 000). He will receive no further payout for medically related illnesses.

- **May be related on the events list**

For future claims that may be related and not necessarily specified as a related event in the events list, Old Mutual's Medical Officer will use their discretion on a case by case basis. Relation must be supported by clear medical evidence.

Example

Babalwa has R1 000 000 Severe Illness Cover with no optional benefits and features. She suffers from chronic kidney failure at severity level C (50%). She receives a tiered payout of R500 000 (R1 000 000 x 50%).

A year later her condition results in peripheral arterial disease, and meets the medical criteria for a severity level A (100%) payout. Peripheral arterial disease may be considered related to chronic kidney failure, as per the related illness list. Medical reports show clear medical evidence that both events result from the same medical condition. In this case, Old Mutual's Medical Officer deems peripheral arterial disease related to chronic kidney failure, and she receives a tiered payout of R1 000 000 x min [100%; (100% - 50%)] = R500 000.

- **Will be related on the events list**

Certain different events are considered medically related. The medically related events for each specific event are shown in the Related illnesses in the Severe Illness Cover events.

The customer can claim at any combination of severities for different (but medically related) events, but only to a maximum of 100% of the sum assured. A subsequent claim for a different, but medically-related event may be at a lower tier.

Example

Sibusiso has R1 000 000 Severe Illness Cover with no optional benefits and features . He meets the medical criteria for the connective tissue disease at severity level C (50%). He receives a tiered payout of R500 000 (R1 000 000 x 50%).

A year later, he meets the criteria for the advanced rheumatoid arthritis event at severity level D (25%). This is deemed automatically medically related to connective tissue disease, as per the related illness list. He receives a tiered payout of R1 000 000 x min [25%; (100% - 50%)] = R250 000.

Six months later, he meets the criteria for the event advanced rheumatoid arthritis at severity level C (50%). This is deemed automatically medically related to both of his previous claims. He will only be able to claim for the remaining cover of R1 000 000 x min [100%; (100% - 50% - 25%)] = R250 000. In total, Sibusiso has received a maximum 100% of his cover amount (R1 000 000). He will receive no further payouts for illnesses related to these claims.

20.5.3 Unrelated claims

Unrelated claims under a similar event

It's possible to claim at the same or lower tier for certain events. This is only in the case where the subsequent claim is deemed medically unrelated. If there is clear medical evidence that there is no medical relation, a claim may be paid. This is at the discretion of Old Mutual's Medical Officer. The event where this is most likely to occur is cancer.

Example: Medically unrelated claim under the same event

Sarah has R1 000 000 Severe Illness Cover with no optional benefits and features. She gets breast cancer and meets the medical criteria for the cancer event at severity level C (50%). She receives a tiered payout of R500 000 (R1 000 000 x 50%).

A year later, she gets lung cancer at severity level D (25%). There is clear medical evidence that the lung cancer is unrelated to her previous breast cancer. Thus, despite the fact that her subsequent claim is for cancer, it's not considered progressive, as it's medically unrelated. Thus, she's able to receive a severity D (25%) payout for the cancer event of R1 000 000 x 25%= R250 000.

Unrelated claims under different events

Certain different events are considered automatically medically related, while others may be considered related. Unrelated illnesses in the Severe Illness Cover events.

For future claims that may be related, Old Mutual's Medical Officer will use their discretion on a case by case basis. Relation must be supported by clear medical evidence.

Example: Automatic unrelated claims

Thabo has R3 000 000 Severe Illness Cover with no optional benefits and features. He's diagnosed with lung cancer, and meets the medical criteria to claim under the cancer event at severity level C (50%). He receives a tiered payout of R1 500 000 (R3 000 000 x 50%). His cancer progresses, and he's now able to claim at severity A (100%). He will only be able to claim for the remaining cover of R3 000 000 x min [100%; (100% - 50%)] = R1 500 000. In total, Thabo has received a maximum 100% of his cover amount (R3 000 000) for cancer. He will receive no further payouts for medically related illnesses.

Thabo subsequently has a heart attack of severity level B (75%). Heart attack isn't shown as a related event in the list of related events given for cancer. He receives a tiered payout of R3 000 000 x 75% = R2 250 000. This is because his cover for all illnesses not medically related to cancer are unaffected by his previous two claims.

Example: May be unrelated

Aamir has R1 000 000 Severe Illness Cover with no benefits and features. He falls and hurts his head, resulting in a claim for the coma event at severity level A (100%). He receives a payout of R1 000 000 (R1 000 000 x 100%).

A year later he meets the criteria for the Activities of Daily Living events, and qualifies for a payout at severity level A (100%). Activities of Daily Living is listed as an event that may be considered related to coma. There is clear medical evidence so that Old Mutual's Medical Officer is satisfied that the two events were unrelated. The two events are deemed medically unrelated, despite the possible relation specified in the list. He will receive a payout of R1 000 000 x 100% = R1 000 000.

How do claims interact with scheduled yearly cover increases?

- The full cover amount will never be paid in a group of related illnesses if severity-based payments were made over a period of time whilst there were yearly cover increases and cover changes. I.e. the payments won't add up to 100% of the scheduled yearly cover increase amount.

20.5.4 Survival period

- 10 days on specified illnesses.
- A survival period is necessary on this benefit to distinguish Severe Illness Cover claims from Life Cover claims. If the insured person has both Life Cover and Severe Illness Cover and dies during the survival period, only the Life Cover is paid.
- No survival period is applicable if Severe Illness Cover is attached to Life Cover.
- The insured person must survive with or without life support.
- The survival period begins on the day that the event occurs example, if the insured person suffers a heart attack on 2 May, the survival period will then end 10 days thereafter on 11 May at midnight. If the insured person dies on 12 May or thereafter, a claim would be considered.
- Premiums must continue to be paid during the survival period and while the claim is being assessed.

20.5.7 Exclusion discounts

- If based on the health information received in the application, the insured person has previously had a severe illness, we'll look at the type of severe illness suffered, when it happened, their gender and their age at the event date.
- Based on this, we may restrict cover by excluding some conditions or declining cover.
- In certain instances, if the insured person has suffered any of the 'big four' illnesses – heart attack, stroke, cancer or coronary artery bypass graft, they may not get full cover for those illnesses at a premium discount. This means that they will only pay for the illnesses that they are covered for.

20.6 Changes to circumstances of the insured person

The owner must inform us if:

- The insured person starts participating recurrently in any risky activities which may expose the insured person to a higher than average risk of accident or injury.

20.7 Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that is generally excluded.

We won't pay if:

- the owner fails to meet our requirement to tell us about changes to the circumstances of the insured person (See changes to the circumstances of the insured person),
- the insured person's illness is caused by:
  - unrest, war or terrorist activity,
  - radioactivity or nuclear explosion,
  - provoking, committing or attempting to commit a crime for example murder, assault, housebreaking, theft, robbery, the forceful detention of another person or any similar crime or

  - self-inflicted injury.
- the insured person's severe illness is before the cover start date,
- we don't recognise the insured person's severe illness,
- the insured person's severe illness is because of an exclusion, or
- the survival period isn't met.

We won't recognise the insured person's severe illness if they suffer a severe illness that:

- isn't on the list of severe illnesses,
- is at the severity that the contract doesn't cover or
- that doesn't meet all the requirements that the severe illness must meet to qualify.

20.8 Severe Illness Cover stops on the earliest of the following:

- When the insured person dies.
- At the end of the term, if term cover was chosen.
- If the cover lapses.
- If the insured person no longer qualifies for the cover because of changes to their circumstances.
- If the contract is cancelled.
- If a claim has been paid out for AIDS or terminal illness.
- If the insured person no longer qualifies for any severe illnesses on the list of severe illnesses that qualify in the event descriptions.

20.10 Automatic features

The following features are automatically included within Severe Illness Cover:

20.9 SEVERE ILLNESS COVER EVENTS

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
ACTIVITIES OF DAILY LIVING		

Activities of Daily Living	Any illness, condition or event that results in the insured person being permanently unable to perform certain Activities of Daily Living, as specified below.
	
	Old Mutual's Medical Officer must confirm that:
	• The insured person has undergone reasonable treatment and has reached an adequate level of functioning that can reasonably be expected of a person suffering from the illness, condition or event
	• The insured person does not qualify, as a result of suffering from an illness, condition or event, for the payment of the cover amount for any other listed severe illness under this benefit
	
	Requirements for a claim to be considered
	• Both of the following must be present:
	  • A permanent inability to perform 2 or more Basic Activities of Daily Living
	  • A permanent inability to perform 2 or more Advanced Activities of Daily Living
		50%

	Any illness, condition or event that results in the insured person being permanently unable to perform certain Activities of Daily Living, as specified below.
	
	Old Mutual's Medical Officer must confirm that:
	• The insured person has undergone reasonable treatment and has reached an adequate level of functioning that can reasonably be expected of a person suffering from the illness, condition or event
	• The insured person does not qualify, as a result of suffering from an illness, condition or event, for the payment of the cover amount for any other listed severe illness under this benefit
	
	Requirements for a claim to be considered
	• Both of the following must be present:
	  • A permanent inability to perform 2 of the Basic Activities of Daily Living
	  • A permanent inability to perform 3 of the Advanced Activities of Daily Living
		75%

	Any illness, condition or event that results in the insured person being permanently unable to perform certain Basic Activities of Daily Living, as specified below. Old Mutual's Medical Officer must confirm that: • The insured person has undergone reasonable treatment and has reached an adequate level of functioning that can reasonably be expected of a person suffering from the illness, condition or event. • The insured person does not qualify, as a result of suffering from an illness, condition or event, for the payment of the cover amount for any other listed severe illness under this benefit. **Requirements for a claim to be considered** • A permanent inability to perform 3 of the Basic Activities of Daily Living	**100%**
	Illnesses that will be considered related: None **Illnesses that may be considered related:** All illnesses	
Terminal illness	Confirmed diagnosis of a medical condition that is or has become incurable by a treating specialist. In the opinion of the treating specialist and as confirmed by our Medical Officer, the condition is likely to result in death within 12 months after the diagnosis.	**100%**
	The benefit terminates after a successful claim on this illness.	

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
AUTOIMMUNE		
Advanced rheumatoid arthritis	Confirmed diagnosis and treatment of rheumatoid arthritis by the treating rheumatologist. **Requirements for a claim to be considered** • Serological markers to be positive • Despite adequate treatment for at least 6 months with disease modifying drugs including biologics, the disease remains unresponsive or poorly responsive • Active rheumatoid arthritis in at least three major joints (e.g. fingers, hands, wrists, knees, hips, elbows, shoulders) as evidenced by clinical signs and x-rays **Exclusions** • Reactive arthritis • Psoriatic arthritis	**25%**
	Confirmed diagnosis and treatment of rheumatoid arthritis by the treating rheumatologist. **Requirements for a claim to be considered** • Serological markers to be positive • Despite adequate treatment for at least 6 months with disease modifying drugs including biologics, the disease remains unresponsive or poorly responsive • The insured person undergoes joint replacement, joint reconstruction or joint fixation **Exclusions** • Reactive arthritis • Psoriatic arthritis	**50%**
	Illnesses that will be considered related: Advanced rheumatoid arthritis, Connective tissue disease **Illnesses that may be considered related:** Activities of Daily Living, Acute kidney failure, Cardiomyopathy, Chronic kidney failure, Chronic pancreatitis, Chronic respiratory failure, Loss of sight, Polymyositis, Terminal illness	
Connective tissue disease	Confirmed diagnosis and treatment of one of the following connective tissue diseases by the treating rheumatologist: • Giant cell arteritis • Polyarteritis nodosa • Systemic Scleroderma • Systemic lupus erythematosus • Sarcoidosis • Wegener's granulomatosis **Requirements for a claim to be considered** • Serological markers, or tissue biopsy (as appropriate) confirming diagnosis • All clinical signs must be supported by special investigations • Despite adequate treatment for at least 6 months with high dose steroids, or disease modifying drugs including biologics, the disease remains unresponsive or poorly responsive **Exclusions** • All other connective tissue or auto-immune conditions not specifically listed above • Limited cutaneous systemic sclerosis • Discoid lupus erythematosus or subacute cutaneous lupus erythematosus • Drug-induced lupus erythematosus	**50%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
	Confirmed diagnosis and treatment of a specified connective tissue disease by the treating rheumatologist. The connective diseases covered are listed in the 50% definition above. **Requirement for a claim to be considered** • Serological markers, or tissue biopsy (as appropriate) confirming diagnosis • Despite adequate treatment for at least 6 months with high dose steroids, or disease modifying drugs including biologics, at least one of the following organ systems remains directly involved: ◦ Gastrointestinal tract	**75%**
	◦ Lungs ◦ Heart ◦ Kidneys • All clinical signs must be supported by special investigations and imaging appropriate to the organ affected **Exclusions** • All other connective tissue or auto-immune conditions not specifically listed above • Limited cutaneous systemic sclerosis • Discoid lupus erythematosus or subacute cutaneous lupus erythematosus • Drug-induced lupus erythematosus	

	Confirmed diagnosis and treatment of a specified connective tissue disease by the treating rheumatologist.
	
	The connective diseases covered are listed in the 50% definition above.
	
	Requirement for a claim to be considered
	
	• Serological markers, or tissue biopsy (as appropriate) confirming diagnosis
	• Despite adequate treatment for at least 6 months with high dose steroids, or disease modifying drugs including biologics, at least two of the following organ systems remains directly involved:
	  ◦ Gastrointestinal tract
	  ◦ Lungs
	  ◦ Heart
	  ◦ Kidneys
	
	• All clinical signs must be supported by special investigations and imaging appropriate to the organ affected
	
	Exclusions
	
	• All other connective tissue or auto-immune conditions not specifically listed above
	• Limited cutaneous systemic sclerosis
	• Discoid lupus erythematosus or subacute cutaneous lupus erythematosus
	• Drug-induced lupus erythematosus
		100%

	Illnesses that will be considered related: Advanced rheumatoid arthritis, Connective tissue disease **Illnesses that may be considered related:** Activities of Daily Living, Acute kidney failure, Cardiomyopathy, Chronic kidney failure, Chronic pancreatitis, Chronic respiratory failure, Loss of sight, Polymyositis, Terminal illness	

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Polymyositis	Confirmed diagnosis of polymyositis by the treating specialist. **Requirements for a claim to be considered** • Positive serology findings • Electromyography positive • Supportive biopsy • Clinical confirmation of dysphonia (voice disorders) and dysphagia (difficulty swallowing)	**100%**
	Illnesses that will be considered related: Polymyositis **Illnesses that may be considered related:** Activities of Daily Living, Acute kidney failure, Advanced rheumatoid arthritis, Cardiomyopathy, Chronic kidney failure, Chronic pancreatitis, Chronic respiratory failure, Connective tissue disease, Loss of sight, Loss of speech, Prolonged mechanical ventilation, Terminal illness, Type 1 diabetes	
CANCER		

Bone marrow failure (including severe aplastic anaemia)	Confirmed diagnosis of complete bone marrow failure by the treating haematologist.
	
	Requirements for a claim to be considered
	
	• The bone marrow failure must result in anaemia, neutropenia and thrombocytopenia.
	• The insured person must require a minimum of one of the following treatments:
	  • at least 1 blood transfusion per month for at least 3 months, or
	  • immunosuppressive therapy, or
	  • bone marrow stimulation therapy
	
	Exclusions
	
	• All other forms of anaemia and blood disorders
		25%

	Illnesses that will be considered related Bone marrow failure (incl severe aplastic anaemia), Chronic blood disorders, Hematopoietic stem cell (bone marrow) transplant **Illnesses that may be considered related** Activities of Daily Living, Acute kidney failure, Arrhythmia, Cancer, Cardiomyopathy, Chronic blood disorders, Chronic kidney failure, Chronic liver failure, Terminal illness	
Cancer	Confirmation of a malignant tumour diagnosed and characterised by the uncontrolled growth of malignant cells and invasion beyond the layer of cells in which it originated into a deeper layer of tissue. The term malignant tumour includes leukaemia, sarcoma and lymphoma. All cancers classified as Stage I by the American Joint Committee for Cancer are covered, where the following cancers are only covered as specified: • Prostate cancer is covered when histologically classified as Gleason score of more than 6, or at least TNM staging T2N0M0 • Malignant melanoma is covered from T1N0M0 • Ductal carcinoma in situ (DCIS) of the breast is covered if microinvasion is present • Borderline ovarian tumours from Stage I are covered • Brain tumours from WHO Grade II are covered	**25%**

	Exclusions
	
	• All cancers which are histologically classified as any of the following:
	  • pre-malignant
	  • non-invasive
	  • cancer in situ, unless specified above
	  • having borderline malignancy, unless specified above
	  • tumours with low malignant potential
	
	• All prostate cancers, unless conforming to the specifications above
	• All skin cancers, except malignant melanoma as specified above	

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%

	Confirmation of a malignant tumour diagnosed and characterised by the uncontrolled growth of malignant cells and invasion beyond the layer of cells in which it originated into a deeper layer of tissue. The term malignant tumour includes leukaemia, sarcoma and lymphoma.
	
	All cancers classified as Stage II by the American Joint Committee for Cancer are covered, where the following cancers are only covered as specified:
	
	• Prostate cancer is covered from Stage III
	• Malignant melanoma is covered from Stage II
	• WHO Grade II brain tumours are covered if neurological deficit is present
	• Blood cancers are covered at the stages specified below
	  • Chronic Lymphocytic Leukemia, from Stage II on the Rai classification
	  • Chronic Myeloid Leukemia (no bone marrow transplant)
	  • Hodgkin's/Non Hodgkin's lymphoma from Stage II on the Ann Arbor classification
	  • Multiple Myeloma Stage from Stage I on the Durie-Salmon Scale
		50%

	Exclusions
	
	• All cancers which are histologically classified as any of the following:
	  • pre-malignant
	  • non-invasive
	  • cancer in situ
	  • having borderline malignancy
	  • tumours with low malignant potential
	
	• All prostate cancers, unless conforming to the specifications above
	• All skin cancers, except malignant melanoma as specified above
	• All blood cancers, unless as specified above	

	Confirmation of a malignant tumour diagnosed and characterised by the uncontrolled growth of malignant cells and invasion beyond the layer of cells in which it originated into a deeper layer of tissue. The term malignant tumour includes leukaemia, sarcoma and lymphoma. All cancers classified as Stage III or IV by the American Joint Committee for Cancer are covered, where the following cancers are only covered as specified: • Prostate cancer is covered from Stage IV • Malignant melanoma is covered from Stage III • WHO Grade III and IV brain tumours • Blood cancers are covered at the stages specified below	**100%**

	• Acute Myeloid Leukemia
	• Chronic Lymphocytic Leukemia, from Stage III on the Rai classification
	• Chronic Myeloid Leukemia (requiring bone marrow transplant)
	• Acute Lymphocytic Leukemia
	• Hodgkin's/Non Hodgkin's lymphoma from Stage III on the Ann Arbor classification
	• Multiple Myeloma Stage from Stage III on the Durie-Salmon Scale
	
	Exclusions
	
	• All cancers which are histologically classified as any of the following:
	  • pre-malignant
	  • non-invasive
	  • cancer in situ
	  • having borderline malignancy
	  • tumours with low malignant potential
	
	• All prostate cancers, unless conforming to the specifications above
	• All skin cancers, except malignant melanoma as specified above
	• All blood cancers, unless as specified above.	

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
	Illnesses that will be considered related None. **Illnesses that may be considered related** Activities of Daily Living, Bone marrow failure (including severe aplastic anaemia), Brain surgery, Cancer, Cancer Enhancer, Chronic blood disorders, Hematopoietic stem cell (bone marrow) transplant, Non-melanoma skin cancer Stage III or IV, Pancreatectomy, Partial mastectomy, Permanent ileostomy or colostomy, Prolonged mechanical ventilation, Terminal illness, Total colectomy, Total cystectomy, Total penectomy.	
Chronic blood disorders	Confirmed diagnosis of any chronic disorder of the blood by a specialist. **Requirements for a claim to be considered** • Objective evidence of the disorder including clinical records of supportive blood counts or bone marrow biopsies • At least four units of blood or blood products has been transfused per month for at least 3 consecutive months.	**50%**
	Illnesses that will be considered related Bone marrow failure (including severe aplastic anaemia), Chronic blood disorders, Hematopoietic stem cell (bone marrow) transplant **Illnesses that may be considered related** Activities of Daily Living, Acute kidney failure, Arrhythmia, Cancer, Cardiomyopathy, Chronic kidney failure, Chronic liver failure, Stroke, Terminal illness	
Hematopoietic stem cell (bone marrow) transplant	**One of the following:** • Undergoing a hematopoietic stem cell (bone marrow) transplant • Inclusion on a bone marrow transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure **Requirements for a claim to be considered** • Confirmation by the treating specialist with supportive evidence	**100%**
	Illnesses that will be considered related Bone marrow failure (including severe aplastic anaemia), Chronic blood disorders, Hematopoietic stem cell (bone marrow) transplant **Illnesses that may be considered related** Activities of Daily Living, Acute kidney failure, Arrhythmia, Cancer, Cardiomyopathy, Chronic blood disorders, Chronic kidney failure, Chronic liver failure, Terminal illness	
Non-melanoma skin cancer Stage III or IV	Confirmed diagnosis of any non-melanoma skin cancer classified as Stage III or IV by the American Joint Committee for Cancer.	**100%**
	Illnesses that will be considered related None. **Illnesses that may be considered related** Activities of Daily Living, Cancer, Non-melanoma skin cancer Stage III or IV, Terminal illness.	
Partial mastectomy	The undergoing of a partial mastectomy for ductal or lobular carcinoma in situ. **Requirements for a claim to be considered** • Histological evidence of ductal or lobular carcinoma in situ • Surgical reports confirming the removal of at least 50% of the affected breast **Exclusions** • Lumpectomy • Quadrantectomy	**25%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
	Illnesses that will be considered related Partial mastectomy **Illnesses that may be considered related** Cancer	
CARDIOVASCULAR		
Aortic surgery	The repair of a narrowing, obstruction, dissection or aneurysm of either the main thoracic or abdominal aorta, by means of any minimally invasive surgical technique. This includes keyhole or catheter techniques, or a mini-thoracoscopic/laparoscopic surgical procedure. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **NOTE:** Branches of the aorta are covered under Artery surgery	**50%**
	The repair of a narrowing, obstruction, dissection or aneurysm of either the main thoracic or abdominal aorta through surgically opening the chest cavity (thoracotomy) or the abdominal cavity (laparotomy). **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **NOTE:** Branches of the aorta are covered under Artery surgery	**100%**
	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related Aortic surgery **Illnesses that may be considered related** Activities of Daily Living, Arrhythmia, Cardiomyopathy, Heart surgery, Heart transplant, Heart valve replacement or repair, Stroke, Terminal illness	

Arrhythmia	Confirmed diagnosis of an arrhythmia by the treating cardiologist, with the insertion of a functioning defibrillator.
	
	Requirements for a claim to be considered
	
	• The arrhythmia must be documented on a 24 hour Holter ECG
	• One of the following devices must be surgically implanted:
	  • Implantable Cardioverter-Defibrillator (ICD)
	  • Cardiac Resynchronization Therapy with Defibrillator (CRT-D).
	
	Exclusions
	
	• Pacemaker insertion
	• Pathway ablation
		75%

	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related Arrhythmia, Cardiomyopathy, Heart attack, Heart surgery, Heart transplant, Heart valve replacement or repair, Stroke **Illnesses that may be considered related** Activities of Daily Living, Terminal illness	

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%

Artery surgery	One of the following:
	• The repair of a narrowing, obstruction, dissection or aneurysm of a specified artery, by means of any surgical technique. This includes keyhole or catheter techniques or bypass grafts. The following arteries are covered:
	  • Subclavian
	  • Brachiocephalic
	  • Splenic
	  • Renal
	  • Iliac
	  • Femoral
	• The undergoing of surgery to correct the narrowing of, or blockage to, any artery in the arms, hands legs or feet by means of a bypass graft
	Requirements for a claim to be considered:
	• Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis
		25%

	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related Artery surgery **Illnesses that may be considered related** Activities of Daily Living, Aortic Surgery, Carotid Artery Surgery, Peripheral Arterial Disease, Terminal illness	
Cardiomyopathy	Confirmed diagnosis of cardiomyopathy by the treating cardiologist. **Requirements for a claim to be considered** • The cardiomyopathy results in permanent and irreversible cardiac impairment, evidenced by echocardiogram findings showing left ventricular ejection fraction (LVEF) of less than 50%, measured twice at least 3 months apart	**50%**
	Confirmed diagnosis of cardiomyopathy by the treating cardiologist. **Requirements for a claim to be considered** • The cardiomyopathy results in permanent and irreversible cardiac impairment, evidenced by echocardiogram findings showing left ventricular ejection fraction (LVEF) of less than 45%, measured twice at least 3 months apart	**75%**
	Confirmed diagnosis of cardiomyopathy by the treating cardiologist. **Requirements for a claim to be considered** • The cardiomyopathy results in permanent and irreversible cardiac impairment, evidenced by echocardiogram findings showing left ventricular ejection fraction (LVEF) of less than 40%, measured twice at least 3 months apart	**100%**
	Illnesses that will be considered related Arrhythmia, Cardiomyopathy, Coronary artery bypass graft, Heart attack, Heart surgery, Heart transplant, Heart valve replacement or repair, Stroke **Illnesses that may be considered related** Activities of Daily Living, Chronic respiratory failure, Terminal illness	

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Carotid artery surgery	The repair of a narrowing, obstruction, dissection or aneurysm of one carotid artery, by means of a bypass graft or endarterectomy. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**25%**
	The repair of a narrowing, obstruction, dissection or aneurysm of both carotid arteries, by means of any surgical technique. This can be conducted over multiple surgeries, including bypass grafts, endarterectomies or endovascular procedures. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**100%**
	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related Carotid artery surgery, Stroke **Illnesses that may be considered related** Activities of Daily Living, Coma, Dementia (incl Alzheimer's disease), Paralysis, Terminal illness	
Coronary artery bypass graft	The undergoing of surgery to correct the narrowing of, or blockage to, one or more coronary arteries by means of a bypass graft.	**50%**
	The undergoing of surgery to correct the narrowing of, or blockage to, two coronary arteries by means of a bypass graft.	**75%**
	The undergoing of surgery to correct the narrowing of, or blockage to, three or more coronary arteries by means of a bypass graft.	**100%**
	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related Arrhythmia, Cardiomyopathy, Coronary artery bypass graft, Heart attack, Heart surgery, Heart transplant **Illnesses that may be considered related** Activities of Daily Living, Terminal illness	

Heart attack	Confirmed diagnosis of a heart attack by the treating cardiologist characterised by death of heart muscle, due to inadequate blood supply.
	
	Requirements for a claim to be considered
	
	• Raised cardiac biomarkers with at least one reading above the upper reference level
	• One of the following must be present:
	  • Compatible clinical symptoms
	  • New characteristic electrocardiography (ECG) changes indicative of myocardial ischaemia or myocardial infarction
	  • Angiography showing critical occlusion of a coronary artery indicative of myocardial ischaemia or myocardial infarction
	  • Evidence of hypokinesis on ECHO confirming the death of heart muscle tissue
	
	Exclusions
	
	• Other acute coronary syndromes (including but not limited to angina and unstable angina)
	• Coronary spasms
	• Elevations of troponin in the absence of overt ischemic heart diseases (e.g. myocarditis, apical ballooning, cardiac contusion, pulmonary embolism, drug toxicity)
		25%

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%

	Confirmed diagnosis of a heart attack by the treating cardiologist characterised by death of heart muscle, due to inadequate blood supply.
	
	Requirements for a claim to be considered
	• Raised cardiac biomarkers with at least one reading above the upper reference level
	• Two of the following must be present:
	  • Compatible clinical symptoms
	  • New characteristic electrocardiography (ECG) changes indicative of myocardial ischaemia or myocardial infarction
	  • Angiography showing critical occlusion of a coronary artery indicative of myocardial ischaemia or myocardial infarction
	  • Evidence of hypokinesis on ECHO confirming the death of heart muscle tissue
	
	Exclusions
	• Other acute coronary syndromes (including but not limited to angina and unstable angina)
	• Coronary spasms
	• Elevations of troponin in the absence of overt ischemic heart diseases (e.g. myocarditis, apical ballooning, cardiac contusion, pulmonary embolism, drug toxicity)
		50%

	Confirmed diagnosis of a heart attack by the treating cardiologist characterised by death of heart muscle, due to inadequate blood supply.
	
	Requirements for a claim to be considered
	• Raised cardiac biomarkers with at least one reading above the upper reference level
	• One of the following must be present:
	  • Compatible clinical symptoms
	  • New characteristic electrocardiography (ECG) changes indicative of myocardial ischaemia or myocardial infarction
	  • Angiography showing critical occlusion of a coronary artery indicative of myocardial ischaemia or myocardial infarction
	  • Evidence of hypokinesis on ECHO confirming the death of heart muscle tissue
	• IN ADDITION to the above, six weeks post infarction, there remains impairment of cardiac function as evidenced by both of the following:
	  • Left Ventricle Ejection Fraction (LVEF) of 40% - 50%
	  • Shortness of breath as per Class II or III New York Heart Association (NHYA) heart failure
	
	Exclusions
	• Other acute coronary syndromes (including but not limited to angina and unstable angina)
	• Coronary spasms
	• Elevations of troponin in the absence of overt ischemic heart diseases (e.g. myocarditis, apical ballooning, cardiac contusion, pulmonary embolism, drug toxicity)
		75%

	Confirmed diagnosis of a heart attack by the treating cardiologist characterised by death of heart muscle, due to inadequate blood supply.
	
	Requirements for a claim to be considered
	• Raised cardiac biomarkers with at least one reading above the upper reference level
	• One of the following must be present:
	  • Compatible clinical symptoms
	  • New characteristic electrocardiography (ECG) changes indicative of myocardial ischaemia or myocardial infarction
	  • Angiography showing critical occlusion of a coronary artery indicative of myocardial ischaemia or myocardial infarction
	  • Evidence of hypokinesis on ECHO confirming the death of heart muscle tissue
	• IN ADDITION to the above, six weeks post infarction, there remains impairment of cardiac function as evidenced by both of the following:
	  • Left Ventricle Ejection Fraction (LVEF) of <40%
	  • Shortness of breath as per Class IV New York Heart Association (NYHA) heart failure
		100%

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
	Exclusions • Other acute coronary syndromes (including but not limited to angina and unstable angina) • Coronary spasms • Elevations of troponin in the absence of overt ischemic heart diseases (e.g. myocarditis, apical ballooning, cardiac contusion, pulmonary embolism, drug toxicity)	
	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related Arrhythmia, Cardiomyopathy, Coronary artery bypass graft, Heart attack, Heart surgery, Heart transplant **Illnesses that may be considered related** Activities of Daily Living, Lifestyle enhancer, Terminal illness	
Heart surgery	The correction of any structural abnormality of the heart, through surgically opening the chest cavity (thoracotomy or sternotomy). **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any investigative procedure **NOTE**: Coronary artery bypass graft is covered as a separate severe illness	**75%**
	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related Arrhythmia, Coronary artery bypass graft, Heart surgery, Heart transplant, Heart valve replacement or repair **Illnesses that may be considered related** Activities of Daily Living, Cardiomyopathy, Terminal illness	
Heart transplant	One of the following: • Undergoing a heart transplant • Inclusion on a heart transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure **Requirements for a claim to be considered** • Confirmation by the treating specialist with supportive evidence	**100%**
	Illnesses that will be considered related Arrhythmia, Heart attack, Heart transplant, Stroke **Illnesses that may be considered related** Activities of Daily Living, Cardiomyopathy, Terminal illness	
Heart valve replacement or repair	The undergoing of heart surgery to repair one or more diseased heart valves by means of any minimally invasive surgery. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any investigative procedure	**50%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
	The undergoing of heart surgery to repair one or more diseased heart valves, through surgically opening the chest cavity (thoracotomy or sternotomy). **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any investigative procedure	**75%**
	The undergoing of heart surgery to replace one or more diseased heart valves, by means of any surgical technique. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any investigative procedure	**100%**
	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related Arrhythmia, Heart surgery, Heart transplant, Heart valve replacement or repair, Stroke **Illnesses that may be considered related** Activities of Daily Living, Aortic surgery, Cardiomyopathy, Pulmonary artery surgery, Terminal illness	
Pericardiectomy	The excision of a portion of the pericardium as treatment for a disease affecting the pericardium/pericardial sac, by means of any surgical technique. This includes endoscopic or keyhole procedures. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any investigative procedure	**25%**
	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related Pericardiectomy **Illnesses that may be considered related** Activities of Daily Living, Heart surgery, Terminal illness	
Peripheral arterial disease	Confirmed diagnosis of peripheral arterial disease by the treating vascular surgeon. **Requirements for a claim to be considered** • Abnormal diminished pulse on Doppler readings • Ankle-Brachial index (ABI) <0.9 • Pain as a result of peripheral arterial disease with claudication on minimal exercise lasting less than 10 minutes	**50%**

	Confirmed diagnosis of peripheral arterial disease by the treating vascular surgeon.
	Requirements for a claim to be considered
	• One of the following must be present:
	  • No recordable pulse on Doppler readings
	  • Gangrene secondary to peripheral arterial disease
		100%

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
	Illnesses that will be considered related Peripheral arterial disease **Illnesses that may be considered related** Activities of Daily Living, Amputation of limb, Terminal illness	
CENTRAL NERVOUS SYSTEM		
Acquired intellectual or cognitive impairment	Confirmed diagnosis of a permanent acquired intellectual or cognitive impairment caused by an organic disease or injury. **Requirements for a claim to be considered** • Confirmation by the treating neurologist or psychiatrist • Objective tests, which could include brain imaging demonstrating appropriate pathology • IQ must be less than 60 as measured by at least two independent psychiatrists using the appropriate Wechsler Intelligence Scale and at least one other internationally recognized equivalent neuropsychological test **Exclusions** • All other mental, psychological and psychiatric conditions	**100%**
	Illnesses that will be considered related Acquired intellectual or cognitive impairment, Dementia (including Alzheimer's disease), Psychiatric disorders **Illnesses that may be considered related** Accidental brain injury, Activities of Daily Living, Benign brain tumour, Brain surgery, Coma, Loss of hearing, Loss of sight, Loss of speech, Paralysis, Status epilepticus, Stroke, Terminal illness	
Benign brain tumour	Confirmed diagnosis of a non-malignant tumour or cyst in the brain, cranial nerves or meninges within the skull. This includes pituitary macroadenomas. **Requirements for a claim to be considered** • Supportive imaging and neurological reports, including confirmation of the diagnosis • The tumour has been removed via complete resection, partial resection or is irresectable **Exclusions** • Pituitary microadenomas • Angiomas • Granuloma, hamartoma or malformation of the arteries or veins of the brain	**25%**
	Confirmed diagnosis of a non-malignant tumour or cyst in the brain, cranial nerves or meninges within the skull. This includes pituitary macroadenomas. **Requirements for a claim to be considered** • Supportive imaging and neurological reports, including confirmation of the diagnosis • The tumour causes permanent neurological deficit. Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months **Exclusions** • Pituitary microadenomas • Angiomas • Granuloma, hamartoma or malformation of the arteries or veins of the brain	**50%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
	Illnesses that will be considered related Benign brain tumour **Illnesses that may be considered related** Acquired Intellectual or Cognitive impairment, Activities of Daily Living, Brain surgery, Coma, Dementia (including Alzheimer's disease), Loss of hearing, Loss of sight, Loss of speech, Paralysis, Psychiatric disorders, Status epilepticus, Stroke, Terminal illness	
Brain surgery	Any condition for which the insured person has undergone open brain surgery. This must involve a craniotomy (where there is surgical removal of part of the bone from the skull to expose the brain). This includes depressed skull fracture requiring removal of bone or reconstruction of the skull. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Stereotactic or radiosurgery • Burr hole surgery • Any minimally invasive surgery such as keyhole or endovascular surgery	**50%**
	Illnesses that will be considered related Brain surgery **Illnesses that may be considered related** Acquired intellectual or cognitive impairment, Activities of Daily Living, Benign brain tumour, Cancer, Coma, Dementia (including Alzheimer's disease), Loss of hearing , Loss of sight, Loss of speech, Paralysis, Psychiatric disorders, Spinal cord tumor, Status epilepticus, Stroke, Terminal illness	
Cavernous sinus thrombosis	Confirmed diagnosis of cavernous sinus thrombosis by the treating specialist. **Requirements for a claim to be considered** • Supportive imaging and neurological reports	**50%**
	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related Cavernous sinus thrombosis, Stroke **Illnesses that may be considered related** Acquired intellectual or cognitive impairment, Activities of Daily Living, Brain surgery, Coma, Dementia (including Alzheimer's disease), Loss of hearing , Loss of sight, Loss of speech, Paralysis, Psychiatric disorders, Status epilepticus, Terminal illness	

Cerebral malaria	Confirmed diagnosis of cerebral malaria by the treating specialist.
	
	Requirements for a claim to be considered
	
	• Supportive blood tests showing malaria infection
	• Admission to ICU for more than 72 hours during which the insured person suffers both of the following:
	
	  ◦ A coma, with a Glasgow Coma Scale of 8 or less, that lasts more than 6 hours
	  ◦ Epileptic seizures as a complication of the cerebral malaria
		25%

	Confirmed diagnosis of cerebral malaria by the treating specialist. Requirements for a claim to be considered • Supportive blood tests showing malaria infection • The cerebral malaria causes permanent neurological deficit. Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months	**50%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related Cerebral malaria **Illnesses that may be considered related** Acquired intellectual or cognitive impairment, Activities of Daily Living, Coma, Dementia (including Alzheimer's disease), Loss of hearing, Loss of sight, Loss of speech, Paralysis, Psychiatric disorders, Status epilepticus, Stroke, Terminal illness	
Coma	Confirmed diagnosis of a coma by the treating neurologist or neurosurgeon. **Requirements for a claim to be considered** • Decreased level of consciousness, with a Glasgow Coma Scale of 8 or less • The coma is constant and present for longer than 96hrs **Exclusions** • Medically induced comas • Comas due to the consumption of alcohol, drugs or medication not used as prescribed	**50%**
	Confirmed diagnosis of a coma by the treating neurologist or neurosurgeon. **Requirements for a claim to be considered** • Decreased level of consciousness, with a Glasgow Coma Scale of 8 or less • The coma is constant and present for longer than 14 days **Exclusions** • Medically induced comas • Comas due to the consumption of alcohol, drugs or medication not used as prescribed	**100%**
	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related None **Illnesses that may be considered related** Accidental brain injury, Acquired intellectual or cognitive impairment, Activities of Daily Living, Brain surgery, Cavernous sinus thrombosis, Chronic kidney failure, Coma, Dementia (including Alzheimer's disease), Lifestyle enhancer, Loss of hearing, Loss of sight, Loss of speech, Major burns, Motor neurone disease, Multiple sclerosis, Paralysis, Parkinson's disease, Parkinson's Plus syndrome, Prolonged mechanical ventilation, Psychiatric disorders, Status epilepticus, Stroke, Terminal illness	
Dementia (including Alzheimer's disease)	Confirmed diagnosis of Alzheimer's disease or any other type of dementia by the treating neurologist. **Requirements for a claim to be considered** • The diagnosis meets the criteria of the latest Diagnostic and Statistical Manual of Mental Disorders (DSM) • Supportive imaging and neurological reports	**100%**
	Illnesses that will be considered related Acquired intellectual or cognitive impairment, Dementia (incl Alzheimer's disease), Psychiatric disorders **Illnesses that may be considered related** Activities of Daily Living, Brain surgery, Coma, Loss of speech, Motor neurone disease, Multiple sclerosis, Parkinson's disease, Parkinson's Plus syndrome, Status epilepticus, Stroke, Terminal Illness	

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Motor neurone disease	Confirmed diagnosis of motor neurone disease by the treating neurologist. **Requirements for a claim to be considered** • There must be appropriate evidence, which could include nerve conduction studies (NCS) and electromyography (EMG)	**25%**
	Illnesses that will be considered related Motor neurone disease **Illnesses that may be considered related** Acquired intellectual or cognitive impairment, Activities of Daily Living, Coma, Dementia (incl Alzheimer's disease), Loss of speech, Paralysis, Prolonged mechanical ventilation, Psychiatric disorders, Terminal illness	
Multiple sclerosis	Confirmed diagnosis of multiple sclerosis by the treating neurologist. **Requirements for a claim to be considered:** • Magnetic resonance imaging (MRI) showing lesion/s of demyelination in the brain or spinal cord characteristic of multiple sclerosis • At least 2 separate episodes resulting in neurological signs and symptoms must have occurred **Exclusions** • Possible multiple sclerosis and clinically or radiologically isolated syndromes suggestive but not diagnostic of multiple sclerosis	**25%**
	Confirmed diagnosis of multiple sclerosis by the treating neurologist. **Requirements for a claim to be considered** • Magnetic resonance imaging (MRI) showing lesion/s of demyelination in the brain or spinal cord characteristic of multiple sclerosis • The multiple sclerosis results in permanent neurological deficit. Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months **Exclusions** • Possible multiple sclerosis and clinically or radiologically isolated syndromes suggestive but not diagnostic of multiple sclerosis	**50%**
	Illnesses that will be considered related Multiple Sclerosis **Illnesses that may be considered related** Acquired intellectual or cognitive impairment, Activities of Daily Living, Chronic respiratory failure, Coma, Dementia (incl Alzheimer's disease), Loss of hearing, Loss of sight, Loss of speech, Paralysis, Prolonged mechanical ventilation, Psychiatric disorders, Status epilepticus, Stroke, Terminal illness	
Muscular dystrophy	Confirmed diagnosis of muscular dystrophy by the treating neurologist. **Requirements for a claim to be considered** • There must be appropriate evidence, which could include characteristic electromyography (EMG) and muscle biopsy findings	**25%**
	Illnesses that will be considered related Muscular dystrophy **Illnesses that may be considered related** Activities of Daily Living, Chronic respiratory failure, Paralysis, Prolonged mechanical ventilation, Terminal illness	

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Myasthenia gravis Class III or higher	Confirmed diagnosis of myasthenia gravis of at least severity Class III (as per the Myasthenia Gravis Foundation of America clinical classification), by the treating neurologist. **Requirements for a claim to be considered** • Supportive electro-diagnostic studies • There must be appropriate evidence, which could include anti–acetylcholine receptor (AChR) antibody (Ab) test positive, or anti-MuSK (muscle-specific kinase) antibody test positive **Exclusions** • Localized ocular myasthenia gravis	**100%**
	Illnesses that will be considered related Myasthenia Gravis Stage III or higher **Illnesses that may be considered related** Activities of Daily Living, Chronic respiratory failure, Dementia (incl Alzheimer's disease), Paralysis, Prolonged mechanical ventilation, Terminal illness	
Paralysis	The total and permanent loss of use of: • A hand or hands at the level of the wrist joint and above, or • A foot or feet at the level of the ankle and above **Requirements for a claim to be considered** • Permanence must be confirmed by the treating specialist • Supportive special investigations	**50%**
	The total and permanent loss of use of two complete limbs. A limb is defined as a whole arm or a whole leg. **Requirements for a claim to be considered** • Permanence must be confirmed by the treating specialist • Supportive special investigations	**100%**
	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related None **Illnesses that may be considered related** Accidental brain injury, Acquired intellectual or cognitive impairment, Activities of Daily Living, Acute kidney failure, Cavernous sinus thrombosis, Chronic kidney failure, Coma, Dementia (incl Alzheimer's disease), Kidney transplant, Lifestyle enhancer, Loss of hearing, Loss of sight, Loss of speech, Myasthenia Gravis Stage III or higher, Paralysis, Prolonged mechanical ventilation, Psychiatric disorders, Status epilepticus, Stroke, Terminal illness	
Parkinson's disease	Confirmed diagnosis of primary idiopathic Parkinson's disease by the treating neurologist. **Requirements for a claim to be considered** The diagnosis must be confirmed by the presence of at least 2 cardinal symptoms of Parkinson's disease, which are: • Bradykinesia • Resting tremor • Muscle rigidity • Postural instability **Exclusions** • Parkinsonian syndromes including but not limited to those caused by the consumption of alcohol, drugs or medication not used as prescribed • Secondary Parkinsonism • Essential tremor	**25%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
	Illnesses that will be considered related Parkinson's disease **Illnesses that may be considered related** Acquired intellectual or cognitive impairment, Activities of Daily Living, Coma, Dementia (incl Alzheimer's disease), Loss of speech, Paralysis, Psychiatric disorders, Stroke, Terminal illness	
Parkinson's Plus syndrome	Confirmed diagnosis of one of the following Parkinson Plus syndromes by the treating neurologist: • Multiple system atrophy • Progressive supranuclear palsy • Parkinsonism-dementia-amyotrophic lateral sclerosis complex • Corticobasal ganglionic degeneration • Diffuse Lewy body disease • Pick's disease • Olivopontocerebellar atrophy **Requirements for a claim to be considered** • Supporting medical and clinical evidence	**25%**
	Exclusions • Parkinsonian syndromes including but not limited to those caused by the consumption of alcohol, drugs or medication not used as prescribed • Secondary Parkinsonism • Essential tremor	
	Illnesses that will be considered related Parkinson's disease, Parkinson's Plus syndrome **Illnesses that may be considered related** Acquired intellectual or cognitive impairment, Activities of Daily Living ,Coma, Dementia (incl Alzheimer's disease), Loss of speech, Paralysis, Psychiatric disorders, Stroke, Terminal illness	
Psychiatric disorders	Confirmed diagnosis of a psychiatric disorder by the treating neurologist. **Requirements for a claim to be considered** • The diagnosis meets the criteria of the latest Diagnostic and Statistical Manual of Mental Disorders (DSM) • Institutionalisation in a registered psychiatric facility for more than 6 consecutive months with appropriate medical certification • Undergoing of constant 24 supervision, with a permanent caregiver • Global Assessment Function (GAF) score of 40 or less certified under the DSM IV classification, or • WHODAS item-response-theory" (IRT) score of 100 which equals full disability The above must be confirmed by at least two independent psychiatric reports	**100%**
	Illnesses that will be considered related Acquired intellectual or cognitive impairment, Dementia (including Alzheimer's disease), Psychiatric disorders **Illnesses that may be considered related** Activities of Daily Living, Benign brain tumour, Coma, Status epilepticus, Stroke, Terminal illness	

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Spinal cord tumour	Confirmed diagnosis of a non-malignant tumour or cyst in the spinal cord, spinal nerves or meninges. **Requirements for a claim to be considered** • Supportive imaging and neurological reports, including confirmation of the diagnosis • The tumour has been removed via complete resection, partial resection or is irresectable • The tumour causes permanent neurological deficit. Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months **Exclusions** • Angiomas • Granuloma and hamartoma	**50%**
	Illnesses that will be considered related Spinal cord tumour **Illnesses that may be considered related** Activities of Daily Living, Benign brain tumor, Brain surgery, Cancer, Chronic respiratory failure, Paralysis, Prolonged mechanical ventilation, Terminal illness	
Status epilepticus	An episode of status epilepticus confirmed by the treating neurologist. **Requirements for a claim to be considered** • Supportive imaging and neurological reports • The status epilepticus causes permanent neurological deficit. Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months	**50%**
	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related Status epilepticus **Illnesses that may be considered related** Accidental brain injury, Acquired intellectual or cognitive impairment, Activities of Daily Living, Brain surgery, Cavernous sinus thrombosis, Coma, Dementia (incl Alzheimer's disease), Loss of hearing, Loss of sight, Loss of speech, Paralysis, Prolonged mechanical ventilation, Psychiatric disorders, Stroke, Terminal illness	
Stroke	Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in neurological deficit lasting longer than 24 hours, confirmed by neuroimaging investigation and appropriate clinical findings by a specialist neurologist. Stroke as a result of traumatic injury to brain tissue or blood vessels is included. **Exclusions** • Transient ischaemic attack • Vascular disease affecting the eye or optic nerve • Migraine and vestibular disorders	**25%**
	Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in neurological deficit, confirmed by neuroimaging investigation and appropriate clinical findings by a specialist neurologist. Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months. Stroke as a result of traumatic injury to brain tissue or blood vessels is included.	**50%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%

	Requirements for a claim to be considered
	• One of the following must be present:
	  • The inability to do 3 or more Advanced Activities of Daily Living
	  • A Whole Person Impairment (WPI) of 11%- 20%. WPI figures are calculated as per the latest version of the American Medical Association Guides to the Evaluation of Permanent Impairment
	Exclusions
	• Transient ischaemic attack
	• Vascular disease affecting the eye or optic nerve
	• Migraine and vestibular disorders	

	Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in neurological deficit, confirmed by neuroimaging investigation and appropriate clinical findings by a specialist neurologist. Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months.
	Stroke as a result of traumatic injury to brain tissue or blood vessels is included.
	Requirements for a claim to be considered
	• One of the following must be present:
	  • The inability to do 6 or more Advanced Activities of Daily Living
	  • A Whole Person Impairment (WPI) of 21%- 35%. WPI figures are calculated as per the latest version of the American Medical Association Guides to the Evaluation of Permanent Impairment.
	Exclusions
	• Transient ischaemic attack
	• Vascular disease affecting the eye or optic nerve
	• Migraine and vestibular disorders
		75%

	Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in neurological deficit, confirmed by neuroimaging investigation and appropriate clinical findings by a specialist neurologist. Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months.
	Stroke as a result of traumatic injury to brain tissue or blood vessels is included.
	Requirements for a claim to be considered
	• One of the following must be present:
	  • The inability to do 3 or more Basic Activities of Daily Living
	  • A Whole Person Impairment (WPI) of greater than 35%. WPI figures are calculated as per the latest version of the American Medical Association Guides to the Evaluation of Permanent Impairment
	Exclusions
	• Transient ischaemic attack
	• Vascular disease affecting the eye or optic nerve
	• Migraine and vestibular disorders
		100%

	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related Carotid Artery Surgery, Stroke **Illnesses that may be considered related** Acquired intellectual or cognitive impairment, Activities of Daily Living, Arrythmia, Brain surgery, Cavernous sinus thrombosis, Chronic blood disorders, Coma, Dementia (incl Alzheimer's disease), Lifestyle enhancer, Loss of hearing, Loss of sight, Loss of speech, Paralysis, Prolonged mechanical ventilation, Psychiatric disorders, Status epilepticus, Terminal illness	

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
GASTROINTESTINAL		
Acute kidney failure	A single episode of acute kidney failure requiring six or more treatments of haemodialysis. **Requirements for a claim to be considered** • Confirmation of acute kidney failure by the treating nephrologist • Blood tests supporting diagnosis • Evidence of number of haemodialysis treatments **Exclusions** • Any acute failure caused by the consumption of alcohol, drugs or medication not used as prescribed	**50%**
	Illnesses that will be considered related Acute kidney failure **Illnesses that may be considered related** Activities of Daily Living, Artery surgery, Cardiomyopathy, Chronic blood disorders, Chronic kidney failure, Chronic liver failure, Coma, Connective tissue disease, Dementia (incl Alzheimer's disease), Kidney transplant, Peripheral arterial disease, Polymyositis, Terminal illness	

Chronic kidney failure	Confirmed diagnosis of chronic renal failure by the treating nephrologist or urologist.
	
	Requirements for a claim to be considered
	• One of the following must be present, despite adequate medical treatment:
	  • Chronic renal disease with an estimated Glomerular Filtration Rate (GFR) ≤ 40ml/min
	  • Chronic renal disease with creatinine clearance of ≤ 55ml/min, with clinically significant progressive renal function decline as confirmed by 3 renal function (creatinine clearance) measurements in a 12 month period
		50%

	Confirmed diagnosis of chronic renal failure by the treating nephrologist or urologist.
	
	Requirements for a claim to be considered
	• One of the following must be present, despite adequate medical treatment:
	  • End-stage renal disease with an estimated Glomerular Filtration Rate (GFR) less than 24ml/min
	  • Renal function deterioration for which either peritoneal dialysis or haemodialysis has been instituted
		100%

	Illnesses that will be considered related Chronic kidney failure, Kidney transplant **Illnesses that may be considered related** Activities of Daily Living, Acute kidney failure, Artery surgery, Cardiomyopathy, Chronic blood disorders, Chronic liver failure. Connective tissue disease, Coma, Dementia (incl Alzheimer's disease), Peripheral arterial disease, Polymyositis, Terminal illness	
Chronic liver failure	Confirmed diagnosis of progressive chronic liver disease by the treating gastroenterologist or equivalent specialist. **Requirements for a claim to be considered** • Supportive clinical, laboratory and histological evidence • The liver failure must be classified as at least Child-Pugh Class A **Exclusions** • Liver disease caused by the consumption of alcohol, drugs or medication not used as prescribed	**50%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
	Confirmed diagnosis of chronic end-stage liver disease by the treating gastroenterologist or equivalent specialist. Requirements for a claim to be considered • Supportive clinical, laboratory and histological evidence • The liver failure must be classified as at least Child-Pugh Class B **Exclusions** • Liver disease caused by the consumption of alcohol, drugs or medication not used as prescribed	**75%**
	Confirmed diagnosis of chronic end-stage liver disease by the treating gastroenterologist or equivalent specialist. **Requirements for a claim to be considered** • Supportive clinical, laboratory and histological evidence • The liver failure must be classified as at least Child-Pugh Class C **Exclusions** • Liver disease caused by the consumption of alcohol, drugs or medication not used as prescribed	**100%**
	Illnesses that will be considered related Chronic liver failure, Liver transplant **Illnesses that may be considered related** Activities of Daily Living, Acute kidney failure, Chronic kidney failure, Coma, Dementia (incl Alzheimer's disease), Terminal illness	
Chronic pancreatitis	Confirmed diagnosis of chronic pancreatitis by the treating gastroenterologist or equivalent specialist. **Requirements for a claim to be considered** • Supportive clinical, laboratory and histological evidence • Malabsorption syndrome caused by exocrine pancreatic insufficiency • Impaired glucose metabolism caused by endocrine pancreatic insufficiency **Exclusions** • Pancreatic disease caused by the consumption of alcohol, drugs or medication not used as prescribed	**50%**
	Illnesses that will be considered related Chronic Pancreatitis, Pancreactomy or pancreas transplant **Illnesses that may be considered related** Activities of Daily Living, Cancer, Chronic liver failure, Terminal illness	
Crohn's disease with specified surgery	Confirmed diagnosis of Crohn's disease by the treating gastroenterologist or equivalent specialist. **Requirements for a claim to be considered** • Supportive colonoscopy and histopathology findings • Despite adequate treatment for at least 6 consecutive months with diet, disease modifying drugs or immuno-modulators, the disease remains unresponsive or poorly responsive • The complications have resulted in at least one surgical intervention other than for diagnostic purposes	**25%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
	Confirmed diagnosis of Crohn's disease by the treating gastroenterologist or equivalent specialist. **Requirements for a claim to be considered** • Supportive colonoscopy and histopathology findings • Despite adequate treatment for at least 6 consecutive months with diet, disease modifying drugs or immuno-modulators, the disease remains unresponsive or poorly responsive • The complications have resulted in at least two surgical interventions, on two separate occasions, other than for diagnostic purposes	**50%**
	Illnesses that will be considered related Crohn's disease with specified surgery **Illnesses that may be considered related** Activities of Daily Living, Cancer, Chronic liver failure, Permanent ileostomy or colostomy, Terminal illness, Total colectomy	
Kidney transplant	One of the following: • Undergoing a kidney transplant • Inclusion on a kidney transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure **Requirements for a claim to be considered** • Confirmation by the treating specialist with supportive evidence	**100%**
	Illnesses that will be considered related Chronic kidney failure, Kidney transplant **Illnesses that may be considered related** Activities of Daily Living, Acute kidney failure, Artery surgery, Cardiomyopathy, Chronic Blood disorders, Chronic liver failure, Coma, Connective tissue disease, Dementia (incl Alzheimer's disease), Polymyositis, Terminal illness	
Liver transplant	One of the following: • Undergoing a liver transplant • Inclusion on a liver transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure **Requirements for a claim to be considered** • Confirmation by the treating specialist with supportive evidence	**100%**
	Illnesses that will be considered related Chronic liver failure, Liver transplant **Illnesses that may be considered related** Activities of Daily Living, Acute kidney failure, Chronic kidney failure, Coma, Dementia (incl Alzheimer's disease), Terminal illness	
Pancreatectomy or pancreas transplant	One of the following: • Undergoing a complete pancreatectomy • Undergoing a complete pancreas transplant • Inclusion on a pancreas transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure **Requirements for a claim to be considered** • Confirmation by the treating specialist with supportive evidence	**100%**
	Illnesses that will be considered related Chronic pancreatitis, pancreactomy or pancreas transplant **Illnesses that may be considered related** Activities of Daily Living, cancer, chronic liver failure, coma , terminal illness	

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Permanent ileostomy or colostomy	Any organic disease or severe physical injury that results in a colostomy or ileostomy which is intended to be permanent. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any temporary ostomy procedure	**100%**
	Illnesses that will be considered related Permanent ileostomy or colostomy **Illnesses that may be considered related** Activities of Daily Living, cancer, terminal illness, total colectomy	
Total colectomy	Any organic disease or severe physical injury that results in a total colectomy, where the entire colon is removed and the small intestine is connected to the rectum. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Partial colectomy • Segmental colectomy • Partial bowel resection	**100%**
	Illnesses that will be considered related Total colectomy **Illnesses that may be considered related** Activities of Daily Living, cancer, permanent ileostomy or colostomy, terminal illness	
Total cystectomy	Any organic disease or severe physical injury that results in a total cystectomy, which is the surgical removal of the entire bladder with the reconstruction of an ileal conduit or neo-bladder. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Partial cystectomy	**100%**
	Illnesses that will be considered related Total cystectomy **Illnesses that may be considered related** Activities of Daily Living, Acute kidney failure, Cancer, Chronic kidney failure	
Total penectomy	Any organic disease or severe physical injury that results in total amputation of the penis (total penectomy) with the surgical construction of a perineal urethrostomy. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon **Exclusions** • Partial penectomy • Surgery due to gender dysphoria • Circumcision or any complications thereof	**50%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
	Illnesses that will be considered related Total penectomy **Illnesses that may be considered related** Cancer	
Ulcerative colitis	Confirmed diagnosis of ulcerative colitis disease by the treating gastroenterologist. **Requirements for a claim to be considered** • Supportive colonoscopy and histopathology findings • Despite adequate treatment for at least 6 consecutive months with diet, disease modifying drugs or immuno-modulators, the disease remains unresponsive or poorly responsive • The complications have resulted in at least one surgical intervention other than for diagnostic purposes	**25%**
	Illnesses that will be considered related Ulcerative colitis **Illnesses that may be considered related** Activities of Daily Living, Chronic liver failure, Permanent ileostomy or colostomy, Terminal illness, Total colectomy	
HIV/AIDS		
Accidental HIV for medical, dental or nurse practitioners	Infection with the human immunodeficiency virus (HIV) as a result of an accident while carrying out occupational duties of a medical, dental or nurse practitioner. For the purpose of this illness an accident is defined as an external, unexpected event that is not traceable, even indirectly, to the insured person's state of mental or physical health before the event. **Requirements for a claim to be considered** • The insured person must be registered as a medical or dental practitioner with the Health Professions Council of South Africa (HPCSA) or as a member of the South African Nursing Council (SANC). Registered dental assistants and oral hygienists are also included • A supportive HIV antibody test must be taken within 48 hours after the accident, and the result must be negative • Proof that the health care institution's written protocol was followed, including the use of post-exposure prophylaxis drugs • Confirmed evidence of seroconversion to HIV must occur within 3 months of the accident	**100%**
	Illnesses that will be considered related Accidental HIV for medical, dental or nurse practitioners, Accidental HIV via a blood transfusion, Accidental HIV via a road traffic accident, Accidental HIV via an organ transplant, Accidental HIV via violent crime, rape or indecent assault, AIDS **Illnesses that may be considered related** Terminal illness	
Accidental HIV via a blood transfusion	Infection with the human immunodeficiency virus (HIV) by infected blood received in a blood transfusion. **Requirements for a claim to be considered** • A recognised institution in the Republic of South Africa must have performed the transfusion • The institution that provided the infected blood must admit liability • Confirmed evidence of seroconversion to HIV must occur within 3 months of the affected blood transfusion	**100%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
	Illnesses that will be considered related Accidental HIV for medical, dental or nurse practitioners, Accidental HIV via a blood transfusion, Accidental HIV via a road traffic accident, Accidental HIV via an organ transplant, Accidental HIV via violent crime, rape or indecent assault, AIDS **Illnesses that may be considered related** Terminal illness	
Accidental HIV via a road traffic accident	Infection with the human immunodeficiency virus (HIV) as a result of involvement in, or assistance at the scene of, a road traffic accident. **Requirements for a claim to be considered** • The event must have been reported to the South African Police Service (SAPS) and a case number issued and/or criminal case opened • A medical examination must have been performed within 24 hours after the event • A supportive HIV antibody test must be taken within 48 hours after the accident, and the result must be negative • Confirmed evidence of seroconversion to HIV must occur within 3 months of the event	**100%**
	Illnesses that will be considered related Accidental HIV for medical, dental or nurse practitioners, Accidental HIV via a blood transfusion, Accidental HIV via a road traffic accident, Accidental HIV via an organ transplant, Accidental HIV via violent crime, rape or indecent assault, AIDS **Illnesses that may be considered related** Terminal illness	
Accidental HIV via an organ transplant	Infection with the human immunodeficiency virus (HIV) by an infected organ received in an organ transplant. **Requirements for a claim to be considered** • A recognised institution in the Republic of South Africa must have performed the transplant • The institution that provided the infected organ must admit liability • Confirmed evidence of seroconversion to HIV must occur within 3 months of the organ transplant	**100%**
	Illnesses that will be considered related Accidental HIV for medical, dental or nurse practitioners, Accidental HIV via a blood transfusion, Accidental HIV via a road traffic accident, Accidental HIV via an organ transplant, Accidental HIV via violent crime, rape or indecent assault, AIDS **Illnesses that may be considered related** Terminal illness	
Accidental HIV via violent crime, rape or indecent assault	Infection with the human immunodeficiency virus (HIV) as a result of being a victim of a violent crime, rape or an indecent assault. **Requirements for a claim to be considered** • The event must have been reported to the South African Police Service (SAPS) and a case number issued and/or criminal case opened • A medical examination must have been performed within 24 hours after the event • A supportive HIV antibody test must be taken within 48 hours after the event, and the result must be negative • Confirmed evidence of seroconversion to HIV must occur within 3 months of the event	**100%**
	Illnesses that will be considered related Accidental HIV for medical, dental or nurse practitioners, Accidental HIV via a blood transfusion, Accidental HIV via a road traffic accident, Accidental HIV via an organ transplant, Accidental HIV via violent crime, rape or indecent assault, AIDS **Illnesses that may be considered related** Terminal illness	

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
AIDS	Confirmed diagnosis of AIDS or Stage 4 HIV infection by the treating specialist. **Requirements for a claim to be considered** • Positive HIV antibody test (or other recognised test for the presence of HIV, acceptable to Old Mutual) • CD4 count of persistently less than 200 cells/mm3 must be present, despite compliance with anti-retroviral treatment as per latest National Guidelines • At least one of the AIDS-defining conditions listed in the current World Health Organization's (WHO) clinical staging of HIV/AIDS	**100%**
	The benefit terminates after a successful claim on this illness.	
RESPIRATORY		

Chronic respiratory failure	Confirmed diagnosis of a chronic respiratory disorder by the treating pulmonologist.
	
	Requirements for a claim to be considered
	• Any one of the below measurements taken on at least 3 occasions, at least 1 month apart:
	  • Impaired airflow with FEV1 (forced expiratory volume in the first second) of ≤50% predicted
	  • FVC (forced vital capacity) of ≤50% predicted
	  • DLCO (diffusing capacity of the lungs for carbon monoxide) of ≤50% predicted
		50%

	Confirmed diagnosis of a chronic respiratory disorder by the treating pulmonologist.
	
	Requirements for a claim to be considered
	• Any one of the below measurements taken on at least 3 occasions, at least 1 month apart:
	  • Impaired airflow with FEV1 (forced expiratory volume in the first second) of ≤40% predicted
	  • FVC (forced vital capacity) of ≤40% predicted
	  • DLCO (diffusing capacity of the lungs for carbon monoxide) of ≤40% predicted
		100%

	Illnesses that will be considered related Chronic respiratory failure, Lung transplant **Illnesses that may be considered related** Activities of Daily Living, Cardiomyopathy, Lung surgery, Pulmonary arterial hypertension, Prolonged mechanical ventilation, Terminal illness	
Lung surgery	The undergoing of surgery to remove more than one lobe of the lung due to any physical injury or disease. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**50%**
	The undergoing of surgery to remove a whole lung due to any physical injury or disease. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**100%**
	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related Chronic respiratory failure, Lung surgery, Lung transplant **Illnesses that may be considered related** Activities of Daily Living, Cardiomyopathy, Prolonged mechanical ventilation, Pulmonary arterial hypertension, Recurrent pulmonary emboli	

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Lung transplant	One of the following: • Undergoing a lung transplant (this includes the whole lung or a lobe of the lung) • Inclusion on a lung transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure **Requirements for a claim to be considered** Confirmation by the treating specialist with supportive evidence	**100%**
	Illnesses that will be considered related Chronic respiratory failure, Lung surgery, Lung transplant **Illnesses that may be considered related** Activities of Daily Living, Cardiomyopathy, Prolonged mechanical ventilation, Pulmonary arterial hypertension, Terminal illness	

Prolonged mechanical ventilation	A severe physical injury or organic disease that results in an extended period of assisted mechanical ventilation.
	
	Requirements for a claim to be considered
	
	• One of the following must be present:
	  • A severe physical injury that results in ICU admission for more than 14 full days, with assisted mechanical ventilation for more than 7 full days
	  • Any organic disease that results in assisted mechanical ventilation of more than 30 consecutive days
	
	NOTE:
	
	• A day is 24 hours
	• This illness will only be considered if the insured person does not qualify for a payment for any other listed severe illness under this benefit
	• The survival period applies from the date this definition has been met
		100%

	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related None **Illnesses that may be considered related** Activities of Daily Living, Acquired intellectual or cognitive impairment, Coma, Dementia (incl Alzheimer's disease), Prolonged mechanical ventilation, Terminal illness	
Pulmonary arterial hypertension	Confirmed diagnosis of pulmonary hypertension by the treating specialist. **Requirements for a claim to be considered** • Mean pulmonary artery pressure of between 25-40 mmHg at rest, measured by right heart catheterisation • Marked limitation in activity due to symptoms, even during less-than-ordinary activity, e.g. walking short distances (New York Heart Association (NYHA) Class III heart failure). Symptoms must be present for a continuous period of at least 3 months	**50%**
	Confirmed diagnosis of pulmonary hypertension by the treating specialist. **Requirements for a claim to be considered** • Mean pulmonary artery pressure of more than 40 mmHg at rest, measured by right heart catheterisation • Marked limitation of physical activities at rest (New York Heart Association (NYHA) Class IV heart failure). Symptoms must be present for a continuous period of at least 3 months	**100%**
	Illnesses that will be considered related Arrhythmia, Cardiomyopathy, Chronic respiratory failure, Heart surgery, Pulmonary arterial hypertension, Pulmonary artery surgery, Recurrent pulmonary emboli **Illnesses that may be considered related** Activities of Daily Living, Chronic blood disorders, Lung surgery, Prolonged mechanical ventilation, Terminal illness	

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Pulmonary artery surgery	The undergoing of surgery to the pulmonary artery through surgically opening the chest cavity (thoracotomy or sternotomy). There must be excision and replacement of a portion of the diseased pulmonary artery with a graft. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any investigative procedure • Any other surgical procedure, e.g. the insertion of stents or endovascular repair	**75%**
	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related Arrhythmia, Cardiomyopathy, Chronic respiratory failure, Heart surgery, Pulmonary arterial hypertension, Pulmonary artery surgery, Recurrent pulmonary emboli **Illnesses that may be considered related** Activities of Daily Living, Chronic blood disorders, Lung surgery, Prolonged mechanical ventilation, Terminal illness	
Recurrent pulmonary emboli	The undergoing of a veno-caval filter insertion to treat recurrent pulmonary embolism. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any investigative procedure	**50%**
	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related Arrhythmia, Cardiomyopathy, Chronic respiratory failure, Heart surgery, Pulmonary arterial hypertension, Pulmonary artery surgery, Recurrent pulmonary emboli **Illnesses that may be considered related** Activities of Daily Living, Chronic blood disorders, Lung surgery, Prolonged mechanical ventilation, Terminal illness	
SENSES		
Enucleation of the eye	The enucleation of one eye, which results from either trauma or the surgical treatment of an organic disease. **Requirements for a claim to be considered** Confirmation by the treating specialist with supportive evidence	**50%**
	Illnesses that will be considered related None **Illnesses that may be considered related** Loss of sight	
Loss of hearing	Confirmed diagnosis of loss of hearing in both ears by the treating ENT specialist. **Requirements for a claim to be considered** • Average auditory threshold, measured at 500, 1000, 2000 and 3000 Hertz in the better ear using a pure tone audiogram, of between 70-89 decibels • This must be confirmed by audiometry conducted with hearing aids	**50%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
	Confirmed diagnosis of loss of hearing in both ears by the treating ENT specialist. **Requirements for a claim to be considered** • Average auditory threshold, measured at 500, 1000, 2000 and 3000 Hertz in the better ear using a pure tone audiogram, of between 90 or more decibels • This must be confirmed by audiometry conducted with hearing aids	**100%**
	Illnesses that will be considered related Loss of hearing. **Illnesses that may be considered related** Activities of Daily Living, Accidental brain injury, Terminal illness	

Loss of sight	Confirmed diagnosis of loss of sight by the treating ophthalmologist. The loss of sight can't be improved through refractive correction or medication.
	
	Requirements for a claim to be considered
	• One of the following must be present:
	  • A reading of 6/30 or worse (or equivalent measure on a non-metric scale) in each eye, after best correction
	  • A visual field loss to a 20° radius, after best correction
	  • Severe non-proliferative diabetic retinopathy
	  • Grade III hypertensive retinopathy
	
	Exclusions
	• Loss of sight due to cataracts, unless there is evidence of failed cataract surgery or contraindications to cataract surgery
		50%

	Confirmed diagnosis of loss of sight by the treating ophthalmologist. The loss of sight can't be improved through refractive correction or medication.
	
	Requirements for a claim to be considered
	• One of the following must be present:
	  • A reading of 6/60 or worse (or equivalent measure on a non-metric scale) in each eye , after best correction
	  • A visual field loss to a 10° radius, after best correction
	  • Severe proliferative diabetic retinopathy
	  • Grade IV hypertensive retinopathy
	  • Permanent hemianopia in both eyes
	
	Exclusions
	• Loss of sight due to cataracts, unless there is evidence of failed cataract surgery or contraindications to cataract surgery
		100%

	Illnesses that will be considered related Loss of sight **Illnesses that may be considered related** Activities of Daily Living, Accidental brain injury, Terminal illness	
Loss of speech	Total permanent and irreversible loss of the ability to speak as a result of physical injury or disease as diagnosed by the treating ENT specialist, neurologist or neurosurgeon. **Requirements for a claim to be considered** • The loss of speech has to be present for a continuous period of at least 6 months **Exclusions** • Loss of speech due to psychiatric causes	**100%**
	Illnesses that will be considered related Loss of speech **Illnesses that may be considered related** Activities of Daily Living, Accidental brain injury, Terminal illness	

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Retinitis pigmentosa	Confirmed diagnosis of retinitis pigmentosa by the treating ophthalmologist. **Requirements for a claim to be considered** • Supporting Electroretinogram (ERG) • Supporting visual field tests	**25%**
	Illnesses that will be considered related Retinitis pigmentosa **Illnesses that may be considered related** Activities of Daily Living, Loss of sight	
TRAUMA		
Accidental brain injury	Death of brain tissue due to traumatic injury as a result of an accident resulting in neurological deficit lasting longer than 24 hours, confirmed by neuroimaging investigation and appropriate clinical findings by a specialist neurologist. **NOTE:** • An accident is an unexpected and visible event of external origin that causes traumatic bodily injury and is not traceable, even indirectly, to the insured person's state of mental or physical health before the event	**25%**

	Death of brain tissue due to traumatic injury as a result of an accident resulting in neurological deficit, confirmed by neuroimaging investigation and appropriate clinical findings by a specialist neurologist. Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months.
	
	Requirements for a claim to be considered
	
	• One of the following must be present:
	  • The inability to do 3 or more Advanced Activities of Daily Living
	  • A Whole Person Impairment (WPI) of 11%- 20%. WPI figures are calculated as per the latest version of the American Medical Association Guides to the Evaluation of Permanent Impairment
	
	NOTE:
	
	• An accident is an unexpected and visible event of external origin that causes traumatic bodily injury and is not traceable, even indirectly, to the insured person's state of mental or physical health before the event
		50%

	Death of brain tissue due to traumatic injury as a result of an accident, resulting in neurological deficit and confirmed by appropriate clinical findings by a specialist neurologist. Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months.
	
	Requirements for a claim to be considered
	
	• One of the following must be present:
	  • The inability to do 6 or more Advanced Activities of Daily Living
	  • A Whole Person Impairment (WPI) of 21%- 35%. WPI figures are calculated as per the latest version of the American Medical Association Guides to the Evaluation of Permanent Impairment
	
	NOTE:
	
	• An accident is an unexpected and visible event of external origin that causes traumatic bodily injury and is not traceable, even indirectly, to the insured person's state of mental or physical health before the event
		75%

	Death of brain tissue due to traumatic injury resulting in neurological deficit as a result of an accident, and confirmed by appropriate clinical findings by a specialist neurologist. Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months.	**100%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%

	Requirements for a claim to be considered
	• One of the following must be present:
	  • The inability to do 3 or more Basic Activities of Daily Living
	  • A Whole Person Impairment (WPI) of greater than 35%. WPI figures are calculated as per the latest version of the American Medical Association Guides to the Evaluation of Permanent Impairment
	NOTE:
	• An accident is an unexpected and visible event of external origin that causes traumatic bodily injury and is not traceable, even indirectly, to the insured person's state of mental or physical health before the event
	The survival period applies to all severities of this illness.	

	Illnesses that will be considered related None **Illnesses that may be considered related** Accidental brain injury, Acquired intellectual or cognitive impairment, Activities of Daily Living, Brain surgery, Coma, Dementia (incl Alzheimer's disease), Lifestyle enhancer, Loss of hearing, Loss of sight, Loss of speech, Paralysis, Prolonged mechanical ventilation, Status epilepticus, Stroke, Terminal illness	
Amputation of limb	Any organic disease or severe physical injury that results in the medically necessary, complete physical severance of: • A hand or hands at the level of the wrist joint or above, or • A foot or feet at the level of the ankle and above **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**50%**
	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related None **Illnesses that may be considered related** Activities of Daily Living, Amputation of limb, Terminal illness	

Major burns	Confirmed diagnosis of external third degree burns (full thickness burns) by the treating plastic surgeon or trauma specialist.
	Requirements for a claim to be considered
	• One of the following must be present:
	  • At least 10% of total body surface affected, as measured on the Lund and Browder Chart or equivalent
	  • 20% of the surface area of the face affected, which for the purposes of this definition includes the forehead and ears
	Exclusions
	• Sunburn or sun exposure
		50%

	Confirmed diagnosis of external third degree burns (full thickness burns) by the treating plastic surgeon or trauma specialist.
	Requirements for a claim to be considered
	• One of the following must be present:
	  • At least 20% of total body surface affected, as measured on the Lund and Browder Chart or equivalent
	  • 30% of the surface area of the face affected, which for the purposes of this definition includes the forehead and ears
	Exclusions
	• Sunburn or sun exposure
		75%

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%

	Confirmed diagnosis of external third degree burns (full thickness burns) by the treating plastic surgeon or trauma specialist.
	
	Requirements for a claim to be considered
	• One of the following must be present:
	  • At least 30% of total body surface affected, as measured on the Lund and Browder Chart or equivalent
	  • 40% of the surface area of the face affected, which for the purposes of this definition includes the forehead and ears
	
	Exclusions
	• Sunburn or sun exposure
		100%

	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related None **Illnesses that may be considered related** Activities of Daily Living, Acute kidney failure, Chronic kidney failure, Major burns, Paralysis, Prolonged mechanical ventilation, Terminal illness	

BASIC ACTIVITIES OF DAILY LIVING (BADL)	
Activity	**Description**
Bathing	The ability to wash/bathe oneself independently.
Transferring	The ability to move oneself from a bed to a chair or from a bed to a toilet independently.
Dressing	The ability to take off and put on one's clothing independently.
Eating	The ability to feed oneself independently.
Toileting	The ability to use a toilet and cleanse oneself thereafter independently.
Locomotion on a level surface	The ability to walk on a flat surface, independently.
Locomotion on an incline	The ability to walk up a gentle slope, or a flight of steps independently.

ADVANCED ACTIVITIES OF DAILY LIVING SCALE (AADL)	
Activity	**Description**
Driving a car	The ability to open a car door, change gears or use a steering wheel.
Medical care	The ability to prepare and take the correct medication.
Money management	The ability to do one's own banking and to make rational financial decisions.
Communicative activities	The ability to communicate either verbally or written.
Shopping	The ability to choose and lift groceries from shelves as well as carry them in bags.
Food preparation	The ability to prepare food for cooking as well as using kitchen utensils.
Housework	The ability to clean a house or iron clothing.
Community ambulation with or without assistive device, but not requiring a mobility device	The ability to walk around in public places using only a walking stick if necessary.
Moderate activities	Activities like moving a table, pushing a vacuum cleaner, bowling, golf.
Vigorous activities	Able to partake in running, heavy lifting, sports.

- Early Diagnosed Illnesses
- Cancer Enhancer

20.10.1 Early Diagnosed Illnesses

Early Diagnosed Illness allow for some events to pay out 15% of the Severe Illness cover amount to a maximum of R100 000. This reduces the claim payout for subsequent related claims so that a maximum of 100% of the cover amount is paid for related illnesses. We won't pay for the same early diagnosed illness more than once.

There nine Early Diagnosed Illnesses:

- Early bladder cancer
- Early breast cancer
- Early cervical cancer
- Early oesophageal cancer
- Early ovarian cancer
- Early prostate cancer
- Early testicular cancer
- Gastrointestinal stromal tumour
- Neuroendocrine tumour

Example

Li has Severe Illness Cover of R1 500 000. She's diagnosed with early stage breast cancer. We pay an Early Breast Cancer payment R100 000 (15% of R1 500 000 or R100 000, whichever is less). Li's cancer then progresses and she qualifies for a payment 100% of the cover amount. We'll only pay R1 400 000 (R1 500 000 less the early diagnosis benefit of R100 000 already paid). In total, we've paid a maximum 100% of the cover amount of R1 500 000. We won't make any further payments for related illnesses.

Years later, Li again meets the criteria for the Early Breast Cancer severe illness. However, because she's previously claimed for this severe illness, she's no longer covered for Early Breast Cancer and we won't pay an early diagnosis claim.

20.10.1.1 EARLY DIAGNOSED ILLNESS EVENTS (9 illnesses)

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Early bladder cancer	Carcinoma in situ of the urinary bladder. **Requirements for a claim to be considered** • Histological confirmation **Exclusions** • Non-invasive papillary carcinoma (Stage Ta bladder cancer)	**15%**
	Illnesses that will be considered related Early bladder cancer **Illnesses that may be considered related** Cancer, Cancer enhancer	
Early breast cancer	The undergoing of either a mastectomy, lumpectomy or quadrantectomy for carcinoma in situ (without micro-invasion) in one or both breasts. **Requirements for a claim to be considered** • Histological confirmation • Relevant surgical reports by the treating surgeon	**15%**
	Illnesses that will be considered related Early breast cancer **Illnesses that may be considered related** Cancer, Cancer enhancer	
Early cervical cancer	The undergoing of a hysterectomy for carcinoma in situ of the cervix uteri. Cervical intraepithelial neoplasia grade 3 (CIN3) is included. **Requirements for a claim to be considered** • Histological confirmation • Relevant surgical reports by the treating surgeon **Exclusions** • All other forms of treatment including trachelectomy (removal of the cervix), loop excision, laser surgery, conisation and cryosurgery	**15%**
	Illnesses that will be considered related Early cervical cancer **Illnesses that may be considered related** Cancer, Cancer enhancer	
Early oesophageal cancer	The undergoing of surgery to remove carcinoma in situ of the oesophagus. **Requirements for a claim to be considered** • Histological confirmation • Relevant surgical reports by the treating surgeon **Exclusions** • Treatment by any other method • Barrett's oesophagus (with or without surgery)	**15%**
	Illnesses that will be considered related Early oesophageal cancer **Illnesses that may be considered related** Cancer, Cancer enhancer	

Early ovarian cancer	The undergoing of an oophorectomy for carcinoma in situ of one or both ovaries. **Requirements for a claim to be considered** • Histological confirmation • Relevant surgical reports by the treating surgeon	**15%**
	Illnesses that will be considered related Early ovarian cancer **Illnesses that may be considered related** Cancer, Cancer enhancer	
Early prostate cancer	The undergoing of either a prostatectomy or radiotherapy for a tumour in the prostate. **Requirements for a claim to be considered** • Histological confirmation that the tumour is classified as Gleason score of between 2-6 inclusive, and at least TNM staging T1N0M0 • Relevant surgical reports by the treating surgeon	**15%**
	Illnesses that will be considered related Early prostate cancer **Illnesses that may be considered related** Cancer, Cancer enhancer	
Early testicular cancer	The undergoing of an orchidectomy for germ cell neoplasia in situ (GCNIS). **Requirements for a claim to be considered** • Histological confirmation • Relevant surgical reports by the treating surgeon	**15%**
	Illnesses that will be considered related Early testicular cancer **Illnesses that may be considered related** Cancer, Cancer enhancer	
Gastrointestinal stromal tumour	The undergoing of surgery for a gastrointestinal stromal tumour of low malignant potential. **Requirements for a claim to be considered** • Histological confirmation • Relevant surgical reports by the treating surgeon	**15%**
	Illnesses that will be considered related Gastrointestinal stromal tumour **Illnesses that may be considered related** Cancer, Cancer enhancer	
Neuroendocrine tumour	The undergoing of surgery for a neuroendocrine tumour of low malignant potential. **Requirements for a claim to be considered** • Histological confirmation • Relevant surgical reports by the treating surgeon	**15%**
	Illnesses that will be considered related Neuroendocrine tumour **Illnesses that may be considered related** Cancer, Cancer enhancer	

20.10.2 Cancer Enhancer

Not all cancers are the same and treatment and length of hospitalisation may vary dramatically. Where an aggressive treatment plan is followed the impact on one's life is much bigger. The Cancer Enhancer boosts the payout on severity level D (25%) and severity level C (50%) cancer claims.

We'll pay up to 25% of the Severe Illness Cover if the insured person:

- suffers cancer as defined in the events descriptions and
- can no longer perform at least two Basic Activities of Daily Living or four advanced Activities of Daily Living for at least three consecutive months from the severe illness event date, as confirmed by the treating specialist and Old Mutual's Medical Officer. Failure to perform the Activities of Daily Living must be because of the cancer (including its treatment or complications of its treatment or hospitalisation because of it).

An insured person can qualify for the Cancer Enhancer if:

- we've not previously paid a Cancer Enhancer for related cancers or
- the insured person meets the requirements for the unrelated cancers as explained above.

We won't pay more than 100% of the cover amount for related cancers.

Example

Previn has Severe Illness Cover of R1 000 000. He's diagnosed with cancer and qualifies for 25% of the cover amount. We pay R250 000 (R1 000 000 x 25%). After not being able to perform at least two Basic Activities of Daily Living for three months thereafter, he qualifies for a Cancer Enhancer payment. We pay another R250 000 (R1 000 000 x 25%). In total we paid R500 000 of the cover amount at this point. His cancer then further progresses and he qualifies for 100% of the cover amount. He will only be able to claim for the remaining cover amount of R500 000 (R1 000 000 less R500 000 already paid). In total, we've paid 100% of the cover amount. We won't make any further payments for related cancer claims.

Claiming Cancer Enhancer

We'll pay up to 25% of the cover amount that applies at the time of the severe illness for the Cancer Enhancer if the insured person:

- suffers cancer on the list of severe illnesses that qualify and the percentage of the cover amount is 25% or 50%, and
- can no longer perform at least two Basic Activities of Daily Living or four advanced Activities of Daily Living for a period of at least three consecutive months, as confirmed by the treating specialist and Old Mutual's Medical Officer. Failure to perform the Activities of Daily Living must be because of the cancer (including its treatment or complications of its treatment or hospitalisation because of it).

The insured person can qualify for a Cancer Enhancer:

- for related cancers, if we haven't previously paid a Cancer Enhancer or
- for unrelated cancers, if the insured person meets the requirements for the Cancer Enhancer as explained above.

For related cancers, we'll never pay more than 100% of the cover amount in total. The cover amount will only be paid once our requirements have been met and the claim is valid.

20.11 Benefits and other features

Severe Illness Cover can be further enhanced by adding the following benefits:

- Top-up Benefit
- Mild Illness Benefit
- For Women Benefit
- Child Illness Benefit
- Returning Illness Benefit (only applicable to Severe Illness Cover sold on its own)

20.11.1 Top-up Benefit

The Top-up Benefit elevates qualifying claimable events that are less than 100% of the cover amount up to 100% of the full cover amount under Severe Illness Cover only.

- It doesn't apply to Early Diagnosed Illnesses or payments made under the Cancer Enhancer.
- The Top-up Benefit won't elevate any of the payments that are made under any optional feature, i.e.:
  - Child Illness Benefit
  - Mild Illness benefit
  - For Women Benefit
  - Returning Illness Benefit

Claiming Top-up Benefits

When this benefit's added, the insured person needs to only meet the severity level D (25%) criteria to receive a 100%. They will receive a 100% payout if they qualify for an event at any severity, unless we've already paid a claim for a related early diagnosed illness under the Severe Illness Cover. After a successful claim, any future claims on related illnesses will receive no payout. The Top-up Benefit only tops up the severe illnesses that are contained in the Severe Illness Cover. This doesn't include early diagnosed illnesses or payments under the Cancer Enhancer.

Subsequent claims

Whenever an Early Diagnosed Illness payout is made and a subsequent claim is made for a related severe illness event, the Top-up Benefit will pay 100% less the percentage of the cover amount already paid the related early diagnosed illness, for a total payout of 100%. If the insured person suffers more than one event within a 30 days, we'll pay for the event with the higher payout amount. This applies across all events covered under Severe Illness Cover and all benefits and other features. If the first claim within the 30-day period has already been paid but the second claim is higher, we'll reduce the second payout to only pay the difference.

Example: Top-up Benefit

Thandi has R1 000 0000 Severe Illness Cover, with the Top-up Benefit. She has a stroke at severity D (25%). Because she has the Top-up Benefit, she receives a payout of 100%, regardless of the severity of the event, i.e. R1 000 000 (R1 000 000 x 100%).

In total she has received a maximum 100% of her cover amount. She'll receive no further payouts for related illnesses.

Example: Top-up Benefit and Cancer Enhancer

Mpho has R1 000 000 Severe Illness Cover with the Top-up Benefit. He meets the medical criteria for the cancer event at severity level D (25%). He has the Top-up Benefit, so he receives a payout of 100%, regardless of the severity of the event, i.e. R1 000 000 (R1 000 000 x 100%).

In total, he has received a maximum 100% of his cover amount. He'll receive no further payouts for related illnesses.

Three months later he meets the criteria for a Cancer Enhancer. He's not eligible for a claim payout, as he has already received 100% for related illnesses.

Example: Top-up Benefit in relation to other benefits and features

Thembeka has R1 000 000 Severe Illness Cover with the Top-up Benefit, Child Illness Benefit, Mild Illness Benefit, For Women Benefit and Returning Illness Benefit.

She's diagnosed with early ovarian cancer. She receives an Early Diagnosed Illnesses payout of R100 000 (min [R1 000 000 x 15%, R100 000]). These types of payouts aren't impacted by the Top-up Benefit.

She then meets the medical criteria for a claim under the cancer event at severity level D (25%). With the Top-up Benefit, she receives a payout of 100% on a severe illness event, regardless of the severity.

She'll only be able to claim for the remaining cover of R900 000 [R1 000 000 x min [100%; (100% -10%)]]. In total, Thembeka has received a maximum 100% of her cover amount for cancer-related illnesses.

Her cancer then recurs at severity level A (100%). Because she has previously claimed a 100% for the cancer-related illness group, she's only eligible for a payout under the Returning Illness Benefit. She receives a payout of R500 000 [R1 000 000 x min (100%; 50%). The Top-up Benefit has no impact on her payout, because it doesn't interact with the other benefits and features.

She then has a minor stroke, and meets the criteria for a 30% payout under the Mild Illness Benefit. She receives R300 000 (R1 000 000 x 30%). The Top-up Benefit has no impact on her payout, because it doesn't interact with additional benefits and features.

She then suffers from endometriosis and meets the criteria for a severity D (15%) payout under the For Women Benefit. She receives R50 000 (R1 000 000 x 15%). The Top-up Benefit has no impact on her payout.

20.11.1.1 Lifestyle Enhancer

The Lifestyle Enhancer can be claimed when the insured person suffers a qualifying claimable event and meets additional medical criteria. They may qualify for a further amount equal to the claim paid on the claimable event.
The Lifestyle Enhancer will be used in conjunction with the following events to pay up to a maximum of 200%:

- Accidental brain injury
- Coma
- Heart attack
- Paralysis
- Stroke

Claiming Lifestyle Enhancer

- The Lifestyle Enhancer is only applicable if the Top-up Benefit's in force. It will pay up to an additional 100% if the insured person meets the required medical criteria at least three months after a qualifying claimable event.
- This can only be used in conjunction with the events specified to qualify for up to a maximum of 200% payout.
- The Lifestyle Enhancer will only be paid once irrespective if the maximum of 200% has been paid or not.
- The insured person must meet the following medical criteria to qualify for the Lifestyle Enhancer:
  - Complete failure of at least four Basic Activities of Daily Living (BADL's), assessed three months, or later, after the claimable event has occurred. This will need to be confirmed by Old Mutual's Medical Officer.

- The Lifestyle Enhancer payment will match the qualifying claimable event payout. This means that:
  - it won't take into account any yearly cover increases that may have occurred in the three months before assessment.
  - if the qualifying event is a related severe illness that has previous claims, the payout will be reduced so that a maximum of 100% is paid for related illnesses. Hence, the lifestyle enhancer claim will match this payout, and will be less than 100% of the cover amount.

Example: Lifestyle Enhancer on the cover

Jane has R1 000 000 Severe Illness Cover with a Top-up Benefit. She has a stroke at severity level D (25%). Because she has the Top-up Benefit, she receives a payout of 100%, regardless of the severity of the event, i.e. R1 000 000 (R1 000 000 x 100%).

Stroke is one of the qualifying claimable events for the Lifestyle Enhancer. Three months later she meets the medical criteria to further receive a Lifestyle Enhancer payout of R1 000 000 (the same as her payout for stroke). In total, Jane has received 100% of her cover amount, as well as a Lifestyle Enhancer payout to match her qualifying claimable payout. She'll receive no further payouts for related illnesses or the Lifestyle Enhancer.

Example: Non-eligibility

Mohammed has R2 000 000 Severe Illness Cover with the Top-up Benefit. He has a heart attack at severity level A (100%). He receives a payout of R2 000 000 (R2 000 000 x 100%). He will receive no further payouts for related illnesses. Three months later he doesn't meet the medical criteria to receive a Lifestyle Enhancer payout. He subsequently has a further heart attack at the same severity. He's not eligible for a claim payout, and is also not eligible for the Lifestyle Enhancer.

A year later he removes the Top-up Benefit. He then meets the medical criteria for a paralysis claim at severity level A (100%). The Lifestyle Enhancer is only applicable if the Top-up Benefit's in force at the date of the qualifying claimable event. Mohammed isn't eligible for a Lifestyle Enhancer payout on this event.

Adding or removing the benefit

- If the Top-up Benefit's added after the start of the contract:
  - the insured person will be re-underwritten
  - all previous claims are unaffected by the Top-up Benefit, i.e. it doesn't apply retrospectively
  - the Top-up Benefit and Lifestyle Enhancer will only apply to all future unrelated claims
  - subsequent related claims won't be impacted. These will be paid in line with the severity requirements of Severe Illness Cover. The Lifestyle Enhancer won't be available on these claims.
- If the Top-up Benefit's deselected after a claim has been made:
  - all future unrelated claims won't have this feature applied, and will be paid in line with the severity requirements of Severe Illness Cover.
  - all subsequent medical related claims will receive no payout, because the maximum of 100% has already been claimed for the related group.

Example: Adding the Top-up Benefit after the start of the cover

Lesedi has R1 000 000 Severe Illness Cover with no benefits and other features. She has a stroke at severity level D (25%). She receives a payout of R250 000 (R1 000 000 x 25%). A year later she adds the Top-up Benefit to her cover. There's no impact on her previous claim. She then has a stroke of severity level C (50%). This claim is considered automatically related to her first claim.

She receives a payout of R500 000 (R1 000 000 x 50%). This amount isn't boosted to 100%, because the event is related to a previous claim that was made when the Top-up Benefit was not added.

She then meets the definition for chronic pancreatitis at severity level C (50%). This is unrelated to her previous claims, and she receives a payout of 100%, regardless of the severity of the event, i.e. R1 000 000 (R1 000 000 x 100%). She'll receive no further payouts for related illnesses.

Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that is generally excluded.

We won't pay if:

- the owner fails to meet our requirement to tell us about changes to the circumstances of the insured person (See changes to the circumstances of the insured person),
- the insured person's illness is caused by:
  - unrest, war or terrorist activity,
  - radioactivity or nuclear explosion,
  - provoking, committing or attempting to commit a crime for example murder, assault, housebreaking, theft, robbery, the forceful detention of another person or any similar crime or
  - self-inflicted injury.
- the insured person's severe illness is before the cover start date,
- we don't recognise the insured person's severe illness,
- the insured person's severe illness is because of an exclusion, or
- if the survival period isn't met.

We won't recognise the insured person's severe illness if they suffer a severe illness that:

- isn't on the list of severe illnesses,
- is at the severity that the contract doesn't cover or
- doesn't meet all the requirements that the severe illness must meet to qualify.

Cover stops on the earliest of the following:

- When the insured person dies.
- At the end of the term, if term cover was chosen.
- If the cover lapses.
- If the insured person no longer qualifies for the cover because of changes to their circumstances.
- If the contract is cancelled.
- If the benefit's removed from the contract.
- If a claim has been paid out for AIDS or terminal illness.
- If the insured person no longer qualifies for any severe illnesses on the list of severe illnesses in the event descriptions.

20.11.2 Mild Illness Benefit

The Mild Illness Benefit pays 30% of the cover amount as a single amount if the insured person suffers a mild illness event.

Claiming Mild Illness Benefit

Mild illness events can be related to other mild or severe illness events. Any previous related claims will reduce a mild illness payout, so that we'll never pay more than 30% of the cover amount in total under the Mild Illness Benefit for related severe illnesses. All previous medically related claims on Severe Illness Cover will be taken into account when calculating Mild Illness Benefit claims.

Subsequent claims

For Severe Illness Cover and Severe Illness Cover add-on you are allowed to claim for subsequent events if:

- the insured person suffers another event more than 30 days after a previous event.
- the total percentage paid for previous events considered related to a subsequent mild illness is less than 30%.
- if the insured person suffers more than one event within 30 days, the total amount we'll pay is for the event that qualifies for the higher payout. This applies across all events covered under Severe Illness Cover, attached benefits and other features. If the first claim within a 30-day period has already been paid but the second claim is higher, we'll reduce the second payout to only pay the difference.

Related claims

- Tiers at the same severity or lower are no longer covered for future related claims on the same event.
- Thus, for most mild illness events there will only be one valid claim (example angioplasty and/or stenting is considered related to pacemaker insertion, and as there is only one tier (30%), only one claim is possible).
- Previous related claims (which may be severe illness or mild illness events) will reduce the Mild Illness Benefit payout.
- Related illnesses are shown separately in each event definition.

Example: Interaction of mild illnesses

Prishen has R1 000 000 Severe Illness Cover with the Mild Illness Benefit. He meets the medical criteria for minor heart surgery. He receives a mild illness payout of R300 000 (R1 000 000 x 30%). A year later he again meets the definition for the same event, minor heart surgery. This is considered related to his previous claim, and hence his subsequent claim isn't valid. He receives R0 (R1 000 000 x min [30%; max [(30% - 30%), 0]]). A year later he meets the criteria for the mild illness event eye stroke. This is unrelated to his previous claims. He receives a mild illness payout of R300 000 (R1 000 000 x 30%).

Six months later he meets the criteria for the mild illness event lobectomy. This is again unrelated to his previous claims. He receives a further mild illness payout of R300 000 (R1 000 000 x 30%). Four years later he meets the criteria for the mild illness event pacemaker insertion. This is related to his previous claim, minor heart surgery. The previous related claim will reduce his payout. He receives R0 (R1 000 000 x min [30%; max [(30% - 30%), 0]]).

Example: Interaction of mild illnesses with severe illness events

Hendrik has R2 000 000 Severe Illness Cover with a Mild Illness Benefit. He meets the medical criteria for the Severe Illness event stroke at severity D (25%). He receives a tiered payout of R500 000 (R2 000 000 x 25%). He then meets the criteria for the mild illness event cerebral aneurysm. This is related to his previous severe illness claim, stroke. He receives a mild illness payout of R100 000 {R2 000 000 x min [30%; max [(30% - 25%), 0]]}. The previous related claim reduces his payout.

Example: First claims for a mild illness and thereafter for a related illness event

Hendrik has R2 000 000 Severe Illness Cover with a Mild Illness Benefit. He meets the medical criteria for the mild illness event minor heart surgery. He receives a payout of R600 000 (R2 000 000 x 30%). Two years later, he meets the criteria for heart attack of severity B (75%). This is considered to be related to the previous claim, minor heart surgery. He therefore receives a payout of R1 400 000 (R2 000 000 x min (75%, 100% - 30%)). The previous related claim reduces his payout.

Example: First claims for a mild illness and thereafter for an unrelated illness event

Hendrik has R2 000 000 Severe Illness Cover with a Mild Illness Benefit. He meets the medical criteria for the mild illness event minor heart surgery. He receives a payout of R600 000 (R2 000 000 x 30%). Two years later, he meets the criteria for cancer of severity A (100%). This is deemed unrelated to the previous claim, minor heart surgery. He therefore receives a payout of R2 000 000 (R2 000 000 x MIN (100%, 100% - 0%)). The previous unrelated claim does not affect his payout.

Adding or removing the benefit

- If the Mild Illness Benefit is added after the start of the contract, the insured person will be re-underwritten.
- This may result in certain events being excluded.
- If the insured person has claimed on Severe Illness Cover before adding the Mild Illness Benefit, it's likely that any mild illness events related to previous claims will be excluded.

Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that is generally excluded.

We won't pay if:

- the owner fails to meet our requirement to tell us about changes to the circumstances of the insured person (See changes to the circumstances of the insured person),
- the insured person's illness is caused by:
  - unrest, war or terrorist activity,
  - radioactivity or nuclear explosion,
  - provoking, committing or attempting to commit a crime for example murder, assault, housebreaking, theft, robbery, the forceful detention of another person or any similar crime or
  - self-inflicted injury.
- the insured person's severe illness is before the cover start date,
- we don't recognise the insured person's severe illness,
- the insured person's severe illness is because of an exclusion or
- the survival period isn't met.

We won't recognise the insured person's severe illness if they suffer a severe illness that:

- isn't on the list of severe illnesses,
- is at the severity that the contract doesn't cover or
- doesn't meet all the requirements that the severe illness must meet to qualify.

Cover stops on the earliest of the following:

- When the insured person dies.
- At the end of the term, if term cover was chosen.
- If the cover lapses.
- If the insured person no longer qualifies for the cover because of changes to their circumstances.
- If the contract is cancelled.
- If the benefit is removed from the contact.

20.11.2.1 MILD ILLNESS BENEFIT EVENTS (19 illnesses)

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
CARDIOVASCULAR		
Angioplasty and/ or stenting	The undergoing of angioplasty and/or the insertion of one or more stents to correct the narrowing of, or blockage to, one or more arteries. Coronary, carotid and peripheral arteries are included. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**30%**
	The survival period applies to this illness.	
	Previous illnesses under the Severe Illness Cover that will be considered related Arrhythmia, Cardiomyopathy, Carotid artery surgery, Coronary artery bypass graft, Heart attack, Heart surgery, Heart transplant **Previous illnesses under the Severe Illness Cover that may be considered related** Artery surgery	
	Illnesses that will be considered related Angioplasty and/or stenting **Illnesses that may be considered related** Pacemaker insertion, Pathway ablation	
Minor heart surgery	The correction of any structural abnormality of the heart, through an endoscopic or keyhole procedure. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any investigative procedure	**30%**
	Previous illnesses under the Severe Illness Cover that will be considered related Arrhythmia, Cardiomyopathy, Coronary artery bypass graft, Heart attack, Heart surgery, Heart transplant, Heart valve replacement or repair, Pericardiectomy **Previous illnesses under the Severe Illness Cover that may be considered related** None	
	Illnesses that will be considered related Minor heart surgery **Illnesses that may be considered related** Pacemaker insertion	

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Pacemaker insertion	Confirmed diagnosis of an arrhythmia by the treating cardiologist, with the permanent insertion of a medically necessary, functioning pacemaker. **Requirements for a claim to be considered** • The arrhythmia must be documented on a 24 hour Holter ECG	**30%**
	The survival period applies to this illness.	
	Previous illnesses under the Severe Illness Cover that will be considered related Arrhythmia, Cardiomyopathy, Coronary artery bypass graft, Heart attack, Heart surgery, Heart transplant, Heart valve replacement or repair **Previous illnesses under the Severe Illness Cover that may be considered related** None	
	Illnesses that will be considered related Pacemaker insertion, Pathway ablation **Illnesses that may be considered related** Angioplasty and/or Stenting, Minor heart surgery	
Pathway ablation	Confirmed diagnosis of an arrhythmia by the treating cardiologist, with the undergoing of pathway ablation. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**30%**
	The survival period applies to this illness.	
	Previous illnesses under the Severe Illness Cover that will be considered related Arrhythmia, Cardiomyopathy, Coronary artery bypass graft, Heart attack, Heart surgery, Heart transplant, Heart valve replacement or repair **Previous illnesses under the Severe Illness Cover that may be considered related** None	
	Illnesses that will be considered related Pacemaker insertion, Pathway ablation **Illnesses that may be considered related** Angioplasty and/or stenting	
CENTRAL NERVOUS SYSTEM		
Bacterial meningitis	Confirmed diagnosis of bacterial meningitis by the treating neurologist, causing inflammation of the membranes of the brain or spinal cord. **Requirements for a claim to be considered** • Growth of pathogenic bacteria from cerebrospinal fluid culture • ICU admission for more for more than 72 hours **Exclusions** • All other forms of meningitis, including aseptic, viral, parasitic or non-infectious meningitis	**30%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
	The survival period applies to this illness.	
	Illnesses that will be considered related Bacterial meningitis **Illnesses that may be considered related** Eye stroke, Minor stroke, Moderate loss of hearing	
Cerebral aneurysm	The repair of a cerebral aneurysm by means of any surgical technique. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**30%**
	The survival period applies to this illness.	
	Previous illnesses under the Severe Illness Cover that will be considered related None **Previous illnesses under the Severe Illness Cover that may be considered related** Coma, Stroke	
	Illnesses that will be considered related Cerebral aneurysm **Illnesses that may be considered related** Eye stroke, Minor stroke	
Cerebral arteriovenous malformation	The repair of a cerebral arteriovenous malformation by means of endovascular treatment using coils or other materials (embolisation). **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**30%**
	Illnesses that will be considered related Cerebral arteriovenous malformation **Illnesses that may be considered related** Eye stroke, Minor stroke	
Encephalitis	Confirmed diagnosis of viral encephalitis by the treating neurologist. **Requirements for a claim to be considered** • Typical clinical symptoms and cerebrospinal fluid findings • ICU admission for more for more than 72 hours **Exclusions** • Encephalitis caused by bacterial or protozoal infections • Myalgic or paraneoplastic encephalomyelitis • Encephalitis caused by a pandemic virus	**30%**
	The survival period applies to this illness.	
	Illnesses that will be considered related Encephalitis **Illnesses that may be considered related** Minor stroke	

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%

Eye stroke	Confirmed diagnosis of loss of sight in one eye by the treating ophthalmologist, as a result of central retinal artery or vein occlusion or haemorrhage. The loss of sight can't be improved through refractive correction or medication.
	
	Requirements for a claim to be considered
	• One of the following must be present:
	  • A reading of 6/60 or worse (or equivalent measure on a non-metric scale), after best correction
	  • A visual field loss to a 10° radius, after best correction
	
	Exclusions
	• Occlusion or haemorrhage in any branches of the retinal artery or vein
	• Visual loss as a result of traumatic injury
		30%

	Previous illnesses under the Severe Illness Cover that will be considered related None **Previous illnesses under the Severe Illness Cover that may be considered related** Retinitis pigmentosa, Stroke	
	Illnesses that will be considered related Eye stroke **Illnesses that may be considered related** Minor stroke	

Guillain Barre syndrome with incomplete recovery	Confirmed diagnosis of Guillain Barre syndrome by the treating specialist. The symptoms required below should persist despite adequate treatment for at least 6 weeks.
	
	Requirements for a claim to be considered
	• Objective laboratory findings
	• Two of the following must be present:
	  • Motor paralysis- life covered is unable to stand or walk on their own without an aid despite reasonable strength
	  • Cranial nerves III-VII or IX-XII involvement
	  • Sensory changes
	  • Autonomic changes
	  • Respiratory involvement
		30%

	Previous illnesses under the Severe Illness Cover that will be considered related None **Previous illnesses under the Severe Illness Cover that may be considered related** Prolonged mechanical ventilation	
	Illnesses that will be considered related Guillain Barre syndrome with incomplete recovery **Illnesses that may be considered related** None	

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Minor stroke	Death of brain tissue due to inadequate blood supply or haemorrhage within the skull. **Requirements for a claim to be considered** • Neurological deficit lasting longer than 1 hour but less than 24 hours, confirmed by neuroimaging investigation and appropriate clinical findings by a specialist neurologist	**30%**
	Previous illnesses under the Severe Illness Cover that will be considered related Arrhythmia, Cardiomyopathy, Carotid artery surgery, Cavernous sinus thrombosis, Heart transplant, Heart valve replacement or repair, Stroke **Previous illnesses under the Severe Illness Cover that may be considered related** Accidental brain injury, Benign brain tumour, Brain surgery, Cerebral malaria, Chronic blood disorders, Coma , Dementia (incl Alzheimer's disease), Multiple sclerosis, Paralysis, Parkinson's disease, Parkinson's Plus syndrome, Psychiatric disorders, Status epilepticus	
	Illnesses that will be considered related Minor stroke **Illnesses that may be considered related** Eye stroke, Moderate loss of hearing	
ENDOCRINE		
Cushing's disease	Confirmed diagnosis of primary Cushing's disease by the treating endocrinologist. **Requirements for a claim to be considered** • Supportive blood tests **Exclusions** • Exogenous or secondary Cushings's syndrome	**30%**
	Illnesses that will be considered related Cushing's disease **Illnesses that may be considered related** None	
Nephrectomy	Any organic disease or severe physical injury that results in a total or partial nephrectomy. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Nephrectomy resulting from analgesic nephropathy • Nephrectomy done for donor purposes	**30%**
	Previous illnesses under the Severe Illness Cover that will be considered related Chronic kidney failure, Kidney transplant **Previous illnesses under the Severe Illness Cover that may be considered related** Acute kidney failure, Cardiomyopathy, Cancer, Chronic blood disorders, Chronic liver failure, Connective tissue disease, Dementia (incl Alzheimer's disease), Peripheral arterial disease, Polymyositis	
	Illnesses that will be considered related Nephrectomy **Illnesses that may be considered related** None	

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%

Type 1 diabetes	Confirmed diagnosis of type 1 diabetes by the treating paediatric endocrinologist or endocrinologist, according to the latest World Health Organisation criteria.
	Requirements for a claim to be considered
	• The diagnosis must be confirmed by the presence of at least 3 of the following:
	  • Anti-GAD65 antibody levels indicative of type 1 diabetes
	  • Islet-cell antibody levels indicative of type 1 diabetes
	  • C-peptide levels indicative of type 1 diabetes
	  • Insulin levels indicative of type 1 diabetes
	Exclusions
	• Type 2 diabetes requiring insulin
	• Gestational Diabetes
		30%

	Previous illnesses under the Severe Illness Cover that will be considered related None **Previous illnesses under the Severe Illness Cover that may be considered related** Advanced rheumatoid arthritis, Connective tissue disease, Polymyositis, Chronic pancreatitis, Pancreatectomy or pancreas transplant	
	Illnesses that will be considered related Type 1 diabetes **Illnesses that may be considered related** None	
RESPIRATORY		
Lobectomy	The undergoing of a lobectomy to remove one entire lobe of the lung due to any physical injury or disease. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Segmentectomy, irrespective of how many lobes affected	**30%**
	The survival period applies to this illness.	
	Previous illnesses under the Severe Illness Cover that will be considered related Lung transplant, Lung surgery **Previous illnesses under the Severe Illness Cover that may be considered related** None	
	Illnesses that will be considered related Lobectomy **Illnesses that may be considered related** Pulmonary embolism	
Pulmonary embolism	Confirmed diagnosis of pulmonary embolism by the treating specialist. **Requirements for a claim to be considered** • Supportive imaging	**30%**
	The survival period applies to this illness.	

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
	Previous illnesses under the Severe Illness Cover that will be considered related Pulmonary arterial hypertension, Pulmonary artery surgery, Recurrent pulmonary emboli **Previous illnesses under the Severe Illness Cover that may be considered related** Chronic respiratory failure, Lung surgery, Prolonged mechanical ventilation	
	Illnesses that will be considered related Pulmonary Embolism **Illnesses that may be considered related** Lobectomy	
SENSES		
Moderate loss of hearing	Confirmed diagnosis of loss of hearing in one ear by the treating ENT specialist. **Requirements for a claim to be considered** • Average auditory threshold, measured at 500, 1000, 2000 and 3000 Hertz in the affected ear using a pure tone audiogram, of 70 decibels or more • This must be confirmed by audiometry, which may be conducted without hearing aids	**30%**
	Previous illnesses under the Severe Illness Cover that will be considered related Loss of hearing **Previous illnesses under the Severe Illness Cover that may be considered related** None	
	Illnesses that will be considered related Moderate loss of hearing **Illnesses that may be considered related** Minor stroke	
TRAUMA		

Less extensive burns	Confirmed diagnosis of external third degree burns (full thickness burns) by the treating plastic surgeon or trauma specialist.
	Requirements for a claim to be considered
	• One of the following must be present:
	  • At least 5% of total body surface affected, as measured on the Lund and Browder Chart or equivalent
	  • 10% of the surface area of the face affected, which for the purposes of this definition includes the forehead and ears
	Exclusions
	• Sunburn or sun exposure
		30%

	Previous illnesses under the Severe Illness Cover that will be considered related None **Previous illnesses under the Severe Illness Cover that may be considered related** Major burns, Paralysis, Prolonged mechanical ventilation	
	Illnesses that will be considered related None **Illnesses that may be considered related** Less extensive burns	

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%

Trauma	Hospitalisation, ICU admission or surgery that results from a severe physical injury inflicted in an accident.
	
	Requirements for a claim to be considered
	• One of the following must be present:
	  • The accident results in hospitalisation within 1 day, for at least 28 consecutive days
	  • The accident results in ICU admission for 7 consecutive days or more, during which assisted ventilation is instituted for at least 4 days
	  • The accident results in multiple traumatic injuries and surgical intervention in at least 2 of the following body regions:
	  • head or neck
	  • face
	  • chest
	  • abdominal or pelvic contents
	  • extremities or pelvic girdle
	
	NOTE:
	• An accident is an unexpected and visible event of external origin that causes traumatic bodily injury and is not traceable, even indirectly, to the insured person's state of mental or physical health before the event
	• A day is defined as 24 hours
		30%

	The survival period applies to this illness.	
	Illnesses that will be considered related None **Illnesses that may be considered related** Trauma	

20.11.3 For Women Benefit

The For Women Benefit pays a single amount if the insured person suffers a female-specific illness event. These events will provide a payout that varies by the severity of the condition.
The For Women Benefit covers three types of events:

- Complications during pregnancy
- Fertility-related events
- Other female-related events

Eligible lives

Only females may take up this benefit.

Entry age maximum limits

41 next birthday.

Exclusion period

- There is a nine-month exclusion period for all complications during pregnancy events.
- This means that claims won't be paid for any severe illnesses that relates to a complication during pregnancy if it occurs within nine months after this benefit has been added.

Example: Exclusion period

Raeesa takes R1 000 000 Severe Illness Cover with the For Women Benefit. Three months later she gives birth, and is eligible for the ectopic pregnancy event under the For Women Benefit. Because the date of claim event occurred within the nine-month exclusion period, Raeesa won't have a valid claim and will receive no payout.

Claiming For Women Benefits

The For Women Benefit pays out a percentage of the cover amount for female-specific illnesses. On a successful claim, the illness at that severity and lower severities are no longer covered for the same event. The maximum amount that will be paid under the For Women Benefit's 100% of the cover amount. Once 100% of the cover amount has been paid, the For Women Benefit stops and the insured person will no longer have cover for For Women Benefit illnesses.

Subsequent claims

For Severe Illness Cover sold on its own or a Severe Illness Cover add-on:

- A subsequent claim is possible if:
  - the insured person suffers another event more than 30 days after a previous one
  - a progressive claim is at a higher severity.
- A progressive claim at the same or lower severity won't be valid.
- If the insured person suffers more than one event within a 30 days, the total amount we'll pay is for the event that qualifies for the higher payout. This applies across all events covered under Severe Illness Cover and it's benefits and features. If the first claim within the 30-day period has already been paid but the second claim is higher, we'll reduce the second payout to only pay the difference.

For Severe Illness Cover sold on its own:

- An insured person is allowed to claim for subsequent For Women Benefit events if the total percentages paid for previous events under the For Women Benefit totals less than 100%.

Percentage payout for subsequent claims

- The maximum amount that will be paid under the For Women Benefit's 100% of the cover amount.
- Once 100% of the cover amount has been paid under the For Women Benefit, the benefit stops and there will no longer be cover for such events.

Example: Severity-based claims, maximum of 100%

Sanele has R1 000 000 Severe Illness Cover with the For Women Benefit. Two years later she falls pregnant, and meets the medical criteria for the eclampsia event at severity level D (25%). She receives a payout of R250 000 [R1 000 000 x min (25%; 100% - 0%)].

On a successful claim, the illness at that severity and lower severities are no longer covered for the same event. Sanele won't longer be able to claim at 25% for the eclampsia event.

A year later she falls pregnant again, and now meets the medical criteria for the eclampsia event at severity level C (50%). She receives a payout of R500 000 [R1 000 000 x min (50%; 100% - 25%)].

Another year later she falls pregnant again. She meets the medical criteria for amniotic fluid embolism at severity level C (50%). She receives a payout of R250 000 [R1 000 000 x min [50%; (100% - 50% - 25%)]]. In total, Sanele has now received 100% of her cover amount under the For Women Benefit. She'll no longer be covered for the female-specific events.

Adding or removing the benefit

- If the For Women Benefit's added after the start of the contract, the insured person will be re-underwritten.
- This may result in certain events being excluded for cover.

Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that's generally excluded.

We won't pay if:

- the owner fails to meet our requirement to tell us about changes to the circumstances of the insured person (See changes to the circumstances of the insured person),
- the insured person's illness is caused by:
  - unrest, war or terrorist activity,
  - radioactivity or nuclear explosion,
  - provoking, committing or attempting to commit a crime for example murder, assault, housebreaking, theft, robbery, the forceful detention of another person or any similar crime,
  - self-inflicted injury or
  - the claim for any severe illness that relates to a complication during pregnancy is within nine months after the start date of this benefit.
- the insured person's severe illness is before the cover start date,
- we don't recognise the insured person's severe illness,
- the insured person's severe illness is because of an exclusion or
- the survival period isn't met.

We won't recognise the insured person's severe illness if they suffer a severe illness that:

- isn't on the list of severe illnesses,
- is at the severity that the contract does not cover, or
- doesn't meet all the requirements that the severe illness must meet to qualify.

Cover stops on the earliest of the following:

- When the insured person dies.
- At the end of the term, if term cover was chosen.
- If the cover lapses.
- If the insured person no longer qualifies for the cover because of changes to their circumstances.
- If the contract is cancelled.
- If the benefit's removed from the contact.

20.11.3.1 FOR WOMEN BENEFIT EVENTS (15 events)

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
CANCER		
Prophylactic bilateral mastectomy	The undergoing of a bilateral mastectomy, at the recommendation of the treating specialist. **Requirements for a claim to be considered** • BRCA1 or BRCA2 mutation must be present • Relevant surgical reports by the treating surgeon	**25%**
COMPLICATIONS DURING PREGNANCY		
Amniotic fluid embolism	Confirmed diagnosis of amniotic fluid embolism by the treating specialist. **Requirements for a claim to be considered** • A blood transfusion of at least 1 unit ICU admission for at least 24 hours **Exclusions** • Women are not covered after their 40th birthday	**50%**
	The survival period applies to this illness.	
Antepartum haemorrhage	Confirmed diagnosis of abruptio placenta or placenta praevia by the treating specialist. **Requirements for a claim to be considered** • The gestational age must be at least 28 weeks, as confirmed by objective imaging • A blood transfusion of at least 1 unit **Exclusions** • Women are not covered after their 40th birthday	**25%**
	The survival period applies to this illness.	
Disseminated intravascular coagulopathy	Confirmed diagnosis of acute diffuse intravascular coagulation by the treating specialist. This may occur during pregnancy or in the 6 week post-partum period. **Requirements for a claim to be considered** • A blood transfusion of at least 1 unit • Supportive blood tests	**50%**
	The survival period applies to this illness.	

Eclampsia	Confirmed diagnosis of severe pre-eclampsia by the treating specialist. This may occur during pregnancy or in the 6 week post-partum period.
	Requirements for a claim to be considered
	• At least three of the following must be present:
	  • Systolic blood pressure > 160 mm Hg
	  • Diastolic blood pressure > 110 mm Hg
	  • Proteinuria (24 h - urine containing > 3 g protein)
	  • Oedema
		25%

	Confirmed diagnosis of eclampsia by the treating specialist. This may occur during pregnancy or in the 6 week post-partum period. **Requirements for a claim to be considered** • New onset seizures (convulsions) or coma due to eclampsia	**50%**
	The survival period applies to this illness.	

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Ectopic pregnancy	The undergoing of surgery as a result of ectopic pregnancy. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**25%**
Miscarriage due to diagnostic procedures	Confirmed foetal loss that results within 72 hours from the performance of medically indicated amniocentesis or chorionic villus sampling. **Exclusions** Foetal loss as a result of any other condition, injury or cause The survival period applies to this illness.	**25%**

Postpartum haemorrhage	Confirmed diagnosis of postpartum haemorrhage by the treating specialist.
	Requirements for a claim to be considered
	• One of the following must be present:
	  • ICU admission for at least 72 hours
	  • The diagnosis of Sheehan's syndrome, supported by blood tests and a MRI scan
	The survival period applies to this illness.
		50%

Severe vaginal tearing	The repair of a recto-vaginal fistula due to third- or fourth-degree vaginal tears during childbirth, by means of any surgical technique. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis The survival period applies to this illness.	**50%**
Stillbirth	Confirmed foetal loss due to natural causes or unintentional trauma. **Requirements for a claim to be considered** • The gestational age must be at least 26 weeks, as confirmed by objective imaging The survival period applies to this illness.	**25%**
Uterine rupture	The undergoing of an emergency hysterectomy for acute rupture of the uterus during vaginal delivery. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis The survival period applies to this illness.	**50%**
FERTILITY-RELATED		
Endometriosis Stage III or IV	The undergoing of a hysterectomy for endometriosis Stage III or higher. Staging is per the revised classification of the American Society of Reproductive Medicine. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**15%**
Multi-fibroid uterus	The undergoing of a hysterectomy for uterine fibroids. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Women are not covered after their 40th birthday	**15%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Premature ovarian failure	Confirmed diagnosis of premature ovarian failure by the treating specialist. **Requirements for a claim to be considered** • Amenorrhea, hypoestrogenism, and elevated serum gonadotropin levels **Exclusions** • Women are not covered after their 40th birthday	**15%**
Prophylactic bilateral oophorectomy	The undergoing of a bilateral oophorectomy, at the recommendation of the treating specialist. **Requirements for a claim to be considered** • BRCA1 or BRCA2 mutation must be present • Relevant surgical reports by the treating surgeon	**15%**

20.11.4 Child Illness Benefit

This benefit pays up to 10% of the cover amount on the Severe Illness Cover if the insured person's child suffers a severe illness or is born with a congenital birth defect and if the survival period is met. The payment of a claim under this feature doesn't affect the cover amount of the Severe Illness Cover.

Eligible lives

- For severe illnesses: biological, legally adopted or step children of the insured person under the associated Severe Illness Cover.
- For congenital birth defects: only biological children of the insured person under the associated Severe Illness Cover.

Age limits

- There is no minimum entry age
- Cover end age: 19 next birthday

Maximum number of claims

- A maximum of two successful claims will be admitted per benefit
- A maximum of one successful claim will be admitted per child

Child cover amount

A single amount of up to 10% of the Severe Illness Cover amount, subject to a maximum of R500 000 per child (across all Child Illness Benefits).

Event limit for child cover amount

- The maximum of R500 000 applies per child of the insured person under the associated Severe Illness Cover, across all Severe Illness Child Benefits they own or may own in future.
- This limit doesn't apply across different benefits. Where multiple claims are submitted on the same child under different Old Mutual Protect products, for example Disability Cover Child Impairment Benefit or Functional Impairment Cover Child Impairment Benefit, the maximum of R500 000 will apply on each of these benefits (not across benefits).

Exclusion period

- There is a nine-month exclusion period on congenital birth defect claim events from the date this benefit has been added.
- There is a six-month exclusion period with respect to all other child claimable events from the date that this benefit has been added.

Claiming Child Illness Benefits

There are two steps to calculate the claim amount payable:

- First calculate:
  Child Illness Benefit cover amount = the lesser of 10% x Severe Illness Cover amount or R500 000.
- Then:
  Payout = Child Illness Benefit cover amount x event payout percentage.

Example: Multiple Child Illness Benefits for the same insured person

Abulela takes out two separate Severe Illness Cover contracts both with the Child Illness Benefit. They have cover amounts of R5 000 000 and R1 000 000. A year later his child Zinhle meets the criteria for the cancer event, which pays out 100%. Abulela's total cover amount is R6 000 000. If we considered his two contracts separately, he would be eligible to claim a Child Illness Benefit cover amount of R600 000 [R500 000 [min (10% x R5 000 000, R500 000) + R100 000 [min (10% x R1 000 000, R500 000)]].

The maximum of R500 000 applies per child at an insured person level, across all Child Illness Benefits. Therefore, the child cover amount for this claim is limited to R500 000. This is the amount that the percentage payout will be calculated on. Abulela will only be paid R500 000.

Example: Multiple Child Illness Benefits for different insured persons

John and Mary both have Severe Illness Cover and both selected the Child Illness Benefit to their respective cover. John has a cover amount of R6 000 000, and Mary has a cover amount of R4 000 000. They have three children: Simon, Kate and Andrew.

Simon suffers accidental brain damage. Accidental brain injury has a 100% payout percentage.
If both parents can claim for Simon, their respective payouts will be:

- John: R500 000

  Min [R500 000, (R6 000 000 x 10%)] x 100%
- Mary: R400 000

  Min [R500 000, (R4 000 000 x 10%)] x 100%

This benefit's limited to one claim per child, so if Simon is diagnosed with another condition neither parent will be able to claim on his life. The cover amount on both parents' Severe Illness Cover isn't reduced by this claim.

Kate suffers total loss of hearing. Loss of hearing has a 100% payout percentage.
If both parents can claim for Kate, their respective payouts will be:

- John: R500 000

  Min [R500 000, (R6 000 000 x 10%)] x 100%
- Mary: R400 000

  Min [R500 000, (R4 000 000 x 10%)] x 100%

This benefit's limited to one claim per child, so if Kate is now diagnosed with another condition neither parent will be able to claim on her life. The cover amount on both parents' Severe Illness Cover is again not reduced by this claim.

At this point both John and Mary's Child Illness Benefits will fall away as the maximum number of claims have been paid out. Both John and Mary won't be able to claim if Andrew gets a child illness.

Example: Child Illness Benefit interaction with other products

David and Sally are married. David has R4 000 000 Functional Impairment Cover with Child Impairment Benefit. Sally has a R6 000 000 Severe Illness Cover with Child Illness Benefit.

David and Sally's son Gabriel is born with a cleft palate which has an event payout percentage of 50% under both the Child Impairment Benefit and the Child Illness Benefit. Both parents are eligible to claim under their respective benefits.
Where both parents claim for Gabriel:

- David: R200 000

  Min [R500 000, (R4 000 000 x 10%)] x 50%

- Sally: R250 000

  Min [R500 000, (R6 000 000 x 10%)] x 50%

Both these benefits are limited to one claim per child, so if Gabriel is diagnosed with another condition neither parent will be able to claim on his life. The cover amount on both parents' cover is again not reduced by this claim.

Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that is generally excluded.

We won't pay if:

- the owner fails to meet our requirement to tell us about changes to the circumstances of the insured person (See changes to the circumstances of the insured person),
- the claim is caused by:
  - unrest, war or terrorist activity,
  - radioactivity or nuclear explosion,
- the claim for a child illness is caused by:
  - the insured person or the child provoking, committing or attempting to commit a crime for example murder, assault, housebreaking, theft, robbery, the forceful detention of another person or any similar crime,
  - the use of alcohol, poison, drugs or non-prescribed medication,
  - self-inflicted injury or
  - a condition that was diagnosed:
    - before or within six months after this benefit's start date or
    - before the child was legally adopted or became the stepchild of the insured person under the

      Severe Illness Cover.
- the claim for a congenital birth defect is for a child born within nine months after this benefit's start date or if it's because of:
  - a self-inflicted injury by the biological mother of the child,
  - the insured person or the biological mother provoking, committing or attempting to commit a crime or
  - the use of alcohol, poison, drugs or non-prescribed medication by the biological mother of the child.

- the insured person's severe illness is before the cover start date,
- we don't recognise the insured person's severe illness,
- the insured person's severe illness is because of an exclusion or
- the survival period isn't met.

We won't recognise the insured event if the child suffers an insured event that:

- isn't on the list of congenital birth defects and child impairments,
- is at the severity that the contract doesn't cover or
- doesn't meet all the requirements that the insured event must meet to qualify.

Cover stops on the earliest of the following:

- At the end of the term, if term cover was chosen.
- If the cover lapses.
- If the contract is cancelled.
- If the benefit's removed from the contract.
- Once we've paid two valid claims under this benefit.
- If the insured person no longer qualifies for any severe illnesses on the list of severe illnesses that qualify in the event descriptions.

In addition to the above, cover for a child under this benefit stops on the earliest of the following:

- On their 18th birthday.
- Once we have paid one valid claim.
- Once we've paid R500 000 for them across all Child Illness Benefits across all Severe Illness Cover benefits for the same insured person.

20.11.4.1 CHILD ILLNESS BENEFIT (80 child illnesses)

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
ACTIVITIES OF DAILY LIVING		
Child-specific catch-all	Any illness, condition or event that results in the insured child having permanent impairment as specified below. **Old Mutual's Medical Officer must confirm that:** • The insured child has undergone reasonable treatment, and has reached an adequate level of recovery that can reasonably be expected of a person suffering from the illness, condition or event • The insured child does not qualify, as a result of suffering from an illness, condition or event, for the payment of the cover amount for any other listed child illness under this benefit **Requirements for a claim to be considered** • In the opinion of the treating specialist and as confirmed by Old Mutual's Medical Officer, the condition has permanently impaired physical and/or mental development to the extent that both the following are met: • At least 35% whole person impairment (WPI) according to the latest edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment • The impairment meets the criteria of a Class 4 impairment according to the latest edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment	**100%**
Terminal illness	Confirmed diagnosis of a medical condition that is or has become incurable by a treating specialist. In the opinion of the treating specialist and as confirmed by Old Mutual's Medical Officer, the condition is likely to result in death within 12 months after the diagnosis.	**100%**
AUTOIMMUNE		
Advanced rheumatoid arthritis	Confirmed diagnosis and treatment of rheumatoid arthritis by the treating rheumatologist. **Requirements for a claim to be considered** • Serological markers to be positive • Despite adequate treatment for at least 6 months with disease modifying drugs including biologics, the disease remains unresponsive or poorly responsive • Active rheumatoid arthritis in at least three major joints (e.g. fingers, hands, wrists, knees, hips, elbows, shoulders) as evidenced by clinical signs and x-rays **Exclusions** • Reactive arthritis • Psoriatic arthritis	**100%**
Connective tissue disease	Confirmed diagnosis and treatment of one of the following connective tissue diseases by the treating rheumatologist: • Giant cell arteritis • Polyarteritis nodosa • Systemic Scleroderma • Systemic lupus erythematosus • Sarcoidosis • Wegener's granulomatosis **Requirements for a claim to be considered** • Serological markers, or tissue biopsy (as appropriate) confirming diagnosis • All clinical signs must be supported by special investigations • Despite adequate treatment for at least 6 months with high dose steroids, or disease modifying drugs including biologics, the disease remains unresponsive or poorly responsive **Exclusions** • All other connective tissue or auto-immune conditions not specifically listed above • Limited cutaneous systemic sclerosis • Discoid lupus erythematosus or subacute cutaneous lupus erythematosus • Drug-induced lupus erythematosus	**100%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Juvenile idiopathic arthritis	Confirmed diagnosis of juvenile idiopathic arthritis by the treating rheumatologist. **Requirements for a claim to be considered** • Age at onset must be less than 16 years • Signs and symptoms must have been present for at least 3 months • Active juvenile idiopathic arthritis in at least two major joints (e.g. fingers, hands, wrists, knees, hips, elbows, shoulders) as evidenced by clinical signs and x-rays	**100%**
Polymyositis	Confirmed diagnosis of polymyositis by the treating specialist. **Requirements for a claim to be considered** • Positive serology findings • Electromyography positive • Supportive biopsy • Clinical confirmation of dysphonia (voice disorders) and dysphagia (difficulty swallowing)	**100%**
CANCER		

Bone marrow failure (including severe aplastic anaemia)	Confirmed diagnosis of complete bone marrow failure by the treating haematologist.
	
	Requirements for a claim to be considered
	
	• The bone marrow failure must result in anaemia, neutropenia and thrombocytopenia.
	• The insured person must require a minimum of one of the following treatments:
	  • at least 1 blood transfusion per month for at least 3 months, or
	  • immunosuppressive therapy, or
	  • bone marrow stimulation therapy
	
	Exclusions
	
	• All other forms of anaemia and blood disorders
		100%

Cancer	Confirmation of a malignant tumour diagnosed and characterised by the uncontrolled growth of malignant cells and invasion beyond the layer of cells in which it originated into a deeper layer of tissue. The term malignant tumour includes leukaemia, sarcoma and lymphoma.
	
	All cancers classified as Stage I by the American Joint Committee for Cancer are covered, where the following cancers are only covered as specified:
	
	• Prostate cancer is covered when histologically classified as Gleason score of more than 6, or at least TNM staging T2N0M0
	• Malignant melanoma is covered from T1N0M0
	• Ductal carcinoma in situ (DCIS) of the breast is covered if microinvasion is present
	• Borderline ovarian tumours from Stage I are covered
	• Brain tumours from WHO Grade II are covered
	
	Exclusions
	
	• All cancers which are histologically classified as any of the following:
	  • pre-malignant
	  • non-invasive
	  • cancer in situ, unless specified above
	  • having borderline malignancy, unless specified above
	  • tumours with low malignant potential
	
	• All prostate cancers, unless conforming to the specifications above
	• All skin cancers, except malignant melanoma as specified above
		100%

Chronic blood disorders	Confirmed diagnosis of any chronic disorder of the blood by a specialist. **Requirements for a claim to be considered** • Objective evidence of the disorder including clinical records of supportive blood counts or bone marrow biopsies • At least four units of blood or blood products has been transfused per month for at least 3 consecutive months	**100%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Hematopoietic stem cell (bone marrow) transplant	One of the following: • Undergoing a hematopoietic stem cell (bone marrow) transplant • Inclusion on a bone marrow transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure **Requirements for a claim to be considered** • Confirmation by the treating specialist with supportive evidence	**100%**
Non-melanoma skin cancer Stage III or IV	Confirmed diagnosis of any non-melanoma skin cancer classified as Stage III or IV by the American Joint Committee for Cancer.	**100%**
Partial mastectomy	The undergoing of a partial mastectomy for ductal or lobular carcinoma in situ. **Requirements for a claim to be considered** • Histological evidence of ductal or lobular carcinoma in situ • Surgical reports confirming the removal of at least 50% of the affected breast **Exclusions** • Lumpectomy • Quadrantectomy	**100%**
CARDIOVASCULAR		
Aortic surgery	The repair of a narrowing, obstruction, dissection or aneurysm of either the main thoracic or abdominal aorta, by means of any minimally invasive surgical technique. This includes keyhole or catheter techniques, or a mini-thoracoscopic/laparoscopic surgical procedure. Requirements for a claim to be considered • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **NOTE:** Branches of the aorta are covered under Artery surgery The survival period applies to this illness.	**100%**

Arrhythmia	Confirmed diagnosis of an arrhythmia by the treating cardiologist, with the insertion of a functioning defibrillator.
	Requirements for a claim to be considered
	• The arrhythmia must be documented on a 24 hour Holter ECG
	• One of the following devices must be surgically implanted:
	  • Implantable Cardioverter-Defibrillator (ICD)
	  • Cardiac Resynchronization Therapy with Defibrillator (CRT-D).
	Exclusions
	• Pacemaker insertion
	• Pathway ablation
	The survival period applies to this illness.
		100%

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%

Artery surgery	One of the following:
	• The repair of a narrowing, obstruction, dissection or aneurysm of a specified artery, by means of any surgical technique. This includes keyhole or catheter techniques or bypass grafts. The following arteries are covered:
	  ◦ Subclavian
	  ◦ Brachiocephalic
	  ◦ Splenic
	  ◦ Renal
	  ◦ Iliac
	  ◦ Femoral
	• The undergoing of surgery to correct the narrowing of, or blockage to, any artery in the arms, hands legs or feet by means of a bypass graft
	Requirements for a claim to be considered:
	Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis
		100%

	The survival period applies to this illness.	
Cardiomyopathy	Confirmed diagnosis of cardiomyopathy by the treating cardiologist. **Requirements for a claim to be considered** • The cardiomyopathy results in permanent and irreversible cardiac impairment, evidenced by echocardiogram findings showing left ventricular ejection fraction (LVEF) of less than 50%, measured twice at least 3 months apart	**100%**
Carotid artery surgery	The repair of a narrowing, obstruction, dissection or aneurysm of one carotid artery, by means of a bypass graft or endarterectomy. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**100%**
	The survival period applies to this illness.	
Coronary artery bypass graft	The undergoing of surgery to correct the narrowing of, or blockage to, one or more coronary arteries by means of a bypass graft.	**100%**
	The survival period applies to this illness.	

Heart attack	Confirmed diagnosis of a heart attack by the treating cardiologist characterised by death of heart muscle, due to inadequate blood supply.
	Requirements for a claim to be considered
	• Raised cardiac biomarkers with at least one reading above the upper reference level
	• One of the following must be present:
	  ◦ Compatible clinical symptoms
	  ◦ New characteristic electrocardiography (ECG) changes indicative of myocardial ischaemia or myocardial infarction
	  ◦ Angiography showing critical occlusion of a coronary artery indicative of myocardial ischaemia or myocardial infarction
	  ◦ Evidence of hypokinesis on ECHO confirming the death of heart muscle tissue
	Exclusions
	• Other acute coronary syndromes (including but not limited to angina and unstable angina)
	• Coronary spasms
	• Elevations of troponin in the absence of overt ischemic heart diseases (e.g. myocarditis, apical ballooning, cardiac contusion, pulmonary embolism, drug toxicity)
		100%

	The survival period applies to this illness.	

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Heart surgery	The correction of any structural abnormality of the heart, through surgically opening the chest cavity (thoracotomy or sternotomy). **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any investigative procedure **NOTE**: Coronary artery bypass graft is covered as a separate severe illness	**100%**
	The survival period applies to this illness.	
Heart transplant	One of the following: • Undergoing a heart transplant • Inclusion on a heart transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure **Requirements for a claim to be considered** • Confirmation by the treating specialist with supportive evidence	**100%**
Heart valve replacement or repair	The undergoing of heart surgery to repair one or more diseased heart valves by means of any minimally invasive surgery. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any investigative procedure	**100%**
	The survival period applies to this illness.	
Pericardiectomy	The excision of a portion of the pericardium as treatment for a disease affecting the pericardium/pericardial sac, by means of any surgical technique. This includes endoscopic or keyhole procedures. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any investigative procedure	**100%**
	The survival period applies to this illness.	
Peripheral arterial disease	Confirmed diagnosis of peripheral arterial disease by the treating vascular surgeon. **Requirements for a claim to be considered** • Abnormal diminished pulse on Doppler readings • Ankle-Brachial index (ABI) <0.9 • Pain as a result of peripheral arterial disease with claudication on minimal exercise lasting less than 10 minutes	**100%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
CENTRAL NERVOUS SYSTEM		
Acquired intellectual or cognitive impairment	Confirmed diagnosis of a permanent acquired intellectual or cognitive impairment caused by an organic disease or injury. **Requirements for a claim to be considered** • Confirmation by the treating neurologist or psychiatrist • Objective tests, which could include brain imaging demonstrating appropriate pathology • IQ must be less than 60 as measured by at least two independent psychiatrists using the appropriate Wechsler Intelligence Scale and at least one other internationally recognized equivalent neuropsychological test **Exclusions** • All other mental, psychological and psychiatric conditions	**100%**
Benign brain tumour	Confirmed diagnosis of a non-malignant tumour or cyst in the brain, cranial nerves or meninges within the skull. This includes pituitary macroadenomas. **Requirements for a claim to be considered** • Supportive imaging and neurological reports, including confirmation of the diagnosis • The tumour has been removed via complete resection, partial resection or is irresectable **Exclusions** • Pituitary microadenomas • Angiomas • Granuloma, hamartoma or malformation of the arteries or veins of the brain	**100%**
Brain surgery	Any condition for which the insured person has undergone open brain surgery. This must involve a craniotomy (where there is surgical removal of part of the bone from the skull to expose the brain). This includes depressed skull fracture requiring removal of bone or reconstruction of the skull. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Stereotactic or radiosurgery • Burr hole surgery • Any minimally invasive surgery such as keyhole or endovascular surgery	**100%**
Cavernous sinus thrombosis	Confirmed diagnosis of cavernous sinus thrombosis by the treating specialist. **Requirements for a claim to be considered** • Supportive imaging and neurological reports The survival period applies to this illness.	**100%**

Cerebral malaria	Confirmed diagnosis of cerebral malaria by the treating specialist.
	Requirements for a claim to be considered
	• Supportive blood tests showing malaria infection
	• Admission to ICU for more than 72 hours during which the insured person suffers both of the following:
	  • A coma, with a Glasgow Coma Scale of 8 or less, that lasts more than 6 hours
	  • Epileptic seizures as a complication of the cerebral malaria
	The survival period applies to this illness.
		100%

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Coma	Confirmed diagnosis of a coma by the treating neurologist or neurosurgeon. **Requirements for a claim to be considered** • Decreased level of consciousness, with a Glasgow Coma Scale of 8 or less • The coma is constant and present for longer than 96 hrs **Exclusions** • Medically induced comas • Comas due to the consumption of alcohol, drugs or medication not used as prescribed The survival period applies to this illness.	**100%**
Dementia (including Alzheimer's disease)	Confirmed diagnosis of Alzheimer's disease or any other type of dementia by the treating neurologist. **Requirements for a claim to be considered** • The diagnosis meets the criteria of the latest Diagnostic and Statistical Manual of Mental Disorders (DSM) • Supportive imaging and neurological reports	**100%**
Motor neurone disease	Confirmed diagnosis of motor neurone disease by the treating neurologist. **Requirements for a claim to be considered** • There must be appropriate evidence, which could include nerve conduction studies (NCS) and electromyography (EMG)	**100%**
Multiple sclerosis	Confirmed diagnosis of multiple sclerosis by the treating neurologist. **Requirements for a claim to be considered:** • Magnetic resonance imaging (MRI) showing lesion/s of demyelination in the brain or spinal cord characteristic of multiple sclerosis • At least 2 separate episodes resulting in neurological signs and symptoms must have occurred **Exclusions** • Possible multiple sclerosis and clinically or radiologically isolated syndromes suggestive but not diagnostic of multiple sclerosis	**100%**
Muscular dystrophy	Confirmed diagnosis of muscular dystrophy by the treating neurologist. **Requirements for a claim to be considered** • There must be appropriate evidence, which could include characteristic electromyography (EMG) and muscle biopsy findings	**100%**
Myasthenia gravis Class III or higher	Confirmed diagnosis of myasthenia gravis of at least severity Class III (as per the Myasthenia Gravis Foundation of America clinical classification), by the treating neurologist. **Requirements for a claim to be considered** • Supportive electro-diagnostic studies • There must be appropriate evidence, which could include anti–acetylcholine receptor (AChR) antibody (Ab) test positive, or anti-MuSK (muscle-specific kinase) antibody test positive **Exclusions** • Localized ocular myasthenia gravis	**100%**
Paralysis	The total and permanent loss of use of: • A hand or hands at the level of the wrist joint and above, or • A foot or feet at the level of the ankle and above **Requirements for a claim to be considered** • Permanence must be confirmed by the treating specialist • Supportive special investigations The survival period applies to this illness.	**100%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Parkinson's disease	Confirmed diagnosis of primary idiopathic Parkinson's disease by the treating neurologist. **Requirements for a claim to be considered** The diagnosis must be confirmed by the presence of at least 2 cardinal symptoms of Parkinson's disease, which are: • Bradykinesia • Resting tremor • Muscle rigidity • Postural instability **Exclusions** • Parkinsonian syndromes including but not limited to those caused by the consumption of alcohol, drugs or medication not used as prescribed • Secondary Parkinsonism • Essential tremor	**100%**
Parkinson's Plus syndrome	Confirmed diagnosis of one of the following Parkinson Plus syndromes by the treating neurologist: • Multiple system atrophy • Progressive supranuclear palsy • Parkinsonism-dementia-amyotrophic lateral sclerosis complex • Corticobasal ganglionic degeneration • Diffuse Lewy body disease • Pick's disease • Olivopontocerebellar atrophy **Requirements for a claim to be considered** • Supporting medical and clinical evidence **Exclusions** • Parkinsonian syndromes including but not limited to those caused by the consumption of alcohol, drugs or medication not used as prescribed • Secondary Parkinsonism • Essential tremor	**100%**
Psychiatric disorders	Confirmed diagnosis of a psychiatric disorder by the treating neurologist. **Requirements for a claim to be considered** • The diagnosis meets the criteria of the latest Diagnostic and Statistical Manual of Mental Disorders (DSM) • Institutionalisation in a registered psychiatric facility for more than 6 consecutive months with appropriate medical certification • Undergoing of constant 24 supervision, with a permanent caregiver • Global Assessment Function (GAF) score of 40 or less certified under the DSM IV classification, or • WHODAS item-response-theory" (IRT) score of 100 which equals full disability The above must be confirmed by at least two independent psychiatric reports	**100%**
Spinal cord tumour	Confirmed diagnosis of a non-malignant tumour or cyst in the spinal cord, spinal nerves or meninges. **Requirements for a claim to be considered** • Supportive imaging and neurological reports, including confirmation of the diagnosis • The tumour has been removed via complete resection, partial resection or is irresectable • The tumour causes permanent neurological deficit. Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months **Exclusions** • Angiomas • Granuloma and hamartoma	**100%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Status epilepticus	An episode of status epilepticus confirmed by the treating neurologist. **Requirements for a claim to be considered** • Supportive imaging and neurological reports • The status epilepticus causes permanent neurological deficit. Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months	**100%**
	The survival period applies to this illness.	
Stroke	Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in neurological deficit lasting longer than 24 hours, confirmed by neuroimaging investigation and appropriate clinical findings by a specialist neurologist. Stroke as a result of traumatic injury to brain tissue or blood vessels is included. **Exclusions** • Transient ischaemic attack • Vascular disease affecting the eye or optic nerve • Migraine and vestibular disorders	**100%**
	The survival period applies to this illness.	
ENDOCRINE		

Type 1 diabetes	Confirmed diagnosis of type 1 diabetes by the treating paediatric endocrinologist or endocrinologist, according to the latest World Health Organisation criteria.
	
	Requirements for a claim to be considered
	• The diagnosis must be confirmed by the presence of at least 3 of the following:
	  • Anti-GAD65 antibody levels indicative of type 1 diabetes
	  • Islet-cell antibody levels indicative of type 1 diabetes
	  • C-peptide levels indicative of type 1 diabetes
	  • Insulin levels indicative of type 1 diabetes
	
	Exclusions
	• Type 2 diabetes requiring insulin
	• Gestational Diabetes
		100%

GASTROINTESTINAL		
Acute kidney failure	A single episode of acute kidney failure requiring six or more treatments of haemodialysis. **Requirements for a claim to be considered** • Confirmation of acute kidney failure by the treating nephrologist • Blood tests supporting diagnosis • Evidence of number of haemodialysis treatments **Exclusions** • Any acute failure caused by the consumption of alcohol, drugs or medication not used as prescribed	**100%**

Chronic kidney failure	Confirmed diagnosis of chronic renal failure by the treating nephrologist or urologist.
	
	Requirements for a claim to be considered
	• One of the following must be present, despite adequate medical treatment:
	  • Chronic renal disease with an estimated Glomerular Filtration Rate (GFR) ≤ 40ml/min
	  • Chronic renal disease with creatinine clearance of ≤ 55ml/min, with clinically significant progressive renal function decline as confirmed by 3 renal function (creatinine clearance) measurements in a 12 month period
		100%

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Chronic liver failure	Confirmed diagnosis of progressive chronic liver disease by the treating gastroenterologist or equivalent specialist. **Requirements for a claim to be considered** • Supportive clinical, laboratory and histological evidence • The liver failure must be classified as at least Child-Pugh Class A **Exclusions** • Liver disease caused by the consumption of alcohol, drugs or medication not used as prescribed	**100%**
Chronic pancreatitis	Confirmed diagnosis of chronic pancreatitis by the treating gastroenterologist or equivalent specialist. **Requirements for a claim to be considered** • Supportive clinical, laboratory and histological evidence • Malabsorption syndrome caused by exocrine pancreatic insufficiency • Impaired glucose metabolism caused by endocrine pancreatic insufficiency **Exclusions** • Pancreatic disease caused by the consumption of alcohol, drugs or medication not used as prescribed	**100%**
Crohn's disease with specified surgery	Confirmed diagnosis of Crohn's disease by the treating gastroenterologist or equivalent specialist. **Requirements for a claim to be considered** • Supportive colonoscopy and histopathology findings • Despite adequate treatment for at least 6 consecutive months with diet, disease modifying drugs or immuno-modulators, the disease remains unresponsive or poorly responsive • The complications have resulted in at least one surgical intervention other than for diagnostic purposes	**100%**
Kidney transplant	One of the following: • Undergoing a kidney transplant • Inclusion on a kidney transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure **Requirements for a claim to be considered** • Confirmation by the treating specialist with supportive evidence	**100%**
Liver transplant	One of the following: • Undergoing a liver transplant • Inclusion on a liver transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure **Requirements for a claim to be considered** • Confirmation by the treating specialist with supportive evidence	**100%**
Pancreatectomy or pancreas transplant	One of the following: • Undergoing a complete pancreatectomy • Undergoing a complete pancreas transplant • Inclusion on a pancreas transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure **Requirements for a claim to be considered** • Confirmation by the treating specialist with supportive evidence	**100%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Permanent ileostomy or colostomy	Any organic disease or severe physical injury that results in a colostomy or ileostomy which is intended to be permanent. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any temporary ostomy procedure	**100%**
Total colectomy	Any organic disease or severe physical injury that results in a total colectomy, where the entire colon is removed and the small intestine is connected to the rectum. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Partial colectomy • Segmental colectomy • Partial bowel resection	**100%**
Total cystectomy	Any organic disease or severe physical injury that results in a total cystectomy, which is the surgical removal of the entire bladder with the reconstruction of a ileal conduit or neo-bladder. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Partial cystectomy	**100%**
Total penectomy	Any organic disease or severe physical injury that results in total amputation of the penis (total penectomy) with the surgical construction of a perineal urethrostomy. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon **Exclusions** • Partial penectomy • Surgery due to gender dysphoria • Circumcision or any complications thereof	**100%**
Ulcerative colitis	Confirmed diagnosis of ulcerative colitis disease by the treating gastroenterologist. **Requirements for a claim to be considered** • Supportive colonoscopy and histopathology findings • Despite adequate treatment for at least 6 consecutive months with diet, disease modifying drugs or immuno-modulators, the disease remains unresponsive or poorly responsive • The complications have resulted in at least one surgical intervention other than for diagnostic purposes	**100%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
HIV/AIDS		
Accidental HIV for medical, dental or nurse practitioners	Infection with the human immunodeficiency virus (HIV) as a result of an accident while carrying out occupational duties of a medical, dental or nurse practitioner. For the purpose of this illness an accident is defined as an external, unexpected event that is not traceable, even indirectly, to the insured person's state of mental or physical health before the event. **Requirements for a claim to be considered** • The insured person must be registered as a medical or dental practitioner with the Health Professions Council of South Africa (HPCSA) or as a member of the South African Nursing Council (SANC). Registered dental assistants and oral hygienists are also included • A supportive HIV antibody test must be taken within 48 hours after the accident, and the result must be negative • Proof that the health care institution's written protocol was followed, including the use of post-exposure prophylaxis drugs • Confirmed evidence of seroconversion to HIV must occur within 3 months of the accident	**100%**
Accidental HIV via a blood transfusion	Infection with the human immunodeficiency virus (HIV) by infected blood received in a blood transfusion. **Requirements for a claim to be considered** • A recognised institution in the Republic of South Africa must have performed the transfusion • The institution that provided the infected blood must admit liability • Confirmed evidence of seroconversion to HIV must occur within 3 months of the affected blood transfusion	**100%**
Accidental HIV via a road traffic accident	Infection with the human immunodeficiency virus (HIV) as a result of involvement in, or assistance at the scene of, a road traffic accident. **Requirements for a claim to be considered** • The event must have been reported to the South African Police Service (SAPS) and a case number issued and/or criminal case opened • A medical examination must have been performed within 24 hours after the event • A supportive HIV antibody test must be taken within 48 hours after the accident, and the result must be negative • Confirmed evidence of seroconversion to HIV must occur within 3 months of the event	**100%**
Accidental HIV via an organ transplant	Infection with the human immunodeficiency virus (HIV) by an infected organ received in an organ transplant. **Requirements for a claim to be considered** • A recognised institution in the Republic of South Africa must have performed the transplant • The institution that provided the infected organ must admit liability • Confirmed evidence of seroconversion to HIV must occur within 3 months of the organ transplant	**100%**
Accidental HIV via violent crime, rape or indecent assault	Infection with the human immunodeficiency virus (HIV) as a result of being a victim of a violent crime, rape or an indecent assault. **Requirements for a claim to be considered** • The event must have been reported to the South African Police Service (SAPS) and a case number issued and/or criminal case opened • A medical examination must have been performed within 24 hours after the event • A supportive HIV antibody test must be taken within 48 hours after the event, and the result must be negative • Confirmed evidence of seroconversion to HIV must occur within 3 months of the event	**100%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
AIDS	Confirmed diagnosis of AIDS or Stage 4 HIV infection by the treating specialist. **Requirements for a claim to be considered** • Positive HIV antibody test (or other recognised test for the presence of HIV, acceptable to Old Mutual) • CD4 count of persistently less than 200 cells/mm3 must be present, despite compliance with anti-retroviral treatment as per latest National Guidelines • At least one of the AIDS-defining conditions listed in the current World Health Organization's (WHO) clinical staging of HIV/AIDS	**100%**
RESPIRATORY		

Chronic respiratory failure	Confirmed diagnosis of a chronic respiratory disorder by the treating pulmonologist.
	
	Requirements for a claim to be considered
	
	• Any one of the below measurements taken on at least 3 occasions, at least 1 month apart:
	  • Impaired airflow with FEV1 (forced expiratory volume in the first second) of ≤50% predicted
	  • FVC (forced vital capacity) of ≤50% predicted
	  • DLCO (diffusing capacity of the lungs for carbon monoxide) of ≤50% predicted
		100%

Lung surgery	The undergoing of surgery to remove more than one lobe of the lung due to any physical injury or disease. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis The survival period applies to this illness.	**100%**
Lung transplant	One of the following: • Undergoing a lung transplant (this includes the whole lung or a lobe of the lung) • Inclusion on a lung transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure **Requirements for a claim to be considered** Confirmation by the treating specialist with supportive evidence	**100%**

Prolonged mechanical ventilation	A severe physical injury or organic disease that results in an extended period of assisted mechanical ventilation.
	
	Requirements for a claim to be considered
	
	• One of the following must be present:
	  • A severe physical injury that results in ICU admission for more than 14 full days, with assisted mechanical ventilation for more than 7 full days
	  • Any organic disease that results in assisted mechanical ventilation of more than 30 consecutive days
	
	NOTE:
	
	• A day is 24 hours
	• This illness will only be considered if the insured person does not qualify for a payment for any other listed severe illness under this benefit
	• The survival period applies from the date this definition has been met
	
	The survival period applies to this illness.
		100%

Pulmonary arterial hypertension	Confirmed diagnosis of pulmonary hypertension by the treating specialist. **Requirements for a claim to be considered** • Mean pulmonary artery pressure of between 25-40 mmHg at rest, measured by right heart catheterisation • Marked limitation in activity due to symptoms, even during less-than-ordinary activity, e.g. walking short distances (New York Heart Association (NYHA) Class III heart failure). Symptoms must be present for a continuous period of at least 3 months	**100%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Pulmonary artery surgery	The undergoing of surgery to the pulmonary artery through surgically opening the chest cavity (thoracotomy or sternotomy). There must be excision and replacement of a portion of the diseased pulmonary artery with a graft. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any investigative procedure • Any other surgical procedure, e.g. the insertion of stents or endovascular repair	**100%**
	The survival period applies to this illness.	
Recurrent pulmonary emboli	The undergoing of a veno-caval filter insertion to treat recurrent pulmonary embolism. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any investigative procedure	**100%**
	The survival period applies to this illness.	
SENSES		
Enucleation of the eye	The enucleation of one eye, which results from either trauma or the surgical treatment of an organic disease. **Requirements for a claim to be considered** • Confirmation by the treating specialist with supportive evidence	**100%**
Loss of hearing	Confirmed diagnosis of loss of hearing in both ears by the treating ENT specialist. **Requirements for a claim to be considered** • Average auditory threshold, measured at 500, 1000, 2000 and 3000 Hertz in the better ear using a pure tone audiogram, of between 70-89 decibels • This must be confirmed by audiometry conducted with hearing aids	**100%**

Loss of sight	Confirmed diagnosis of loss of sight by the treating ophthalmologist. The loss of sight can't be improved through refractive correction or medication.
	Requirements for a claim to be considered
	• One of the following must be present:
	  • A reading of 6/30 or worse (or equivalent measure on a non-metric scale) in each eye, after best correction
	  • A visual field loss to a 20° radius, after best correction
	  • Severe non-proliferative diabetic retinopathy
	  • Grade III hypertensive retinopathy
	Exclusions
	• Loss of sight due to cataracts, unless there is evidence of failed cataract surgery or contraindications to cataract surgery
		100%

Loss of speech	Total permanent and irreversible loss of the ability to speak as a result of physical injury or disease as diagnosed by the treating ENT specialist, neurologist or neurosurgeon. **Requirements for a claim to be considered** • The loss of speech has to be present for a continuous period of at least 6 months **Exclusions** • Loss of speech due to psychiatric causes	**100%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Retinitis pigmentosa	Confirmed diagnosis of retinitis pigmentosa by the treating ophthalmologist. **Requirements for a claim to be considered** • Supporting Electroretinogram (ERG) • Supporting visual field tests	**100%**
TRAUMA		
Accidental asphyxiation	ICU admission that results from accidental asphyxiation. **Requirements for a claim to be considered** • The accidental asphyxiation results in ICU admission for 48 hours or more **NOTE:** • An accident is an unexpected and visible event of external origin that causes traumatic bodily injury and is not traceable, even indirectly, to the insured child's state of mental or physical health before the event	**100%**
Accidental brain injury	The survival period applies to this illness. Death of brain tissue due to traumatic injury as a result of an accident resulting in neurological deficit lasting longer than 24 hours, confirmed by neuroimaging investigation and appropriate clinical findings by a specialist neurologist. **NOTE:** • An accident is an unexpected and visible event of external origin that causes traumatic bodily injury and is not traceable, even indirectly, to the insured person's state of mental or physical health before the event The survival period applies to this illness.	**100%**
Accidental near drowning	ICU admission that results from accidental near drowning. **Requirements for a claim to be considered** • The accidental near drowning results in ICU admission for 48 hours or more **NOTE:** • An accident is an unexpected and visible event of external origin that causes traumatic bodily injury and is not traceable, even indirectly, to the insured child's state of mental or physical health before the event The survival period applies to this illness.	**100%**
Amputation of limb	Any organic disease or severe physical injury that results in the medically necessary, complete physical severance of: • A hand or hands at the level of the wrist joint or above, or • A foot or feet at the level of the ankle and above **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis The survival period applies to this illness.	**100%**
Dog bites	The undergoing of facial plastic surgery under general anaesthesia to treat a dog bite to the face. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis The survival period applies to this illness.	**100%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%

Major burns	Confirmed diagnosis of external third degree burns (full thickness burns) by the treating plastic surgeon or trauma specialist.
	
	Requirements for a claim to be considered
	• One of the following must be present:
	  • At least 10% of total body surface affected, as measured on the Lund and Browder Chart or equivalent
	  • 20% of the surface area of the face affected, which for the purposes of this definition includes the forehead and ears
	
	Exclusions
	• Sunburn or sun exposure
		100%

	The survival period applies to this illness.	

20.11.4.2 CONGENITAL BIRTH DEFECTS (26 events)

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Achondroplasia	The undergoing of surgery to treat complications of achondroplasia. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**50%**
	The survival period applies to this illness.	
Anal atresia	The undergoing of surgery to correct anal atresia. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**50%**
	The survival period applies to this illness.	
Autosomal recessive polycystic kidney disease	Confirmed diagnosis of autosomal recessive polycystic kidney disease by the treating specialist. **Requirements for a claim to be considered** • Supportive genetic tests	**100%**
	The survival period applies to this illness.	
Biliary atresia	Confirmed diagnosis of biliary atresia by the treating specialist. **Requirements for a claim to be considered** • Supportive imaging and blood tests	**100%**
	The survival period applies to this illness.	
Brain and skull disorders	Confirmed diagnosis of one of the following disorders by the treating specialist: • Microcephaly • Hydrocephaly • Craniostenosis • Craniosynostosis **Requirements for a claim to be considered** • Supportive imaging and blood tests • The disorder results in severe neurological deficit	**100%**
	The survival period applies to this illness.	

Cerebral palsy	Confirmed diagnosis of cerebral palsy by the treating specialist.
	Requirements for a claim to be considered
	• One of the following must be present for at least 6 months:
	  • Spastic diplegia
	  • Spastic hemiplegia
	  • Spastic quadriplegia
		100%

	The survival period applies to this illness.	
Choanal atresia	The undergoing of surgery to correct choanal atresia. **Requirements for a claim to be considered** • The complications have resulted in at least two surgical interventions, on two separate occasions, other than for diagnostic purposes • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**50%**
	The survival period applies to this illness.	

Cleft lip and complete cleft palate	Confirmed diagnosis of cleft lip and complete cleft palate (hard and soft palate) by the treating specialist. The survival period applies to this illness.	**50%**
Clubbed feet (talipes)	The undergoing of surgery to correct a clubbed foot. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**25%**
	The undergoing of surgery to correct bilateral clubbed feet. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**50%**
	The survival period applies to this illness.	
Congenital blindness	Confirmed diagnosis of total visual loss in one eye at birth by the treating specialist. **Requirements for a claim to be considered** • Supportive clinical evidence	**50%**
	Confirmed diagnosis of total visual loss in both eyes at birth by the treating specialist. **Requirements for a claim to be considered** • Supportive clinical evidence	**100%**
	The survival period applies to this illness.	
Congenital deafness	Confirmed diagnosis of total hearing loss in one ear at birth by the treating specialist. **Requirements for a claim to be considered** • Supportive clinical evidence using the Automated Otoacoustic Emission Test or the Automated Brainstem Response Test (or equivalent measure)	**50%**
	Confirmed diagnosis of total hearing loss in both ears at birth by the treating specialist. **Requirements for a claim to be considered** • Supportive clinical evidence using the Automated Otoacoustic Emission Test or the Automated Brainstem Response Test (or equivalent measure)	**100%**
	The survival period applies to this illness.	
Congenital heart disease	The correction of any congenital structural abnormality of the heart, through any minimally invasive surgery. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any investigative procedure • Patent ductus arteriosus	**50%**
	The correction of any congenital structural abnormality of the heart, through surgically opening the chest cavity (thoracotomy or sternotomy). **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any investigative procedure	**100%**
	The survival period applies to this illness.	

Congenital hip dislocation	The undergoing of surgery to correct congenital unilateral hip dislocation. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**25%**
	The undergoing of surgery to correct congenital bilateral hip dislocation. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**50%**
	The survival period applies to this illness.	
Cystic fibrosis	Confirmed diagnosis of cystic fibrosis by the treating specialist. **Requirements for a claim to be considered** • A diagnostic sweat test • Pulmonary complications (e.g. recurrent pneumonia, suppurative lung disease, lung abscesses) confirmed by radiological investigations	**100%**
	The survival period applies to this illness.	
Down syndrome	Confirmed diagnosis of Down syndrome by the treating specialist. **Requirements for a claim to be considered** • Supportive genetic tests	**100%**
	The survival period applies to this illness.	
Duchenne syndrome or congenital myotonic dystrophy	Confirmed diagnosis of one of the following by the treating specialist: • Duchenne muscular dystrophy • Congenital myotonic muscular dystrophy (MMD 1) **Requirements for a claim to be considered** For Duchenne muscular dystrophy: • Evidence of clinical symptoms • Raised creatine kinase • Muscle biopsy with abnormal levels of dystrophin protein For congenital myotonic muscular dystrophy: • Supportive genetic tests	**100%**
	The survival period applies to this illness.	

Haemophilia	Confirmed diagnosis of haemophilia by the treating haematologist.
	Requirements for a claim to be considered
	• Despite adequate treatment for at least 6 consecutive months, both of the following are present:
	  • 1% of the normal clotting factor in the blood
	  • At least four units of blood or blood products has been transfused per month for at least 3 consecutive months
		50%

	The survival period applies to this illness.	
Hirschsprung's disease	Confirmed diagnosis of Hirschsprung's disease by the treating specialist. **Requirements for a claim to be considered** • Full-thickness rectal biopsy	**50%**
	The survival period applies to this illness.	

20.11.5 Returning Illness Benefit

For Severe Illness Cover, once 100% of the cover amount has been paid out for a group of related illnesses, an insured person will no longer receive a payout for subsequent related claims. The Returning Illness Benefit provides only one additional payout on a future related claim for 15 qualifying events where 100% has previously been claimed. The benefit provides a payment on recurrence of certain related illnesses, once 100% of the cover amount has been paid. The maximum benefit payment is 50% of the cover amount.

- The Returning Illness Benefit only applies to the following 15 events offered under Severe Illness Cover:
  - Aortic Surgery
  - Artery Surgery
  - Brain surgery
  - Cancer
  - Carotid Artery Surgery
  - Coronary Artery Bypass Graft
  - Heart Attack
  - Heart Surgery
  - Heart Valve Replacement or Repair
  - Lung surgery
  - Non-melanoma skin cancer Stage III or IV
  - Partial mastectomy
  - Pericardiectomy
  - Pulmonary Artery Surgery
  - Stroke
- The Returning Illness Benefit may provide multiple payouts for unrelated claims.

Suspension period

- A Returning Illness Benefit payment is subject to a 180-day benefit suspension period.
- No claim will be considered under the Returning Illness Benefit during the suspension period.
- The start date of the suspension period is as follows:
  - For cancer and non-melanoma skin cancer Stage III or IV, the date of complete remission by the treating specialist.
  - For the other qualifying events, the date of the last related claim's date of event.
- For cancer and non-melonoma skin cancer Stage III or IV, the Returning Illness Benefit will only pay out on cancer recurrence.
  - Cancer recurrence is defined as the return of cancer after the insured person was deemed to be in complete remission.
  - Complete remission is when cancer can't be detected after the completion of any relevant treatment, as confirmed by the treating specialist.

Claiming Returning Illness Benefits

An insured person will only be eligible for a payout under the Returning Illness Benefit if 100% of the cover amount has already been paid for a group of related illnesses containing the qualifying event. If say, 75% of cover amount had been paid, the insured person would not be eligible for the Returning Illness Benefit on the next claim. The insured person would have to first receive the remaining 25% of the cover amount. If they then submit a second subsequent valid claim, they would be eligible for the Returning Illness Benefit.

Subsequent Returning Illness Benefit claims

For Severe Illness Cover sold on its own, an insured person is allowed to claim for subsequent events if:

- the insured person suffers another returning severe illness more than 30 days after a previous one, and
- the total percentage already paid for a related illness group containing one of the qualifying events equals 100%,
- the insured person hasn't received a previous payout under the Returning Illness Benefit for the same related event.
  - The Returning Illness Benefit can also only be claimed once for the same related event.
  - If a potential future claim is related to a previous successful claim paid under the Returning Illness Benefit, it won't be valid.

If the insured person suffers more than one event within 30 days, the total amount we'll pay is for the event that qualifies for the higher payout. This applies across all events covered under Severe Illness Cover and all benefits and features. If the first claim within 30 days has already been paid but the second claim is higher, we'll reduce the second payout to only pay the difference.

Returning Illness Benefit won't be available on Severe Illness Cover add-on. Once the insured person has claimed 100% of the cover amount on Severe Illness Cover add-on that's attached to Life Cover, the benefit stops.

Percentage payout for subsequent claims

- The maximum payout under the Returning Illness Benefit will be 50% of the cover amount.
- The actual payout will depend on the severity of the illness. The insured person will receive either:
  - 25% (at severity level D) or
  - 50% (at all other severity levels).
- This benefit's capped at 50%. If the insured person has an illness that recurs at the 75% or 100% severity level, they'll only be paid 50% of the cover amount.

Example: Returning illness claims

Sally has R1 000 000 Severe Illness Cover with the Returning Illness Benefit. She's diagnosed with cancer at severity level A (100%). She receives a tiered payout of R1 000 000 (R1 000 000 x 100%). In total, Sally has received a maximum 100% of the cover amount (R1 000 000). Sally undergoes treatment and is subsequently deemed to be in complete remission by her treating specialist. Sally's cancer recurs one year later at severity level D. Under the Returning Illness Benefit, she receives a payout of R250 000 (R1 000 000 x 25%). The Returning Illness Benefit's only paid once for related illnesses.

When Sally's cancer later progresses to severity level C (50%), she's isn't eligible for a payout. Sally then has an unrelated heart attack of severity A (100%). She receives a tiered payout of R1 000 000 (R1 000 000 x 100%). Three years later she suffers a further heart attack at severity level C (50%). Under the Returning Illness Benefit, she receives a further payout of R500 000 (R1 000 000 x 50%).

Example: Suspension period

Maryke has R1 000 000 Severe Illness Cover with the Returning Illness Benefit. She suffers a heart attack at severity level A (100%). She receives a tiered payout of R1 000 000 (R1 000 000 x 100%). In total, Maryke has received a maximum 100% of her cover amount (R1 000 000). She has a further heart attack two months later at severity level D (25%). Because the event occurred within the 180-day suspension period, she's not eligible for a Returning Illness Benefit payment, and receives no payout.

195 days after her first heart attack (for which she received a 100% payout), Maryke has another heart attack at severity level B (75%). The date of the event isn't in the suspension period, and she receives a payout of R500 000 [R1 000 000 x min (75%; 50%)] under the Returning Illness Benefit. In total, Maryke has received a maximum of 150% of her cover amount. She'll receive no further payouts for related illnesses.

Example: Requirement to have previously claimed 100%

Rethabile has R1 000 000 Severe Illness Cover with the Returning Illness Benefit. She's diagnosed with cancer at severity level D (25%). She receives a tiered payout of R250 000 (R1 000 000 x 25%). Rethabile undergoes treatment and is subsequently deemed to be in complete remission by her treating specialist. Rethabile's cancer recurs one year later at severity level D (25%). She doesn't have a valid claim under Severe Illness Cover, because her cancer isn't at a higher severity. She doesn't qualify for a payment under the Returning Illness Benefit, because 100% hasn't been paid for the group of related illnesses containing the cancer severe illness.

She then has brain surgery, covered at severity level A (100%) which is deemed related to her previous cancer payout. She receives a payout of R750 000 [R1 000 000 x min [100%; (100% - 25%)]]. In total, she has received a maximum of 100% of her cover amount for related illnesses.

She subsequently goes into complete remission again. Her cancer recurs five years later at severity level C (50%). She doesn't have a valid claim under Severe Illness Cover, because she has received a maximum of 100% for related illnesses. She now has a valid claim under the Returning Illness Benefit. She receives a payout of R500 000
[R1 000 000 x (min 50%; 50%)].

Adding or removing the benefit

- If the Returning Illness Benefit's added after the start of the contract, the insured person will be re-underwritten.
- This may result in specific exclusions. If the insured person claimed on Severe Illness Cover before adding the Returning Illness Benefit, it's likely that any events related to previous claims will be excluded.

Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that is generally excluded.

We won't pay if:

- the owner fails to meet our requirement to tell us about changes to the circumstances of the insured person (See changes to the circumstances of the insured person),
- the insured person's illness is caused by:
  - unrest, war or terrorist activity,
  - radioactivity or nuclear explosion,
  - provoking, committing or attempting to commit a crime for example murder, assault, housebreaking, theft, robbery, the forceful detention of another person or any similar crime or
  - self-inflicted injury.
- the insured person suffers a related severe illness within 180 days of suffering a severe illness that resulted in us paying 100% of the cover amount in total for related severe illnesses,
- the insured person's returning severe illness is before the cover start date,
- we don't recognise the insured person's returning severe illness,
- the insured person's returning severe illness is because of an exclusion or
- the survival period isn't met.

We won't recognise the insured person's returning severe illness if they suffer a returning severe illness that:

- isn't on the list of returning severe illnesses,
- is at the severity that the contract doesn't cover or
- doesn't meet all the requirements that the returning severe illness must meet to qualify.

Cover stops on the earliest of the following:

- At the end of the term, if term cover was chosen.
- If the cover lapses.
- If the insured person no longer qualifies for the cover because of changes to their circumstances.
- If the contract is cancelled.
- If the benefit's removed from the contract.

20.11.5.1 RETURNING ILLNESS BENEFIT EVENTS (15 Illnesses)

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
CANCER		

Cancer	Confirmation of a malignant tumour diagnosed and characterised by the uncontrolled growth of malignant cells and invasion beyond the layer of cells in which it originated into a deeper layer of tissue. The term malignant tumour includes leukaemia, sarcoma and lymphoma.
	
	All cancers classified as **Stage I** by the American Joint Committee for Cancer are covered, where the following cancers are only covered as specified:
	• Prostate cancer is covered when histologically classified as Gleason score of more than 6, or at least TNM staging T2N0M0
	• Malignant melanoma is covered from T1N0M0
	• Ductal carcinoma in situ (DCIS) of the breast is covered if microinvasion is present
	• Borderline ovarian tumours from Stage I are covered
	• Brain tumours from WHO Grade II are covered
	
	Exclusions
	• All cancers which are histologically classified as any of the following:
	  • pre-malignant
	  • non-invasive
	  • cancer in situ, unless specified above
	  • having borderline malignancy, unless specified above
	  • tumours with low malignant potential
	• All prostate cancers, unless conforming to the specifications above
	• All skin cancers, except malignant melanoma as specified above
		25%

	Confirmation of a malignant tumour diagnosed and characterised by the uncontrolled growth of malignant cells and invasion beyond the layer of cells in which it originated into a deeper layer of tissue. The term malignant tumour includes leukaemia, sarcoma and lymphoma.
	
	All cancers classified as **Stage II** by the American Joint Committee for Cancer are covered, where the following cancers are only covered as specified:
	• Prostate cancer is covered from Stage III
	• Malignant melanoma is covered from Stage II
	• WHO Grade II brain tumours are covered if neurological deficit is present
	• Blood cancers are covered at the stages specified below
	  • Chronic Lymphocytic Leukemia, from Stage II on the Rai classification
	  • Chronic Myeloid Leukemia (no bone marrow transplant)
	  • Hodgkin's/Non Hodgkin's lymphoma from Stage II on the Ann Arbor classification
	  • Multiple Myeloma Stage from Stage I on the Durie-Salmon Scale
	
	Exclusions
	• All cancers which are histologically classified as any of the following:
	  • pre-malignant
	  • non-invasive
	  • cancer in situ
	  • having borderline malignancy
	  • tumours with low malignant potential
	• All prostate cancers, unless conforming to the specifications above
	• All skin cancers, except malignant melanoma as specified above
	• All blood cancers, unless as specified above
		50%

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%

	Confirmation of a malignant tumour diagnosed and characterised by the uncontrolled growth of malignant cells and invasion beyond the layer of cells in which it originated into a deeper layer of tissue. The term malignant tumour includes leukaemia,
	
	All cancers classified as **Stage III or IV** by the American Joint Committee for Cancer are covered, where the following cancers are only covered as specified:
	• Prostate cancer is covered from Stage IV
	• Malignant melanoma is covered from Stage III
	• WHO Grade III and IV brain tumoursBlood cancers are covered at the stages specified below
	  • Acute Myeloid Leukemia
	  • Chronic Lymphocytic Leukemia, from Stage III on the Rai classification
	  • Chronic Myeloid Leukemia (requiring bone marrow transplant)
	  • Acute Lymphocytic Leukemia
	  • Hodgkin's/Non Hodgkin's lymphoma from Stage III on the Ann Arbor classification
	  • Multiple Myeloma Stage from Stage III on the Durie-Salmon Scale	

	Exclusions
	• All cancers which are histologically classified as any of the following:
	  • pre-malignant
	  • non-invasive
	  • cancer in situ
	  • having borderline malignancy
	  • tumours with low malignant potential
	• All prostate cancers, unless conforming to the specifications above
	• All skin cancers, except malignant melanoma as specified above
	• All blood cancers, unless as specified above sarcoma and lymphoma	

	Illnesses that will be considered related None **Illnesses that may be considered related** Brain surgery, Cancer, Non-melanoma skin cancer Stage III or IV, Partial mastectomy	
Non-melanoma skin cancer Stage III or IV	Confirmed diagnosis of any non-melanoma skin cancer classified as Stage III or IV by the American Joint Committee for Cancer.	**50%**
	I**llnesses that will be considered related** None **Illnesses that may be considered related** Cancer, Non-melanoma skin cancer Stage III or IV	
Partial mastectomy	The undergoing of a partial mastectomy for ductal or lobular carcinoma in situ. **Requirements for a claim to be considered** • Histological evidence of ductal or lobular carcinoma in situ • Surgical reports confirming the removal of at least 50% of the affected breast **Exclusions** • Lumpectomy • Quadrantectomy	**25%**
	Illnesses that will be considered related Partial mastectomy **Illnesses that may be considered related** Cancer	

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
CARDIOVASCULAR		
Aortic surgery	The repair of a narrowing, obstruction, dissection or aneurysm of either the main thoracic or abdominal aorta, by means of any minimally invasive surgical technique. This includes keyhole or catheter techniques, or a mini-thoracoscopic/laparoscopic surgical procedure. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **NOTE**: Branches of the aorta are covered under Artery surgery	**25%**
	The repair of a narrowing, obstruction, dissection or aneurysm of either the main thoracic or abdominal aorta through surgically opening the chest cavity (thoracotomy) or the abdominal cavity (laparotomy). **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **NOTE**: Branches of the aorta are covered under Artery surgery	**50%**
	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related Aortic surgery **Illnesses that may be considered related** Heart surgery, Heart valve replacement or repair, Stroke	

Artery surgery	One of the following:
	• The repair of a narrowing, obstruction, dissection or aneurysm of a specified artery, by means of any surgical technique. This includes keyhole or catheter techniques or bypass grafts. The following arteries are covered:
	  • Subclavian
	  • Brachiocephalic
	  • Splenic
	  • Renal
	  • Iliac
	  • Femoral
	• The undergoing of surgery to correct the narrowing of, or blockage to, any artery in the arms, hands legs or feet by means of a bypass graft
	
	Requirements for a claim to be considered:
	
	Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis
		25%

	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related Artery surgery **Illnesses that may be considered related** Carotid Artery Surgery	

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Carotid artery surgery	The repair of a narrowing, obstruction, dissection or aneurysm of one carotid artery, by means of a bypass graft or endarterectomy. **Requirements for a claim to be considered** Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**25%**
	The repair of a narrowing, obstruction, dissection or aneurysm of both carotid arteries, by means of any surgical technique. This can be conducted over multiple surgeries, including bypass grafts, endarterectomies or endovascular procedures. **Requirements for a claim to be considered** Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**50%**
	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related Carotid artery surgery, Stroke **Illnesses that may be considered related** None	
Coronary artery bypass graft	The undergoing of surgery to correct the narrowing of, or blockage to, one or more coronary arteries by means of a bypass graft.	**50%**
	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related Coronary artery bypass graft, Heart attack, Heart surgery **Illnesses that may be considered related** None	

Heart attack	Confirmed diagnosis of a heart attack by the treating cardiologist characterised by death of heart muscle, due to inadequate blood supply.
	
	Requirements for a claim to be considered
	
	• Raised cardiac biomarkers with at least one reading above the upper reference level
	• One of the following must be present:
	  • Compatible clinical symptoms
	  • New characteristic electrocardiography (ECG) changes indicative of myocardial ischaemia or myocardial infarction
	  • Angiography showing critical occlusion of a coronary artery indicative of myocardial ischaemia or myocardial infarction
	  • Evidence of hypokinesis on ECHO confirming the death of heart muscle tissue
	
	Exclusions
	
	• Other acute coronary syndromes (including but not limited to angina and unstable angina)
	• Coronary spasms
	
	Elevations of troponin in the absence of overt ischemic heart diseases (e.g. myocarditis, apical ballooning, cardiac contusion, pulmonary embolism, drug toxicity)
		25%

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%

	Confirmed diagnosis of a heart attack by the treating cardiologist characterised by death of heart muscle, due to inadequate blood supply.
	
	Requirements for a claim to be considered
	• Raised cardiac biomarkers with at least one reading above the upper reference level
	• Two of the following must be present:
	  • Compatible clinical symptoms
	  • New characteristic electrocardiography (ECG) changes indicative of myocardial ischaemia or myocardial infarction
	  • Angiography showing critical occlusion of a coronary artery indicative of myocardial ischaemia or myocardial infarction
	  • Evidence of hypokinesis on ECHO confirming the death of heart muscle tissue
	
	Exclusions
	• Other acute coronary syndromes (including but not limited to angina and unstable angina)
	• Coronary spasms
	
	Elevations of troponin in the absence of overt ischemic heart diseases (e.g. myocarditis, apical ballooning, cardiac contusion, pulmonary embolism, drug toxicity)
		50%

	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related Coronary artery bypass graft, Heart attack, Heart surgery **Illnesses that may be considered related** None	
Heart surgery	The correction of any structural abnormality of the heart, through surgically opening the chest cavity (thoracotomy or sternotomy). **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any investigative procedure **NOTE**: Coronary artery bypass graft is covered as a separate severe illness	**50%**
	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related Coronary artery bypass graft, Heart surgery, Heart valve replacement or repair **Illnesses that may be considered related** None	
Heart valve replacement or repair	The undergoing of heart surgery to repair one or more diseased heart valves, through surgically opening the chest cavity (thoracotomy or sternotomy). **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any investigative procedure	**50%**

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
	The undergoing of heart surgery to replace one or more diseased heart valves, by means of any surgical technique. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any investigative procedure	**50%**
	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related Arrhythmia, Heart surgery, Heart transplant, Heart valve replacement or repair, Stroke **Illnesses that may be considered related** Activities of Daily Living, Aortic surgery, Cardiomyopathy, Pulmonary artery surgery, Terminal illness	
Pericardiectomy	The excision of a portion of the pericardium as treatment for a disease affecting the pericardium/pericardial sac, by means of any surgical technique. This includes endoscopic or keyhole procedures. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** Any investigative procedure	**25%**
	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related Pericardiectomy **Illnesses that may be considered related** Heart surgery	
CENTRAL NERVOUS SYSTEM		
Brain surgery	Any condition for which the insured person has undergone open brain surgery. This must involve a craniotomy (where there is surgical removal of part of the bone from the skull to expose the brain). This includes depressed skull fracture requiring removal of bone or reconstruction of the skull. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Stereotactic or radiosurgery • Burr hole surgery Any minimally invasive surgery such as keyhole or endovascular surgery	**50%**
	Illnesses that will be considered related Brain surgery **Illnesses that may be considered related** Cancer, Stroke	

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Stroke	Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in neurological deficit lasting longer than 24 hours, confirmed by neuroimaging investigation and appropriate clinical findings by a specialist neurologist. Stroke as a result of traumatic injury to brain tissue or blood vessels is included. **Exclusions** • Transient ischaemic attack • Vascular disease affecting the eye or optic nerve Migraine and vestibular disorders	**25%**

	Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in neurological deficit, confirmed by neuroimaging investigation and appropriate clinical findings by a specialist neurologist. Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months.
	
	Stroke as a result of traumatic injury to brain tissue or blood vessels is included.
	
	Requirements for a claim to be considered
	
	• One of the following must be present:
	  • The inability to do 3 or more Advanced Activities of Daily Living
	  • A Whole Person Impairment (WPI) of 11%- 20%. WPI figures are calculated as per the latest version of the American Medical Association Guides to the Evaluation of Permanent Impairment
	
	Exclusions
	
	• Transient ischaemic attack
	• Vascular disease affecting the eye or optic nerve
	
	Migraine and vestibular disorders
		50%

	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related Carotid Artery Surgery, Stroke **Illnesses that may be considered related** Brain surgery	
RESPIRATORY		
Lung surgery	The undergoing of surgery to remove more than one lobe of the lung due to any physical injury or disease. **Requirements for a claim to be considered** Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	**50%**
	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related Lung surgery **Illnesses that may be considered related** None	

BODY SYSTEM	REQUIREMENTS TO QUALIFY	%
Pulmonary artery surgery	The undergoing of surgery to the pulmonary artery through surgically opening the chest cavity (thoracotomy or sternotomy). There must be excision and replacement of a portion of the diseased pulmonary artery with a graft. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any investigative procedure Any other surgical procedure, e.g. the insertion of stents or endovascular repair	**50%**
	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related Heart surgery, Pulmonary artery surgery **Illnesses that may be considered related** None	

ADVANCED ACTIVITIES OF DAILY LIVING SCALE (AADL)	
Activity	**Description**
Driving a car	The ability to open a car door, change gears or use a steering wheel.
Medical care	The ability to prepare and take the correct medication.
Money management	The ability to do one's own banking and to make rational financial decisions.
Communicative activities	The ability to communicate either verbally or written.
Shopping	The ability to choose and lift groceries from shelves as well as carry them in bags.
Food preparation	The ability to prepare food for cooking as well as using kitchen utensils.
Housework	The ability to clean a house or iron clothing.
Community ambulation with or without assistive device, but not requiring a mobility device	The ability to walk around in public places using only a walking stick if necessary.
Moderate activities	Activities like moving a table, pushing a vacuum cleaner, bowling, golf.
Vigorous activities	Able to partake in running, heavy lifting, sports.

FUTURE INSURANCE

21. OLD MUTUAL PROTECT FUTURE INSURANCE

FUTURE LIFE COVER

Future Life Cover doesn't pay any cover amount. It allows customers to use their current state of health to secure the option to apply for cover in the future with very limited underwriting at the time of exercising the option. It gives the owner the option to apply for new Old Mutual Protect products and/or increase the level of cover on an existing product every two years or on specific events.

Future Life Cover allows the owner to increase or add new cover for:

- Life Cover
- Life Income Cover
- Business Life Cover

Adding the Disability and Illness Benefit expands the list of cover to include:

- Disability Cover
- Functional Impairment Cover
- Physical Impairment Cover
- Severe Illness Cover
- Disability Income Cover
- Functional Impairment Income Cover
- Business Disability Cover
- Business Severe Illness Cover
- Business Expenses Cover

Cover will be available for these products provided that we haven't discontinued the cover and/or range. The owner can apply for any other cover(s) as determined by us at the time of application. We are entitled from time to time to determine the cover(s) Future Life Cover can be exercised on.

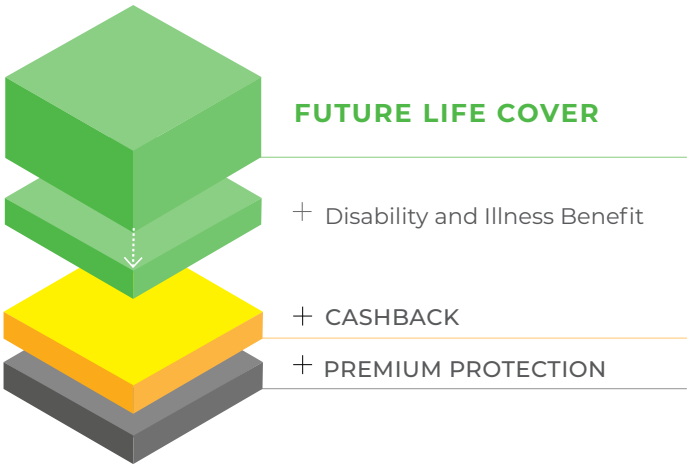
Exercising an option to apply for cover under one event doesn't affect the owner's ability to apply for cover on other events.

A Future Life Cover contract will only cover events that happen after the applicable (new or increased) cover starts.

Future Life Cover is designed for customers with the following needs:

- Want to increase or take new cover for their personal or business insurance as their needs change.
- Want to get Old Mutual Protect insurance with their current state of health.

21.1 Future Life Cover overview



21.2 Future Life Cover product features

TYPE OF COVER	FUTURE LIFE COVER
Eligible lives	· All lives are eligible, subject to entry age limits and underwriting · Not available to insured persons who, at inception would be subject to a risk premium increase
Relationship to owner	There must be an insurable interest if the owner and insured person aren't the same person.
Maximum number of insured persons	One
Entry age limits	**Minimum:** 15 next birthday **Maximum**: 55 next birthday
Premium frequency	Monthly Monthly with the option to skip one premium a year Yearly
Premium term	Benefit term or Retirement (minimum premium term of 10 years)
Compulsory yearly premium increase	0% fixed rate
Guarantee term	1 year
Cover amount limits	**Minimum**: R400 000 **Maximum:** · Employed: R15 000 000 · Home executives: R2 500 000 · Students: R2 500 000 · Unemployed: R2 500 000

Benefit term	**Term** (minimum of 5 years)
Cover end age	65 next birthday
Scheduled yearly cover increase	0% fixed rate 5% fixed rate 10% fixed rate Inflation-linked: CPI + 0%, 1%, 2%, 3%, -1%, -2% Scheduled yearly cover increases apply to the full cover amount of Future Life Cover, irrespective of whether a portion of the cover has been exercised already.
Underwriting method	· No medical tests, only questions · Medical tests, questions or both
Underwriting credit	If the insured person completed 'medical tests, questions or both' for an amount less that the upper limit of a particular underwriting band, they could qualify for: · Single underwriting credit · Comprehensive underwriting credit

21.3 Definitions

Cover amount for Future Life Cover:

- This is the amount of future cover that can be used to apply for new Old Mutual Protect products or increase cover on an existing Old Mutual Protect product.
- The cover amount of Future Life Cover will escalate if a scheduled yearly cover increase is selected.
- The total options exercised for all Future Life Cover may not exceed the cover amount of Future Life Cover.
- The cover amount of Future Life Cover doesn't decrease if exercising an option.

21.4 Exercising Future Life Cover

21.4.1 Exercise percentage

- This is the percentage of the cover amount of Future Life Cover available.
  - These percentages vary according to the event covered.
  - Specified events have specific rules and conditions in terms of when of how many times they may be exercised which must be checked.
  - The owner can choose how much of the exercise percentage to apply for on each event, as long as:
    - it doesn't exceed the underwriting limits
    - it doesn't exceed the respective cover limits at the time
    - the total amount exercised doesn't exceed the cover amount of the Future Cover.
  - At exercise date, the financial underwriting of the cover that is purchased will be applied. This may limit the exercise percentage.

21.4.2 Exercise amount

- The exercise amount is the amount of cover that can be applied for with limited medical underwriting.
- The exercise amount is the exercise percentage times the cover amount of Future Life Cover at the time of exercising the option, subject to financial underwriting limits.
- The exercise amount available will be constrained to the amount that hasn't yet been exercised on Future Life Cover.
- If the Disability and Illness Benefit is selected, the exercise amount can be used to purchase any combination of Old Mutual Protect products.
- The owner can apply for cover when an option event happens to the insured person.
- The owner can apply for a percentage of the cover amount that applies on the date of the option event, as determined by us.
- The option events, their requirements and the maximum percentage of the benefit's cover amount in each case are shown in the list of option events that qualify in the tables which follow.
- The cover amount for Future Life Cover won't display the decreased amount after an option is exercised. However, the total amount for all events exercised can't exceed the cover amount of the Future Life Cover.
- The following will be implemented according to the cover applied for:
  - Cover minimums
  - Cover maximums (all similar benefits with us will be considered when determining the specific maximum cover limit applicable to the insured person)
  - Minimum contractual premium
  - Benefit term
  - Cover increases
  - Premium patterns
- The owner and insured person on the new or increased cover must be the same as the owner and insured person on Future Life Cover.
- The rules and limitations of the product that is purchased will be applied (e.g. entry age).
- When exercising an option, the financial underwriting of the cover being purchased will be applied.

21.5 Validity period of options

- An application must be made within 60 days from the date the option event occurred.
- In the event of a same-sex or heterosexual union, the validity period is a period of 60 days from the date on which our requirements in regard to the marriage, or in regard to the permanent separation, as the case may be, have been satisfied.

21.6 Income cover that can be applied for

A single cover amount needs to be converted to a monthly cover amount if Future Life Cover is exercised to buy any of the following income products:

- Life Income Cover
- Disability Income Cover
- Functional Impairment Income Cover
- Business Expenses Cover

21.7 Financial conversion factors

A financial conversion factor is used to calculate the monthly cover amount that can be applied for.

AGE NEXT BIRTHDAY OF THE INSURED PERSON	FINANCIAL CONVERSION FACTOR	
	LIFE INCOME COVER	DISABILITY INCOME COVER FUNCTIONAL IMPAIRMENT INCOME COVER BUSINESS EXPENSES COVER
1-20	360	240
21-25	360	240
26-30	360	240
31-35	360	240
36-40	300	240
41-45	300	240
46-50	300	240
56-60	240	144
61-65	180	96
>65	120	12

The exercise amount is calculated as follows:

Exercise amount = min (exercise % x cover amount time of exercise, max (cover amount of Future Life Cover - cover amount of Future Life Cover exercised to date,0)) x (1 / financial conversion factor)

Example

Sam, 30 next birthday, has R4 000 000 Future Life Cover and has never exercised any of his cover to date. He just got married and would like to exercise his Future Life Cover to buy Disability Income Cover. The maximum percentage of the cover amount that can be exercised is 50%.

His maximum exercise amount can be calculated as follows:

Exercise amount = min (exercise % x cover amount at time of exercise, max(cover amount of Future Life Cover –cover amount of Future Life Cover exercised to date,0)) x (1/(12 x financial conversion factor))

$$\frac{\text{Minimum (50\% x R4 000 000; Maximum(R4 000 000 - R0 ; 0))}}{240}$$

= R8 334

Sam's wife Amanda, 28 next birthday, also has R4 000 000 Future Life Cover. She would like to exercise her Future Life Cover to buy Functional Impairment Income Cover, but has previously exercised 50% (R2 000 000) and 25% (R1 000 000) respectively.

Her maximum exercise amount can be calculated as follows:

Exercise amount = min (exercise %×cover amount time of exercise, max(cover amount of Future Life Cover −cover amount of Future Life Cover exercised to date, 0)) x (1/(12 x financial conversion factor))

$$\text{Minimum (50\% x R4 000 000; Maximum(R4 000 000 - R3 000 000 ; 0))} \over 240$$

= R4167

21.8 Benefits and other features

The following benefit can be attached to Future Life Cover:

- Disability and Illness Benefit.

21.8.1 Disability and Illness Benefit

Adding the Disability and Illness Benefit to Future Life Cover allows the owner to apply for cover for additional disability and illness products when an option event happens to the insured person.

21.9 Add-ons

Premium protection

A maximum of two premium protection add-ons may be selected with a combination of the following:

- Premium Protection Death

  The insured person on Premium Protection Death must be different from the insured person on the cover.
- Premium Protection Retrenchment

  The insured person on Premium Protection Retrenchment must be the same as the insured person on the cover.
- Premium Protection Disability or Premium Protection Functional Impairment

  The insured person on Premium Protection Disability or Premium Protection Functional Impairment doesn't have to be the same as the insured person on the cover.

This means that adding Premium Protection Death will preclude the addition of Premium Protection Retrenchment and vice versa. See Premium Protection for more details.

Cashback

See Cashback for more details.

21.10 Option events

See the Limited Underwritng Options for more details.

21.11 Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that's generally excluded.

21.12 Future Life Cover stops on the earliest of the following:

- When the insured person dies.
- On the cover end date.
- If 100% of the cover amount for Future Life Cover has been applied for.
- If the cover lapses.
- If the contract is cancelled.

21.13 Future Life Cover events

21.13.1 Individual events

- 15% Every second anniversary of the Future Life Cover start date
- 25% The insured person's salary increases by 25% or more.
  - Only one application for this option event is allowed.
  - The insured person must be a salary earner.
  - A certified copy of the official salary slips.
- 25% The insured person starts employment in their selected field of study for the first time.
  - Only one application for this option event is allowed.
  - A certified copy of the insured person's letter of employment and proof of qualification.
- 50% The insured person's marriage.
  - If the insured person has been permanently separated (meeting the requirements for permanent separation), the new marriage must occur at least six months afterwards. Only one application for this option event is allowed. The application for cover must be within 90 days after the date of the option event.
  - Proof required on event where marriage means:
    - a marriage, customary union or union recognised under South African law, or
    - a relationship similar to marriage that is intended to be permanent.
- 50% The insured person's permanent separation.
  - The separation must occur at least six months after a marriage.
  - The insured person may only apply once for this option event.
  - The insured person must apply for cover within 90 days after the date of the option event.
  - Proof of permanent separation of two parties to a marriage.
- 50% (limited to the value of the bond)
  - The bond must be registered in the insured person's name, and
  - The application for cover must be made within three months from the date of the registration of the mortgage bond.
  - The application to exercise future cover can be made on the registration of a new or an increase in the existing mortgage bond.

- Confirmation letter from conveyancers that mortgage registration guides are ready to be lodged or
- Confirmation letter of the application to exercise future cover must be made within three months from the date of the registration of the mortgage bond.
- There is no minimum future cover amount that has to be exercised.

21.13.2 Family events

- 25% The birth of the insured person's biological child or the insured person's legal adoption of a child.
  - Certified copy of a birth certificate or a certified copy of an order of adoption.
- 25% (Limited to the first year's tuition costs multiplied by the number of years the child intends to study plus the first year's accommodation costs multiplied by the number of years the child intends to be in residence.)
  - A child's registration for studies.
  - The child must be financially dependent on the insured person, and registered for study at a:
    - Non-government funded school, or
    - Tertiary education institution. Tertiary education institution means an institution where an education qualification with an NQF (National Qualifications Framework or its replacement) Level of 5 or its equivalent and above can be obtained. Included is a university degree, national higher diploma from a recognised University of Technology or a teaching diploma from a recognised teaching college.
  - Letter from the educational institution confirming first registration and receipt of tuition fee payment.
- 25% The diagnosis of congenital mental retardation of a child.
  - A neurologist or paediatrician must diagnose that the child was born with moderate, severe or profound mental retardation using the Griffith's mental development scale (birth to two years).
  - The insured person must be the child's step, biological or adoptive parent. To qualify for cover, a stepchild's biological or legally adoptive parent must, at any time after the birth of the stepchild, have been married to the insured person. For the purposes of this definition, married means a marriage (including a customary marriage) or union recognised under South African law.
  - Letter from a neurologist or paediatrician confirming diagnosis of moderate, severe or profound mental retardation using the Griffith's mental development scale (birth to two years).
- 25% The birth of a child with spina bifida.
  - The diagnosis of spina bifida cystica with myelo-meningocoele by a neurologist or paediatrician.
  - The insured person must be the child's step, biological or adoptive parent. To qualify for cover, a stepchild's biological or legally adoptive parent must, at any time after the birth of the stepchild, have been married to the insured person. For the purposes of this definition, married means a marriage (including a customary marriage) or union recognised under South African law.
  - Letter from a neurologist or paediatrician confirming diagnosis of spina bifida cystica with myelo-meningocoele.
- 25% The diagnosis of cerebral palsy of a child.
  - The diagnosis of cerebral palsy with evidence of:
    - Impairment of motor function with established diplegic, hemiplegic or quadriplegic spasticity observed over a minimum of six months or
    - Documented mental retardation, by a neurologist or paediatrician.
  - The insured person must be the child's step, biological or adoptive parent. To qualify for cover, a stepchild's biological or legally adoptive parent must, at any time after the birth of the stepchild, have been married to the insured person. For the purposes of this definition, married means a marriage (including a customary marriage) or union recognised under South African law.

  - Letter from a neurologist or paediatrician confirming diagnosis of moderate, severe or profound mental retardation using the Griffith's mental development scale (birth to two years).
- 50% Death of a spouse/partner.
  - Only one application for this option event is allowed.
  - A certified copy of the spouse/partner's death certificate and marriage certificate.
  - Spouse/partner is the person to whom the insured person is married or with whom they are in a relationship similar to marriage that is intended to be permanent.

21.13.3 Business events

- 100% (Limited to the increased amount that the owner requires under the buy and sell agreement. Subject to financial underwriting). On the death of business partner which results in a change to the value required of the buy and sell agreement between the owner and insured person.
  - The owner can increase the existing cover on the existing buy and sell agreement between the owner and insured person within six months of the death of the business partner.
  - A certified copy of the business partner's death certificate and partnership agreement.
  - Financial underwriting evidence as per the financial underwriting requirements grid.
- 100% (Limited to the increased amount that the owner requires under the buy and sell agreement) The owner starts a new business with the insured person and as a result of a new buy and sell agreement, the owner requires more cover on the insured person.
  - The owner can increase cover on the insured person.
  - The owner and insured person can't be the same.
  - Financial underwriting evidence as per the financial underwriting requirements grid.
- 100% (Limited to the increased amount that the owner requires under the buy and sell agreement). The insured person increases their share in a business by at least 25% and as a result of a buy and sell agreement, the owner requires more cover on the insured person.
  - The owner can increase cover on the insured person.
  - The owner and insured person can't be the same.
  - Financial underwriting evidence as per the financial underwriting requirements grid.
- 50% (Limited to the increase of the insured person's monetary liability for the business). An increase in the insured person's obligations to the business' debts by at least 25%.
  - The business must have increased its business liability for a business loan by 25% or more.
  - Financial underwriting evidence as per the financial underwriting requirements grid.
- 25% (Limited to the increase of the insured person's share in the business expenses.) An increase in the insured person's obligations to the business' expenses by at least 25%.
  - The business must have increased its business expenses by 25% or more.
  - Financial underwriting evidence as per the financial underwriting requirements grid.
  - 50% (Limited to the increase of the insured person's value to business as a key individual.)
  - The insured person starts a new business and requires key person insurance.
  - Financial underwriting evidence as per the financial underwriting requirements grid.
- 50% (Limited to the increase of the insured person's value to business as a key individual). The insured person's value to a business increases by at least 25% as a key person.
  - Financial underwriting evidence as per the financial underwriting requirements grid.

RETRENCHMENT INSURANCE

22. OLD MUTUAL PROTECT RETRENCHMENT INSURANCE

Retrenchment Cover pays a monthly amount for a maximum period of up to six months if the insured person is retrenched. Retrenchment is defined as the termination of employment of the insured person by their employer as a result of, or in anticipation of business conditions, or any other business decision of the employer resulting in a staff reduction.

The insured person won't be considered as being retrenched for the following:

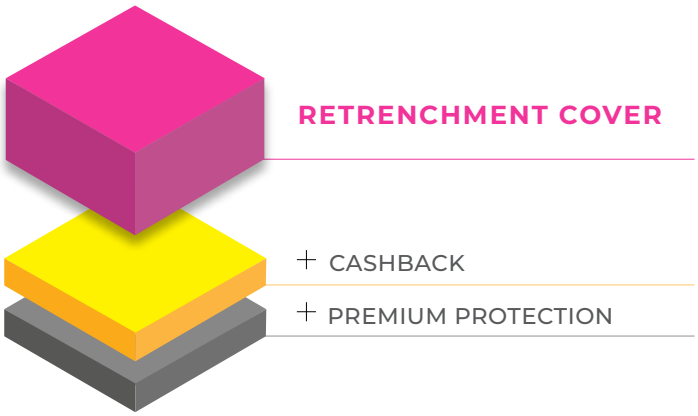
- retirement
- resignation or voluntary retrenchment
- dismissal
- the end of a fixed-term employment contract
- medically boarded because of a nervous breakdown, stress, burnout, disability or sickness.

Retrenchment Cover can't exist on its own and must be linked to another product. The insured person on Retrenchment Cover must be the same as one of the insured persons on the product it's linked to. The cover amount of Retrenchment Cover must be less than or equal to the cover amount of the product it's linked to. Similarly, the cover term must be less than or equal to the cover term of the product it's linked to.

Retrenchment Cover can be linked to the following Old Mutual Protect products:

- Old Mutual Protect Life Insurance:
  - Life Cover
  - Life Income Cover
  - Last Survivor Cover
  - Accidental Death Cover
- Old Mutual Protect Severe Illness insurance:
  - Severe Illness Cover
- Old Mutual Protect Disability Insurance:
  - Disability Income Cover
  - Functional Impairment Income Cover
  - Disability Cover
  - Functional Impairment Cover
  - Physical Impairment Cover
  - Accidental Disability and Death Cover

22.1 Retrenchment Cover overview



Retrenchment Cover is designed for customers with the following needs:

- Want a monthly income if they should get retrenched.

22.2 Retrenchment Cover product features

TYPE OF COVER	LINKED COVER THAT IS PAID AS A MONTHLY AMOUNT
Eligible lives	· Employed lives for selected occupations, subject to entry age limits and underwriting. · At the date of application the insured person must have been continuously employed in a permanent full-time job for at least two years, of which at least one year must have been with their existing employer. · The following insured persons won't qualify for Retrenchment Cover: – contract workers, part-time worker, temporary worker, casual worker, seasonal worker, self employed, sole proprietor, business partner – unemployed, employed in a family business where they're a member of the family, employed where the employer, branch, office or business is outside South Africa. · Insured persons working in the following industries won't qualify for Retrenchment Cover: – mining, fishing, building, sports, taxi, debt collecting, civil service, state-owned enterprise or – in an industry that's associated with any of the above.

Relationship to owner	There must be an insurable interest if the owner and insured person aren't the same person.
Maximum number of insured persons	One
Entry age limits	**Minimum:** 18 next birthday **Maximum:** 60 next birthday
Cover end age	65 next birthday
Benefit term	**Term** (minimum of 5 years) The term must be less than or equal to that of the cover to which Retrenchment Cover is linked to.
Premium frequency	Monthly (excluding the option to skip one premium)
Premium term	Benefit term
Compulsory yearly premium increase	0% fixed rate
Guarantee term	1 year
Cover amount limits	**Minimum:** R3 000 per month **Maximum:** The minimum of: · R30 000 per month · If linked to a product that pays a single amount, the Retrenchment Cover will be limited to the cover amount of the product it's linked to divided by 12. · If linked to a product that pays a monthly amount, the Retrenchment Cover will be limited to the cover amount of the product it's linked to. The R30 000 limit will be imposed at underwriting stage. The monthly payments will be limited to 60% of the insured person's average monthly income at claims stage.
Waiting period	1 month
Scheduled yearly cover increase	0% fixed rate 5% fixed rate Inflation-linked: CPI + 0%, 1%, 2%, 3%, -1%, -2%
Underwriting method	No medical tests, only questions Subject to financial and occupational underwriting.

22.3 Add-ons

Premium protection

A maximum of two premium protection add-ons may be selected with a combination of the following:

- Premium Protection Death

  The insured person on Premium Protection Death must be different from the insured person on the cover.
- Premium Protection Disability or Premium Protection Functional Impairment

  The insured person on Premium Protection Disability or Premium Protection Functional Impairment doesn't have to be the same as the insured person on the cover. See Premium Protection for more details.

Cashback

See Cashback for more details.

22.4 Claiming Retrenchment Cover

- The cover amount can be claimed if the insured person becomes retrenched.
- A maximum of two successful claims are allowed with up to six monthly payments for each claim.
- If the insured person takes up new employment before the six monthly payments are made, the payments will stop.
- No payments will be carried from one retrenchment period to the next. The cover will end after a second valid claim whether six payments were made or not.

The monthly payment depends on both:

- The average monthly income the insured person was earning from their occupation before they became retrenched.
  - Monthly payments will be limited to 60% of the average monthly income at date of retrenchment.
  - The average monthly income is the income (salary, fees, commission) less tax that the insured person earns from their occupation, profession or business. Since the income may vary from month to month, we calculate the average over a period of time. In calculating the average monthly income, we may consider inflation.
    - Only income from occupations for which the insured person is insured under Retrenchment Cover will be included in this calculation.
    - Where the insured person is insured for two occupations under Retrenchment Cover, only the income from the occupation(s) from which the insured person has been retrenched will be included in this calculation.
- The total payment the insured person receives from retrenchment products (from both Old Mutual and other insurance companies) mustn't exceed the maximum allowable monthly payment on this Retrenchment Cover. We'll reduce the monthly payment of this Retrenchment Cover to enforce this limit.

Example: Monthly payment limited to eligible average monthly income

Jacob is an actuary and is also self-employed as an artist. His monthly income as an actuary was R50 000 and his monthly income from selling his art was R5 000 when he bought Retrenchment Cover. Jacob can buy cover for R30 000 for his occupation as an actuary (60% of his average monthly income as an actuary). Artist isn't an eligible occupation for Retrenchment Cover.

He chose a 10% scheduled yearly cover increase to ensure that the cover amount increased each year. At his first increase date, we automatically changed Jacob's cover to R33 000. Jacob then became retrenched from his employment as an actuary and his monthly income was only R52 000. We'll reduce the cover amount payable to R31 200 (60% of his average monthly income as an actuary). Jacob's income from art sales won't be considered in reducing the cover amount payable, because he's not insured for Retrenchment Cover for this occupation.

22.4.1 Monthly payments start

Once all our requirements have been met, the monthly payments for a valid claim will start at the end of the waiting period. If all our requirements are only met after the waiting period has passed, we'll start making the monthly payments but will also pay a single amount to cover the time between the end of the waiting period and the start of the monthly payments. We won't pay interest on any of these amounts. We'll make the monthly payments on the same day that the premium is due.

22.4.2 Waiting period

The waiting period is the one month during which the insured person must not become employed before we'll start making payments. It starts on the date of retrenchment as confirmed by us. Premiums must continue to be paid during the waiting period and while we decide if the claim is valid but premiums can stop once we start claim payouts. If the contract is cancelled before the waiting period ends, we won't start making payments.

22.4.3 Rules for claiming a second time

- The insured person must have been continuously employed (doesn't need to be the same employer) and qualified for this cover for at least 12 months before retrenchment for a second claim is valid.
- Where the insured person is covered for two occupations under Retrenchment Cover and is retrenched from one, a claim for their remaining occupation within 12 months of the first claim is valid, as long as they have been employed in their second occupation for more than 12 months.

Example: Maximum payments per claim

John is an accountant. He's retrenched by the firm that he works for on 1 April 2019. He lodges a Retrenchment Cover claim with us. John is unable to find employment for one month after which time Retrenchment Cover payments begin at the start of the second month of unemployment (1 May 2019). After three months of claiming, John is able to find employment with another firm and the payments stop. John is then retrenched by the new firm on 1 December 2020. He has been continuously employed for 12 months following his last retrenchment claim (1 July 2019). Thus, he's eligible for a second claim. After failing to find a job for one month, payments begin on 1 January 2021.

John can receive a maximum number of six claim payments during this retrenchment period. Even though John didn't receive the full six payments during the initial retrenchment period (he only received three), he's unable to carry forward any payments that weren't made to the second retrenchment period.

22.4.4 Payment rules

- The first monthly income payment is due on the premium due date following the expiry of the waiting period or when the claim is approved, whichever is later.
- If a claim is approved after the expiry of the waiting period, a single amount will be paid in respect of payments that were due between the end of the waiting period and the start of the monthly income payments. No interest will be added to these payments.
- Retrenchment Cover premiums aren't waived during the waiting period and are only waived while we pay the claim.

- Scheduled yearly cover increases are applicable while a claim is in payment.
- Payment will be made monthly on the same day of the month as the premium due date, unless this isn't a business day. In this case payment will be made on the first business day thereafter.
- Pro-rata payments won't be allowed. If the insured person returns to work or enters into new employment between two payment due dates (i.e. middle of the month) , the latter payment due won't be made. If the insured person has entered into new employment on the payment date no payment will be made.

22.4.5 Monthly payments stop on the earliest of the following:

- When the insured person dies.
- On the cover end date.
- If the insured person becomes employed.
- If we've made the last monthly payment that the insured person qualifies for.
- If the insured person no longer qualifies for the cover because of changes to their circumstances.
- If the contract is cancelled.

22.5 Taxation

- Under current revenue practice, premiums for income replacement cover aren't tax deductible and the income payment is exempt from tax (tax free).
- For personal income tax purposes, where the owner, insured person and beneficiary aren't the same person, the tax exemption for income benefit payments may be jeopardised.

22.6 Changes to the circumstances of the insured person on Retrenchment Cover

The owner needs to inform us if:

- there have been any changes in employment, the nature of work or income.
- the insured person make changes to their occupation, industry or employment status.
- the insured person starts performing a new occupation.
- the insured person starts performing more than one occupation, the hours per week spent performing each occupation need to be disclosed.
- the insured persons income decreases.

A new occupation class will need to be determined for the insured person if there is a change in occupation and/or industry and/or employment status and/or hours per week spent performing the occupation.

27.7 Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that is generally excluded.

We won't pay if:

- the insured person receives notice of retrenchment at any time before the cover start date,
- the insured person is retrenched or receives retrenchment notification within six months of the cover start date. This exclusion will restart from the date of any cover increase (other than as a result of scheduled yearly cover increases.)

- Termination of employment for the following reasons won't be considered as retrenchment:
  - Retirement (early, normal or ill-health) of the insured person.
  - Resignation or voluntary retrenchment of the insured person.
  - Dismissal of the insured person.
  - A fixed-term employment contract coming to an end.
  - Nervous breakdown, stress, burnout, disability or illness of the insured person.
  - Retrenchment resulting from government action.

22.8 Retrenchment Cover stops on the earliest of the following:

- When the insured person dies.
- On the cover end date.
- If we do not receive premiums and the grace period has passed.
- If the insured person no longer qualifies for the cover because of changes to their circumstances.
- Once we've paid two valid claims.
- If the contract is cancelled.

BUSINESS INSURANCE

23. OLD MUTUAL PROTECT BUSINESS INSURANCE

Business insurance ensures that businesses are accurately and comprehensively covered against long-term financial risks. Business insurance usually involves some form of financial dependency between a business and an individual. This could relate to experience and expertise provided, provision of finance, or funding the purchase of a partner/shareholder's interest in the business.

Cover initiated for the purpose of business insurance also need to consider tax implications depending on who the owner is, the insured person, what type of insurance need is addressed, who pays the premiums and who the proceeds are paid to at claim stage. Some of the tax implications that need to be considered are:

- Income tax
- Estate duty
- Capital gains tax

There are four business insurance needs:

Old Mutual Protect Business Insurance Products that cover the above needs:

- Business Life Cover
- Business Expenses Cover

23.1 Add-ons

The following add-ons can't exist on their own and have to be attached to Business Life Cover, depending on the business insurance need:

- Business Disability Cover (with or without the Own Occupation Benefit) or
- Business Functional Impairment Cover and/or
- Business Severe Illness Cover (with or without the Top-up Benefit)

23.2 BUY AND SELL INSURANCE

Buy and Sell Insurance covers the business if one of the insured persons were to die, become disabled or functionally impaired. The insurance solution allows the co-owners to take cover on each other's lives, which enables them to buy a deceased/disabled co-owners share in the business. It consists of insurance cover and a buy and sell agreement.

A buy and sell agreement is an agreement between the members of a business, obligating them to sell their interest in the business to the survivors in the business when they die or become disabled/functionally impaired. The surviving parties to the buy and sell agreement then have to purchase the deceased share in the business from the proceeds of the insurance product.

A buy and sell agreement usually comprises the following:

- Co-owners will sell their share in the business on death, disability or functional impairment.
- The remaining partners agree to buy the share in the business.
- The share in the business and method of determining the purchase price.
- An agreement as to who will pay the premiums of the contracts taken out.

Provision for the cession for value of contracts held by the executor of the first dying's estate on the lives of the surviving co-owners.

- The procedure to follow in terms of simultaneous death.
- Contracts are usually paid by the co-owners other than the insured person.

Old Mutual Protect Buy and Sell Insurance products

- Business Life Cover with the option to add-on:
  - Business Disability Cover with the option to attach Own Occupation Benefit
  - Business Functional Impairment Cover

Example

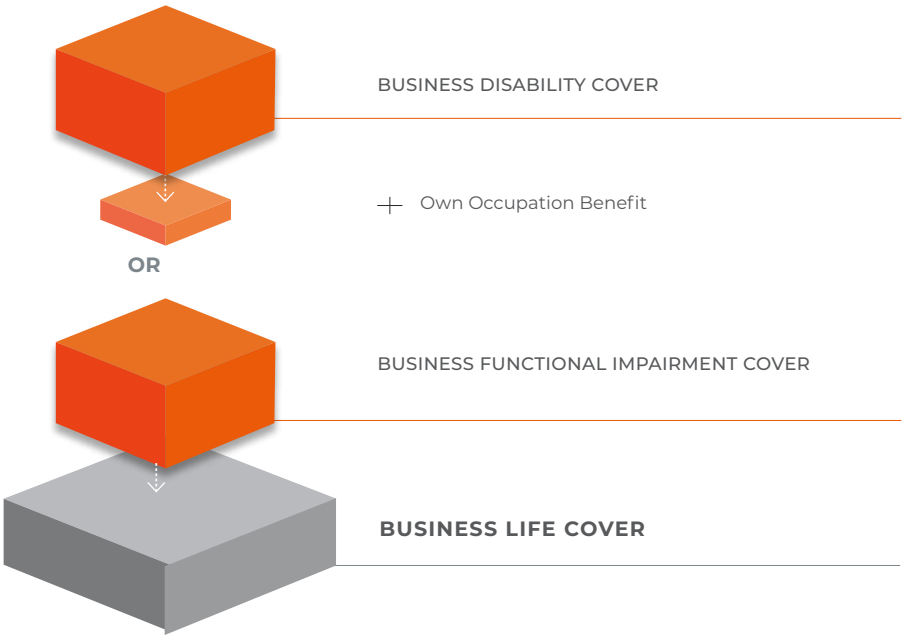
XYZ (Pty) Limited has three shareholders: Mr A, Mr B and Mr C with a shareholding in the business of 25%, 25% and 50% respectively. They have a buy and sell agreement in place that should one of the co-owners die, they can purchase the deceased co-owner's share in the business. The business accountant has valued the business at R10 000 000, and have taken out Business Life Cover as follows:

Contract 1: Mr A and Mr B are the owners and beneficiaries on this contract and Mr C is the insured person on Business Life Cover with a cover amount of R5 000 000.

Contract 2: Mr A and Mr C are the owners and beneficiaries on this contract and Mr B is the insured person on Business Life Cover with a cover amount of R2 500 000.

Contract 3: Mr B and Mr C are the owners and beneficiaries on this contract and Mr A is the insured person on Business Life Cover with a cover amount of R2 500 000.

23.2.1 Buy and Sell Insurance overview



23.3 BUSINESS CONTINGENCY

There is a risk to the business if the person standing surety for business debt dies, becomes disabled or suffers a severe illness. Finances are then required to repay the debt or any outstanding costs.

The person standing surety could incur personal liability for the debt:

- if the business can't repay the debt,
- on death, disability or severe illness,
- if no one can replace the person and no alternative security can be given.

The solution to the above is a business contingency plan. The business insures the life of the person who has signed surety for the debt/loan effected by the business. The amount of life, disability or severe illness cover should be equal to the loan amount. The business pays the premiums and an agreement is entered into between the business and the person standing surety and the business then repays the debt/loan with the proceeds of the insurance product.

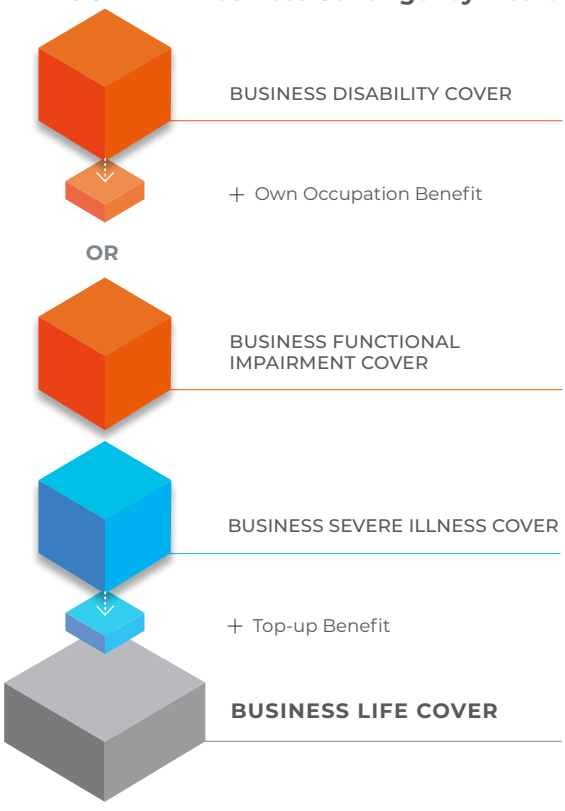
Old Mutual Protect Business Contingency Insurance products

- Business Life Cover with the option to add-on:
  - Business Disability Cover with the option to attach Own Occupation Benefit
  - Business Functional Impairment Cover or
  - Business Severe Illness Cover with the option to attach the Top-up Benefit

Example

Edmund is a co-owner in a business and stands personal surety for a loan of R1 000 000 received from ABC Bank. The funds will be used to finance a new contract that the business has received. In order to provide collateral to ABC Bank, Edmund has taken out a R1 000 000 Business Life Cover with a Business Disability Cover. In the event of Edmund dying or becoming disabled, the loan commitment to ABC Bank will be settled with the claim proceeds from Business Life Cover that was put in place as collateral, therefore ensuring that the business debt for which Edmund provided surety doesn't form part of his personal estate.

23.3.1 Business Contingency Insurance overview



23.4 KEYPERSON INSURANCE

Key person insurance is when a contract is purchased by an employer on the life of an employee to compensate the business for the loss it will have when the insured person dies, become disabled or suffers a severe illness. It guarantees that the cover amount will be paid to make up for any disruptions to the business or recruitment and training costs of a replacement. The key person should be an individual that has an important impact on future income and profits of the business.

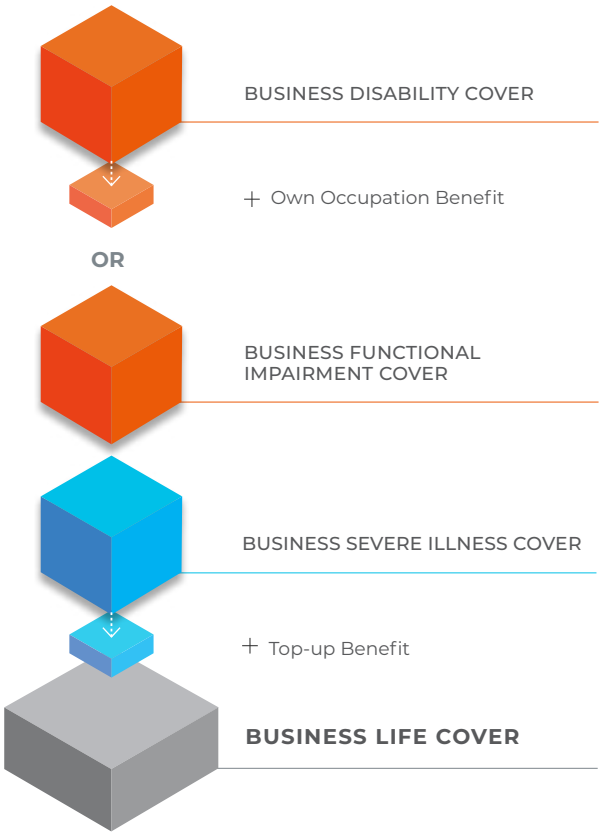
Old Mutual Protect Keyperson Insurance products:

- Business Life Cover with the option to add-on:
  - Business Disability Cover with the option to attach Own Occupation Benefit
  - Business Functional Impairment Cover or
  - Business Severe Illness Cover with the option to attach the Top-up Benefit

Example

ABC (Pty) Limited is a small company with 10 employees. Mrs Green is regarded by the owners as a key employee within the business as she's responsible for 80% of the business' monthly revenue due to her expertise in product marketing and placement. The owners of ABC (Pty) Ltd decided to take out keyperson insurance on the life of Mrs Green, due to her contribution to the monthly revenue of the business. A R500 000 Business Life Cover with a Business Disability Cover and a Business Severe Illness Cover was taken out on Mrs Green's life. If she becomes disabled, suffers a severe illness or dies, the proceeds from the cover will pay out to ABC (Pty) and can be used to up-skill and train a suitable replacement.

23.4.1 Keyperson Insurance overview



23.5 BUSINESS EXPENSES INSURANCE

There is a risk to the business if the person responsible for contributing to paying the business's monthly expenses dies or becomes disabled or functionally impaired. The overhead expenses will still need to be covered. Business expenses insurance will provide monthly payments for a limited period of time if the insured person is unable to work, due to illness or injury or suffers a functional impairment.

The monthly amount paid out will depend on how long the insured person was unable to work during the month and the extent of the disability. The principle is that the cover amount is paid out to make good the contribution that the insured person would have made to the allowable overhead expenses. If an insured person's time off work was at least as long as the selected waiting period, a claim would be considered.

Old Mutual Protect Business Expenses Insurance products:

- Business Expenses Cover

Example
Joshua is a sole proprietor and runs a plumbing business. To ensure that monthly business expenses are paid if he becomes temporarily disabled, he purchased a Business Expenses Cover with a seven-day waiting period and monthly temporary income of R10 000 per month, which will provide a temporary monthly income which can be used in the event of him being unable to work, due to illness or injury or functional impairment.

23.5.1 Business Expenses Cover overview

BUSINESS EXPENSES COVER

24. BUSINESS LIFE COVER

Business Life Cover pays the cover amount as a single amount when the insured person dies or becomes terminally ill during the term of the cover. It consists of cover with the owner having the option to select up to two additional add-ons and two premium protections.

What type of protection does Business Life Cover offer?

It's designed for business owners with the following needs:

- Want to protect their business and themselves against financial consequences of death or terminal illness.
- Want to be able to adjust their cover as their needs change.
- Want to provide the ability for the surviving co-owners in the business to buy the deceased shares in the business.
- Wants to protect the insured person against personal liability that may incur against them in the event of their death or terminal illness.
- Would like to ensure that the business would continue to operate.

24.1 Business Life Cover product features

TYPE OF COVER	BUSINESS LIFE COVER PAID AS A SINGLE AMOUNT
Eligible lives	All lives are eligible, subject to entry age limits and underwriting.
Relationship to owner	There must be an insurable interest if the owner and insured person aren't the same person.
Maximum number of insured persons	One
Entry age limits	**Minimum:** 15 next birthday **Maximum**: 80 next birthday
Premium frequency	Monthly Monthly with the option to skip one premium Yearly
Premium term	Benefit term
Compulsory yearly premium increase	0% fixed rate 5% fixed rate Age-linked
Guarantee term	5 years 10 years 15 years
Cover amount limits	**Minimum**: R100 000 per month **Maximum:** · None (Subject to underwriting)

Benefit term	· Whole-life · Term (minimum of 5 years)
Cover end age	Whole-life 100 next birthday for term cover
Scheduled yearly cover increase	0% fixed rate 5% fixed rate 10% fixed rate Inflation-linked: CPI + 0%, 1%, 2%, 3%, -1%, -2% Currency-linked: · R/GB Pound exchange rate + 0%, 5%, 10%, UK inflation · R/US Dollar exchange rate + 0%, 5%, 10%, Dollar inflation · R/EUR exchange rate 0%, 5%, 10%, Euro inflation
Underwriting method	· No medical tests, only questions · Medical tests, questions or both
Underwriting credit	If the insured person completed 'medical tests, questions or both' for an amount less than the upper limit of a particular underwriting band, they could qualify for: · Single underwriting credit · Comprehensive underwriting credit

24.2 Automatic features

Terminal illness benefit

If the insured person is diagnosed with a medical condition which, at the discretion of Old Mutual's Medical Officer will result in death within 12 months, the owner may request the payment for a terminal illness benefit. The amount of the terminal illness payout is the full cover amount of Business Life Cover at the time of claim and a successful claim will result in the Business Life Cover stopping. The terminal illness payout isn't available in the last year that cover ends if term cover was selected.

24.3 Business Life Cover stops on the earliest of the following:

- When the insured person dies.
- If the cover amount is paid when the insured person becomes terminally ill.
- On the cover end date.
- If the cover lapses.
- If the contract is cancelled.

24.4 Add-ons

A maximum of two add-ons may be attached to enhance the Business Life Cover with a combination of the following:

- Business Disability Cover

or

- Business Functional Impairment Cover

and/or

- Business Severe Illness Cover

The insured person on the cover add-on must be the same as the insured person on the Business Life Cover. Linked cover, premium protection and cashback add-ons are not available under Business Life Cover. There are no conversion options available.

24.4.1 Business Disability Cover

Business Disability Cover can't exist on its own and has to be attached to Business Life Cover.

- Business Disability Cover provides for a single amount if the insured person is permanently and irreversibly:
  - unable to perform the main duties of their occupation or another occupation for which they are reasonably suited, because of a sickness or injury or
  - becomes permanently and irreversibly functionally impaired.
- Attaching the Own Occupation Benefit allows a payment on occupational disability when the insured person is permanently and irreversibly unable to perform the main duties of their occupation because of a sickness or injury regardless of whether they are able to do another occupation for which they are reasonably suited.

24.4.1.1 Business Disability Cover product features

TYPE OF COVER	BUSINESS DISABILITY COVER IS ADD-ON COVER THAT PAYS A SINGLE AMOUNT
Eligible lives	Specified occupations as determined by our underwriters. Eligible lives are subject to underwriting and age limits.
Relationship to owner	There must be an insurable interest if the owner and insured person aren't the same person.
Maximum number of insured persons	One
Entry age limits	**Minimum:** 15 next birthday **Maximum**: 60 next birthday
Cover end age	Whole-life 70 next birthday for term cover

Premium frequency	Monthly Monthly with the option to skip one premium Yearly
Premium term	Benefit term
Compulsory yearly premium increase	0% fixed rate 5% fixed rate Age-linked
Guarantee term	5 years 10 years
Cover amount limits	**Minimum**: R100 000 **Maximum:** · R6 000 000 for whole-life cover · R30 000 000 for term cover Limited to the cover it's attached to.
Benefit term	· Whole-life · Term (minimum of 5 years)
Scheduled yearly cover increase	0% fixed rate 5% fixed rate 10% fixed rate Inflation-linked: CPI + 0%, 1%, 2%, 3%, -1%, -2% Currency-linked: · R/GB Pound exchange rate + 0%, 5%, 10%, UK inflation · R/US Dollar exchange rate + 0%, 5%, 10%, Dollar inflation · R/EUR exchange rate 0%, 5%, 10%, Euro inflation
Underwriting method	Medical tests, questions or both
Underwriting credit	If the insured person completed 'medical tests, questions or both' for an amount less than the upper limit of a particular underwriting band, they could qualify for: · Single underwriting credit · Comprehensive underwriting credit

24.4.1.2 Definitions

Occupationally disabled means that the insured person is permanently and irreversibly unable to perform the main duties of their occupation or another occupation for which they are reasonably suited, because of a sickness or injury.

Reasonably suited means an occupation that the insured person could reasonably do after re-skilling and taking into account their education, training, experience and employment history.

Functionally impaired means that the insured person has permanently and irreversibly suffered and met the requirements of a qualifying functional impairment.

Permanent and irreversible means that the insured person can't recover from the sickness or injury despite following reasonable medical advice, adequate medical treatment and having achieved maximum medical improvement as confirmed by Old Mutual's Medical Officer.

Reasonable medical advice means the medical opinion provided by a health professional that the insured person can reasonably be expected to follow to improve or preserve their health. This may include investigations, recommendations, lifestyle adjustments and treatment options based on the best available information and appropriate to the condition, the health professional's knowledge and scope of practice.

Adequate medical treatment means the best possible treatment that a person can reasonably be expected to undergo. It includes the use of simple external assistive devices for example hearing aids, glasses, contact lenses, a walking stick or a Zimmer frame but doesn't include the use of complex external assistive devices for example a wheelchair or leg prosthesis. The general meaning of the terms 'simple external
assistive devices' and 'complex external assistive devices' isn't limited by the specific examples provided.

Maximum medical improvement means that the insured person's condition can't be improved any further. It means that the insured person has fully recovered from their medical condition or that their medical condition has stabilised to the point that no major medical or emotional change can be expected despite continuing medical treatment or rehabilitative programmes.

24.4.1.3 Claiming Business Disability Cover

- The cover amount for the insured person can be claimed when they become occupationally disabled or suffer a qualifying functional impairment.
- 100% of the cover amount that applies on the date of the occupational disability or functional impairment as confirmed by Old Mutual's Medical Officer will be paid.
- The cover amount will only be paid once our requirements have been met and if the claim is valid.
- After a claim has been paid under this benefit, the cover under it stops.
- For functional impairments, the insured person will be assessed under qualifying functional impairment definitions at a severity of 100% only, with no payments for less severe functional impairments.

Example
Anthony is the insured person with R10 000 000 Business Life Cover and Business Disability Cover of R5 000 000. Anthony becomes occupationally disabled and we make a payment of R5 000 000 (R5 000 000 * 100%) under the Business Disability Cover. Because the full cover amount under the Business Disability Cover has been paid, this cover stops and the Business Life Cover reduces to R5 000 000 (R10 000 000 – R5 000 000).

How does a claim on Business Disability Cover affect the other benefits in the contract?

- A claim under Business Disability Cover will decrease the Business Life Cover's cover amount by the claim amount paid, and the Business Life Cover will continue unless the amount paid was 100% of the Business Life Cover amount.
- If Business Severe Illness Cover is also attached to Business Life Cover, its cover amount will be decreased to equal the Business Life Cover if its cover amount is higher than the remaining Business Life Cover amount.
- If the insured person qualifies for a claim on Business Disability Cover and Business Life Cover at the same time, we'll pay the claim on the Business Life Cover.

Example
Anthony is the insured person with R10 000 000 Business Life Cover, R8 000 000 Business Disability Cover and R5 000 000 Business Severe Illness Cover. Anthony becomes occupationally disabled. We make a payment of R8 000 000 (R8 000 000 * 100%) and the cover amount of the Business Disability Cover reduces to R0 and the Business Disability Cover stops.
We decrease the cover amount of the Business Life Cover to R2 000 000 (R10 000 000 – R8 000 000) and the cover amount of the Business Severe Illness Cover to R2 000 000 so that it's the same as the cover amount of the Business Life Cover.

Example
Jamie is the insured person with R2 000 000 Business Life Cover and R2 000 000 Business Disability Cover. Jamie suffers chronic respiratory failure – he qualifies for a payment equal to 100% of the cover amount on the Business Disability Cover. We pay R2 000 000 (R2 000 000 * 100%) and the cover amount of Business Disability Cover reduces to R0 and the Business Disability Cover stops.
We decrease the cover amount of the Business Life Cover to R0 (R2 000 000 – R2 000 000) and the Business Life Cover and the contract stops.

24.4.1.4 Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that is generally excluded.

We won't pay if:
- the owner fails to meet our requirement to tell us about changes to the circumstances of the insured person (See changes to the circumstances of the insured person),
- the insured person refuses to follow reasonable medical advice or adequate medical treatment or to undergo re-skilling for an occupation for which the insured person is reasonably suited,
- the insured person's occupational disability or functional impairment is caused by:
  - unrest, war or terrorist activity,
  - radioactivity or nuclear explosion,
  - them provoking, committing or attempting to commit a crime for example murder, assault, housebreaking, theft, robbery, the forceful detention of another person or any similar crime or
  - self-inflicted injury.
- the insured person's occupational disability or functional impairment is before the cover start date,
- the insured person isn't occupationally disabled,
- we don't recognise the insured person's functional impairment,
- the insured person's occupational disability or functional impairment is because of an excluded event, activity or condition.

We won't recognise the insured person's functional impairment if the insured person suffers a functional impairment:

- that isn't on the list of functional impairments,
- at the severity that the contract doesn't cover or
- that doesn't permanently and irreversibly meet all the requirements that the functional impairment must meet to qualify.

24.4.1.5 Business Disability Cover stops on the earliest of the following:

- When the insured person dies.
- At the end of the term, if term cover was selected.
- If the cover lapses.
- If 100% of the cover amount is paid.
- If the insured person no longer qualifies for the cover because of changes to their circumstances.
- If the contract is cancelled.
- If the cover is removed from the contract.

In addition to the above the insured person's occupational disability cover also stops on the earliest of the following:

- The date the insured persons retires.
- On the insured person's 69th birthday.

24.4.1.6 Benefits and other features

The following benefit can be attached to Business Disability Cover:

- Own Occupation Benefit

The insured person on the product must be the same as the insured person on the Own Occupation Benefit.

24.4.1.6.1 Own Occupation Benefit

The Own Occupation Benefit will pay on occupational disability when the insured person is permanently and irreversibly unable to perform the main duties of their occupation because of a sickness or injury regardless of whether they are able to do another occupation for which they are reasonably suited.

Definitions

Occupationally disabled: For the purposes of the Own Occupation Benefit, occupational disability means that the insured person is permanently and irreversibly unable to perform the main duties of their occupation because of a sickness or injury.

Claiming Own Occupation Benefit

- The cover amount for the insured person can be claimed when they become occupationally disabled.
- We'll pay 100% of the Business Disability Cover's cover amount that applies on the date of the occupational disability as confirmed by Old Mutual's Medical Officer.

- If the insured person qualifies for a claim on this benefit and on the Business Disability Cover at the same time, we'll only pay the claim on this benefit.
- When we pay a claim under this benefit, the cover under it and under the Business Disability Cover stops.
- The cover amount will only be paid once our requirements have been met and if the claim is valid.

How does a claim on this benefit affect the other benefits in the contract?
Same as under Business Disability Cover.

Cover stops on the earliest of the following:

- Same as under Business Disability Cover.
- In addition, cover under this benefit stops if it's removed from the contract.

Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that is generally excluded.

We won't pay if:

- the owner fails to meet our requirement to tell us about changes to the circumstances of the insured person (See changes to the circumstances of the insured person),
- the insured person refuses to follow reasonable medical advice or adequate medical treatment,
- the insured person's occupational disability is caused by:
  - unrest, war or terrorist activity,
  - radioactivity or nuclear explosion,
  - them provoking, committing or attempting to commit a crime for example murder, assault, housebreaking, theft, robbery, the forceful detention of another person or any similar crime or
  - self-inflicted injury.
- the insured person's occupational disability is before the cover start date,
- the insured person isn't occupationally disabled or
- the insured person's occupational disability is because of an excluded event, activity or condition.

Changes to the circumstances of the insured person

The owner must inform us if the insured person:

- starts participating recurrently in any risky activities which may expose the insured person to a higher than average risk of accident or injury or
- makes a change to their occupational circumstances with regards to:
  - occupation or any detail of their occupation,
  - industry,
  - duty split,
  - employment type or
  - starting/stopping a second occupation or changes the number of hours per week that they work.

Occupational disability stops when:

Same as under Business Disability Cover.

24.4.2 Business Functional Impairment Cover

Business Functional Impairment Cover can't exist on its own and has to be attached to Business Life Cover. It pays the cover amount as a single amount when the insured person is permanently and irreversibly functionally impaired.

24.4.3.1 Business Functional Impairment Cover product features

TYPE OF COVER	BUSINESS FUNCTIONAL IMPAIRMENT COVER IS ADD-ON COVER AND PAYS A SINGLE AMOUNT
Eligible lives	Specified occupations as determined by our underwriters. Eligible lives are subject to underwriting and age limits.
Relationship to owner	There must be an insurable interest if the owner and insured person aren't the same person.
Maximum number of insured persons	One
Entry age limits	**Minimum:** 15 next birthday **Maximum**: 65 next birthday
Premium frequency	Monthly Monthly with the option to skip one premium Yearly
Premium term	Benefit term
Compulsory yearly premium increase	0% fixed rate 5% fixed rate Age-linked
Guarantee term	5 years 10 years
Cover amount limits	**Minimum**: R100 000 per month **Maximum:** · R6 000 000 for whole-life cover · R30 000 000 for term cover Limited to the cover it's attached to.
Benefit term	· Whole-life · Term (minimum cover term of 5 years)
Cover end age	70 next birthday for term cover

Scheduled yearly cover increase	0% fixed rate 5% fixed rate 10% fixed rate Inflation-linked: Inflation-linked scheduled yearly cover increase CPI + 0%, 1%, 2%, 3%, -1%, -2% Currency-linked scheduled yearly cover increase: · R/GB Pound exchange rate + 0%, 5%, 10%, UK Inflation · R/US Dollar exchange rate + 0%, 5%, 10%, US Dollar Inflation · R/EUR exchange rate 0%, 5%, 10%, Euro Inflation
Underwriting method	· No medical tests, only questions · Medical tests, questions or both
Underwriting credit	If the insured person completed 'medical tests, questions or both' for an amount less than the upper limit of a particular underwriting band, they could qualify for: · Single underwriting credit · Comprehensive underwriting credit

24.4.2.2 Definitions

Functionally impaired means that the insured person has permanently and irreversibly suffered and met the requirements of a qualifying functional impairment.

Permanent and irreversible means that the insured person can't recover from the sickness or injury despite following reasonable medical advice, adequate medical treatment and having achieved maximum medical improvement as confirmed by Old Mutual's Medical Officer.

Reasonable medical advice means the medical opinion provided by a health professional that the insured person can reasonably be expected to follow to improve or preserve their health. This may include investigations, recommendations, lifestyle adjustments and treatment options based on the best available information and appropriate to the condition, the health professional's knowledge and scope of practice.

Adequate medical treatment means the best possible treatment that a person can reasonably be expected to undergo. It includes the use of simple external assistive devices for example hearing aids, glasses, contact lenses, a walking stick or a Zimmer frame but doesn't include the use of complex external assistive devices for example a wheelchair or leg prosthesis. The general meaning of the terms 'simple external assistive devices' and 'complex external assistive devices' isn't limited by the specific examples provided.

Maximum medical improvement means that the insured person's condition can't be improved any further. It means that the insured person has fully recovered from their medical condition or that their medical condition has stabilised to the point that no major medical or emotional change can be expected despite continuing medical treatment or rehabilitative programmes.

24.4.2.3 Claiming Business Functional Impairment Cover

- The cover amount for the insured person can be claimed when they suffer a qualifying functional impairment.
- We'll pay 100% of the cover amount that applies on the date of the functional impairment as confirmed by Old Mutual's Medical Officer.
- After we have paid a claim under this benefit, the cover under it stops.
- The cover amount will only be paid once our requirements have been met and if the claim is valid.

For functional impairments, the insured person will be assessed under qualifying functional impairment definitions at a severity of 100% only, with no payments for less severe functional impairments.

Example
Functional Impairment Cover. Anthony becomes functionally impaired and we'll make a payment of R5 000 000 (R5 000 000 * 100%) under the Business Functional Impairment Cover. Because the full cover amount under the Business Functional Impairment Cover has been paid, the Business Functional Impairment Cover stops and the cover amount under the Business Life Cover reduces to R5 000 000 (R10 000 000 – R5 000 000).

How does a claim on this Business Functional Impairment Cover affect the other benefits in the contract?

- A claim under Business Functional Impairment Cover will decrease the cover amount of the Business Life Cover and the Business Life Cover will continue unless the amount paid was 100% claim payout on the Business Life Cover.
- If Business Severe Illness Cover is also attached to the Business Life Cover, its cover amount will be decreased to equal the Business Life Cover if its cover amount is higher than the remaining cover amount of the Business Life Cover.

If the insured person qualifies for a claim on Business Functional Impairment and Business Life Cover at the same time, we'll pay the claim on Business Life Cover.

Example
Anthony is the insured person with R10 000 000 Business Life Cover, R8 000 000 Business Functional Impairment Cover and R5 000 000 Business Severe Illness Cover. Anthony becomes functionally impaired and a payment equal to 100% of the cover amount on the Business Functional Impairment Cover of R8 000 000 (R8 000 000 * 100%) is paid. The cover amount of the Business Functional Impairment Cover is reduced to R0 and the Business Functional Impairment Cover stops. The cover amount on the Business Life Cover reduces to R2 000 000 (R10 000 000 – R8 000 000) and the cover amount of the Business Severe Illness Cover reduces to R2 000 000 so that it's the same as the cover amount of the Business Life Cover.

Example
Jamie is the insured person with R2 000 000 Business Life Cover and R2 000 000 Business Functional Impairment Cover. Jamie suffers chronic respiratory failure – he qualifies for a payment equal to 100% of the cover amount on the Business Functional Impairment Cover. We pay R2 000 000 (R2 000 000 * 100%) and the cover amount of the Business Functional Impairment Cover reduces to R0 and the Business Functional Impairment Cover stops. The cover amount of the Business Life Cover reduces to R0 (R2 000 000 – R2 000 000) and the Business Life Cover and the contract stops.

24.4.3 Business Severe Illness Cover

Business Severe Illness Cover pays the cover amount if the insured person suffers a severe illness after the cover started.

24.4.3.1 Business Severe Illness Cover product features

TYPE OF PRODUCT	BUSINESS SEVERE ILLNESS COVER IS ADD-ON COVER AND PAYS A SINGLE AMOUNT
Eligible lives	All lives are eligible, subject to entry age limits and underwriting.
Relationship to owner	There must be an insurable interest if the owner and insured person aren't the same person.
Maximum number of insured persons	One
Entry age limits	**Minimum:** 15 next birthday **Maximum:** 70 next birthday
Premium frequency	Monthly Monthly with the option to skip one premium Yearly
Premium term	Benefit term
Compulsory yearly premium increase	0% fixed rate 5% fixed rate Age-linked
Guarantee term	5 years 10 years
Cover amount limits	**Minimum:** R100 000 **Maximum:** Employed: R6 000 000 (subject to underwriting)
Benefit term	Whole-life Term (minimum of 5 years)
Cover end age	Whole-life 100 next birthday for term cover
Scheduled yearly cover increase	0% fixed rate 5% fixed rate 10% fixed rate Inflation-linked: CPI + 0%, 1%, 2%, 3%, -1%, -2% Currency-linked: · R/GB Pound + 0%, 5%, 10%, UK inflation · R/US Dollar + 0%, 5%, 10%, US inflation · R/Euro + 0%, 5%, 10%, Euro Inflation

Underwriting method	· No medical tests, only questions · Medical tests, questions or both
Underwriting credit	If the insured person completed 'medical tests, questions or both' for an amount less than the upper limit of a particular underwriting band, they could qualify for: · Single underwriting credit · Comprehensive underwriting credit

24.4.3.2 Claiming Business Severe Illness Cover

We'll pay a percentage of the cover amount that applies on the date of the severe illness as confirmed by Old Mutual's Medical Officer. The percentage of the cover amount depends on the severity of the severe illness. The severe illnesses, their definitions and the percentage of the cover amount payable in each case are shown in severe illnesses events description list at the end of this guide.

The insured person can claim more than once:

- If the insured person suffers another severe illness at least 30 days after the previous severe illness.
- If for the same related severe illness, it's more severe than was previously claimed for.
- If the insured person suffers more than one severe illness within 30 days, we'll pay the claim under the benefit in this contract that results in the highest payout.
- Each time we pay a claim under Business Severe Illness Cover, its cover amount will decrease by the amount paid and the benefit will continue unless the amount paid was 100% of the cover amount.
- We'll pay 15% of the cover amount that applies at the time of the severe illness for any of the early diagnosed illnesses that are in the list of early diagnosed events that qualify at the end of this guide. Each payment is limited to R100 000. We won't pay for the same early diagnosed illness more than once.
- We'll pay 25% of the cover amount that applies at the time of the severe illness for the Cancer Enhancer if the insured person:
  - suffers cancer on the list of qualifying severe illness events at the end of this guide and the percentage of the event payout is 25% or 50%, and can no longer perform at least two Basic Activities of Daily Living or four Advanced Activities of Daily Living for a period of at least 3 consecutive months from the event date as confirmed by the treating specialist and Old Mutual's Medical Officer. Failure to perform the Activities of Daily Living must be because of the same cancer event (including its treatment or complications of its treatment or hospitalisation because of it).

The insured person can qualify for the Cancer Enhancer:

- for related cancers, if we have not previously paid a Cancer Enhancer or
- for unrelated cancers, if the insured person meets the requirements for the Cancer Enhancer as explained above.

The cover amount will only be paid once our requirements have been met and if the claim is valid.

How does a claim on the Cancer Enhancer affect the other benefits in the contract?

- Each time we pay a claim under this benefit, the cover amount of the Business Life Cover will decrease by the amount paid and the Business Life Cover will continue unless the amount paid was 100% of the cover amount of Business Life Cover.
- If the insured person also has Business Disability Cover or Business Functional Impairment Cover in this contract, its cover amount will be decreased to equal the cover amount of the Business Life Cover if its cover amount is higher than the remaining cover amount of Business Life Cover.
- If the insured person qualifies for a claim on this benefit and the Business Life Cover at the same time, we'll pay the claim on the Business Life Cover.

24.4.3.3 Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that is generally excluded.

We won't pay if:

- the owner fails to meet our requirement to tell us about changes to the circumstances of the insured person (See changes to the circumstances of the insured person),
- the insured person's illness is caused by:
  - unrest, war or terrorist activity,
  - radioactivity or nuclear explosion,
  - them provoking, committing or attempting to commit a crime for example murder, assault, housebreaking, theft, robbery, the forceful detention of another person or any similar crime or
  - self-inflicted injury.
- the insured person's severe illness is before this benefit's cover start date,
- we don't recognise the insured person's severe illness or
- the insured person's severe illness is because of an excluded event, activity or condition.

We won't recognise the insured person's severe illness if they suffer a severe illness:

- that isn't on the list of severe illnesses,
- at the severity that the contract doesn't cover or
- that doesn't meet all the requirements that the severe illness must meet to qualify.

Business Severe Illness Cover stops on the earliest of the following:

- When the insured person dies.
- On the cover end date.
- If the cover lapses.
- If the insured person no longer qualifies for the benefit because of changes to their circumstances.
- If the contract is cancelled.
- If this benefit's removed from the contract.
- If 100% of the cover amount is paid.

24.4.3.4 Benefits and other features

The following benefit can be attached to Business Severe Illness Cover:

- Top-up Benefit

The insured person on the product must be the same as the insured person on the Top-up Benefit.

24.4.3.4.1 Top-up Benefit

The Business Severe Illness Cover will pay a percentage of the cover amount that depends on the severity of the severe illness if the insured person suffers a severe illness. The severe illnesses, their definitions and the percentage of the cover amount payable in each case are shown in the events descriptions in the claims section of this guide.

This Top-up Benefit will pay 100% of the Business Severe Illness Cover's cover amount that applies at the time if an insured person suffers any qualifying severe illness that qualifies for less than 100% of the cover amount.

Claiming Top-up Benefit

- We'll pay 100% of the Business Severe Illness Cover's cover amount that applies on the date of the severe illness as confirmed by Old Mutual's Medical Officer. After we have paid a claim under this benefit, the cover under it stops.
- The Top-up Benefit doesn't apply to Cancer Enhancer or any early diagnosed illnesses that are in the list of early diagnosed illness events that qualify under the Business Severe Illness Cover.
- The cover amount will only be paid once our requirements have been met and if the claim is valid.

How does a claim on this benefit affect the other benefits in the contract?

- When we pay a claim under the Top-up Benefit, the cover amount of Business Severe Illness Cover and the Business Life Cover will decrease by the amount paid. The Business Severe Illness Cover stops and the Business Life Cover will continue unless the amount paid was 100% of the cover amount of the Business Life Cover.
- If the insured person also has a Business Disability Cover or Business Functional Impairment Cover in this contract, its cover amount will be decreased to equal the cover amount of the Business Life Cover if its cover amount is higher than the remaining cover amount of the Business Life Cover.
- If the insured person qualifies for a claim on this benefit and the Business Life Cover at the same time, we'll pay the claim on the Business Life Cover.

24.5 Claiming Business Life Cover

Payment rules

- The single amount payable will be the same as the cover amount at the date of claim.
- The claim amount will be paid out net of any premiums owing on the cover at the claim event date.
- All premiums received after the approved claim event will be refunded.
- Scheduled yearly cover increases won't be taken into account if it's applied after the claim event date but before we approve the payout.

Example

Arianna has R1 000 000 Business Life Cover on her life with an R800 000 Business Disability Cover add-on. Her contract has a fixed rate scheduled yearly cover increase of 10% scheduled to apply on 18 September every year. On 1 September she has a heart attack but due to complications, she only manages to submit her claim on 23 September. The assessor confirms that payment should be made on 30 September. On 30 September, due to the scheduled yearly cover increase applying to the contract, she has R1 100 000 Business Life Cover and R880 000 Business Disability Cover.

Although she qualifies for a 100% payout, her claim event happened before the scheduled yearly cover increase applied i.e. when the Business Disability Cover add-on was R800 000. Following the 100% Business Disability payout of R800 000, there will be no Business Disability cover remaining as the Business Disability Cover add-on would have ceased before the scheduled yearly cover increase application date. The Business Life Cover should have a remaining value of R220 000 as at 30 September (1 September: R1000 000 – R800 000 = R200 000. 18 September: 10% scheduled yearly cover increase applies = R220 000).

Business Life Cover with no add-ons

On the death or terminal illness of the insured person, the full cover amount for the Business Life Cover will be paid as a single amount.

Example

Alpha/Omega (Pty) Ltd takes out a R2 000 000 Business Life Cover on Maddox's life as Key Person Insurance. On her death, Alpha/Omega (Pty) Ltd submits a claim on the Business Life Cover and will receive a single amount of R2 000 000.

Business Life Cover with one add-ons

Any claims paid for the add-ons will reduce the cover amount of the Business Life Cover.

Example

Paragon Pty Ltd buys R3 000 000 Business Life Cover on Hailey's life with a R2 000 000 Business Severe Illness Cover attached. Hailey's house burns down and she suffers major burns in the fire which qualifies her for a payout at the 75% severity level on the Business Severe Illness Cover. The payout on the claim is assessed to be R1 500 000. Both the attached Business Severe Illness Cover and the Business Life Cover will reduce by R1 500 000 such that the remaining Business Life Cover will be equal to R1 500 000 with Business Severe Illness Cover of R500 000.

Business Life Cover with two add-ons

On the death or terminal illness of the insured person, the full cover amount of the Business Life Cover will be paid as a single amount. However, while the insured person is alive and the cover remains on books, any of the events covered under either of the add-ons can result in a claim. A claim on any of these events will reduce the cover amount of the respective add-on and the Business Life Cover.

The claim payout on one add-on won't impact the cover amount on the other add-on unless the claim payout causes the cover amount of the Business Life Cover to reduce lower than the cover amount of the add-on. In this instance the cover amount of the add-on will reduce to be equal to the cover amount of the Business Life Cover.

Example

ABC (Pty) Ltd has R15 000 000 Business Life Cover on Cassandra's life with a R10 000 000 Business Severe Illness Cover and R5 000 000 Business Disability Cover. Cassandra suffers an injury and is assessed to be permanently disabled under the reasonable occupational definition and is paid out the full amount of R5 000 000. The Business Disability Cover reduces to R0 and ends and Business Life Cover will reduce by R5 000 000, while the Business Severe Illness Cover will be unaffected. Business Life Cover will have R10 000 000 remaining cover with Business Severe Illness Cover of R10 000 000.

Example

Decadent (Pty) Ltd has R10 000 000 Business Life Cover on Joanna's life with a R7 000 000 Business Severe Illness Cover and R10 000 000 Business Functional Impairment Cover. Joanna suffers a heart attack with a 100% severity and is paid out the full amount of R7 000 000 under the Business Severe Illness Cover. The Business Severe Illness Cover reduces to R0 and ends and Business Life Cover will reduce by R7 000 000. As the remaining cover on Business Life Cover of R3 000 000 is less than the R10 000 000 Business Functional Impairment Cover amount, the Business Functional Impairment Cover will be adjusted downward such that the Business Life Cover will be R3 000 000 remaining cover with Business Functional Impairment Cover of R3 000 000.

24.5 Business Life Cover stops on the earliest of the following:

- When the insured person dies.
- On the cover end date.
- If the cover lapses.
- If 100% of the cover amount is paid.
- If the insured person no longer qualifies for the benefit because of changes to their circumstances.
- If this benefit's removed from the contract.
- If the contract is cancelled.

25. BUSINESS EXPENSES COVER

Provides monthly payments for a limited period of time if the insured person is unable to work due to illness or injury or suffers a qualifying functional impairment and meets the waiting period.

What type of protection does Business Expenses Cover offer?

Business Expenses Cover is designed for business owners to cover the contribution that the insured person would have made to the allowable overhead expenses.

This benefit pays up to 100% of the cover amount monthly if the insured person becomes:

- occupationally disabled
- functionally impaired
- suffers a fracture

after the cover started and if the waiting period is met.

25.1 Business Expenses Cover product features

TYPE OF COVER	MONTHLY PAYMENTS MADE TO COVER BUSINESS EXPENSES ON THE DISABILITY OF THE INSURED PERSON
Eligible lives	Owners/partners or key persons in a business are eligible to be the insured person on Business Expenses Cover. The insured person must: · be actively involved in the business, and · have special skills, qualifications, knowledge or experience that would make it difficult to find another person to perform the insured person's business activities in time to prevent the business from suffering a significant drop in turnover in the event of the insured person's disability, and · make a significant contribution to turnover (typically a contribution in excess of 25% is considered significant). Subject to entry age limits and underwriting
Relationship to owner	There must be an insurable interest if the owner and insured person aren't the same person.
Maximum number of insured persons	One
Entry age limits	**Minimum:** 18 next birthday **Maximum**: 60 next birthday
Premium frequency	Monthly
Premium term	Benefit term

Compulsory yearly premium increase	0% fixed rate 5% fixed rate Age-linked
Guarantee term	1 year 5 years
Cover amount limits	**Minimum**: R6 000 per month **Maximum:** The total cover can't exceed the smaller of 100% of average monthly earnings and · R60 000 per month for whole-life · R250 000 per month for term cover
Benefit term	· Whole-life · Term (minimum of 5 years)
Cover end age	Whole-life Term (70 next birthday)
Scheduled yearly cover increases	0% fixed rate 5% fixed rate Inflation-linked: CPI + 0%, 1%, 2%, 3%, -1%, -2%
Waiting period	· 7 days · 1 month · 3 months Fractures are only covered if a waiting period of seven days or one month is selected.
Underwriting method	· No medical tests, only questions (up to R10 000) · Medical tests, questions or both
Underwriting credit	If the insured person completed 'medical tests, questions or both' for an amount less than the upper limit of a particular underwriting band, they could qualify for: · Single underwriting credit · Comprehensive underwriting credit

25.2 Definitions

Occupationally disabled means that the insured person is, in part or completely and despite following reasonable medical advice and adequate medical treatment, unable to perform the main duties of their occupation, because of a sickness or injury.

Functionally impaired means that the insured person has suffered and meets the requirements of a qualifying functional impairment, despite following reasonable medical advice and adequate medical treatment.

Reasonable medical advice means the medical opinion provided by a health professional that the insured person can reasonably be expected to follow to improve or preserve their health. This may include investigations, recommendations, lifestyle adjustments and treatment options based on the best available information and appropriate to the condition, the health professional's knowledge and scope of practice.

Adequate medical treatment means the best possible treatment that a person can reasonably be expected to undergo. It includes the use of simple external assistive devices for example hearing aids, glasses, contact lenses, a walking stick or a Zimmer frame but doesn't include the use of complex external assistive devices for example a wheelchair or leg prosthesis. The general meaning of the terms 'simple external assistive devices' and 'complex external assistive devices' isn't limited by the specific examples provided.

A fracture means damage to the continuity of a bone. Not all fractures qualify for benefits under this product, for example hairline fractures or fractures of the toe. See the list of qualifying fractures and how many payments each fracture qualifies for depending on the waiting period selected under events descriptions in the claim section of this guide.

Related events
Old Mutual's Medical Officer, supported by published medical evidence, determines if events are related. Typically this means that they stem from the same incident (for example a certain car accident) or condition (for example cancer) or from complications or treatment following the same incident or condition.

25.3 Other role players

- Where the business is a sole proprietorship, the sole proprietor must be the owner.
- Where the business is a partnership, either one or all of the partners must be the owner. This means that someone who isn't a partner in the business may not be an owner.
- For all other forms of business, the business must be the owner.
- No beneficiaries may be nominated on this benefit. The owner must be the beneficiary in the case of all business entities.

Franchises and similar arrangements

Franchisors receive royalties from their franchise outlets/vendors. The franchisor therefore has an insurable interest in the franchisees, but only to the extent that they will lose the royalties, and only for a limited period of time (maximum one year).

If the franchisor provided funding to the franchise, additional insurance can be taken out, which would then fall under Business Contingency cover.

Buy and sell cover can also be taken out between the owners of the franchise, or for joint owners of a franchise outlet. The normal buy and sell rules will apply.

Key persons in the franchises can be covered with the normal key person cover.

Overlap of Keyperson, Buy and Sell and Personal Insurance

Confusion often exists regarding the above types of cover, especially for sole proprietors or smaller businesses.

For sole proprietors, cover on the business owner's life will be indistinguishable between business insurance and personal insurance. No buy and sell cover can be taken out. However, if the business employs a key person, keyperson cover can be taken out on that person's life. Smaller businesses can have all types of cover, as long as the need matches the cover. For example in a family business, if one of the family members is key in the business, keyperson cover can be taken out on his life, as long it can be justified that the person covered is a key person.

25.4 Taxation

Income Tax impact

In certain cases, where the benefit is owned by the employer (commonly referred to as company-owned), the premiums paid by the employer may be tax deductible in terms of s11(w) of the Income Tax Act. This can easily be the case for Keyperson Cover.

If premiums are tax deductible, the cover proceeds are included as part of the employer's income and are thus taxable. To cater for the tax payable, the cover amount can be multiplied by a ratio to increase the cover amount to pay for estate duty by up to 39% (=1/1(1-28%)). If the premiums are not tax deductible, the entire proceeds would be tax free.

Premiums paid by an employer will generally be tax deductible in terms of s11(w) of the Income Tax Act if:

- The contract is a pure risk contract (without any cash or surrender value).
- The employer is the sole owner of the policy at the time of payment of the premium (other than holding of technical title by creditors as collateral security).
- The contract states that the section applies in respect of premiums payable under the contract.

Estate duty impact

For business cover, estate duty should not be payable if the contract has been structured correctly. If the cover amount is ratioed up for estate duty, the case needs to be investigated further to ensure that the adviser has structured the contract correctly.

One instance where estate duty might be payable is for buy and sell arrangements where the owner is a trust. In these cases, the cover amount can be increased by up to 25% (=1 / (1-20%)).

Capital Gains Tax

The proceeds of all pure risk contract (without any cash or surrender value) are exempted from Capital Gains Tax. Where the ownership of a pure risk policy changes (for example through cession), no Capital Gains Tax will be payable.

Capital Gains Tax in respect of buy and sell agreements

The sale of an interest in a business may give rise to a capital gains tax liability.

This liability can arise in the event of death or permanent disability when the interest in the business is disposed of in terms of a buy and sell agreement.

The deceased or permanently disabled business owner, who is disposing of the interest in the business, will be liable for tax on any capital gain realised on the sale of the business or a portion thereof.

The business owner who is disposing of an interest in the business should thus be aware of such a possible liability.

The proceeds of a benefit taken out in terms of a buy and sell agreement should not be subject to capital gains tax. This capital gains tax exemption will, however, only apply if the cover was acquired to obtain a business owner's interest in the business.

25.5 Claiming Business Expenses Cover

The cover amount for the insured person can be claimed when they become occupationally disabled or functionally impaired and the waiting period is met. Payments for a fracture are also available on Business Expenses with a seven-day or one-month waiting period.

Occupational disability

The cover amount for the insured person can be claimed when they become occupationally disabled, and the waiting period is met.

Each monthly payment is equal to a percentage of the cover amount that applies on the payment day. For occupational disability, the percentage of the cover amount depends on:

- the insured person's ability as determined by us, to continue doing some of the material and substantial duties of their occupation
- the part of the business expenses that the insured person continues to be responsible for while being occupationally disabled and
- any payments received from any product provider including Old Mutual or other insurers, for the specific purpose of covering continuing business expenses that the insured person is responsible for while they are occupationally disabled.

Example: Percentage of the cover amount payable on occupational disability

Jacob is a business owner and is responsible for all of his company's business expenses. The business expenses were R100 000 when he bought his Old Mutual Protect Business Expenses Cover so he bought cover for R100 000 and he chose a scheduled yearly cover increase of 10% to ensure that the cover amount increased each year. At his first scheduled cover increase date, we automatically changed Jacob's cover to R110 000. Jacob then became occupationally disabled and the business expenses he was responsible for, was only R105 000. We'll never pay more than R105 000. Jacob is unable to do any of the material and substantial duties of his occupation and we'll start paying R105 000 per month.

Functional Impairment

The cover amount for the insured person can be claimed when they suffer a qualifying functional impairment, and the waiting period is met.

- Each monthly payment is equal to a percentage of the cover amount that applies on the payment day.
- For functional impairment, the percentage of the cover amount depends on:
  - the severity of the functional impairment. The functional impairments, their requirements and the percentage of the cover amount payable in each case are shown at the end of this guide.
  - the part of the business expenses that the insured person continues to be responsible for while being functionally impaired and
  - any payments received from any product provider including Old Mutual or other insurers, for the specific purpose of covering continuing business expenses that the insured person is responsible for while they are functionally impaired.

Fractures

If the insured person suffers a fracture, each monthly payment will be equal to 100% of the cover. We specify the number of monthly payments that we will make for fractures. We won't pay for a fracture if the insured person have selected a waiting period of longer than one month or if the insured person suffers a fracture while we are already making monthly payments for occupational disability or functional impairment.

If the insured person suffers more than one fracture or suffers another fracture while we are making monthly payments for a previous one, we'll pay the number of monthly payments that applies to the one with the highest number of payments.

Example: Insured person suffers a fracture while receiving monthly payments for another fracture

Mark is the insured person under an Old Mutual Protect Business Expenses Cover contract that has a seven-day waiting period. He was in an accident and fractured his shoulder blade. Mark qualified for two monthly payments. Before receiving the second payment, he falls and fractures the shaft of his thigh bone. This qualifies him for three monthly payments, but because we are still making monthly payments for his previous fracture, we'll pay the number of monthly payments that applies to the fracture with the highest number of payments, which is the fracture to the shaft of the thigh bone. We'll make two more monthly payments (in total three monthly payments).

25.5.1 Waiting periods

- A waiting period is the number of consecutive days or months for which the insured person's occupational disability or functional impairment must have continued, or from the date of the fracture, that must have passed before we'll start the monthly payments.
- There will be no monthly payments in the waiting period.
- It starts on the date of the occupational disability, functional impairment or the fracture as confirmed by Old Mutual's Medical Officer.
- Premiums must continue to be paid during the waiting period. If the contract is cancelled before the waiting period ends, we'll not start the monthly payments.
- The waiting period can be increased or decreased after start of the contract, subject to the following:
  - Premiums will change to reflect the new waiting period
  - Additional underwriting will apply where the waiting period is decreased.
- If the seven-day waiting period is selected and the occupational disability or functional impairment is directly or indirectly caused by a condition below, a one-month waiting period will apply to the following:
  - cosmetic surgery or procedures, unless reconstructive in nature, following an accident or illness which happened after the cover start date,
  - fertility treatments to facilitate pregnancy,
  - non-surgical treatment to cure impotence or to improve potency,
  - uncomplicated pregnancy,
  - uncomplicated birth including caesarean sections,
  - any spinal conditions unless:
    - diagnosed by a specialist orthopaedic or neurosurgeon,
    - supported by medical evidence of spinal pathology and
    - for which they were hospitalised for at least 24 hours
  - any mechanical musculoskeletal disorder primarily causing pain, decreased range of motion or loss of sensation unless :
    - diagnosed by a specialist orthopaedic or neurosurgeon and
    - for which they were hospitalised for at least 24 hours,

- all psychiatric disorders unless diagnosed by a psychiatrist and for which they were hospitalised for at least 24 hours,
- headaches and migraines unless diagnosed by a neurologist and for which they were hospitalised for at least 24 hours,
- the common cold (coryza), rhinitis, sinusitis, influenza, bronchitis, pharyngitis, laryngitis, pneumonia or any combination of these, unless they were hospitalised for at least 24 hours, or
- any functional pain disorders including
  - chronic fatigue syndrome,
  - fibromyalgia, or
  - myalgic encephalopathy (yuppie flu)

unless diagnosed by a specialist orthopaedic or neurosurgeon or rheumatologist and for which they were hospitalised for at least seven days.

25.5.2 Monthly payments start

The monthly payments for a valid claim will start after the end of the waiting period.

The payment day is the day of the month on which the owner has chosen to receive the monthly payments. When the owner of the contract claims, they can choose the payment day. If the owner doesn't choose a day of the month, the payment day will be the last day of the month.

If all our requirements are met before the waiting period has passed, we'll pay the first monthly payment on the payment day immediately after the end of the waiting period to cover the time after the end of the waiting period and up to the date of the first monthly payment.

If all our requirements are met after the waiting period has passed and:

- If there was at least one payment day between the end of the waiting period and the date our requirements are met, we'll pay:
  - a single amount to cover the time after the end of the waiting period and up to the payment day immediately before or on the date our requirements are met and
  - the first monthly payment on the payment day immediately after the date our requirements are met to cover the time after the payment day immediately before or on the date our requirements are met and up to the date of the first monthly payment
- If there was no payment day between the end of the waiting period and the date our requirements are met, we'll pay the first monthly payment on the payment day immediately after the date our requirements are met to cover the time after the end of the waiting period and up to the date of the first monthly payment.

We won't pay interest on any of these amounts. If the contract is canceled before the waiting period ends,

We won't start the monthly payments.

Example: All our requirements are only met after the waiting period and at least one payment day has passed

Jolene is the insured person on the R80 000 Business Expenses Cover and a one-month waiting period. She becomes functionally impaired on 1 May. The waiting period starts on 1 May and ends at midnight on 31 May. All our requirements are met on 15 July and she chose to receive the monthly payments at the end of the month. The first monthly payment of R80 000 will be made on 31 July because she chose to receive monthly payments at the end of the month. We'll make a single payment of R80 000 (for June) because our requirements were only met after the waiting period has passed.

Example: All our requirements are only met after the waiting period has passed but no payment day has passed

Jane has R80 000 Business Expenses Cover and a one-month waiting period. She becomes functionally impaired on 1 May. The waiting period starts on 1 May and ends at midnight on 31 May. All our requirements are met on 21 June and she chose to receive the monthly payments at the end of the month. The first monthly payment of R80 000 (for June) will be made on 30 June because she chose to receive monthly payments at the end of the month. No single payment will be made because there was no payment day between the end of the waiting period and the date our requirements were met.

25.5.3 Payment rules

We'll make up to 24 full monthly payments for occupational disability and functional impairment for related events.

Multiple claims can be made if:

- for related events, we have not made 24 full monthly payments, or
- the incident or condition that caused the occupational disability or functional impairment is completely unrelated to the reason for previous claims. We'll make up to 24 full monthly payments in this case.

A full monthly payment is 100% of the cover amount. Where the monthly payment is less than 100% of the cover amount this will increase the number of payments available such that a maximum of 24 full monthly payments is made.

If the insured person is occupationally disabled or functionally impaired for part of a month when the monthly payment is payable, we'll pay a proportion of the monthly payment that would have applied for that month.

The percentage of the cover amount that is paid for occupational disability or functional impairment may change over time as the insured person's condition worsens or improves or the part of the business expenses that the insured person continues to be responsible for changes.

If the insured person qualifies for more than one claim at the same time, we'll pay the claim that results in the highest percentage of the cover amount.

Example: How the monthly payments work on occupational disability and functional impairment

Jenna suffers from chronic liver failure at the highest severity and receives six full monthly payments (or 100% of the cover amount) for her functional impairment. She recovers but is later diagnosed with chronic gastrointestinal disease at the highest severity. Because Old Mutual's Medical Officer considered her chronic liver failure and chronic gastrointestinal disease as related, she will only qualify for up to 18 more full monthly payments for this functional impairment. If she's later diagnosed with a functional impairment that's unrelated to chronic liver failure and chronic gastrointestinal disease, she can qualify for up to 24 full monthly payments.

Example: Number of monthly payments where insured person only qualifies for partial payments

Jenna suffers from hypertension and qualifies for 50% of the cover amount. She may receive up to 48 monthly payments of 50% of the cover amount. Chris loses his sight in one of his eyes and qualifies for 25% of the cover amount. He may receive up to 96 monthly payments of 25% of the cover amount.

- For occupational disability, we'll determine the number of monthly payments that we make, in line with the period of time the insured person is occupationally disabled which may not exceed the average recommended period of recovery according to the latest edition of The Medical Disability Advisor: Workplace Guidelines for Disability Duration, by Presley Reed, M.D., or its replacement as determined by us. We'll consider making further payments if the treating doctor can provide us with sufficient medical motivation in the form of specialist reports or test results. Any supporting medical proof that we need will be at the owner's own cost.
- The number of monthly payments we make for fractures is specified.
- For functional impairment, we'll determine the number of monthly payments that we make, in line with the period of time the insured person continuously meets all the requirements of the functional impairment, as evidenced by sufficient specialist reports or test results from the treating doctor. Any supporting medical proof that we need will be at the owner's own cost.
- In-payment escalation: If a scheduled yearly cover increase option was selected, this will continue to apply even though claim payments are being made.

25.5.4 Premiums in claim

Premiums must continue to be paid during the waiting period and while we decide if the claim is valid, but the premiums are no longer due when we start the monthly payments.

Premiums are payable again if the monthly claim payments stop and cover continues.

25.5.5 Linked claims

For benefits with a seven-day or one-month waiting period, the waiting period on a subsequent related claim event may be waived if:

- the insured person had been continuously occupationally disabled/functionally impaired for at least one month on the previous valid claim and
- the claim event date on the subsequent related claim is within three months after recovery date of that previous valid claim.

For benefits with a three-month waiting period, the waiting period on a subsequent related claim event may be waived if:

- The claim event date on the subsequent related claim is within a period equal to the length of the waiting period after recovery date of the previous valid claim.

Cover won't be paid between the date of recovery and the date of the subsequent claim event.

If we decide not to apply the waiting period, we'll start the monthly payments from the date of the occupational disability or functional impairment.

The monthly payments stop on the earliest of the following:

- When the insured person dies.
- At the end of the term, if term cover was selected.
- If we no longer recognise the insured person's functional impairment or occupational disability.
- If the insured person fails to meet our requirements for following reasonable medical advice or adequate medical treatment.
- If the insured person fails to meet our requirements for regular evaluation of their occupational disability or functional impairment. (We may need the insured person to prove that they still qualify for payments by undergoing regular evaluation.)
- When we have made the last monthly payment that the insured person qualifies for.
- If the insured person no longer qualifies for the benefit because of changes to their circumstances.
- If the contract is cancelled.
- When their occupational disability cover stops while we are making monthly payments because of occupational disability. If the monthly payments for occupational disability has stopped because the insured person's occupational disability cover has stopped, we'll re-evaluate the claim. If the insured person is functionally impaired, we'll start making monthly payments for functional impairment until the monthly payments stop for one of the other reasons listed above. If not, we'll stop making monthly payments under occupational disability but the benefit will continue until the cover end date and the insured person can claim in future for functional impairment or a fracture.

If the insured person qualified for more than one claim at the same time, once we stop making payments for the claim that resulted in the highest percentage of the cover amount, we'll continue to make monthly payments at a lower percentage of the cover amount if the insured person still qualifies for monthly payments under another claim.

25.6 Changes to the circumstances of the insured person on Business Expenses Cover

The owner must inform us if the insured person starts participating recurrently in any risky activities which may expose the insured person to a higher than average risk of injury.

The owner must inform us if the insured person makes a change with respect to their:

- occupation,
- industry,
- duty split,
- employment status or
- starts/stops a second occupation or changes the number of hours per week that they work.

We must be informed if:

- the insured person's part of the business expenses that they are responsible for decreases while we are making payments,
- the insured person's health/medical status changes (insured person recover or their condition improves) while we are making payments or
- the insured person dies.

25.7 Exclusions

General exclusions always apply. It means that we won't pay a claim if it's as a direct or indirect result of an event, activity or condition that is generally excluded.

We won't pay if:

- the owner fails to meet our requirement to tell us about changes to the circumstances of the insured person (See changes to the circumstances of the insured person),
- the insured person refuses to follow reasonable medical advice or adequate medical treatment,
- the insured person's occupational disability, functional impairment or fracture is caused by:
  - unrest (example: riot, civil commotion, insurrection and rebellion, war or terrorist activity,
  - radioactivity or nuclear explosion or
  - them provoking, committing or attempting to commit a crime for example murder, assault, housebreaking, theft, robbery, the forceful detention of another person or any similar crime or
  - self-inflicted injury.

We won't pay the cover amount:

- if the insured person's occupational disability, functional impairment or fracture is before the cover start date,
- if we don't recognise the insured person's occupational disability, functional impairment or fracture,
- if the insured person's occupational disability, functional impairment or fracture is because of an excluded event, activity or condition or
- if the waiting period is not met.

We won't recognise the insured person's occupational disability if:

- they don't qualify for at least 25% of the cover amount or
- they are able to do more than 75% of the main duties of their occupation.

We won't recognise the insured person's functional impairment if they suffer a functional impairment:

- that isn't on the list of functional impairments,
- at the severity that the contract doesn't cover, or
- that doesn't meet all the requirements that the functional impairment must meet to qualify.

We won't recognise the insured person's fracture if:

- they suffer a fracture that isn't on the list of fractures that the contract cover or
- a waiting period longer than one month is selected.

25.8 Business Expenses Cover stops on the earliest of the following:

- If the insured person dies.
- On the cover end date if term cover was selected.
- If the insured person no longer qualifies for the benefit because of changes to their circumstances.
- If the insured person refuses to follow reasonable medical advice or adequate medical treatment.
- If the cover lapses.
- If the contract is cancelled.

In addition to the above, the insured person's occupational disability cover stops on the earliest of the following:

- The date the insured person retires.
- On the insured person's 69th birthday.

25.9 Business Expenses Cover events

Business expenses are those monthly costs incurred in the day-to-day running of a business and is recognised by us.

BUSINESS EXPENSES INCLUDED	BUSINESS EXPENSES EXCLUDED
• rent • interest portion of repayments on debt, for example, a mortgage bond or loan • property taxes • electricity, water and telephone • regular maintenance services • equipment leasing costs • insurance premiums • accounting fees • remuneration payable to staff who – don't directly impact on or contribute to turnover or – directly impact on or contribute to turnover but who are unable to do so because of the insured person's occupational disability, functional impairment or fracture.	• any provision, for example, for depreciation or bad debt • remuneration payable to the insured person • remuneration payable to staff who directly impact on or contribute to turnover but who are still able to do so despite the insured person's occupational disability, functional impairment or fracture • cost of trading stock or merchandise • any expenses of a personal nature and not related to the business of the owner • any capital expenses • capital portion of repayments on debt, for example, a mortgage bond or loan or • expenses not related directly to the continued functioning of the business.

We'll assume that the part of the business expenses that the insured person is responsible for, expressed as a percentage, is the same as their contribution to the total monthly turnover.
Business Protection protects businesses against risk. As always, appropriate structuring and advice must be in place to effect a complete and tax-efficient solution.

UNDERWRITING

26. UNDERWRITING

26.1 Underwriting explained

Underwriting is the process of assessing the medical, financial, avocational, occupational and territorial risks associated with the insured person. The underwriter's job is to add a price tag to each individual risk to ensure that insured persons with a similar chance of claiming are offered cover at a similar price.

Old Mutual Protect underwrites in an interactive way. Certain underwriting steps will happen at appropriate points in the sales process as the information becomes relevant and available. Underwriting decision making will be automated as far as possible with only complex cases referred for manual underwriting. This allows the adviser to know upfront during the application process whether:

- an underwriting decision can be made automatically
- additional requirements are necessary or
- the application needs to be reviewed by an underwriter.

Our underwriting approach is to:

- provide most of the underwriting outcomes at point of sale, using the available information supported by our underwriting automation capability. Our underwriting engine was designed to limit the underwriting questions asked to the insured person. Depending on the answers provided, the underwriting engine will ask for more information to support the assessment.
- only underwrite an insured person once at new business stage. This means that we have taken all the risks disclosed upfront into account. At claim stage, we may verify some of the information initially provided, but we won't underwrite the insured person again.
- provide an accurate assessment to offer the best possible terms to our customers.
- accept most of our customers at standard rates and only apply special terms where necessary to balance the risk-taking process in the underwriting risk pools. Old Mutual Protect introduces a simple underwriting process and a new way of approaching underwriting assessment by offering more options to our customers. Our trained underwriters will ensure that all cases, including all complex and high cover amount cases are processed as quickly as possible.
- ensure that the insured person pays an appropriate premium. We assess each person individually by considering their health (morbidity) or how long they may live (mortality), or both. This means we may ask for personal medical and financial information or other information. We always treat all medical and financial information as confidential.

Old Mutual Protect recognises that people have different needs and preferences. We have taken into consideration the socio-economic status, traditions, values, time constraints, stressors and worries of our insured persons. Instead of being prescriptive, we want to empower insured persons to choose the type of underwriting that is right for them based on the cover amount. There are three underwriting methods:

- No medical tests or questions
- No medical tests, only questions
- Medical tests, questions or both

The level of underwriting influences the premium that the insured person is charged. The more comprehensive the level of underwriting an insured person is prepared to go for, the more affordable their premium will be. See the methods of underwriting later in this guide.

26.2 Non-disclosure

It's important that the insured person is thorough and accurate when they answer all the applicable questions including health and lifestyle questions. We use the answers to determine if we can offer them cover and what they will pay for it.

All the information they share is included as part of their legal contract with us. If an insured person is required to provide us with information of their health and lifestyle or other information related to financial activities, occupational profile, participation in risky activities and sports or travel they must give us as much information as possible. We may verify this information when they apply for cover or when they claim. If this information is incorrect or they withheld information (non-disclosure), the contract could be invalid. This means that we may reduce the claim pay out or we may not pay the claim.

What can the adviser do to prevent non-disclosure?

- Include all information and don't use their discretion when capturing information.
- Gather as much information as possible to provide a clear view of any medical condition or other risk, to avoid us from requesting extra underwriting requirements.

26.3 Underwriting questions and evidence

The main source of underwriting information under the No medical tests, only questions or the medical tests, questions or both is the health and lifestyle questionnaire and the information disclosed in the application form.

We'll always do our best to assess the risk based on the information provided by the insured person. We may need extra evidence from the insured person and their treating doctor, the contract owner or third-party information to complete the underwriting assessment. Some of the underwriting requirements will be called for automatically based on the insured person's age, cover amount and type of cover applied for.

26.4 Underwriting assessment categories

The following categories are the main sources of information required to complete the underwriting assessment:

- Occupational
- Avocational
- Territorial
- Medical
- Financial

26.5 Underwriting outcomes

Standard rates

Based on the medical, financial, occupational, avocational and territorial information, the insured person doesn't pose an increased risk to us and is granted standard rates.

Healthy lives discount

Based on the medical information the insured person is a better than average risk to us and is granted terms at discounted standard rates.

Altered terms: load or exclude

'Altered terms' means that based on the medical, financial, occupational, territorial and/or participation in risky activities or sports information, the insured person is offered altered terms because we were unable to offer standard rates or healthy lives discount. Altered terms could be applied as a percentage risk premium increase, cover risk premium increase or exclusion clause.

When terms are offered we must get acceptance of these altered terms from the contract owner. The adviser will automatically be notified that terms have been offered and that a new quote accepting the new terms is required.

Percentage risk premium increase:

- is a percentage of the actual standard mortality or morbidity risk (for example 50%) and is

  used when the additional risk posed by the insured person is higher than the average insured population.
- can be applied for medical, occupational, travel or participation in risky activity or sports reasons.
- may vary by age, severity of the medical condition or the nature of the risky activity.
- is permanent.

Cover risk premium increase:

- is expressed as a number, for example: R5.00 per R1 000 cover amount per year.
- is used when the additional risk posed by the insured person is higher than the average insured population.
- can be permanent or temporary, i.e. a limited number of years.

  Example

  R5.00 per R1 000 cover amount per year for four years. At the end of the period, the risk premium increase will be removed and the premium reduced accordingly.

A temporary and permanent cover risk premium increase may be applied at the same time.

Exclusion(s)

Exclusion clauses may be imposed per insured person per product, for example impose a spinal exclusion

on the Occupational Disability Benefit such that no claim will be paid if the insured person is unable to perform duties of their occupation as a result of a spine condition.

One type of cover can have multiple percentage risk premium increases, cover risk premium increases and/or exclusion(s) imposed as well as a combination of all three.

Risk premium increase or exclusion

Under certain circumstances the customer may be offered a choice between a risk premium increase or an exclusion.

This outcome is only applicable to the following underwriting categories:

- Avocational
- Territorial

The purpose of offering the choice is to allow the customer to decide between receiving full cover for participation in a risky activity or sport or excluding the risk from the contract upfront.

Example

Jane participates in motorcycle racing which presents an increased risk because of accidents. Jane was offered a choice between a risk premium increase or an exclusion on Life Cover:

- A permanent cover premium increase of R2.00 or
- An exclusion for motorcycle racing.

If Jane chooses the permanent risk premium increase, she will receive full cover for participation in motorcycle racing. If she chooses an exclusion for motorcycle racing, any claims related to motorcycle races will not be paid.

Decline

Being declined means that due to medical, financial or other information received about the insured person we are not prepared to offer the insured person cover under the specific cover.

Defer for additional requirements

'Defer for additional requirements' means that the underwriter is deferring their decision to request additional information. Once the additional information is received, a decision can be made.

26.6 Underwriting restrictions

As part of the underwriting decision making, the underwriters may request that the application is amended for a number of reasons such as:

UNDERWRITING DECISION	POSSIBLE REASON(S)
Reduce cover amount	Due to over insurance.
Remove the yearly cover increase	Due to limitations of cover.
Reduce cover term	Due to health reasons.
Change smoker status to smoker	Due to evidence that supports applying smoker rates.
Change occupation class	Due to the insured person giving information that would place them in a lower occupational class category.
Increase waiting period	To reduce the risk related to the occupational duties or circumstances or due to health reasons.

26.7 Manual underwriting

'Refer to underwriters' means that based on the medical, financial, occupational and territorial or participation in risky activity or sport information, this cover must be manually assessed by an underwriter.

26.8 Underwriting review

Many of the underwriting altered medical decisions can be reviewed after a period of time, depending on the medical condition or risk. As part of the new business process the adviser will be notified if the underwriting decision is reviewable. The insured person can request a review of the underwriting decision and the review requirements as well.

Where the application was declined, possible alternative cover will be communicated with the adviser. It's the responsibility of the adviser to review the financial planning report to establish if the new proposed cover will meet the insured person's need.

26.9 Information we may collect during the application process

- **A fully completed application form**

This is a requirement for applying for any protection cover. It includes details about the type of cover, how much cover and, depending on the underwriting method, personal, medical and financial details about the insured person. It also includes specific information related to the contract owner who is applying for cover.

- **Health and life style questionnaire**

The questionnaire completed by the insured person provides us with personal, medical and financial information. The questionnaire is interactive, which means we can reflexively ask questions and collect targeted and relevant information based on the answers. The insured person can choose to complete the questionnaire with their adviser or via a tele-interview. The questions are comprehensive but simple, in plain language, easy to understand and quick to answer.

- **Occupational**

Some occupations have a higher degree of inherent risk. Occupational underwriting is used to identify and assess potentially hazardous occupations or industries with a higher than average risk of death, disability or illness.

- **Work and travel**

Certain countries are considered more hazardous because of civil war, unrest etc. Any work-related travel outside South Africa and Namibia will be assessed to establish if it will have an impact on the pricing of the cover.

- **Risky activities or sports**

If the insured person participates in risky activities or sports, it may pose a higher than average risk of injury or death. The risk will be assessed to establish if it will have an impact on the pricing of the cover.

- **Financial**

Depending on the reason for cover, we gather information about the insured person or the business entity to ensure that the cover applied for is relevant to the financial need identified.

- **Medical**

Depending on the underwriting method selected we may ask for medical tests or request reports from the insured person's treating doctor to establish the facts related to a medical condition or disease.

- **Retrenchment**

If the insured person applies for retrenchment insurance, they must complete a few questions, and depending on the answers an automated decision will be made.

26.10 Medical underwriting

Medical underwriting is used to assess the insured person's likelihood of death, disability or illness. For this assessment we collect and use the following information:

- Personal medical history, collected from the health and lifestyle questionnaire.
- Family history, collected from the health and lifestyle questionnaire.
- Information from the Life and Claims Register.
- Screening tests, doctors' reports and medical examinations, collected as part of medical underwriting requirements (also sourced from external data sources).

- **Health and lifestyle questionnaire**

The health and lifestyle information is a series of questions completed by the insured person that provides us with personal, financial, medical and family history information.

- **Medical tests**

Medical tests or reports are requested from the insured person's treating doctor.

We allow for two methods of medical testing:

- Collection of venous blood using a needle and syringe which is sent to a pathology lab.
- Rapid testing using a drop of blood that is collected from a finger prick and applied to a test strip.

Examples of venous blood tests:

- Cholesterol – a raised cholesterol level can lead to heart (cardiovascular) disease.
- Blood sugar – a raised blood sugar level gives an indication that the insured person may be diabetic.
- Gamma GT – this is a liver enzyme which indicates if the insured person has a disorder of the liver or liver damage.
- Cotinine - this test indicates if the insured person is a smoker. If the result is above the limit, smoker rates will apply.
- HIV test – to screen for the presence of HIV antibodies and the presence of the virus, which is an indication of their HIV status.

Examples of blood rapid tests:

- HIV
- Cholesterol
- Cotinine
- Blood sugar

Depending on the underwriting method, after completing the health and lifestyle questionnaire.

Medical evidence required to support the underwriting assessment:

Medical questionnaires from the treating doctor or specialist

These are a series of medical questions to gather information related to a specific medical condition. May be completed by:

- A registered medical doctor or specialist

Manual medical questionnaires from the insured person

These are a series of questions to gather information related to a specific medical condition. May be completed by:

- The insured person

Executive medicals

Many people go for yearly medical check-ups. If such an executive medical has been done in the last year, we'll ask permission from the insured person to request the report and use it to assess the risk.

The underwriters may ask for extra medical requirements.

Medicals performed for another insurance company within the last six months

With the permission from the insured person, we'll request any medical tests or reports completed within the previous six months from other insurance companies. We'll use them to assess the insured person's health, provided that the medicals satisfy our internal underwriting requirements.

The underwriters may ask for extra medical requirements.

Existing Old Mutual medicals

With the permission from the insured person, we'll continue to use internal valid medicals to process new cover if the insured person is still within their underwriting requirements band.

Depending on the underwriting method, we may ask for this information after completing the health and lifestyle questionnaire

Rapid testing

Rapid medical testing is used for preliminary medical screening where results can be read off a test strip within a short period of time. Insured persons in certain cover amounts and age bands (and who have not failed any evaluations for which a full blood sample is required), no longer need to have blood drawn with a needle and syringe. If the insured person qualifies for rapid testing, they will have the option to do blood tests or the rapid tests.

Rapid test results will only be accepted if carried out by Old Mutual approved nurses through the Interactive Medical Services (IMS) – a subsidiary of Old Mutual Life Assurance Company South Africa.

The following tests are available via the rapid testing method:

TEST	METHOD
HIV	Finger prick
Cotinine	Finger prick
Cholesterol	Finger prick
Blood sugar	Finger prick

Rapid testing is quick, less painful and has immediate results. It can be performed by a travelling nurse and will only take 30 minutes. If the rapid testing results are adverse or inconclusive, additional time will be needed to draw blood.

The instant test results will be captured and submitted to Old Mutual electronically which means at least an eight-hour reduction in the new business cycle time.

26.10.1 How we collect the underwriting information

During the application process, insured persons will be able to choose how they would like to complete the health and lifestyle questionnaire. They may choose to complete it with their adviser (face-to-face) or via a tele-interview (if available to the adviser).

Tele-interviewing is a process whereby a trained tele-interviewer captures the answers to the underwriting questions based on the information provided telephonically by the insured person. The tele-interviewer will complete the underwriting interview and set up nurse and doctors' appointments with the insured person.

Tele-interviews have the following advantages:

- Saves the adviser time by reducing administration.
- Allows easy access to insured persons living in remote areas.
- Allows sensitive information to be disclosed telephonically, rather than face-to-face.
- Reduces the risk of non-disclosure by the insured person or adviser.
- Facilitates the collection of good quality data, which leads to less follow ups.
- Allows insured persons who don't have access to the internet or a personal computer to complete the underwriting process confidentially.

Our tele-interviewing service is not available to:

- Children under the age of 15 years or
- Persons who are outside the borders of South Africa or Namibia at the time of application.

26.10.2 Underwriting methods

The underwriting requirements will be qualified depending on the underwriting method:

UNDERWRITING METHOD	EXPLANATION
No medical tests or questions	Requires that we establish insurable interest between the owner and the insured person and that the insured person is not over insured.
No medical tests, only questions	Requires that we do medical, financial, risky activities or sports, occupational and work and travel underwriting without requesting any medical tests, examinations or reports.
Medical tests, questions or both	Requires that we perform medical, financial, avocational, occupational and territorial underwriting.

Underwriting method applicability

The following tables explain the allowable types of cover and cover amount under each underwriting method.

The underwriting methods limits indicate the minimum and maximum cover amounts at which certain underwriting methods become available. These bands are not the minimum or maximum allowable cover amounts per cover (minimums and maximums can be found in the product sections of this guide).

26.10.2.1 Types of cover per underwriting method

COVER	UP TO R50 000	R50 001 – R100 000
Family Funeral Cover · Individual · Spouse · Children*** · Nominated Child	No medical tests or questions	No medical tests – only questions (Individual and spouse only)
Extended Family Funeral Cover · Parent · Sibling · Other family	No medical tests or questions	n/a
Funeral Paid-Up	n/a	n/a

COVER	UP TO R3 000 000	>R3 000 000
Life Cover	No medical tests, only questions or Medical tests, questions or both	Medical tests, questions or both

COVER	UP TO R1 000 000	>R1 000 000
Last Survivor Cover **Disability Cover** · Own Occupation Benefit · Partial Functional Impairment Benefit · Child Impairment Benefit**** **Functional Impairment Cover** · Partial Functional Impairment Benefit · Child Impairment Benefit*** **Severe Illness Cover** · Top-up Benefit · Mild Illness Benefit · Child Illness Benefit*** · For Women Benefit · Returning Illness Benefit **Physical Impairment Cover** **Future Life Cover** · Disability and Illness Benefit **Premium Protection Death** **Premium Protection Disability** **Premium Protection Functional Impairment**	No medical tests, only questions or Medical tests, questions or both	Medical tests, questions or both
Accidental Death Cover **Accidental Disability and Death Cove**	Medical tests, questions or both*	Medical tests, questions or both
Retrenchment Cover **Premium Protection Retrenchment**	Medical tests, questions or both**	Medical tests, questions or both**

COVER	UP TO R10 000 PER MONTH	>R10 000 PER MONTH
Life Income Cover	No medical tests, only questions or Medical tests, questions or both	Medical tests, questions or both
Disability Income Cover · Income Extender Benefit · Sickness Benefit · Family Support Benefit***		
Functional Impairment Income Cover · Family Support Benefit***		

* No medical underwriting is required for accidental cover and therefore only the lifestyle questions are required. This cover is only available under the medical tests, questions or both method.

** Subject to retrenchment questions, financial and occupational underwriting only.

***These types of cover don't have named insured persons and don't require any underwriting

COVER	UP TO R3 000 000	>R3 000 000
Business Life Cover	No medical tests, only questions or Medical tests, questions or both	Medical tests, questions or both

COVER	UP TO R1 000 000	>R1 000 000
Business Disability Cover · Own Occupation Benefit **Business Severe Illness Cover** · Top-up Benefit **Business Functional Impairment Cover**	No medical tests, only questions or Medical tests, questions or both	Medical tests, questions or both

COVER	UP TO R10 000 PER MONTH	>R10 000 PER MONTH
Business Expenses Cover	No medical tests, only questions or Medical tests, questions or both	Medical tests, questions or both

26.10.2.2 Rules related to underwriting methods

General rules

- Aggregation for product maximum limits will always be applicable under all the underwriting methods.
- At new business, if bought at the same time, add-on cover will follow the same underwriting method as the parent cover.
- In one quote or solution recommendation report for one insured person, the insured person may only select the following underwriting method combinations:
  - All cover - No medical tests or questions
  - All cover - No medical tests, only questions
  - All cover - Medical tests, questions or both
  - A combination of 'No medical tests or questions' and 'No medical tests, only questions' underwriting methods due to the fact that some cover in the quote or solution recommendation are only offered under the no medical tests or questions method and some cover can only be offered under the No medical tests, only questions method.
  - A combination of 'No medical tests or questions' and 'Medical tests, questions or both' due to the fact that some cover on the quote/solution recommendation are only offered under the 'No medical tests or questions' underwriting method and some cover can only be offered under the 'Medical tests, questions or both' underwriting method.
  - A combination of 'No medical tests, only questions' and 'Medical tests, questions or both' underwriting methods due to the fact that some cover on the quote or solution recommendation are only offered under the 'No medical tests, only questions' underwriting method and some cover can only be offered under the 'Medical tests, questions or both' underwriting method.
  - We'll always apply the most comprehensive underwriting model if two models for the same insured person is available (except for in the examples above where 'No medical tests or questions' underwriting method has been selected).

26.10.2.3 Maximum cover amount for 'No medical tests, only questions'

- First convert the cover amount of income cover to single amount before adding it to the cover amount of any other single amount applied for to arrive at the maximum amount of cover across each insurance need.
- Existing cover on the same model must be added to the above-mentioned calculations
- To determine the cover amount of the income cover for the purpose of determining the eligibility for the underwriting method use the following:
  - Equivalent single amount of income cover (excluding Life Income Cover) = Cover amount of income x 12 x 8.333
  - Equivalent single amount of Life Income Cover = Cover amount of income x annuity factor*

    * annuity factor varies depending on term and scheduled yearly cover increase

- Based on the total single amount of cover calculated for each insurance need, determine the eligibility for the cover by applying the maximum allowed from the following table:

INSURANCE NEEDS	ALLOWABLE COVER	MAXIMUM SINGLE AMOUNT COVER ALLOWED
Life Insurance	· Life Cover · Business Life Cover	R3 000 000*
	· Last Survivor Cover · Life Income Cover	R1 000 000*
Illness Insurance	· Severe Illness Cover · Business Severe Illness Cover	R1 000 000
Disability Insurance	· Disability Cover · Functional Impairment Cover · Physical Impairment Cover · Disability Income Cover · Functional Impairment Income Cover · Business Expenses Cover · Business Disability Cover · Business Functional Impairment Cover	R1 000 000
Future Insurance	· Future Life Cover	R1 000 000

* The maximum cover for all allowable cover in the Life Insurance needs is R3 000 000.

26.10.3 The underwriting approach to common medical conditions

The following examples provide a view of how the underwriter would approach a specific medical condition.

Hypertension (high blood pressure)
This is a condition in which the force of the blood against the artery walls is too high. It's usually defined as a blood pressure reading above 140/90, and is considered severe if the reading is above 180/120.
Why do we underwrite the condition? High blood pressure often has no symptoms but if left untreated, it can cause damage to organs and lead to health conditions, such as heart disease, stroke, impaired vision and kidney dysfunction over time.
Possible underwriting outcomes: · Life Insurance - Depending on how well controlled the blood pressure is, with or without treatment, the decision could either be standard rates, a risk premium increase or in severe cases a decline. Other conditions such as diabetes, high cholesterol and kidney problems will be factored into the underwriting decision. · Disability Insurance and Illness Insurance - Depending on how well controlled the blood pressure is, with or without treatment, the decision could either be standard rates, a risk premium increase or in severe cases a decline. The tolerance level for a risk premium increase for the disability cover is usually lower than for the death cover. Other conditions such as diabetes, high cholesterol and kidney problems will be factored in the underwriting decision.

Possible additional underwriting requirements:

- Medical report
- ECG
- Blood pressure questionnaire

Raised cholesterol

Cholesterol is a fatty substance found in the blood stream. When there is an abnormally high level of cholesterol it's referred to as hyperlipidaemia, hypercholesterolaemia or simply high cholesterol. There are two types of cholesterol, LDL (bad cholesterol), and HDL (good cholesterol). High levels of LDL and low levels of HDL increase the risk of cholesterol building up in the walls of the arteries.

Why do we underwrite the condition?

High cholesterol is a major risk factor for cardiovascular diseases. When cholesterol builds up in the artery walls it causes hardening and narrowing of the arteries. This results in poor circulation of blood and oxygen and can lead to heart attacks, strokes and peripheral vascular disease.

Possible underwriting outcomes:

- Life Insurance - The decision depends on the cholesterol level. If the level is within normal limits it would be accepted at standard rates. These are usually insured persons who are on cholesterol-lowering medication. A raised cholesterol would attract a health risk premium increase and a very high level of cholesterol may result in a decline.
- Disability Insurance and Illness Insurance - The decision depends on the cholesterol level. If the level is within normal limits it would be accepted at standard rates, and these are usually insured persons who are on cholesterol-lowering medication. A raised cholesterol would attract a risk premium increase and a very high level of cholesterol may result in a decline. The tolerance level for a risk premium increase for the disability cover is usually lower than for the death cover.

Possible additional underwriting requirements:

- Cholesterol blood test

Raised Body Mass Index (BMI)

BMI is a measure of how healthy a person's weight is in relation to their height. A raised BMI indicates that a person is overweight or obese.

Why do we underwrite the condition?

Being overweight or obese increases the risk of developing multiple health conditions including heart disease, strokes, high cholesterol, hypertension, diabetes and certain cancers.

Possible underwriting outcomes:

- Life Insurance - A normal BMI would be accepted at standard rates, a higher BMI would attract a risk premium increase and a very high BMI may result in a decline.
- Disability Insurance and Illness Insurance - A normal BMI would be accepted at standard rates, a higher BMI would attract a risk premium increase and a very high BMI may result in a decline. The tolerance level for a risk premium increase for the disability cover is usually lower than for the death cover.

Possible additional underwriting requirements: Medical report

Smoker status

This refers to whether a person is a smoker or a non-smoker. A smoker is considered someone who has smoked cigarettes or tobacco, nicotine or any nicotine substitution products within the last six months such as e-cigarettes, vapes, hookah or hubbly bubbly, pipe, snuff and cigars.

Why do we underwrite the condition?
Smoking has a negative impact on overall health. It's a major risk factor for developing multiple conditions including heart disease, stroke, poor circulation, respiratory conditions and cancers.

Possible underwriting outcomes:

- Life Insurance, Disability Insurance and Illness Insurance - Smokers will receive smoker rates resulting in a higher premium.

Possible additional underwriting requirements:

- Cotinine blood test
- Lung function test, is excessive smoking has been established

Diabetes

Diabetes is a chronic condition resulting in abnormally high levels of glucose (sugar) in the blood. It develops when the body can't produce enough insulin or effectively use insulin which it needs to transport sugar from the blood stream to the body cells.

Why do we underwrite the condition?
Diabetes is a complex condition that can affect multiple body systems. If left untreated or poorly managed it may lead to heart disease, blindness, amputations, strokes, kidney disease and coma. Good management of diabetes may decrease the risks of complications, but being a chronic disease, long-term risks would still be a concern.

Possible underwriting outcomes:

- Life Insurance - Favourable diabetics with well-controlled blood sugar levels will receive a health risk premium increase. Unfavourable diabetics with bad control may receive a high-risk premium increase or the cover may be declined.
  If diabetes exists with multiple significant risk factors such as heart attack, stroke or chronic kidney disease, the cover will be declined.
- Disability Insurance and Illness Insurance - Favourable diabetics with well controlled blood sugar levels will receive a health-risk premium increase. Unfavourable diabetics with bad control may receive a high-risk premium increase or the cover may be declined. The tolerance level for a risk premium increase for the disability cover is usually lower than for the death cover. If diabetes exists with multiple significant risk factors such as heart attack, stroke or chronic kidney disease, the cover will be declined.

Possible additional underwriting requirements:

- Medical report
- Diabetes questionnaire from the treating doctor
- HbA1c blood test
- Microalbuminuria test

Cancer

Cancer, also known as a malignancy, is a disease characterised by uncontrolled growth of abnormal cells that invade and destroy healthy body tissue. There are many different types of cancer that can occur in various parts of the body.

Why do we underwrite the condition?

Cancer affects quality of life and is associated with a decrease in life expectancy. This worsens depending on the stage of cancer. Treatment often involves a combination of chemotherapy, radiotherapy and surgery which further impact quality of life. Even years after receiving treatment, recurrence is common and on-going surveillance is required.

In all cancer cases, it's crucial to obtain all the medical information required about the cancer before offering any indication of terms.

Possible underwriting outcomes:

- Life Insurance - This depends on the type, stage and grade of the cancer, whether it was recurrent and years since last treatment. Typically cover would be postponed until a number of years following remission at which point the risk is considered acceptable. Cover may then be offered with a risk premium increase over a number of years. Certain cancer diagnoses may result in a decline due to the associated higher risks.
- Disability Insurance - This depends on the type, stage and grade of the cancer, whether it was recurrent and years since last treatment. Typically cover would be postponed for a longer number of years compared to the death benefit. Certain cancer diagnoses may result in a decline due to the associated higher risks.
- Illness Insurance - This depends on the type, stage and grade of the cancer, whether it was recurrent and years since last treatment. If cover is considered under Life Cover, it will usually be considered under the Severe Illness Cover (with the applicable exclusions). Certain cancer diagnoses may result in a decline due to the associated higher risks.

Possible additional underwriting requirements:

- Medical report
- Tumour questionnaire from the treating doctor including details on investigations, pathology results and treatments.

Heart attack

A heart attack, also known as a myocardial infarction, is a life-threatening event. It occurs when an artery supplying the heart with oxygen-rich blood and nutrients is blocked, cutting off the blood supply and resulting in death of the heart muscle.

Why do we underwrite the condition?

Heart attacks result in damage to the heart muscle that may weaken the heart's ability to pump blood. Heart attack sufferers are at higher risk of having another heart attack, strokes, and other heart diseases like arrhythmias, heart failure and sudden cardiac death.

Possible underwriting outcomes:

- Life Insurance - Provided that the insured person has made a complete recovery and their health is stable, terms can be considered after six months from the date of the heart attack. Otherwise the cover will be loaded or declined depending on the severity of the condition and the complications if any. If there is a history of heart attack combined with multiple significant risk factors for example diabetes, stroke or chest pain, the cover will be declined.
- Disability Insurance - Provided that the insured person has made a complete recovery and their health is stable, terms can be considered after a number of years from the date of remission. Otherwise the cover will be declined depending on the severity of the condition and the complications if any. If there is a history of heart attack combined with multiple significant risk factors for example diabetes, stroke or chest pain, the case will be declined.
- Illness Insurance - If cover is considered under the Life Cover, cover will usually be considered under the Severe Illness Cover (with the applicable exclusions). If there is a history of heart attack combined with multiple significant risk factors for example diabetes, stroke or chest pain, the cover will be declined.

Possible additional underwriting requirements:

- Medical report
- Questionnaire from the treating doctor
- ECG

Stroke

A stroke is a condition affecting the blood vessels that supply the brain with oxygen and nutrients. It occurs when one of these blood vessels is blocked by a clot or bursts, interrupting the blood flow to the brain and causing death of brain tissue.

Why do we underwrite the condition?

Stroke is one of the leading causes of death and disability. It results in a range of physical impairments depending on the extent and location of the brain damage which may be permanent. A stroke increases overall cardiovascular risk and the risk of having one again in future.

Possible underwriting outcomes:

- Life Insurance - Provided that the insured person has made a complete recovery with no remaining symptoms or residual neurological complications and their health is stable terms can be considered. Otherwise the cover will be declined. If a stroke exists with multiple severe risk factors, for example diabetes, heart attack or chest pain the cover will be declined.
- Disability Insurance and Illness Insurance - No cover will be considered

Possible additional underwriting requirements:

- Medical report
- Questionnaire from the treating doctor

Rheumatoid arthritis

A chronic autoimmune disorder that effects multiple joints causing inflammation and pain. In advanced cases it may affect internal organs.

Why do we underwrite the condition?

Rheumatoid arthritis can cause damage throughout the body including the skin, kidney, heart, lungs and gastrointestinal tract. Damage to joints can lead to disability and functional impairments effecting the quality of life.

Possible underwriting outcomes:

- Disability Insurance - No cover will be considered
- Illness Insurance - If cover is considered under the Life Cover, cover will usually be considered under the Severe Illness Cover (with the applicable exclusions). Unfavourable cases with severe complications and multiple attacks will be declined.

Possible additional underwriting requirements:

- Musculoskeletal questionnaire from the treating doctor.

Asthma

Asthma is a condition in which the airways become inflamed and swollen making it difficult to breathe. Symptoms include wheezing, shortness of breath, tight chest and coughing.

Why do we underwrite the condition?

Asthma has a negative impact on quality of life and can lead to recurrent hospitalisation, work absenteeism and disability. In severe cases it can lead to respiratory failure.

Possible underwriting outcomes:

- Life Insurance - Most of the asthma cases can be classified under the mild category and will receive standard rates. Unfavourable cases will receive a risk premium increase or will be declined.
- Disability Insurance and Illness Insurance - Most of the asthma cases can be classified under the mild category and will receive standard rates. Unfavourable cases will receive a risk premium increase or will be declined. The tolerance level for a risk premium increase for disability cover is usually lower than for the death benefit.

Possible additional underwriting requirements:

Pulmonary function test

Mental health

This refers to a group of disorders that affect your mood, thoughts and behaviours, the cause of which is often unclear. They include anxiety disorders, stress, depression, and substance-related disorders.

Why do we underwrite the condition?

Mental health disorders are complex and often difficult to treat. They can have a negative impact on quality of life and are one of the leading causes of work absenteeism and occupational disability.

Possible underwriting outcomes:

- Illness Insurance - The terms will be considered based on the diagnosis, frequency of the condition, number of episodes and most importantly the date of last symptoms. The longer the insured person is symptom free, the more favourable the terms will be. For example, adjustment disorders (reactive depression) can be viewed favourably after a short period of time and accepted at standard rates. Suicide ideation or attempts may attract a permanent suicide exclusion
- Disability Insurance - Disability Insurance may receive exclusions for mental health and Activities of Daily Living depending on the control of the condition. For example, adjustment disorders (reactive depression) can be viewed favourably after a short period of time and accepted at standard rates without an exclusion.
- Severe Illness Insurance - Severe Illness may receive exclusions for psychiatric disorders and Activities of Daily Living depending on the control of the condition.

Possible additional underwriting requirements:

Mental health questionnaire from the treating doctor

Family history

This refers to the medical history of a person's close relatives, usually first and second generation.

Why do we underwrite the condition?

A family history helps identify individuals who are at higher risk of developing certain diseases e.g. cancer, heart disease, diabetes and asthma.

Possible underwriting outcomes:

- Life Insurance and Disability Insurance - Depending on the number of cases in the family history, the relationship to the insured person and the age at the onset of the disease, an underwriting outcome will be generated by the Underwriting Rules Engine (URE). In the majority of cases standard rates will be offered, but a few a conditions may have a risk premium increase.
- Illness Insurance - Depending on the number of cases in the family history, the relationship to the Insured person and the age at the onset of the disease an underwriting outcome will be generated by the Underwriting Rules Engine (URE). In the majority of cases standard rates will be offered, but a few conditions may have a risk premium increase or exclusions.

Possible additional underwriting requirements:

The insured person will have to answer the relevant questions in the health and lifestyle questionnaire and A medical report may be required for a few conditions.

Hereditary disease

These are genetic diseases that are passed down from parents and are caused by an abnormality in the genes of one or both parents. Examples include Huntington's, sickle cell disease and haemophilia.

Why do we underwrite the condition?

Many hereditary disorders are associated with serious health problems and may decrease life expectancy.

Possible underwriting outcomes:

- Life Insurance, Disability Insurance and Illness Insurance - Individual consideration will be given depending on the condition and its severity. The decision could either be at standard rates, accepted with a risk premium increase or a decline.

Possible additional underwriting requirements:

- Medical report and
- Questionnaire from the treating doctor

Use of recreational drugs

The use of substances (such as cannabis, cocaine, heroin) or prescription medication (such as stimulants, depressants, analgesics) without medical justification or for its psychoactive effects..

Why do we underwrite the condition?

The use of recreational drugs can have detrimental effects on overall health. It increases the risks of heart disease, bronchitis and asthma, liver disease, infectious diseases and mental health disorders.

Possible underwriting outcomes:

- Life Insurance, Disability Insurance and Illness Insurance - Recreational or medicinal drug abuse will usually result in a decline. A risk premium increase can be considered in specific scenarios based on the type of drug, rehabilitation history, date of last use etc. Recreational use of cannabis can be viewed favourably if not used excessively.

Possible additional underwriting requirements:

- The insured person will have to answer the relevant questions in the health and lifestyle questionnaire and if required medical underwriting requirements will be based on the disclosure.

Alcohol consumption

Drinking of beverages containing ethyl alcohol such as spirits, wine, beer.

Why do we underwrite the condition?

There are many health risks associated with excessive alcohol consumption which include liver disease, heart disease, increased risks of cancer and mental health disorders.

Possible underwriting outcomes:

- Life Insurance, Disability Insurance and Illness Insurance - If the alcohol consumption is within the standard acceptable parameters, the case will be accepted at standard rates. Excessive drinking or alcohol abuse will result in extra underwriting requirements and in some cases may attract a risk premium increase or be declined.

Possible additional underwriting requirements:

- The insured person will have to answer the relevant questions in the health and lifestyle questionnaire and if required medical underwriting requirements will be based on the disclosure.

26.10.4 Calculating maximum cover amounts

Cover amount calculations for determining medical underwriting requirements.

Once the cover amount is determined it can be used together with the underwriting requirements table to determine the medical requirements. Additional underwriting requirements may be needed at the discretion of our underwriters.

The cover amount taken into consideration when calculating medical underwriting requirements are for single amount cover. When it's an income product, the income cover amount must be converted into a single amount before it can be used in the cover amount calculations.

Cover amount for:

- Disability Income Cover (with Income Extender Benefit)
- Functional Impairment Income Cover

is calculated as follows:

Medical cover amount = monthly benefit x medical conversion factor from table below

NUMBER OF RELATED BENEFIT PAYMENTS COVERED	MEDICAL CONVERSION FACTOR
24 months	96

Cover amount for:

- Life Income

is calculated as follows:

Medical cover amount = monthly benefit x medical conversion factor*

*The medical conversion factor varies depending on the term selected and scheduled yearly cover increase selected.

Cover amounts for:

- Disability Income Cover (without Income Extender Benefit)
- Disability Income Cover (with Sickness Benefit)
- Business Expenses Cover

is calculated as follows:

Medical cover amount = monthly benefit x medical conversion factor from the table below

REMAINING TERM (YEARS)	MEDICAL CONVERSION FACTOR
1-7	40
8-14	70
15-19	110
20-24	128
25-29	128
30-34	160
35-39	176
40-44	192
45-49	208
50-54	240
55-59	320
60-64	320
65+	320

The cover amount for the Future Cover:

For Future Cover and Future Cover with Disability and Illness Cover attached:

Cover amount = 50% x medical cover amount

26.10.4 Initial medical underwriting requirements

Initial medical underwriting requirements are based on the cover selected and the insured person's age.

If any of the questions in the health and lifestyle questionnaire are answered adversely or if the insured person's body mass index (BMI) is out of range, the requirements are automatically adjusted to call for additional information.

Initial medical underwriting requirements are only applicable to the medical tests, questions or both underwriting method. This excludes the health and lifestyle questionnaire – these questionnaires are applicable for both the No medical tests, only questions and medical tests, questions or both underwriting methods.

26.10.6 Medical underwriting requirements across personal and business cover

COVER AMOUNT	AGE NEXT BIRTHDAY**	REQUIREMENT(S)
Up to R100 000	All	· Health and lifestyle questionnaire
R100 000 – R299 999	15-80	· Health and lifestyle questionnaire · HIV test *
R300 000 to R999 999	15-80	· Health and lifestyle questionnaire · HIV test * · Cotinine test*
R1 000 000 to R2 999 999	15-45	· Health and lifestyle questionnaire · HIV test * · Cotinine test* · Cholesterol test*
R3 000 000 to R4 999 999	15-45	· Health and lifestyle questionnaire · HIV test * · Cotinine test* · Cholesterol test* · Short medical report
R1 000 000 to R4 999 999	46-59	· Health and lifestyle questionnaire · HIV test * · Cotinine test* · Cholesterol test* · Blood sugar test* · Short medical report
	60+	· Health and lifestyle questionnaire · HIV test · Cotinine test · Cholesterol test · HBA1C test · Gamma GT test · Short medical report

R5 000 000 to R9 999 999	15-45	· Health and lifestyle questionnaire · HIV test · Cotinine test · Cholesterol test · Gamma GT test · Short medical report
	46+	· Health and lifestyle questionnaire · HIV test · Cotinine test · Cholesterol test · HBA1C test · Gamma GT test · Short medical report
R10 000 000 to R30 000 000	15-45	· Health and lifestyle questionnaire · HIV test · Cotinine test · Cholesterol test · Gamma GT test · Short medical report
	46-49	· Health and lifestyle questionnaire · HIV test · Cotinine test · Cholesterol test · HBA1C test · Gamma GT test · Short medical report
	60+	· Health and lifestyle questionnaire · HIV test · Cotinine test · Cholesterol test · HBA1C test · Gamma GT test · Standard medical report · Resting and effort ECG

R30 000 001 to R100 000 000	15-59	· Health and lifestyle questionnaire · HIV test · Cotinine test · HBA1C test · Gamma GT test · Standard medical report · Resting and effort ECG · Medical questionnaire (from doctor) · Aspartate aminotransferase (AST) and Alanine aminotransferase (ALT) test · Fasting Lipogram test · Urea and creatinine test
	60+	· Health and lifestyle questionnaire · HIV test · Cotinine test · HBA1C test · Gamma GT test · Standard medical report · Resting and effort ECG · Medical questionnaire (from doctor) · Aspartate aminotransferase (AST) and Alanine aminotransferase (ALT) test · Fasting Lipogram test · Urea and creatinine test · Prostate Specific Antigen (PSA) (for males only)
≥ R100 000 001	15-59	· Health and lifestyle questionnaire · HIV test · Cotinine test · HBA1C test · Gamma GT test · Standard medical report · Resting and effort ECG · Medical questionnaire (from doctor) · Aspartate aminotransferase (AST) and Alanine aminotransferase (ALT) test · Fasting Lipogram test · Urea and creatinine test · Full blood count

	60+	· Health and lifestyle questionnaire · HIV test · Cotinine test · Standard medical report · HBA1C test · Gamma GT test · Resting and effort ECG · Medical questionnaire (from doctor) · Aspartate aminotransferase (AST) and Alanine aminotransferase (ALT) test · Fasting Lipogram test · Urea and creatinine test · Prostate specific antigen (PSA) (for males only) · Full Blood Count

* The life covered may qualify for rapid testing subject to underwriting.

** Each product will stipulate its minimum and maximum entry age

The cotinine test is only required if the insured person indicates that they are a non-smoker.

Please note:

- No medical tests are required for Premium Protection Death, Premium Protection Disability and Premium Protection Functional Impairment. Only the health and lifestyle questionnaire is required.
- No medical tests are required for Premium Protection Retrenchment, Accidental Death Cover, Accidental Disability and Death Cover and Retrenchment Cover. Only the non-health related questions in the health and lifestyle questionnaire are required.

26.11 Occupational underwriting

Insured persons with specific occupations or belonging to specific industries will need to complete an occupation assessment when applying for cover. We'll use the occupation assessment to determine eligibility for the cover.

The occupational questions are available during the quote process by selecting 'get more accurate premium'.

If it's determined that the occupation and industry combination is riskier than average and additional reflexive information is required, questions will be presented in the quote. The insured person doesn't have to complete this information until application.

Occupation, industry and employment status

To perform this assessment, the following information will be collected:

QUESTION	DESCRIPTION
What is your occupation?	The insured person must select an occupation from a pre-defined list.
Which industry do you work in?	The insured person must select an industry from a pre-defined list. This question will only appear if the occupation selected appears in more than one industry. The following industries have been identified as risky: · mining · diving · aviation · oil and gas · air force · police services · defence force · navy · security services · taxi / transport · debt collectors · fishing · sports
Employment status	The insured person must select one of the following: · contract worker · part-time worker · temporary worker · casual worker · seasonal worker · self employed · sole proprietor · full-time employee (salaried) · full-time employee (commission earner) · business partner · unemployed
Administration or management tasks*	Time that is spent on administration, clerical, managerial duties and meetings (as a percentage)
Physical activities*	Time that is spent on physical and/or a supervisory role that includes physical work (as a percentage)

Travelling*	Time that is spent travelling for work purposes excluding travelling to and from work (as percentage)
*The total % across administration or management tasks , physical activities and travelling must add up to 100%	
Would you like to add another occupation?	If 'yes', then all the responses to the above questions must be provided for the second occupation
How many hours a week are spent on performing your primary or secondary occupation?	These questions will only appear if a second occupation has been specified

26.11.1 Occupation classes

An occupation class reflects the likelihood of the insured person making a morbidity-related claim. Occupations that present a similar morbidity risk have been grouped together. There are four classes, specified below from highest (A) to lowest (D), depending on the percentage of admin, physical or travel tasks:

CLASS	DESCRIPTION
A	Office-based professional, executive, managerial, commercial, administrative or clerical occupations.
B	Master craftsman or master tradesman engaged in management and supervision only. Participates in a skilled occupation. Some degree of manual work or motor vehicle travel forms part of the daily activities of the individual.
C	Heavier than average manual work. More than average motor vehicle travel. Higher than average industry risk.
D	Semi or unskilled occupation. Very heavy manual work. Very frequent motor vehicle travel. Subject to extra hazards.

The insured person can receive a lower occupation class than the standard class for the occupation/industry combination, depending on the percentage of time they spend travelling and performing manual work. If they spend a higher percentage of time travelling or performing manual work, the underwriters will change their occupation class.

26.11.2 Two occupations

Where the insured person has specified a second occupation, we must establish whether the time spent performing each occupation is significant or not.

- If the time spent performing either occupation is less than 15% of the total time spent performing both occupations per week, the occupation that is less than 15% is not considered a significant risk. It must then not be subject to the above risky industry or occupation assessment.
- If the time spent performing each occupation is equal to or greater than 15% of the total time spent performing both occupations per week, both occupations are considered significant. Both occupations must be subject to the above risky industry/occupation assessment. The lowest occupation class will be assigned to the insured person.

Example

OCCUPATION	OCCUPATION CLASS	HOURS SPENT PERFORMING OCCUPATION (PER WEEK)	% SPENT PERFORMING OCCUPATION	"FINAL" OCCUPATION
Accountant	A	40	89%	A
Driver	D	5	11%	

OCCUPATION	OCCUPATION CLASS	HOURS SPENT PERFORMING OCCUPATION (PER WEEK)	% SPENT PERFORMING OCCUPATION	"FINAL" OCCUPATION
Accountant	A	40	80%	D
Driver	D	10	20%	

26.11.3 Specific occupations

Farmers

The underlying basis for insurance is not enrichment, but maintaining the insured person's lifestyle and/or financial situation. This implies that insurance should not be taken out to make an inheritance larger than it would have been in the absence of insurance (other than estate duty considerations). This results in enrichment and could create potential incentive for foul play, including non-disclosure at application.

Example

A farmer has a family farm worth R5 000 000. It's too small to subdivide and needs to remain in the family. The farmer has a son and a daughter. (The mother passed away.) The continuation plan is for the son to take over the farm, but with the daughter getting half the value of the estate. An easy option would seem to take out R5 000 000 cover on his life (ignoring estate duty). This covers the need for the daughter to also get her share of the inheritance, without having to sell the farm. Would this violate any of the insurance principles? The simple answer is yes, as enrichment would result. The combined estate has increased from R5 000 000 to R10 000 000. Even if the daughter only inherited half the value of the farm, R2 500 000 extra cover would have been taken out, once again increasing the estate from R5 000 000 to R7 500 000. The farmer would be financially worth more dead than alive, creating a potential incentive for suicide or foul play. But there is a real need that needs to be addressed, namely how to provide an inheritance for the daughter without having to sell the farm.

We'll make some concessions in certain specific situations with regard to inheritances:

- This standard practice will only apply to farms. Farmers derive their livelihood from farms and there has been a long history of farms being inherited, creating a definite need for cover.
- Farms below a certain size can't be divided, as that impacts the income-generation ability.
- Insurance up to the value of that asset will be considered. The maximum value is R30 000 000, however, Life Cover more than R30 000 000 will be individually assessed. (For example, if the farm is worth R10 000 000, insurance up to R10 000 000 will be considered.) This rule remains the same, regardless of the number of inheritors involved.

- If there are other assets that can be divided and distributed, these must be used to reduce the value of the indivisible asset.
- Another complication with the farm example is where the farm is held in trust. Long before the father (original farmer) dies, the farm might already have been put in a trust to bypass estate duty. The farm is now owned by a trust, governed by a trust deed with trustees responsible for enforcing the trust deed. The trustees might be the farmer, the son and the uncle. If the daughter is also a beneficiary and will also share in the ongoing proceeds of the farm, the inheritance issue has been dealt with. No further insurance will be allowed to cover inheritance provision.
- However, if the son is going to continue running the farm, and on the father's death (or before) he becomes the main beneficiary, a need for inheritance provision exists.
- This is very different to the case where cover is taken out for estate duty purposes, which has been dealt with previously.

26.11.4 Farmer's spouse

Farmers' spouse is a special sub-category. The spouses mostly stay at home and look after the household, but they are often also instrumental in running the farm. The farmer's spouse can be seen as a key person on the farm. Cover up to seven times the deemed yearly salary can be taken out.

The following tables show the allowable cover that can be considered up to specified amounts:

26.11.5 Home executives

TYPE OF COVER		MAX COVER
Single amount cover	· **Life Cover** · **Life Income Cover**** · **Last Survivor Cover** · **Accidental Death Cover** · **Premium Protection Death** · **Business Life Cover**	R4 000 000*
	· **Physical Impairment Cover**	R2 500 000
	· **Functional Impairment Cover** Partial Functional Impairment Benefit · **Premium Protection Functional Impairment** · **Business Functional Impairment Cover**	R2 500 000
	· **Severe Illness Cover** Top-up Benefit Mild Illness Benefit For Women Benefit Returning Illness Benefit Child Illness Benefit · **Business Severe Illness Cover**	R2 000 000
	· **Future Life Cover** Disability and Illness Benefit	R2 500 000
Monthly amount cover	· **Functional Impairment Income Cover**	R15 000

* Where the cover is greater than R2 500 000, the cover offered is subject to three times the yearly income of the spouse.

** The monthly amount of Life Income that can be purchased is equivalent to the single amount of cover remaining in this category. The factors used to convert the income into a single amount varies depending on the term and scheduled yearly cover increase selected.

Example

Jana Williams is a 34-year old home executive with three children and a husband who is working hard to establish a career. Jana also brings in extra income by selling furniture from home. If something happened to stop Jana from working in the home, the family would need help in terms of childcare, shopping and household management. If she was sick (even for a little while) they simply wouldn't be able to cope. If she passed away, her husband would need live-in childcare as well as domestic help as he would have to work even harder to compensate for the loss of income.

Jana may need:

- Life Cover
- Family Funeral Cover
- Functional Impairment or Functional Impairment Income Cover
- Severe Illness Cover
- Future Cover

26.11.6 Student / scholar

TYPE OF COVER		MAX COVER
Single amount cover	· **Life Cover** · **Life Income Cover*** · **Last Survivor Cover** · **Accidental Death Cover** · **Premium Protection Death** · **Business Life Cover**	R1 000 000
	· **Physical Impairment Cover**	R1 250 000
	· **Functional Impairment Cover** Partial Functional Impairment Benefit · **Premium Protection Functional Impairment** · **Business Functional Impairment Cover**	R2 000 000
	· **Severe Illness Cover** Top Up Benefit Mild Illness Benefit For Women Benefit Returning Illness Benefit Child Illness Benefit · **Business Severe Illness Cover**	R2 000 000
	· **Future Life Cover** Disability and Illness Benefit	R2 500 000
Monthly amount cover	· **Functional Impairment Income Cover**	R15 000

* The monthly amount of Life Income that can be purchased is equivalent to the single amount of cover remaining in this category. The factors used to convert the income into a single amount varies depending on the term and scheduled yearly cover increase selected.

Example

Steve is a 23-year old student who lives on campus. Steve is completely reliant on his parents for an income.

Steve may need:

- Funeral Cover
- Functional Impairment Income Cover
- Severe Illness Cover
- Future Life Cover

26.11.7 Unemployed lives

Cover can be considered up to specified amounts under the allowable benefits:

TYPE OF COVER		MAX COVER
Single amount cover	· **Life Cover** · **Life Income Cover*** · **Last Survivor Cover** · **Accidental Death Cover** · **Premium Protection Death** · **Business Life Cover**	R650 000
	· **Functional Impairment Cover** Partial Functional Impairment Benefit · **Physical Impairment Cover** Premium Protection Functional Impairment · **Business Functional Impairment Cover**	R1 250 000
	· **Severe Illness Cover** Top Up Benefit Mild Illness Benefit For Women Benefit Returning Illness Benefit Child Illness Benefit · **Business Severe Illness Cover**	R1 250 000
	· **Future Life Cover** Disability and Illness Benefit	R2 500 000

* The monthly amount of Life Income Cover that can be purchased is equivalent to the single amount of cover remaining in this category. The factors used to convert the income into a single amount varies depending on the term and scheduled yearly cover increase selected.

Example

Alan is in his late forties and married. He has no dependents but lives off his wife's income.

Alan may need:

- Life Cover
- Funeral Cover
- Functional Impairment Cover
- Severe Illness Cover
- Premium Protection

26.11.8 Sole proprietors

Cover for sole proprietors spans both personal and business cover as the proceeds will ultimately go to the business owner or his family. Personal and business cover for persons falling into this category are combined (aggregated).

Cover can be motivated through a personal cover multiple or a business valuation. Sole proprietors' income is derived solely from their own business. It's probably less certain than a salary and also more volatile. Depending on the absolute amount of cover and the past history of the business, a multiple up to the personal cover multiple can be used. For the full personal multiple to be used, there should be a two-year earnings history.

26.12 Risky activity and sports underwriting

Insured persons who participate in risky activities or sports may pose a higher than average risk of injury or death. We ask a risky activities and sports question and follow up with other related questions to assess this risk. Based on this information cover can be accepted at standard rates, receive a risk premium increase, be excluded or referred for manual underwriting.

The risky activities and sports questionnaire can optionally be completed when doing a quote by ticking 'Do you want to get a more accurate premium?' If not completed during a quote, the risky activities and sports questionnaire becomes mandatory when doing the application.

26.13 Work and travel underwriting

The underwriting approach to the territorial risk is based on the premise that the product is priced for South Africa and Namibia. Any work-related travel outside of these countries must be underwritten. If the travel pattern associated with the insured person's occupation is riskier than average based on the underwriting guidelines, an additional risk premium increase or exclusion will apply.

Travelling for the purpose of a holiday is excluded.

26.14 Financial underwriting

26.14.1 Insurable interest

When an insured person applies for cover they can insure themselves or someone else. If they're planning on insuring someone else there must be an insurable interest between the two individuals. This means that the insured person would likely lose money or get into debt when the other person dies, becomes disabled, impaired or ill. If there is no insurable interest we won't be able to offer cover.

A person can insure:

- themselves, their prospective spouse, spouse, children or extended family members
- anyone who depends on them financially
- co-business owners or key employees in a business

26.14.2 An appropriate amount of insurance

Just because an insurable interest exists does not mean that any amount of cover will be granted.

- Affordability needs to be considered.
- The net asset value of the insured person is important, mostly for estate duty cover.
- It's often necessary to refer to the financial statements of the businesses involved and the relevant agreements, such as loan agreements and financing agreements. This to determine whether a financial liability or dependency on the insured person or the business entity exists and what the realistic value of this dependency is.
- A bank's willingness to extend a loan does not necessarily mean that we would automatically offer cover.
- Just because an insurable interest exists does not mean that any amount of cover will be granted. The amount of insurance must not be out of proportion with what is reasonably required to compensate for the loss or infringement of the particular interest involved.
- Additionally, the contract must be supported by a serious intention to be legally sound. This implies that affordability needs to be considered. Details of the actual earnings of the insured person is crucial. This is capitalised using earnings multiples. Additionally, the net asset value of the insured person is important, mostly for estate duty cover.
- It's often necessary to refer to the financial statements of the businesses involved and the relevant agreements, such as loan agreements and financing agreements. This to determine whether a financial liability or dependency on the insured person or the business entity exists and what the realistic value of this dependency is.
- A bank's willingness to extend a loan does not necessarily mean that we would automatically offer cover. The bank's credit risk is usually well covered with assets, sureties and the like, whereas the insurer's loss is immediate upon the insured event occurring.

26.14.3 Income definitions

INCOME	DEFINITION
Passive income	Passive income (Example: rental income, dividends received from share portfolio etc.)
Retirement income	Includes · Retirement annuity income and · Pension
Business proceeds	Where the individual is also a business owner, business proceeds is an optional addition to monthly taxable income derived from their occupation. This will require the insured person to disclose additional information over and above their normal income disclosure as stated above. Proceeds from a business are calculated as: (Net annual business profits before tax x % holding in the business)/12

Gross monthly income for salary earners (pre-tax)	Total monthly cost to company before tax is deducted and taking any exemptions, deductions or allowances into account. Cost to company includes: · Monthly salary · Allowances provided by your employer and · Benefits paid by your employer · (Examples: contribution to medical scheme, retirement fund contributions)
	Guaranteed annual bonus This excludes non-guaranteed performance bonuses. (Example: ad-hoc, non-guaranteed yearly bonus (including 13th cheques), performance type bonuses, merit awards, share incentives or bonuses/incentives paid to retain services)
Gross monthly income for commission earners (pre-tax)	Total monthly cost to company before tax is deducted and taking any exemptions, deductions or allowances into account. Cost to company, includes: · Basic monthly salary · Allowances provided by your employer and · Benefits paid by your employer · (Examples: contribution to medical scheme, retirement fund contributions, guaranteed bonuses)
	Average monthly commission earned over 12 months
Gross monthly income for non-salaried employees (self-employed and professionals)	Share of average monthly fees earned for services rendered less share of business expenses and overheads. Averaged over 12 months.
Net monthly income for non-salaried employees (self-employed and professionals)	Net income from trading activities (sales less cost of sales, less business overheads that relate to the trading activities). Averaged over 12 months.

Including net assets

In addition to the above, net assets (total assets less liabilities) may also be used to augment monthly income

This is an optional addition but where the individual wishes to use this it will be added personal income based on the following: Net assets x annuity factor.

The customer will only need to enter the net position but for information purposes the definition for what should be included in the calculation of assets and liabilities is as follows:

Assets include the following:

- Property
- Valuables
- Investments
- Cash and Savings

Liabilities include the following:

- Home loan/ bond
- Personal Loan
- Credit Cards
- Overdraft facility

Example

Mr Jean, aged 38 next birthday, earns R500 000 per year. He has existing life cover of R13 000 000 in force and requests a further R5 000 000 to provide for his family's needs, estate duty and to cover liabilities.

- Based on the income multiple (for a 38-year-old next birthday, the multiple is 25) we deem his insurable risk to be R12 500 000. We would therefore NOT provide any additional cover.
- However, Mr Jean provides details of his assets and liabilities and this reflects the following position:

ASSETS	**AMOUNT**
3 Houses	R4 800 000
Holiday apartment	R650 000
Vehicles	R800 000
Furniture and other personal assets	R800 000
Investments (deposits, unit trusts, shares)	R1 200 000
Business interest	R850 000
Total Assets	**R8 700 000**
LIABILITIES	**AMOUNT**
Mortgage bonds over fixed property	R2 300 000
Vehicle finance	R350 000
Total liabilities	**R2 650 000**
Net Assets	**R6 050 000**

- Mr Jean therefore has a net asset position of R6 050 000. This, together with existing life cover, will result in a large estate, which will attract estate duty and executor's fees, which could be used to justify extra cover. However, the full R13 000 000 existing cover is already more than the maximum that we will grant, so only R12 500 000 will be used for calculating the dutiable estate. (Estate duty is covered in more detail later in the Estate Duty section.)
- The example above illustrates the importance of including assets and liabilities in the calculation when determining the insurable interest.

26.14.4 Replacement of cover

Just because cover is being replaced, doesn't mean that all financial underwriting requirements will be waived. The usual financial underwriting requirements may apply.

If the total amount of cover being replaced is under R10 000 000, we won't require any financial underwriting.

It's crucial to ensure that the existing cover is cancelled.

26.14.5 Personal protection versus business protection

Personal and business cover are considered separately. They are not aggregated when considering how much cover is appropriate, and appropriate amounts for both can be taken out independently.

Each has different requirements and will be dealt with separately in this reference guide.

26.14.6 Assessing the cover amount

The new cover requested and the total existing cover in force must be added. This total must then be compared with the income multiplied by the relevant earnings multiple.

For larger cases, especially where liquidity in the estate become factors, the net asset value needs to be taken into account as this may increase the cover that we are willing to provide.

26.14.7 Personal protection

There are various reasons for personal cover. Our financial underwriting requirements differ based on the reason for cover.

The following section explains the financial underwriting requirements for each of the reasons for cover:

- Family protection
- Farmer's inheritance
- Suretyship
- Liquidity in the estate
- Personal loan
- Funeral cover

26.14.7.1 Family protection

The purpose of family protection cover is to provide security for bread winners by protecting their income.

Roles

- The application for family protection cover must have at least an owner and insured person role.
- The owner can be a natural person or a non-natural entity.
- The insured person must be a natural person.
- Multiple owners are allowed.

Roles for Business Expenses Cover when applied for as a sole proprietor

- The application for family protection cover must have at least an owner and insured person role.
- The owner can only be a natural person.

- The insured person must be a natural person.
- The owner and the insured person must be the same.
- The employment status of the owner and the insured person must be 'sole proprietor'
- Multiple owners are not allowed.

Financial underwriting requirements for family protection cover:

FINANCIAL COVER AMOUNT	FINANCIAL UNDERWRITING REQUIREMENTS
R10 000 000	· Health and lifestyle questionnaire
> R10 000 000	· Health and lifestyle questionnaire and · Application financial questions including insolvency and assets and liabilities.

26.14.7.2 Farmer's inheritance

The purpose of farmer's inheritance is to allow family members of a farm owner to receive their share of the farm when the farm owner dies, without the family having to sell the farm.

Roles

- The application for farmer's inheritance cover must have at least an owner, insured person and business entity role.
- The owner may be a natural person (the farmer) or a trust (family trust).
- The insured person must be a natural person (the farmer).
- The business entity must be a non-natural entity (the farm).
- The insured person(s) must be owners of the business entity. Their percentage ownership must be specified and must add up to 100%. This information is mandatory and must be collected as part of the business entity information captured during the application process.
- The owner must not be the same as the business entity.
- Multiple owners are allowed.

Financial underwriting requirements for farmer's inheritance

COVER AMOUNT	FINANCIAL UNDERWRITING REQUIREMENTS
Up to R10 000 000	· Health and lifestyle questionnaire and · Application business entity information (including business value, ownership and ownership %).
R10 000 001 to R20 000 000	· Health and lifestyle questionnaire and · Application business entity information (including business value, ownership and ownership %) and · Application financial questions including the insolvency question and assets and liabilities

> R20 000 000	· Health and lifestyle questionnaire and · Application business entity information (including business value, ownership and ownership %) and · Application financial questions including the insolvency question and assets and liabilities and · Latest financial statements of the business entity/farm.

Allowable cover

Only the following types of cover may be selected when the reason for cover is farmer's inheritance:

- Life Cover
- Accidental Death Cover
- Premium Protection Death
- Premium Protection Disability
- Premium Protection Functional Impairment
- Premium Protection Retrenchment

26.14.7.3 Liquidity in the estate

The purpose of liquidity in the estate cover is to ensure that there is sufficient cash in the estate to pay for expenses for example estate duty, capital gains tax etc. when the insured person dies.

Estate duty explained

This category is concerned with ensuring sufficient liquidity in the deceased's estate to meet the estate duty. All the financial information required to calculate the value of estate duty should be supplied, and where appropriate, audited financial statements of any farm or business concerned. All of this will be set out in the application financial questionnaire.

Estate duty can be covered via a simple will or a massing of estates.

A simple will

The deceased's portion of the estate accrues to the surviving spouse. The liability is deferred until the death of the surviving spouse. Last Survivor Cover should be taken on the lives of the partners.

Massed estate

Massing occurs when two or more people draw up a will, leaving their assets to an heir, subject to the surviving testator (or testators) enjoying usufructuary rights until one of them dies. The testators don't have to be related or married.

Massing protects the inheritance of the ultimate heir, because the surviving testator (or testators) may not dispose of, or deal in, the assets. It assures the surviving signatory (or signatories) of an income and entitle them to use the assets.

What this means is that the main financial liability is created on the first death. Special consideration will be given to these cases.

Estate duty cover is separate from other cover granted, and is not included in the maximum cover that can be taken out with reference to the earnings multiples. If a large amount of insurance is already available and not earmarked for any specific needs, the amount of estate duty cover may be limited.

Roles

- The application for liquidity in the estate cover must have at least an owner, insured person and beneficiary role.
- The owner must be a natural person.
- The insured person must be a natural person.
- The owner must be the same as the insured person.
- The owner must be the beneficiary (the estate).
- Where Last Survivor Cover has been selected, there must be two owners. The owners must be the same as the insured persons.

COVER AMOUNT	FINANCIAL UNDERWRITING REQUIREMENTS
Up to R1 000 000	· Health and lifestyle questionnaire
R1 000 001 to R10 000 000	· Health and lifestyle questionnaire and · Application financial questions including assets and liabilities and estate duty calculations. · Optional: legal adviser report or CFP report
R10 000 001 to R20 000 000	· Health and lifestyle questionnaire and · Application financial questions including insolvency question, assets and liabilities and estate duty calculations and · Legal adviser report or CFP report.
R20 000 001 to R30 000 000	Health and lifestyle questionnaire and Application financial questions including insolvency question, assets and liabilities and estate duty calculations and Legal adviser report.
> R30 000 000	Health and lifestyle questionnaire and Application financial questions including insolvency question, assets and liabilities and estate duty calculations and Additional requirements to be determined by an underwriter.

Allowable cover

Only the following types of cover may be selected when the reason for cover is liquidity in the estate:

- Life Cover
- Last Survivor Cover
- Accidental Death Cover
- Premium Protection Death
- Premium Protection Disability or Premium Protection Functional Impairment
- Premium Protection Retrenchment

26.14.7.4 Future protection

Roles

- The application for Future Life Cover must have at least an owner and insured person role.
- The owner can be a natural person or a non-natural entity.
- The insured person must be a natural person.
- Multiple owners are allowed

Financial underwriting requirements for Future Protection

There are no financial requirements applicable. Only a health and lifestyle questionnaire is required.

Allowable cover

Only the following types of cover may be selected when the reason for cover is future protection:

- Future Life Cover
  - Disability and Illness Cover
- Premium Protection Retrenchment
- Premium Protection Death
- Premium Protection Disability
- Premium Protection Functional Impairment

26.14.7.5 Funeral cover (No medicals or questions)

Funeral cover provides immediate liquidity on the death of the insured person or their insured family members. This is an affordable way to ensure that funeral costs and immediate living expenses can be met.

Roles

- The application for funeral cover must have an owner and insured person role.
- The owner must be a natural person.
- The insured person must be a natural person.
- Multiple owners are not allowed.

Allowable cover

Only the following types of cover may be selected when the reason for cover is funeral cover with no medical tests or questions:

- Family Funeral Cover
- Individual
  - Children
  - Nominated Child
  - Spouse
- Extended Family Funeral Cover
  - Parent
  - Siblings
  - Other family

26.14.7.6 Funeral cover (No medical tests, only questions)

Funeral cover provides immediate liquidity on the death of the insured person or their insured family members. This is an affordable way to ensure that funeral costs and immediate living expenses can be met.

Roles

- The application for funeral cover must have an owner and insured person role.
- The owner must be a natural person.
- The insured person must be a natural person.
- Multiple owners are not allowed

Allowable cover

Only the following types of cover may be selected when the reason for cover is funeral cover with No medical tests, only questions:

- Family Funeral Cover
  - Individual
  - Spouse

Financial underwriting requirements for funeral insurance

There are no financial requirements applicable. Only a health and lifestyle questionnaire is required.

26.14.7.7 Personal suretyship

Personal suretyship cover allows an individual who stands personal surety to take cover on their own life and provides security when the insured person dies, becomes disabled or suffers a severe illness.

Roles

- The application for personal suretyship cover must have at least an owner, insured person and beneficiary role.
- The owner must be a natural person.
- The insured person must be a natural person.
- The owner must be the same as the insured person.
- The owner must be the beneficiary (the estate). A beneficiary can't be appointed.

COVER AMOUNT	FINANCIAL UNDERWRITING REQUIREMENTS
Up to R10 000 000	· Health and lifestyle questionnaire and · Suretyship agreement.
> R10 000 000	· Health and lifestyle questionnaire and · Application financial questions including insolvency and assets and liabilities and · Suretyship agreement.

Personal loan

A personal loan is a transaction where an individual lends money to another individual with the expectation that it will be paid back over a specific period of time. This transaction must be documented legally in the way of a loan agreement.

Any loans from third-party institutions or banks are not covered under this reason for cover.

These type of loans will be considered under the 'family protection' reason for cover or 'specific business cover' reason for cover such as Business Contingency Insurance.

Roles

- The application for personal loan cover must have at least an owner and insured person role.
- The owner can only be a natural person.
- The insured person must be a natural person.
- The owner and insured person must not be the same person.
- Multiple owners are allowed.

Financial underwriting requirements for personal loan cover

COVER AMOUNT	FINANCIAL UNDERWRITING REQUIREMENTS
Up to R500 000	· Health and lifestyle questionnaire and · Application financial questions including insolvency and personal loan details.
R500 001 to R3 000 000	· Health and lifestyle questionnaire and · Application financial questions including insolvency and personal loan details and · Personal Loan Agreement.
> R4 000 000	· Health and lifestyle questionnaire and · Application financial questions including insolvency and personal loan details, and assets and liabilities and · Personal loan agreement.

Allowable cover

Only the following benefits may be selected when the reason for cover is personal loan:

- Life Cover
- Accidental Death Cover
- Accidental Disability and Life Cover
- Physical Impairment Cover (add-on cover only)
- Severe Illness Cover (add-on cover only)
  - Top-up Benefit
  - Mild Illness Benefit
  - For Women Benefit
  - Returning Illness Benefit

- Disability Cover (add-on cover only)
  - Own Occupation Benefit
  - Partial Functional Impairment Benefit
- Functional Impairment (add-on cover only)
  - Partial Functional Impairment Benefit
- Retrenchment Cover
- Premium Protection Retrenchment
- Premium Protection Death
- Premium Protection Disability
- Premium Protection Functional Impairment

26.14.7.8 Determining the correct cover amount

The cover amounts taken into consideration when calculating financial underwriting requirements are single amounts. With an income product, the income cover amount must be converted into a single amount cover before it can be used to determine the financial cover amount in some instances.

For income cover (excluding Life Income Cover), the cover amount must be converted from an income to a single amounts as follows:

Financial cover amount = monthly cover amount x 12 x financial conversion factor

For Life Income Cover, the cover amount must be converted from an income to a single amounts as follows:

Financial cover amount = monthly cover amount x financial conversion factor*

* The financial conversion factor is a annuity factor that varies depending on the term and scheduled yearly cover increase selected.

Derive the multiples based on the current age next birthday (as at cover start date) or number of related payments covered from below table.

Financial conversion lookup table for:

- Disability Income Cover
  - Income Extender Benefit
- Functional Impairment Income Cover

AGE NEXT BIRTHDAY	FINANCIAL CONVERSION FACTOR
1-20	20
21-25	20
26 – 30	20
31 – 35	20
36 – 40	20
41 – 45	20
46 – 50	20
51 – 55	12
56 – 60	12
61 – 65	8
>65	0

*Please note: There is no conversion factor for the Business Expenses Cover because the business expenses questionnaire is the only financial requirement needed and it's asked from R1.

26.14.7.9 Determining the maximum cover amount

Reasons for cover are considered. The following factors are applicable to the following reasons for cover:

- Family protection
- Future cover
- Personal loan
- Suretyship

The maximum cover amount is calculated by multiplying the insured person's total taxable yearly income by the below multiples:

COVER CATEGORY					
AGE NEXT BIRTHDAY		**LIFE INSURANCE**	**ILLNESS INSURANCE**	**DISABILITY INSURANCE**	**FUTURE COVER INSURANCE**
≥	≤				
	20	30	10	20	30
21	25	30	8	20	30
26	30	30	6	20	37.5
31	35	30	5	20	37.5
36	40	25	4	20	37.5
41	45	25	4	20	34.5
46	50	25	4	20	30
51	55	20	4	12	22.5
56	60	20	4	12	0
61	65	15	4	8	0
66		10	4	6	0

For other reasons for cover, the following apply:

- For Retrenchment Cover we apply a multiple of 0.6 of the taxable monthly income.
- If the reason for cover is farmer's inheritance, the maximum cover amount is 100% of the farm value.

If an insured person applies for cover above the cover amount, the case will be referred for manual underwriting.

The product maximum cover limits will continue to apply.

26.14.8 Business protection

All business cover applications, due to their reliance on paper requirements for financial underwriting will result in manual underwriting.

Business protection involves some form of dependency by a business enterprise on the insured person. This could relate to experience and expertise provided, provision of finance, or funding the purchase of a partner/shareholder's interest in the business. The point of reference here would be the value of the insured person's interest in the business, such as the value of shares, amount of debt on a loan account or provided by a third party or the benefit the business received from this individual's participation in its trading activities.

The key points that we'll consider when deciding whether to grant business cover are:

- whether there is an insurable interest and
- what the financial implication of the insured interest is.

26.14.8.1 Buy and Sell Insurance

Buy and Sell Insurance allows co-owners to take cover on each other's lives, which enables them to buy the deceased or disabled co-owner's share in the business.

Roles

- The application for Buy and Sell Insurance must have at least an owner, insured person and business entity role.
- The owner may be a natural person or a non-natural entity.
- The insured person must be a natural person.
- The business entity must be a non-natural entity.
- The owner can (but does not have to) be the same as the business entity.
- The insured person and the owner must be owners of the business entity. Their percentage ownership must be specified and must add up to 100%. This information is mandatory and must be collected as part of the business entity information captured during the application process.
- Multiple owners are allowed.

A business entity can be any of the following:

- Public company (ends in Pty)
- Private company (ends in Pty Ltd)
- Partnership
- Closed corporation
- Trust
- Non-profit companies

Financial underwriting requirements for buy and sell

COVER AMOUNT	FINANCIAL UNDERWRITING REQUIREMENTS
≤ R5 000 000	· Health and lifestyle questionnaire; and · Application business entity information (including business Value), ownership and ownership %).
From R5 000 001 to ≤ R20 000 000	· Health and lifestyle questionnaire; and · Application business entity information (including business Value), ownership and ownership %). Optional: · Legal adviser report; or · CFP report.
> R20 000 000	· Health and lifestyle questionnaire; and · Application business entity information (including business value, ownership and ownership %); and · Latest financial statements of the business entity.

Allowable cover

Only the following benefits may be selected when the reason for cover is 'buy and sell':

- Business Life Cover
  - Business Disability Cover (add-on cover only)
  - Business Functional Impairment Cover (add-on cover only)
- Future Life Cover

26.14.8.2 Unilateral Buy and Sell Insurance

Unilateral (or 'one sided') Buy and Sell insurance provides continuity for businesses or professional practices where the founder of the business or practice is the 100% owner or a majority shareholder.

Roles

- The application for Unilateral Buy and Sell Insurance must have at least an owner, insured person and business entity role.
- The owner may be a natural person or a non-natural entity.
- The insured person must be a natural person.
- The business entity must be a non-natural entity.
- The owner must not be the same as the business entity.
- The insured person must be an owner of the business entity. The insured persons percentage ownership must be specified, total ownership percentage does not have to add up to 100%. This information is mandatory and must be collected as part of the business entity information captured during the application process.
- Multiple owners are not allowed.

A business entity can be any of the following:

- Public company (ends in Pty)
- Private company (ends in Pty Ltd)
- Partnership
- Closed corporation
- Trust
- Non-profit companies

Financial underwriting requirements for unilateral buy and sell

COVER AMOUNT	FINANCIAL UNDERWRITING REQUIREMENTS
≤ R5 000 000	· Health and lifestyle questionnaire; and · Application business entity information (including business Value), ownership and ownership %).
From R5 000 001 to ≤ R20 000 000	· Health and lifestyle questionnaire; and · Application business entity information (including business Value), ownership and ownership %). Optional: · Legal adviser report; or · CFP report.
> R20 000 000	· Health and lifestyle questionnaire; and · Application business entity information (including business value, ownership and ownership %); and · Latest financial statements of the business entity.

Allowable cover

Only the following may be selected when the reason for cover is unilateral buy and sell:

- Business Life Cover
  - Business Disability Cover (add-on cover only)
  - Business Functional Impairment Cover (add-on cover only)
- Future Life Cover

26.14.8.3 Business Contingency Insurance

Business Contingency Insurance allows a business to take out cover on the life of an individual who is responsible for the business' debt and provides cover when the insured person dies, becomes disabled or suffers a severe illness.

Roles

- The application for Business Contingency Insurance must have at least an owner, insured person and business entity role.
- The owner must be a non-natural entity.
- The insured person must be a natural person.
- The business entity must be a non-natural entity.
- The owner must be the same as the business entity.
- The allocation of owners to the business entity role is optional. The percentage ownership does not have to add up to 100%.
- Multiple owners are not allowed.

A business entity can be any of the following:

- Public company (ends in Pty)
- Private company (ends in Pty Ltd)
- Partnership
- Closed corporation
- Trust
- Non-profit companies

Financial underwriting requirements for business contingency

COVER AMOUNT	FINANCIAL UNDERWRITING REQUIREMENTS
≤ R10 000 000	· Health and lifestyle questionnaire; and · Application business entity information (including business value, ownership and ownership %).
From R10 000 001 to ≤ R20 000 000	· Health and lifestyle questionnaire; and · Application business entity information (including business Value), ownership; and ownership %); and · Proof of loan letter (produced by the bank and signed by the manager of the credit division) or · Legal adviser report; or · CFP report; or · Latest financial statements of the business entity.
> R20 000 00 to R30 000 000	· Health and lifestyle questionnaire; and · Application business entity information (including business value, ownership and ownership %); and · Proof of loan letter (produced by the bank and signed by the manager of the credit division); or · Latest financial statements of the business entity.
> R30 000 000	· Health and lifestyle questionnaire; and · Application business entity information (including business value, ownership and ownership %); and · Latest financial statements of the business entity.

For cover amount from R10 000 001 to R30 000 000 we'll require a bank letter where the business loan was granted. Only letters from the following banks will be accepted:

- South Africa: Nedbank, ABSA, FNB, Capitec or Standard Bank.
- Namibia: Bank Windhoek, Nedbank, FNB, or Standard Bank.

Long term loans (>3 years term) can be considered up to R10 000 000 as well as Short term loans (≤3 years term) can be considered) up to R10 000 000 without aggregation between the short term loan and the long term loan.

Allowable cover

Only the following may be selected when the reason for cover is business contingency:

- Business Life Cover
  - Business Severe Illness Cover (add-on cover only)
    - Top-up Benefit
  - Business Disability Cover (add-on cover only)
  - Business Functional Impairment Cover (add-on cover only)
- Future Life Cover

26.14.8.4 Keyperson Insurance

If a key person in a business becomes disabled, suffers a severe illness or dies, Key Person Insurance pays a single amount to sustain the business until a suitable replacement can be found.

Roles

- The application for keyperson insurance must have at least an owner, insured person and business entity role.
- The owner may be a non-natural entity.
- The insured person must be a natural person.
- The business entity must be a non-natural entity.
- The owner must be the same as the business entity.
- The allocation of owners to the business entity role is optional. The percentage ownership does not have to add up to 100%.
- Multiple owners are not allowed

A business entity can be any of the following:

- Public company (ends in Pty)
- Private company (ends in Pty Ltd)
- Partnership
- Closed Corporation
- Trust
- Non-profit companies

Financial underwriting requirements for key person insurance

COVER AMOUNT	FINANCIAL UNDERWRITING REQUIREMENTS
≤ R7 500 000	· Health and lifestyle questionnaire; and · Application business entity information (including business value). Optional: · Legal adviser report; or · CFP report.
> R7 500 000	· Health and lifestyle questionnaire; and · Application business entity information (including business value); and · Latest financial statements of the business entity.

Allowable cover

Only the following may be selected when the reason for cover is key person:

- Business Life Cover
  - Business Severe Illness Cover (add-on cover only)
    - Top-up Benefit
  - Business Disability Cover (add-on cover only)
  - Business functional Impairment Cover (add-on cover only)
- Future Life Cover

26.14.8.5 Business Expenses Cover

Business Expenses Cover provides monthly payments for a limited period of time if the insured person who contributes to the business's monthly expenses is unable to work due to illness or injury or suffers a functional impairment.

Roles

- The application for Business Expenses Cover must have at least an owner, insured person and business entity role.
- The owner must be a non-natural entity.
- The insured person must be a natural person.
- The business entity must be a non-natural entity.
- The owner may be the same as the business entity.
- The allocation of owners to the business entity role is optional. The percentage ownership does not have to add up to 100%.
- Multiple owners are not allowed

A business entity can be any of the following:

- Public company (ends in Pty)
- Private company (ends in Pty Ltd)
- Partnership
- Closed corporation
- Trust
- Non-profit companies

Financial underwriting requirements for Business Expenses Cover

COVER AMOUNT	FINANCIAL UNDERWRITING REQUIREMENTS
Any amount	· Health and lifestyle questionnaire; and · Application business entity information (including ownership and ownership %); and · Application financial questions (business expenses questionnaire)

Allowable cover

Only the following may be selected when the reason for cover is 'Business Expenses Cover:

· Business Expenses Cover

The Business Expenses Cover can also be bought as personal cover under the family protection reason for cover when the owner and insured person is a sole proprietor.

LIMITED UNDERWRITING OPTIONS

27 LIMITED UNDERWRITING OPTIONS

A limited underwriting option is created when a customer buys cover with Old Mutual for which they have been fully underwritten. The limited underwriting option provides the customer with the opportunity to buy more cover in future with reduced underwriting requirements.

There are two types of limited underwriting options:

- Underwriting credit
- Future cover

General rules

An insured person may not use different limited underwriting options in one application. For example, a customer may not buy Life Cover using an underwriting credit and, in the same application, exercise their future cover option to buy Disability Cover.

27.1 Underwriting credit

Old Mutual Protect has two types of underwriting credits:

- Single underwriting credit
- Comprehensive underwriting credit

27.7.1 Single underwriting credit

A single underwriting credit allows a customer to:

- buy additional cover for the same product,
- without further medical tests,
- within five years from the start date of the contract that created the underwriting credit.

A customer qualifies for a single underwriting credit if:

- the insured person has been fully underwritten for an Old Mutual Protect product (excluding premium protection benefits),
- for an amount less than the upper limit of a particular underwriting requirements band, and
- the cover was issued with risk premium increases or specific exclusions,
- all medical questions on the health and lifestyle questionnaire are not clear, or
- any of the medical test results are outside normal Old Mutual limits.

Where the cover was issued with risk premium increases or specific exclusions, it will be applied to the additional cover bought with the single underwriting credit.

Below is a summary of the cover that creates a single underwriting credit. It shows the allowable cover that can be bought with that underwriting credit.

COVER THAT CREATED THE SINGLE UNDERWRITING CREDIT		COVER THAT CAN BE BOUGHT WITH THE SINGLE UNDERWRITING CREDIT	
OLD MUTUAL PROTECT COVER	**TYPE OF COVER/ADD-ON**	**OLD MUTUAL PROTECT COVER**	**TYPE OF COVER/ADD-ON**
Life Cover	Cover	Life Cover	Cover
		Business Life Cover	Cover
Business Life Cover	Cover	Life Cover	Cover
		Business Life Cover	Cover
Last Survivor Cover	Cover	Last Survivor Cover	Cover
Life Income Cover	Cover	Life Income Cover	Cover
Disability Cover	Cover/Add-on cover	Disability Cover	Cover/Add-on cover
		Business Disability Cover	Add-on cover
Business Disability Cover	Add-on cover	Business Disability Cover	Add-on cover
		Disability Cover	Cover/Add-on cover
Functional Impairment Cover	Cover/Add-on cover	Functional Impairment Cover	Cover/Add-on cover
		Business Functional Impairment Cover	Add-on cover
Business Functional Impairment Cover	Add-on cover	Business Functional Impairment Cover	Add-on cover
		Functional Impairment Cover	Cover/Add-on cover
Disability Income Cover	Cover	Disability Income Cover	Cover
		Business Expenses Cover	Cover
Business Expenses Cover	Cover	Business Expenses Cover	Cover
		Disability Income Cover	Cover
Functional Impairment Income Cover	Cover	Functional Impairment Income Cover	Cover
Severe Illness Cover	Cover/Add-on cover	Severe Illness Cover	Cover/Add-on cover
		Business Severe Illness Cover	Add-on cover

Business Severe Illness Cover	Add-on cover	Business Severe Illness Cover	Add-on cover
		Severe Illness Cover	Cover/Add-on cover
Physical Impairment Cover	Cover/Add-on cover	Physical Impairment Cover	Cover/Add-on cover
Future Life Cover	Cover	Future Life Cover	Cover

27.7.2 Comprehensive underwriting credit

A comprehensive underwriting credit allows a customer to:

- buy additional cover for any fully underwritten Old Mutual Protect product,
- without further medical tests,
- within five years from the start date of the contract that created the underwriting credit.

A customer qualifies for a comprehensive underwriting credit if:

- the insured person has been fully underwritten for an Old Mutual Protect product,
- for an amount less than the upper limit of a particular underwriting requirements band,
- the cover was issued at standard rates with no specific exclusions,
- all medical questions on the health and lifestyle questionnaire are clear, and
- all medical test results are within normal Old Mutual limits.

Below is a summary of the cover that creates a comprehensive underwriting credit. It also shows the cover that can be bought with that underwriting credit.

COVER THAT CREATED THE COMPREHENSIVE UNDERWRITING CREDIT		**COVER THAT CAN BE BOUGHT WITH THE COMPREHENSIVE UNDERWRITING CREDIT**	
OLD MUTUAL PROTECT COVER	**TYPE OF COVER/ADD-ON**	**OLD MUTUAL PROTECT COVER**	**TYPE OF COVER/ADD-ON**
Life Cover	Cover	Life Cover	Cover
Business Life Cover	Cover	Business Life Cover	Cover
Last Survivor Cover	Cover	Last Survivor Cover	Cover
Life Income Cover	Cover	Life Income Cover	Cover
Disability Cover	Cover/Add-on cover	Disability Cover	Cover/Add-on cover
Business Disability Cover	Add-on cover	Business Disability Cover	Add-on cover
Functional Impairment Cover	Cover/Add-on cover	Functional Impairment Cover	Cover/Add-on cover

Business Functional Impairment Cover	Add-on cover	Business Functional Impairment Cover	Add-on cover
Physical Impairment Cover	Cover/Add-on cover	Physical Impairment Cover	Cover/Add-on cover
Disability Income Cover	Cover	Disability Income Cover	Cover
Business Expenses Cover	Cover	Business Expenses Cover	Cover
Functional Impairment Income Cover	Cover	Functional Impairment Income Cover	Cover
Severe Illness Cover	Cover/Add-on cover	Severe Illness Cover	Cover/Add-on cover
Business Severe Illness Cover	Add-on cover	Business Severe Illness Cover	Add-on cover
Future Life Cover	Cover	Future Life Cover	Cover
Premium Protection Death	Benefit	Premium Protection Death	Benefit
Premium Protection Disability	Benefit	Premium Protection Disability	Benefit
Premium Protection Functional Impairment	Benefit	Premium Protection Functional Impairment	Benefit

Maximum allowable cover amount

The maximum total cover amount of underwriting credit will be the lower of:

- the cover amount of the product that created the underwriting credit
- the difference between the top of the underwriting band in which the insured person was underwritten and the cover amount of the product that created the underwriting credit, and
- R2 500 000

In addition to the maximum total cover amount of underwriting credit, there will be sub-limits on the cover that can be bought within each insurance need.

MAXIMUM COVER THAT CAN BE BOUGHT WITHIN EACH INSURANCE NEED	
INSURANCE NEED	**COVER AMOUNT**
Life insurance	R2 500 000
Disability insurance	R2 000 000
Severe illness insurance	R1 000 000
Future insurance	R1 000 000
Premium protection	R500 000

For example, Peter was issued with a R2 500 000 comprehensive underwriting credit and will be able to buy additional cover for any fully underwritten Old Mutual Protect product. Even though he has a R2 500 000 credit, he won't be able to buy more than R1 000 000 Severe Illness Cover.

Medical test criteria for a comprehensive underwriting credit

The insured person's body mass index (BMI) and other test results must be within normal Old Mutual limits to qualify for a comprehensive underwriting credit.

MEDICAL TEST	RESULT TO QUALIFY FOR A COMPREHENSIVE UNDERWRITING CREDIT
HIV	Negative
Cholesterol	7.2 or lower
Gamma GT	140 or lower
Blood sugar	8 or lower

27.2 How to calculate the underwriting credit created

Single underwriting credit

John bought R3 000 000 Life Cover and was underwritten in the R1 000 000 - R10 000 000 underwriting requirements band. The case issued at standard rates although some medical tests were slightly outside of normal Old Mutual limits. Because some medical tests were not within normal limits, John doesn't qualify for a comprehensive underwriting credit. He qualifies for a R2 500 000 single cover underwriting credit that he can use to buy new Life Cover or Business Life Cover, or increase his existing Life Cover.

Comprehensive underwriting credit

Anne bought R3 000 000 Life Cover and was underwritten in the R1 000 000 - R5 000 000 underwriting band. The case issued at standard rates. She also had a clean health and lifestyle questionnaire and all medical tests were within normal limits. Anne qualifies for a R2 000 000 comprehensive underwriting credit that she can use to buy new cover across products, or increase existing cover. The maximum cover that Anne can buy for all products in total will be equal to the value of the comprehensive underwriting credit created.

Anne uses the comprehensive underwriting credit and buys R1 000 000 Life Cover, R500 000 Severe Illness Cover and R500 000 Future Life Cover. She used the full R2 000 000 comprehensive underwriting credit available.

27.3 Validity period

Both a single underwriting credit and comprehensive underwriting credit's valid for five years from the start date of the contact that created the underwriting credit.

The full underwriting credit amount can be exercised at any time in the first two years. Thereafter, only a reduced percentage of the underwriting credit amount can be exercised on specified events until the end of year five.

Underwriting credits are not removed if a product is cancelled. Customers could have no active cover, but still have valid underwriting credits.

27.4 Decrease in allowable cover amount and requirements

The table shows the percentage of the underwriting credit amount that can be exercised in each year with the underwriting and admin requirements.

YEAR	PERCENTAGE OF THE UNDERWRITING CREDIT AMOUNT THAT CAN BE EXERCISED	NEW BUSINESS UNDERWRITING AND ADMIN REQUIREMENTS	EXISTING BUSINESS UNDERWRITING AND ADMIN REQUIREMENTS
Year 1	100%	Health and lifestyle questionnaire	Declaration of health and lifestyle
Year 2	100%	Health and lifestyle questionnaire	Declaration of health and lifestyle
Year 3	50%	Health and lifestyle questionnaire Proof of event	Health and lifestyle questionnaire Proof of event
Year 4	50%	Health and lifestyle questionnaire Proof of event	Health and lifestyle questionnaire Proof of event
Year 5	50%	Health and lifestyle questionnaire Proof of event	Health and lifestyle questionnaire Proof of event

27.5 Option events

After year two, the reduced percentage of the underwriting credit amount can only be exercised on specified events until the end of year five.

Individual events

- Every second anniversary date.
- The insured person's marriage.
  - If the insured person has been permanently separated (meeting the requirements for permanent separation), the new marriage must occur at least six months afterwards.
  - Only one application for this option event is allowed.
  - The application for cover must be within 90 days after the date of the option event
  - Evidence on event where marriage means:
    - a marriage, customary union or union recognised under South African law, or
    - a relationship similar to marriage that is intended to be permanent.
- The insured person's permanent separation.
  - The separation must occur at least six months after a marriage.
  - The insured person may only apply once for this option event.
  - The insured person must apply for cover within 90 days after the date of the option event
  - Evidence of permanent separation of two parties to a marriage.
- The registration of a new or increase in an existing bond on a property.
  - The bond must be registered in the insured person's name, and
  - The application for cover must be made within three months from the date of the registration of the mortgage bond.
  - The application to exercise underwriting credit can be made on the registration of a new or an increase in the existing mortgage bond.
  - Confirmation letter from conveyancers that mortgage registration guides are ready to be lodged or
  - Confirmation letter of the application to exercise underwriting credit must be made within three months from the date of the registration of the mortgage bond.
  - There is no minimum underwriting credit amount that has to be exercised.
- The registration of a new or increase in an existing bond on a property.
  - The bond must be registered in the insured person's name, and
  - The application for cover must be made within three months from the date of the registration of the mortgage bond.
  - The application to exercise underwriting credit can be made on the registration of a new or an increase in the existing mortgage bond.
  - Confirmation letter from conveyancers that mortgage registration guides are ready to be lodged or
  - Confirmation letter of the application to exercise underwriting credit must be made within three months from the date of the registration of the mortgage bond.
  - There is no minimum underwriting credit amount that has to be exercised.

- The insured person's salary increases by 25% or more.
  - Only one application for this option event is allowed.
  - The insured person must be a salary earner.
  - A certified copy of the official salary slips.
- The insured person starts employment in their selected field of study for the first time.
  - Only one application for this option event is allowed.
  - A certified copy of the insured person's letter of employment and proof of qualification.

Family events

- The birth of the insured person's biological child or the insured person's legal adoption of a child.
  - Certified copy of a birth certificate or a certified copy of an order of adoption.
- A child's registration for studies.
  - The child must be financially dependent on the insured person, and registered for study at a:
  - Non-government funded school, or
  - Tertiary education institution. Tertiary education institution means an institution where an education qualification with an NQF (National Qualifications Framework or its replacement) Level of 5 or its equivalent and above can be obtained. Included is a university degree, national higher diploma from a recognised University of Technology or a teaching diploma from a recognised tea ching college.
  - Letter from the educational institution confirming first registration and receipt of tuition fee payment.
- The diagnosis of congenital mental retardation of a child.
  - A neurologist or paediatrician must diagnose that the child was born with moderate, severe or profound mental retardation using the Griffith's mental development scale (birth to two years).
  - The insured person must be the child's step, biological or adoptive parent. To qualify for cover, a stepchild's biological or legally adoptive parent must, at any time after the birth of the stepchild, have been married to the insured person. For the purposes of this definition, married means a marriage (including a customary marriage) or union recognised under South African law.
  - Letter from a neurologist or paediatrician confirming diagnosis of moderate, severe or profound mental retardation using the Griffith's mental development scale (birth to two years).
- The birth of a child with spina bifida.
  - The diagnosis of spina bifida cystica with myelo-meningocoele by a neurologist or paediatrician.
  - The insured person must be the child's step, biological or adoptive parent. To qualify for cover, a stepchild's biological or legally adoptive parent must, at any time after the birth of the stepchild, have been married to the insured person. For the purposes of this definition, married means a marriage (including a customary marriage) or union recognised under South African law.
  - Letter from a neurologist or paediatrician confirming diagnosis of spina bifida cystica with myelo-meningcoele.

- The diagnosis of cerebral palsy of a child.
  - The diagnosis of cerebral palsy with evidence of:
    - Impairment of motor function with established diplegic, hemiplegic or quadriplegic spasticity observed over a minimum of 6 months or
    - Documented mental retardation,
    - Documented mental retardation,

    by a neurologist or paediatrician.
  - The insured person must be the child's step, biological or adoptive parent. To qualify for cover, a stepchild's biological or legally adoptive parent must, at any time after the birth of the stepchild, have been married to the insured person. For the purposes of this definition, married means a marriage (including a customary marriage) or union recognised under South African law.
  - Letter from a neurologist or paediatrician confirming diagnosis of cerebral palsy by a neurologist or paediatrician.
- Death of a spouse/partner.
  - Only one application for this option event is allowed.
  - A certified copy of the spouse/partner's death certificate and marriage certificate.
  - Spouse/partner is the person to whom the insured person is married or with whom they are in a relationship similar to marriage that is intended to be permanent.

Business cover events

- On the death of business partner which results in a change to the value required of the buy and sell agreement between the owner and insured person.
  - The owner can increase the existing cover on the existing buy and sell agreement between the owner and insured person within six months of the death of the business partner.
  - A certified copy of the business partner's death certificate and partnership agreement.
  - Financial underwriting evidence as per the financial underwriting requirements grid.
- The owner starts a new business with the insured person and as a result of a new buy and sell agreement, the owner requires more cover on the insured person.
  - The owner can increase cover on the insured person.
  - The owner and insured person cannot be the same.
  - Financial underwriting evidence as per the financial underwriting requirements grid.
- The insured person increases their share in a business by at least 25% and as a result of a buy and sell agreement, the owner requires more cover on the insured person.
  - The owner can increase cover on the insured person.
  - The owner and insured person cannot be the same.
  - Financial underwriting evidence as per the financial underwriting requirements grid.
- An increase in the insured person's obligations to the business' debts by at least 25%.
  - The business must have increased its business liability for a business loan by 25% or more.
  - Financial underwriting evidence as per the financial underwriting requirements grid.

- An increase in the insured person's obligations to the business' expenses by at least 25%.
  - The business must have increased its business expenses by 25% or more.
  - Financial underwriting evidence as per the financial underwriting requirements grid.
- The insured person starts a new business and requires key person insurance.
  - Financial underwriting evidence as per the financial underwriting requirements grid.
- The insured person's value to a business increases by at least 25% as a key person.
  - Financial underwriting evidence as per the financial underwriting requirements grid.25.28.1.7 Limited underwriting for underwriting credit
- Medical underwriting
  - Health and lifestyle questionnaire
  - Life and claims register check
- Financial underwriting
  - Over-insurance check

Occupational, risky activities and sports, and work and travel underwriting will still apply and the relevant questionnaires need to be completed if applicable.

- Occupational underwriting
  - Occupational questionnaire
- Avocational underwriting
  - Risky activities and sports questionnaire
- Territorial underwriting
  - Work and travel questionnaire

27.6 Underwriting outcomes

When exercising an underwriting credit, the underwriting outcome can be any of the following:

- Accept at standard rates
  - If the insured person's health has not materially changed from the start date of the contract that created the underwriting credit.
- Accept with risk premium increase
  - If there is a pre-existing risk premium increase due to medical underwriting and the insured person's health has not materially changed from the start date of the contract that created the underwriting credit, or
  - If occupational, risky activities and sports or work and travel information received requires a risk premium increase.
- Accept with exclusion(s)
  - If there is a pre-existing exclusion due to medical underwriting and the insured person's health has not materially change from the start date of the contract that created the underwriting credit, or
  - If occupational, risky activities and sports, or work and travel information received requires an exclusion.
- Decline
  - If the insured person's health has materially changed since the start date of the contract that created the underwriting credit.

27.7 Conditions for exercising an underwriting credit

Underwriting credits may be used to increase existing cover or buy new cover. The cover bought with an underwriting credit's still subject to overall product limits and takes into account the combined total cover of an insured person. A customer does not need to exercise the full percentage of the underwriting credit amount available, but can choose to exercise a part of the credit.

Underwriting credits may be combined. For example, a customer can use two underwriting credits created by two separate events to buy one new product.

An underwriting credit created by personal cover can be exercised as business cover and vice versa.

CHANGING THE CONTRACT

28. CHANGING THE CONTRACT

A contact change is any change a customer/adviser wants to make to a contract that's already issued. A contract change will only be allowed provided the effective date is after the first premium due date, except for the cool-off of new business. Changes prior to "issue" stage are not considered a contact change.

28.1 Contractual changes

You need to do an existing business quote for the following changes:

Benefit and premium details

- A voluntary increase or decrease in cover
- Add other cover to or remove other cover from Life Cover or Business Life Cover
- Add benefits to or remove benefits from cover
- Change the waiting period
- Add or remove premium protection benefits
- Add or remove Individual, Spouse/Partner, Children or Nominated Children to/from Family Funeral Cover
- Add or remove Monthly Grocery Benefit and/or Monthly Education Benefit to/from Family Funeral Cover
- Add or remove the Double Accidental Benefit
- Add or remove Funeral Paid-up
- Add or remove Cashback
- Change the underwriting method
- Change the benefit term
- Change the scheduled yearly cover increase option
- Change the compulsory yearly premium increase option
- Change the compulsory yearly premium increase date
- Change the guarantee term
- Change the premium payment term
  - from the benefit term to retirement, or
  - from retirement to the benefit term
- Change the retirement age of owner for the premium term
- Change the premium frequency
  - from monthly to yearly, or
  - from yearly to monthly
- Add or remove a premium skip month
- Change the payment method
  - bank deduction to salary deduction, or
  - from salary deduction to bank deduction

General details

- Change in marital status
- Change in smoker status
- Change in education
- Change in professional membership

Occupation and income details

- Change in occupation or second occupation
- Add or remove a second occupation
- Change in industry
- Change in employment type
- Change in time spent on doing tasks
- Change in income details
- Change in hours a week spent on first and/or second occupation

The following changes are only allowed as part of an existing business quote in case of reactivation

- Change premium deduction date
- Change premium payer
- Change bank account details or payroll details

28.2 Other changes

You do not need to do an existing business quote for the following changes:

Role player details

- Owner
  - Update owner details
- Business or organisation
  - Update business entity details
- Insured person
  - Update insured person details not listed under 'existing business quote changes'
  - Name a child insured person under Family Funeral Cover
- Premium payer
  - Change premium payer
- Beneficiaries
  - Update beneficiary details
  - Add or remove a beneficiary
  - Change beneficiary percentage allocation
  - Update replacement owner details
  - Add or remove a replacement owner

- Cashback
  - Change Cashback recipient
- Change correspondent
- Legal representative
  - Update legal representative details
  - Add or remove a legal representative
- Adviser
  - Change adviser
  - Add, remove or replace a second adviser
  - Update commission sharing percentage

Premium holiday

- Request a premium holiday
- Cancel requested premium holiday
- Pay back premium holiday

Cessions

- Add or remove security cession
- Outright cession

Underwriting

- Add or remove risky activities
- Remove travel outside of territory
- Request underwriting review – health, avocational or territorial

Cancellations and reactivations

- Cancel a contract
- Reversal of cancellation
- Reactivation

Other

- Change bank account details or payroll details
- Change premium deduction date
- Change premium skipping month
- Change scheduled yearly cover increase date
- Remove the scheduled yearly cover increase
- Forgo the scheduled yearly cover increase
- Change protection need
- Change the cover to which Retrenchment Cover is linked

28.3 General rules

- The first premium deduction date may not be changed.
- No change may be made retrospectively. The effective date for any changes will always be after the change has been requested.
- Underwriting will be required for some changes, in line with the underwriting rules at the time of change.
- For voluntary cover increases, underwriting will apply on the additional cover.
- A voluntary cover decrease may not reduce cover below minimum new business levels at the time of the change.

CLAIMS AND ASISA SCIDEP

29.1 CLAIMS

29.1.1 Who can submit a claim

The tables below give an overview of who can submit a claim, the different types of cover and when a person can claim.

ROLE PLAYER	CAN THIS PERSON SUBMIT A CLAIM?
Owner The person who owns the contract.	Yes
Insured person The person who is insured, and if an event that they're covered for happens, it may lead to a claim.	Yes
Beneficiary The person nominated to receive the claim payout	No, but a beneficiary can contact us or the adviser.
Premium payer **The person who pays the insurance premiums. However, the owner is ultimately responsible for honouring the contract terms, which includes ensuring that premiums are paid.**	No, but a premium payer can contact us or inform the adviser.
Executor The person who finalises the estate (what the deceased owes and owns). They may be appointed in the will or by a court.	Yes
Cessionary The person to whom rights to, or the ownership of the contract, has been transferred.	Yes
Adviser The accredited financial adviser appointed to look after the claimant's financial needs.	Yes

29.1.2 Claim events

EVENT	WHAT A PERSON CAN CLAIM FOR	WHAT WE WILL PAY*
The insured person has died.	Funeral Insurance Life Insurance	A tax-free single amount, A tax-free single amount or a monthly payment.
The insured person has been diagnosed with a terminal illness with less than 12 months to live.	Life Insurance, Illness insurance	A tax-free single amount.
The insured person suffers an illness (such as cancer or a heart attack).	Illness Insurance	A tax-free single amount.

The insured person has become disabled (can't work or take care of themselves because of an illness or injury) or has become impaired (such as a loss of an arm or leg).	Disability Insurance	A tax-free single amount or a monthly payment.
The insured person has been retrenched.	Retrenchment Insurance	A tax-free monthly payment.

*Please refer to the contract for the specific terms and conditions.

The required documents will depend on the type of cover bought, but the following will always be when submitting a claim:

- Identity document of the insured person and beneficiary
- Marriage certificate or divorce order (if married in community of property)
- Police report in the case of an accidental death
- Proof of banking details of the insured person or the beneficiary

29.1.3 Next steps

- We will review the claim
- We will ask for any additional information
- The claim will be assessed and we'll make a decision
- We will inform the claimant of the outcome, which will be one of the following:
  - **Accepted** – this means that the claim is successful and we will pay.
  - **Rejected** – this means the claim was unsuccessful and we will not pay, as well as tell you the reason why.
  - **On hold** – this is usually due to a waiting period, usually for severe illness and disability claims. A waiting period is the amount of time an insured person must wait before some or all of their cover comes into effect. The insured person may not receive benefits for claims submitted during the waiting period.

How long will it take to find out the outcome of a claim?

We will advise you of the claim outcome within 14 working days from the date we have received all the necessary documents. Generally most claims take less time to process.

29.2 ASISA SCIDEP DISCLOSURES

The Financial Services Board (FSB) and the Competition Commission gave South African life insurers the go-ahead to standardise certain disclosures to consumers of when critical illness products will pay out. This takes the form of a "disclosure grid" underpinned by standard medical definitions to which companies will have to refer when they make the required disclosures and when a claim is assessed.

SCIDEP disclosure grid

SCIDEP requires that a set of ASISA definitions for the four most common critical illnesses and the percentage payout for these four illnesses are shown in the table below. The definitions cover four severity tiers (A, B, C and D), with A being the most severe and D being the least severe.

The tables below illustrate what Old Mutual Protect Severe Illness Cover will pay out in relation to ASISA SCIDEP.

SEVERE ILLNESS COVER				
Event	**Severity A**	**Severity B**	**Severity C**	**Severity D**
Cancer	100%	100%	50%	25%
Coronary artery bypass graft (CABG)	100%	75%	50%	50%
Heart attack	100%	75%	50%	25%
Stroke	100%	75%	50%	25%

SEVERE ILLNESS COVER WITH TOP-UP BENEFIT				
Event	**Severity A**	**Severity B**	**Severity C**	**Severity D**
Cancer	100%	100%	100%	100%
Coronary artery bypass graft (CABG)	100%	100%	100%	100%
Heart attack	100%	100%	100%	100%
Stroke	100%	100%	100%	100%

SEVERE ILLNESS COVER WITH CHILD ILLNESS BENEFIT (PERCENTAGE OF THE CHILD COVER AMOUNT ON THE CHILD ILLNESS BENEFIT)				
Event	**Severity A**	**Severity B**	**Severity C**	**Severity D**
Cancer	100%	100%	100%	100%
Coronary artery bypass graft (CABG)	100%	100%	100%	100%
Heart attack	100%	100%	100%	100%
Stroke	100%	100%	100%	100%

ASISA critical illness definitions

The standard definitions for the four "core" diseases are set out below. A layman's definition for each disease has also been included to assist with understanding, but these don't form part of the definitions.

Stroke – ASISA critical illness definition

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

For the above definition, the following are not covered:

- Transient ischaemic attack (TIA)
- Vascular disease affecting the eye or optic nerve
- Migraine and vestibular disorders
- Traumatic injury to brain tissue or blood vessels.

Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months.

LEVEL A STROKE WITH SEVERE IMPAIRMENT	LEVEL B STROKE WITH MODERATE IMPAIRMENT	LEVEL C STROKE WITH MILD IMPAIRMENT	LEVEL D STROKE WITH ALMOST FULL RECOVERY
Needs constant assistance, as measured by: · the inability to do three or more basic ADL's or · a Whole Person Impairment (WPI) of greater than 35%	Cannot function independently, as measured by: · the inability to do six or more advanced ADL's or · a Whole Person Impairment (WPI) of 21% to 35%	Cannot function independently, but has impairment as measured by: · the inability to do three or more advanced ADL's or · a Whole Person Impairment (WPI) of 11% to 20%	Almost full recovery, with little residual symptoms or sings as measured by: · the ability to do all basic and advanced ADL's or · a Whole Person Impairment (WPI) of 10% or less

WPI figures are calculated as per the American Medical Association Guides to the Evaluation of Permanent Impairment 6th edition.

Basic Activities of Daily Living (ADL)

- Bathing: the ability to wash/bathe oneself independently
- Transferring: the ability to move oneself from a bed to a chair or from a bed to a toilet independently
- Dressing: the ability to take off and put on ones clothes independently
- Eating: the ability to feed oneself independently. This does not include the making of food
- Toileting: the ability to use a toilet and cleanse oneself thereafter, independently
- Locomotion on a level surface: the ability to walk on a flat surface, independently
- Locomotion on an incline: the ability to walk up a gentle slope, or a flight of steps independently

Advanced Activities of Daily Living (ADL)

- Driving a car
- Medical care: prepares and takes correct medications
- Money management
- Communicative activities: use of phone, writing cheques, writing letters
- Shopping: lifting or carrying groceries
- Food preparation
- Housework
- Community ambulation with or without assistive device, but not requiring a mobility device
- Moderate activities: moving table, pushing vacuum cleaner, bowling, golf
- Vigorous activities: running, heavy lifting, sports.

Notes

TIA exclusion included only for clarity. Trauma isn't covered in this instance as a "stroke" is meant to be as a result of an illness not a head injury.

Stroke – a layman definition

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 long-standing uncontrolled high blood pressure.

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).

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 of more of the following symptoms:

- a loss of sensation
- dizziness
- lameness of a limb
- loss of speech, which only occur for a few minutes to hours and recovery is quick and spontaneous.

CABG – ASISA critical illness definition

The undergoing of surgery to correct the narrowing of, or blockage to, one or more coronary artery/arteries by means of a bypass graft.

Level A	The undergoing of surgery to correct the narrowing of, or blockage to, three or more coronary arteries by means of a by-pass graft.
Level B	The undergoing of surgery to correct the narrowing of, or blockage to, two coronary arteries by means of a by-pass graft.
Level C	The undergoing of surgery to correct the narrowing of, or blockage to, left main or proximal left anterior descending coronary artery by means of a by-pass graft.
Level D	The undergoing of surgery to correct the narrowing of, or blockage to, any one coronary artery by means of a by-pass graft.

CABG – a layman definition

Coronary artery bypass graft surgery, also called heart bypass or bypass surgery, is a surgical procedure performed to relieve chest pain and reduce the risk of death from heart disease.

Arteries or veins from elsewhere in the patient's body (most commonly the leg) are joined to the coronary arteries of the heart to bypass the narrowing of the affected or diseased arteries. This improves the blood supply and circulation to the heart muscle. The terms "single bypass", "double bypass", "triple bypass", "quadruple bypass" and "quintuple bypass" refer to the number of coronary arteries bypassed in the procedure.

This surgery is usually performed with the heart stopped, necessitating the usage of highly specialised theatre equipment to keep the heart and the lungs working during the course of the operation.

Heart attack – ASISA critical illness definition

The undergoing of surgery to correct the narrowing of, or blockage to, one or more coronary artery/arteries by means of a bypass graft.

LEVEL A: HEART ATTACK WITH SEVERE PERMANENT IMPAIRMENT IN FUNCTION

A heart attack that meets the criteria as defined under Level C, with permanent impairment in one or more of the following functional criteria, as measured six weeks post-infarction:

CRITERION	VALUE
NYHA classification	Class 4
MET reading	1 or less
LVEF	< 30%
LVEDD	> 72%
Ultrasound FS in %	<16%

Notes

If more than one functional criterion is impaired, but their values do not conform to only one severity level (for example one impaired value is Level A and another Level B), the final severity level should be determined by giving preference to the more objective criteria, that is in the following order:

- LVEF
- LVEDD
- Ultrasound FS
- MET reading
- NYHA

LEVEL B: HEART ATTACK WITH MILD PERMANENT IMPAIRMENT IN FUNCTION

A heart attack that meets the criteria as defined under Level C, with permanent impairment in one or more of the following functional criteria, as measured 6 weeks post-infarction:

CRITERION	VALUE
NYHA classification	Class 2 or 3
MET reading	2 - 7
LVEF	30% · 50%
LVEDD	59% · 72%
Ultrasound FS in %	16% · 25%

LEVEL C: MODERATE HEART ATTACK OF SPECIFIED SEVERITY

This is defined as the death of heart muscle, due to inadequate blood supply, as evidenced by two of the following criteria:

1. Compatible clinical symptoms

2. Characteristic ECG changes, which can be either of the following:

- New pathological Q-waves as defined in Annexure A, or
- ST-segment and T-wave changes indicative of myocardial injury, as defined in Annexure A, but only when accompanied by raised cardiac markers as described hereafter.

3. Raised cardiac markers:

- Trop T > 1,0 ng/ml or Trop I > 0,5 ng/ml, or
- Raised CK-MB mass More than two times normal values in acute presentation phase,

  or
- More than four times normal values post-intervention.
- Total CPK elevation of more than two times normal values, with at least 6% being CK-MB.

LEVEL D: MILD HEART ATTACK OF SPECIFIED SEVERITY

This is defined as the death of heart muscle, due to inadequate blood supply, as evidenced by all three of the following criteria:

1. Compatible clinical symptoms

2. Characteristic ECG changes, e.g. ST-segment and T-wave changes indicative of myocardial ischaemia or myocardial infarction, and

3. Raised cardiac markers:

- Trop T > 0,5 ng/ml or Trop I > 0,25 ng/ml, or
- Raised CK-MB mass
- Up to 2 times normal values in acute presentation phase,

  or
- Up to 4 times normal values post-intervention.
- Total CPK elevation of up to 2 x normal values, with at least 6%
- being CK-MB.

The evidence must show a definite acute myocardial infarction. Other acute coronary syndromes, including but not limited to angina, are not covered by this definition.

Definitions of ECG changes

a. ECG changes indicative of myocardial ischaemia that may progress to myocardial infarction:

Patients with ST-segment elevation: New or presumed new ST segment elevation at the J point in two or more contiguous leads with the cut-off points greater than or equal to 0.2mV in leads V1, V2,or V3, and greater than or equal to 0.1mV in other leads.
Contiguity in the frontal plane is defined by the lead sequence AVL, I and II, AVF, III. (Ref. 1)

Patients without ST-segment elevation: ST-segment depression of at least 0.1 mV;
T-wave abnormalities only. (Ref. 1)

b. Definition of new pathological Q-waves:

Any new Q-wave in leads V1 through V3;
A Q-wave greater than or equal to 40 ms (0.04s) in leads I, II, AVL, AVF, V4, V5 or V6;
The Q-wave changes must be present in any two contiguous leads, and be greater than or equal to 1mm in depth. (Ref. 1);
Appearance of new complete bundle branch block.

Heart attack – a layman description

Four levels of severity of heart attacks are defined:
Level D is the mildest and Level A the most severe.
In both levels C and D the patient recovers fully and the heart function returns to normal.
In levels A and B, more permanent damage has resulted, which means the heart function is less than 100% after recovery.

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

Cancer – ASISA critical illness definition

Cancer is a malignant tumour positively diagnosed with histological confirmation and is characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukaemia, lymphoma and sarcoma.

The following conditions are excluded from this definition:
All cancers in situ and all pre-malignant conditions.

All tumours of the prostate unless histologically classified as having a Gleason score greater than six or having progressed to at least clinical TNM classification T2N0M0.

All skin cancers, other than malignant melanoma that has been histologically classified as T1N0M0 or worse.

Severity levels for cancers are done according to the general classification of cancers into four stages. However, brain and prostate cancer, leukaemia and lymphoma don't conform to this general classification. Therefore additional tiering levels are proposed for these cancers.

Tiering of all cancers except prostate, leukaemia, lymphoma and brain tumours.

The levels are correlated to the general classification used by the American Joint Committee for Cancer for the type of cancer involved:

LEVEL A	LEVEL B	LEVEL C	LEVEL D
Stage 4 cancer	Stage 3 cancer	Stage 2 cancer	Stage 1 cancer

Tiering of prostate cancer

STAGE 1	T1a, NO, MO Gleason ≤ 4	Excluded
STAGE 2	T1a-c, NO, MO Gleason 5-6	Excluded
	T1b-c, NO, MO Gleason 2-6	Excluded
	T1a-c, NO, MO Gleason ≤ 7	Severity D
	T2, NO, MO any Gleason	Severity D
STAGE 3	T3, NO, MO any Gleason	Severity C
STAGE 4	T4, NO, MO any Gleason	Severity B
	Any T, N1 - 3 , MO any Gleason	Severity A
	Any T, any N, M1 any Gleason	Severity A

Tiering of brain tumours

WHO GRADE II	Without neurological deficit	Severity D
WHO GRADE II	With neurological deficit	Severity C
WHO GRADE III	On diagnosis	Severity B
WHO GRADE IV	On diagnosis	Severity A

Notes

- Histological confirmation is required.
- There is no requirement to undergo treatment.
- Prophylactic mastectomy for carcinoma in situ won't qualify under this definition as the cancer isn't invasive.
- The committee tried to avoid using classification or staging terms, but could not in the case of prostate. This was because staging definitions may change over time and are complex for the consumer.
- The committee decided not to exclude any HIV related cancers.

Tiering of leukaemia and lymphoma

LEVEL A	LEVEL B	LEVEL C	LEVEL D
This benefit pays for any one of the following diagnoses: · Acute Myeloid Leukaemia; · Chronic Lymphocytic Leukaemia, stage III or IV on the Rai classification; · Chronic Myeloid Leukaemia (requiring bone marrow transplant); · Acute Lymptiocytic Leukaemia (adults); · Hodgkins/ Non-Hodgkins lymphoma Stage IV on Ann Arbor classification system; · Multiple Myeloma Stage III on the Durie-Salmon scale.	This benefit pays for any one of the following diagnoses: · Hodgkins/ Non-Hodgkins lymphoma Stage III on Ann Arbor classification system	This benefit pays for any one of the following diagnoses: · Chronic Lymphocytic Leukaemia (stage II on the Rai classification); · Acute Lymptiocytic Leukaemia (children); · Chronic Myeloid Leukaemia [no bone marrow transplantation); · Hodgkins/ Non-Hodgkins lymphoma Stage III on Ann Arbor classification system; · Multiple Myeloma Stage I and II on the Durie-Salmon scale.	This benefit pays for any one of the following: · Chronic Lymphocytic Leukaemia (stage 0 or 1); · Hariy cell leukaemia; Hodgkins/ · Non-Hodgkins lymphoma Stage 1 on Ann Arbor classification system.

Cancer – a layman description

- 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 cells 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;
- Treatment is neither expensive nor extensive.
- There are specific exclusions to this definition that include;
- Cancerous cells that have not invaded the surrounding or underlying tissue;
- Early cancer of the prostate gland and the breast;
- All cancers of the skin except cancerous moles that have invaded underlying tissue.

Staging of cancer

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.

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. In order to standardise staging we have used the AJCC system which is the same system used in clinical practice by specialists who treat cancer.

Detail on cancer staging

The classification systems referred to in the annexure is for reference purposes only and won't form art of the definitions.

1. Lymphoma

Hodgkin's and Non-Hodgkin's Lymphoma

2. Ann Arbor Staging System

STAGE 1	STAGE 2	STAGE 3	STAGE 4
The lymphoma is in a lymph node or nodes in only one region. The lymphoma is found only in one area of a single organ outside of the lymphatic system (E).	The lymphoma is in two or more groups of lymph nodes on the same side of the diaphragm. The lymphoma extends locally from a single group of lymph nodes into a nearby organ (IIE). It may also affect other groups of lymph nodes on the same side of the diaphragm.	The lymphoma is found in lymph node areas on both sides of the diaphragm. The lymphoma may also have extended into an area or organ next to the lymph nodes (II IE), into the spleen (1115), or both (IIE,S).	The lymphoma has spread outside of the lymph system into an organ that is not right next to an involved node. The lymphoma has spread to the bone marrow, liver, brain or spinal cord or the pleura.

3. Burkitt's lymphoma staging

A – Single solitary extra-abdominal site

AR – Intra-abdominal, more than 90% of tumour resected

B – Multiple extra abdominal tumours

C – Intra abdominal tumour

D – Intra-abdominal plus one or more extra-abdominal sites

4. Leukaemia

Rai Classification System

STAGE	CLINICAL FEATURES AT DIAGNOSIS
Stage 0	Lymphocytosis > 15,000 / cu mm, bone marrow infiltration >40%
Stage I	Lymphocytosis and adenopathy
Stage II	Lymphocytosis and hepatomegaly and/or splenomegaly (with or without adenopathy)
Stage III	Lymphocytosis and anaemia (Hb < 11.0 g/dl)
Stage IV	Lymphocytosis and thrombocytopenia (< 100,000 / cu mm)

5. Durie-Salmon classification

STAGE	DURIE-SALMON CRITERIA		
Stage I	All of the following: · Haemoglobin value> l0g/dL · Serum calcium value normal or ≤ l2mg/dL · Bone x-ray, normal bone structure (scale 0) or solitary bone plasmacytoma only - low M-component production rate - lgG value <5 gklL; lgA value <3 g/dL - Bence Jones protein < 4 g/24 h	β_2 -M < 3.5 mg/dL and albumin ≥ 3.5 g/dl	61 months median survival
Stage II	Neither Stage I or Stage III	Neither Stage I or Stage III	41 months
StageIII	One of more of the following: · Haemoglobin value <8.5 g/dL · Serum calcium value >l2 mg/dL · Advanced lytic bone lesions (scale 3) · High M-component production rate - lgG value >7 gklL; lgA value >5 d/dL · Bence Jones Protein> 12g/24 h	β_2 -M ≥ 5.5 mg/dL	23 months

Durie-Salmon sub classification (either A or B)

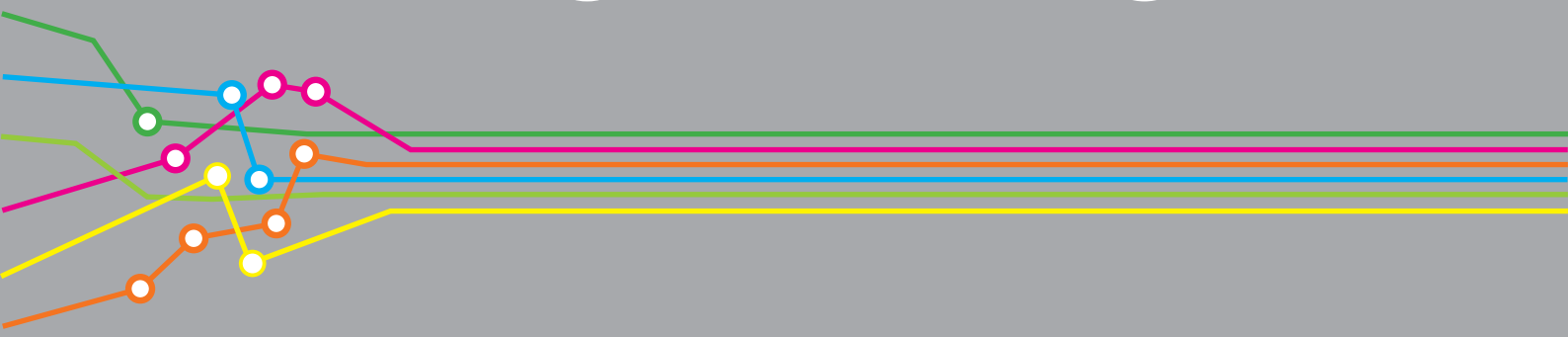
A: Relatively normal renal function (serum creatinine value <2.0 mg/dL (<177 µmol/ℓ)

B: Abnormal renal function (serum creatinine value ≥ 2.0 mg/dL (> 177

µmol/ℓ) – Stage B worse outcome

* Stage II = β2 –M <3.5 or β2 –M 3.5 – 5.5 mg/dL, and albumin <3.5 g/dL

REMUNERATION



30. REMUNERATION

- Commission is the remuneration paid to an adviser for introducing a risk product.
- The cost of commission is included in the premium payable by the owner.
- The adviser and the owner should agree on the commission scaling and the commission payment type.
- The commission can be scaled from 100% to 0%.
  - Scaling commission will reduce the premium.
  - The commission scaling is selected during the quote process and can't be changed.
- Three commission payment types are available: full upfront commission, full as-and-when commission and as-and-when commission with a percentage payable immediately.
  - The selection of commission payment type doesn't impact the premium.
  - The commission payment type is selected during the quote process and can't be changed.
- Depending on the adviser agreement, commission can also be paid in the form of a salary and other benefits (which may include non-cash incentives).
- An adviser may share commission with up to four advisers.
  - Sharing commission doesn't impact the premium.
  - The commission sharing is selected during the application process.
- Commission will be paid on any future increases in premium. The method of calculation is the same and takes into account the remaining term of the risk cover at the time of the premium increase.
- Commission isn't payable while a claim is in progress.
- Adjustments to commission including commission reversals, once-off commission payments and internal replacement scaling are applied immediately on the effective date of the transaction.

30.1 Full upfront commission

Upfront commission consists of a primary upfront commission payment and a secondary upfront commission payment one year later.

- Primary commission is paid on the contract start date.
  - It's calculated as the smaller of 3.25% x commission term x annual premium and 85% x annual premium.
  - The commission term is the smaller of the premium paying term (or 120 minus age for whole-life cover) and the greater of 10 and 75 minus age.
- Secondary commission is paid on the contract anniversary date, provided that the contract is still active.
  - It's calculated as one third of primary commission.

Example

Peter is 25 next birthday and has taken out Life Cover with an annual premium of R4 800. The premium-paying term of the Life Cover is 65 years. His adviser has selected upfront commission.

- Commission term = min (65, max (10, 75-25)) = 50
- Primary commission payment = min (3.25% x 50 x R4 800, 85% x R4 800) = R4 080
- Secondary commission payment = R4 080/3 = R1 360.

30.2 As-and-when commission

As-and-when commission is a spreading of upfront commission over a term.

30.2.1 Full as-and-when commission

It's paid each time a premium is paid over either the full commission term or five years, as selected during the quote process. The as-and-when commission is paid provided the corresponding premium is paid and provided the contract is still active. The rate at which commission is paid depends on the premium frequency, the commission term.

Example

Peter is 25 next birthday and has taken out Life Cover with an annual premium of R4 800. The premium-paying term of the Life Cover is 65 years. His adviser has selected as-and-when commission payable over the full commission term.

- Commission payment term = commission term = min (65, max (10, 75-25)) = 50
- As-and-when commission payment = commission rate x premium = 14.3% x R4 800 = R686.40

Example

Peter is 25 next birthday and has taken out Life Cover with an annual premium of R4 800. The premium-paying term of the Life Cover is 65 years. His adviser has selected as-and-when commission payable over five years.

- Commission payment term = five years
- As-and-when commission payment = commission rate x premium = 28.4% x R4 800 = R1 363.20

30.2.2 As-and-when commission with a percentage payable immediately

Up to 50% of the commission (as selected during the quote process) can be paid on the contract start date and the balance is paid each time a premium is paid over the full commission term. The as-and-when commission is paid provided the corresponding premium is paid and the contract is still active. The rate at which commission is paid depends on the premium frequency, the commission term and the selected commission payment term.

Example

Peter is 25 next birthday and has taken out Life Cover with an annual premium of R4 800. The premium-paying term of the Life Cover is 65 years. His adviser has selected as-and-when commission with 50% payable immediately.

- Commission payment term = commission term = min (65, max (10, 75-25)) = 50
- Immediate commission payment = commission rate x premium x immediate percentage x annuity factor = 14.3% x R4 800 x 50% x 7.66 = R2 628.91
- As-and-when commission payment = commission rate x premium x (1 – immediate percentage) = 14.3% x R4 800 x (1 – 50%) = R343.20

30.3 Changing commission selections

- **Commission type**

Certain contract changes that add cover to existing cover allow a new commission type to be selected. This won't change the commission type of the existing cover and will only apply to the premium in respect of the additional cover.

Example

Peter has taken out Life Cover and his adviser selected as-and-when commission. Peter increases his cover five years later, and his adviser selects upfront commission. As-and-when commission continues to get paid on the premium due to original cover, and any scheduled annual increases on this. Upfront commission is paid for the additional cover and any scheduled annual increases on this.

- **Commission scaling**

In a similar way, these same contract changes that add cover to existing cover allow a new commission scaling to be selected. This won't change the commission scaling of existing cover and will only apply to the premium in respect of the additional cover.

Example

Peter has taken out Life Cover and his adviser selected 100% commission. Peter increases his cover five years later, and his adviser selects 50% commission. 100% of the commission continues to get paid on premium due to original cover, and any scheduled annual increases on this. 50% of the commission is paid in respect of additional cover and any scheduled annual increases on this.

30.4 Changing adviser receiving commission

- The adviser who receives the commission on the above-mentioned contract changes, which add extra cover to existing cover or on restart of a contract, can be different to the adviser on the existing cover. This adviser can share the commission differently too.
- Any Future commission will be paid based on the initial commission option selected at inception. Commission will be paid on any premium increases. It will be calculated on the same basis.

30.5 Commission clawback

Upfront and immediate commission aren't fully earned until two years' worth of premiums have been received from the customer.

As-and-when commission isn't fully earned until six months' worth of premiums have been received from the customer.

Clawback percentages

Premiums received with an equivalent value to monthly premiums for	CLAWBACK %			
	Primary	Secondary	Immediate	As-and-when
0 – 6 months	100.00%	n/a	100.00%	100.00%
7 months	70.83%	n/a	70.83%	0.00%
8 months	66.67%	n/a	66.67%	0.00%
9 months	62.50%	n/a	62.50%	0.00%
10 months	58.33%	n/a	58.33%	0.00%

11 months	54.17%	n/a	54.17%	0.00%
12 months	50.00%	n/a	50.00%	0.00%
13 months	45.83%	91.67%	45.83%	0.00%
14 months	41.67%	83.33%	41.67%	0.00%
15 months	37.50%	75.00%	37.50%	0.00%
16 months	33.33%	66.67%	33.33%	0.00%
17 months	29.17%	58.33%	29.17%	0.00%
18 months	25.00%	50.00%	25.00%	0.00%
19 months	20.83%	41.67%	20.83%	0.00%
20 months	16.67%	33.33%	16.67%	0.00%
21 months	12.50%	25.00%	12.50%	0.00%
22 months	8.33%	16.67%	8.33%	0.00%
23 months	4.17%	8.33%	4.17%	0.00%
24 months	0.00%	0.00%	0.00%	0.00%

Events that would result in a full reversal of commission:

- Cool-off
- If no Replacement Advice Record was completed and we discover that the cover was in fact a replacement

Events that would result in a clawback of commission:

- Lapse
- Cancellation

Any change that results in a premium decrease will have a part of the commission clawed back.

30.6 Internal replacements

An internal replacement occurs when cover has lapsed or cancelled and replaced with other cover for the same insured person or owner (conditional). This results in a reversal of new business commission and correctly adjusted commission being applied to the contract.

The adjustment in commission for internal replacements is designed to limit the commission paid on the replaced cover to any clawed-back commission plus commission on the increased portion of the premium.

Internal replacement commission is calculated based on premium not cover amount.

When commission is internally scaled because of an internal replacement, there is no reduction in premium.

Submitting a Replacement Advice Record is compulsory for all internal and external replacements.

If no Replacement Advice Record is submitted and Old Mutual discovers that it was a replacement then the full commission amount will be clawed back. In line with PPR regulations.

The reduction is only applied to the commission arising from the new business transaction of the replacement cover. Commission on subsequent transactions will not carry the internal replacement adjustment.

- The reduction in commission as a result of internal replacement doesn't reduce the premium. This is because the cost of paying the commission (across both the replaced and replacement cover) is still being recovered from the replaced cover and therefore the full premium on the replaced cover needs to be received, despite commission being reduced.
- An internal replacement will still be applied even if the replaced cover is sold by a different adviser.
- Internal replacements are applied across all risk products.

Internal replacement commission scaling is applied:

- When cover for the same insured person is lapsed or cancelled regardless of who the owner is, and replaced with a similar risk cover
- If the new cover issues 4 months before or after the lapse/cancellation of the original cover
- Across internal risk products that cover the same need
- Across all types of insurance needs. (See benefit mapping for internal replacements)
- Based on the total premium of the cover, which may include add-ons, benefits and other features that were not previously available on GREENLIGHT
- Regardless of which adviser wrote the original cover
- Regardless of how long the cover was on books. (For example: outside two year commission clawback period)
- Even if all revivals have been exhausted
- Even if new cover was bought as a result of a trade-up offer
- Across all commission structures, even if different from that of the original cover (For example: upfront to combo)
- Across different premium paying frequencies. (For example: yearly to monthly premium payments)
- Across different benefit terms. (For example: term to whole-life)
- Across multiple owned products for same insured person. (For example: One Old Mutual Protect Life Cover replaces three GREENLIGHT Death benefits).

The table below reflects which insurance needs will be regarded as internal replacements if replaced with a similar internal product.

Benefit mapping for internal replacements

OMP INSURANCE NEEDS	GREENLIGHT INSURANCE NEEDS
Life Insurance	Life Cover
Funeral Insurance	Final Expenses Benefits
Disability Insurance (monthly and single amounts)	Earning Ability Cover (income and lump sum amounts)
Severe Illness Insurance	Lifestyle Adjustment Cover
Future Insurance	Future Needs Cover
Retrenchment Insurance	Retrenchment Cover
Business Insurance	Business Life Cover
Business Expenses Insurance	Business Overheads Replacer

Internal replacement commission scaling can be reversed on request if:

- The cover that is internally replaced was done to correct the structure of business cover to mitigate tax implications. Example: correctly structuring cover for a buy and sell agreement.
- The original cover is subsequently revived after internal scaling was applied to the new cover and the first revival premium has been paid.

Transactions that are not defined as internal replacements

- When conversions are done. For example, term ending benefits or Group Life Cover
- When adding a scheduled cover increase
- When existing cover is increased
- If there are changes made to the type of cover. For example, Disability Cover is replaced with Severe Illness Cover.

QUICK FACTS

31. QUICK FACTS

31.1 Personal protection

31.1 .1 Life Insurance

COVER	LIFE COVER	LIFE INCOME COVER	LAST SURVIVOR COVER	ACCIDENTAL DEATH COVER
Payout	Single amount	Monthly amount	Single amount	Single amount
Benefits automatically included	· Terminal Illness Benefit	· None	· Terminal Illness Benefit (on last survivor)	· None
Other benefits	-	-	-	-
Add-ons	· Disability Cover · Functional Impairment Cover · Physical Impairment Cover · Severe Illness Cover · Premium Protection Death · Premium Protection Disability · Premium Protection Functional Impairment · Premium Protection Retrenchment · Cashback	· Premium Protection Death · Premium Protection Disability · Premium Protection Functional Impairment · Premium Protection Retrenchment · Cashback	· Premium Protection Death · Premium Protection Disability · Premium Protection Functional Impairment · Premium Protection Retrenchment · Cashback	· Premium Protection Death · Premium Protection Disability · Premium Protection Functional Impairment · Premium Protection Retrenchment · Cashback
Eligible lives	All lives (subject to entry age limits and underwriting)	All lives (subject to entry age limits and underwriting)	All lives (subject to entry age limits and underwriting)	All lives (subject to entry age limits and underwriting)

Relationship to owner	There must be an insurable interest if the owner and insured person aren't the same person	There must be an insurable interest if the owner and insured person aren't the same person	The insured person must be the same as the owner and each of the insured persons must meet the definition of spouse/partner with respect to the other insured person on the cover	There must be an insurable interest if the owner and insured person aren't the same person
Maximum number of insured persons	One	One	Two	One
Minimum entry age	15 next birthday	18 next birthday	15 next birthday	15 next birthday
Maximum entry age	80 next birthday	80 next birthday	80 next birthday	60 next birthday
Premium frequency	· Monthly · Monthly with option to skip a month · Yearly	· Monthly · Monthly with option to skip a month · Yearly	· Monthly · Monthly with option to skip a month · Yearly	· Monthly · Monthly with option to skip a month · Yearly
Premium term	· Benefit term · Retirement - minimum premium term of 10 years	· Benefit term · Retirement - minimum premium term of 10 years	· Benefit term · Retirement - minimum premium term of 10 years	· Benefit term · Retirement - minimum premium term of 10 years
Compulsory yearly premium increase	· 0% fixed rate · 5% fixed rate · Age-linked	· 0% fixed rate · 5% fixed rate · Age-linked	· 0% fixed rate · 5% fixed rate	· 0% fixed rate · 5% fixed rate · Age-linked
Guarantee term	· 5 years · 10 years · 15 years	· 5 years · 10 years · 15 years	· 5 years · 10 years · 15 years	· 5 years · 10 years · 15 years
Minimum cover amount	R100 000	R3 000 monthly	R100 000	R100 000

Maximum cover amount	· Employed: None (subject to financial underwriting) · Home executives: R4 000 000 (subject to 3 times annual salary of spouse/ partner for cover above R2 500 000) · Students: R1 000 000 · Unemployed: R650 000	· None (subject to financial underwriting)	· None (subject to financial underwriting)	· Employed: R2 000 000 · Home executives: R2 000 000 · Students: R650 000 · Unemployed: R650 000
Benefit term	· Whole-life · Term (minimum of 5 years)	· Term (minimum of 5 years)	· Whole-life	· Term (minimum of 5 years
Maximum cover end age for term cover	100 next birthday	100 next birthday	Whole-life of the last survivor	65 next birthday
Scheduled yearly cover increase	· 0% fixed rate · 5% fixed rate · 10% fixed rate · Inflation-linked · Currency-linked	· 0% fixed rate · 5% fixed rate · 10% fixed rate · Inflation-linked · Currency-linked	· 0% fixed rate · 5% fixed rate · 10% fixed rate · Inflation-linked · Currency-linked Cover will continue to increase after the first death	· 0% fixed rate · 5% fixed rate · 10% fixed rate · Inflation-linked · Currency-linked
Underwriting method	· No medical tests, only questions OR · Medical tests, questions or both	· No medical tests, only questions OR · Medical tests, questions or both	· No medical tests, only questions OR · Medical tests, questions or both	· No medical tests, only questions

31.1 .2 Funeral Insurance

FAMILY FUNERAL COVER				
COVER	**INDIVIDUAL**	**SPOUSE/ PARTNER**	**CHILDREN**	**NOMINATED CHILD**
Payout	· Single amount · Monthly payment if Monthly Grocery Benefit/ Monthly Education Benefit added	· Single amount · Monthly payment if Monthly Grocery Benefit/ Monthly Education Benefit added	· Single amount	· Single amount
Benefits automatically included	· (Early Accidental cover) · (Unlimited cover for stillbirth) · Premium holiday · Money back guarantee		· Premium holiday · Money back guarantee	· Premium holiday · Money back guarantee
Add-ons	· Funeral Paid-up · Double Accidental Benefit · Cashback · Monthly Education Benefit (Individual and Spouse/partner cover only) · Monthly Grocery Benefit (Individual and Spouse/partner cover only)			
Eligible lives	All lives (subject to entry age limits and underwriting)	All lives (subject to entry age limits and underwriting)	All lives (subject to entry age limits and underwriting)	All lives (subject to entry age limits and underwriting)
Relationship to owner	Self	Spouse/partner of owner	Biological, legally adopted, step children and grandchildren of the owner or their spouse/partner	A child who is dependent on and lives with the owner and does not qualify for cover under the Children benefit
Maximum number of insured persons	One	Three	Unlimited	Two
Minimum entry age	15 next birthday	15 next birthday	Child automatically covered from 1 next birthday	1 next birthday

Maximum entry age	80 next birthday	80 next birthday	· 21 next birthday where the child is unmarried · 26 next birthday where the child is a full-time student and unmarried · Unmarried financially dependent children with physical or mental disability can be covered indefinitely	18 next birthday
Premium frequency	· Monthly · Monthly with option to skip a month · Yearly	· Monthly · Monthly with option to skip a month · Yearly	· Monthly · Monthly with option to skip a month · Yearly	· Monthly · Monthly with option to skip a month · Yearly
Premium term	Benefit term unless Funeral Paid-up is attached			
Compulsory yearly premium increase	· 0% fixed rate · 5% fixed rate	· 0% fixed rate · 5% fixed rate	· 0% fixed rate · 5% fixed rate	· 0% fixed rate · 5% fixed rate
Guarantee term	· 1 year · 5 years	· 1 year · 5 years	· 1 year · 5 years	· 1 year · 5 years
Minimum cover amount	R5 000	R5 000	R5 000	R5 000
Maximum cover amount	R100 000 (Single amount payout excluding Monthly Education Benefit amount x 12 AND Monthly Grocery Benefit amount x 12)	R100 000 (Single amount payout excluding Monthly Education Benefit amount x 12 AND Monthly Grocery Benefit amount x 12)	R50 000 (Legislative age related claim maximum payout on death of child will apply at claim stage)	R50 000 (Legislative age related claim maximum payout on death of child will apply at claim stage)
Benefit term	· Whole-life	· Whole-life	· Whole-life	· Term, set equal to the length of time until the policy anniversary where the nominated child reaches the cover end age (25 next birthday).

Maximum cover end age	None	None	· 22 next birthday where the child is unmarried · 27 next birthday where the child is a full time student and unmarried · Unmarried financially dependent children with physical or mental disability can be covered indefinitely.	· 25 next birthday
Scheduled yearly cover increase	· 0% fixed rate · 5% fixed rate · 10% fixed rate · inflation-linked · Currency-linked	· 0% fixed rate · 5% fixed rate · 10% fixed rate · inflation-linked · Currency-linked	· 0% fixed rate · 5% fixed rate · 10% fixed rate · inflation-linked · Currency-linked	· 0% fixed rate · 5% fixed rate · 10% fixed rate · inflation-linked · Currency-linked
Underwriting method	· No medical tests or questions · No medical tests, only questions	· No medical tests or questions · No medical tests, only questions	· No medical tests or questions	· No medical tests or questions
Exclusion period	· Six month suicide exclusion · Six month non-accidental death exclusion period for cover issued with no medical tests or questions.	· Six month suicide exclusion · Six month non-accidental death exclusion period for cover issued with no medical tests or questions.	· Six month suicide exclusion · Six month non-accidental death exclusion period	· Six month suicide exclusion · Six month non-accidental death exclusion period

EXTENDED FAMILY FUNERAL COVER			
COVER	**SIBLING**	**PARENT**	**OTHER FAMILY**
Payout	Single amount	Single amount	Single amount
Benefits automatically included	· Premium holiday · Money Back Guarantee		
Add-ons	· Funeral Paid-up · Double Accidental Benefit · Cashback	· Funeral Paid-up · Double Accidental Benefit · Cashback	· Funeral Paid-up · Double Accidental Benefit · Cashback
Eligible lives	All lives (subject to entry age limits and underwriting)	All lives (subject to entry age limits and underwriting)	All lives (subject to entry age limits and underwriting)
Relationship to owner	Biological brother or sister	· Mother/Father · Mother-in-law/ Father-in-law · Step mother/Step father · Step mother/ Father-in-law · Adoptive mother/ father · Adoptive mother-in-law/father-in-law	Relationship to owner · Ex-husband/ex-wife · Spouse/Partner · Stepson/ stepdaughter Relationship to the owner owner's spouse/ partner: · Aunt/uncle · Brother/sister · Brother-in-law/ sister-in-law · Son/daughter · Son-in-law/ daughter-in-law · Grandfather/ grandmother · Biological, step or legally adoptive Father/mother (if four Parent benefits already used) · Cousins · Niece/nephew · Children/ Nominated children
Maximum number of insured persons	Four	Four	Eight

Minimum entry age	1 next birthday	15 next birthday	1 next birthday
Maximum entry age	85 next birthday	85 next birthday	85 next birthday
Premium frequency	· Monthly · Monthly with option to skip a month · Yearly	· Monthly · Monthly with option to skip a month · Yearly	· Monthly · Monthly with option to skip a month · Yearly
Premium term	Benefit term	Benefit term	Benefit term
Compulsory yearly premium increase	· 0% fixed rate · 5% fixed rate	· 0% fixed rate · 5% fixed rate	· 0% fixed rate · 5% fixed rate
Guarantee term	· 1 years · 5 years	· 1 years · 5 years	· 1 years · 5 years
Minimum cover amount	R5 000	R5 000	R5 000
Maximum cover amount	R50 000	R50 000	R50 000
Benefit term	· Whole-life	· Whole-life	· Whole-life
Scheduled yearly cover increase	· 0% fixed rate · 5% fixed rate · 10% fixed rate · Inflation-linked · Currency-linked	· 0% fixed rate · 5% fixed rate · 10% fixed rate · Inflation-linked · Currency-linked	· 0% fixed rate · 5% fixed rate · 10% fixed rate · Inflation-linked · Currency-linked
Underwriting method	No medical tests or questions	No medical tests or questions	No medical tests or questions
Exclusion period	· Six month suicide · Six month non-accidental death exclusion period	· Six month suicide · Six month non-accidental death exclusion period	· Six month suicide · Six month non-accidental death exclusion period

31.1.3 Disability insurance

31.1.3.1 Disability Insurance monthly amount

COVER	DISABILITY INCOME COVER	FUNCTIONAL IMPAIRMENT INCOME COVER	BUSINESS EXPENSES COVER
Payout	Monthly amount	Monthly amount	Monthly amount
Other benefits	· Income Extender Benefit · Sickness Benefit · Family Support Benefit	Family Support Benefit	-
Add-ons	Cashback	Cashback	-
Eligible lives	· Only specific occupations and employment types · Unemployed lives at entry will not be eligible for cover	· All lives (subject to entry age limits and underwriting · Available to home executives and students · Unemployed lives at entry will not be eligible for cover	· Sole proprietors · Partners is a partnership
Relationship to owner	There must be an insurable interest if the owner and insured person aren't the same person	There must be an insurable interest if the owner and insured person aren't the same person	There must be an insurable interest if the owner and insured person aren't the same person
Maximum number of insured persons	One	One	One
Minimum entry age	18 next birthday	18 next birthday	18 next birthday
Maximum entry age	60 next birthday	65 next birthday	60 next birthday
Premium frequency	Monthly	Monthly	Monthly
Premium term	Benefit term	Benefit term	Benefit term
Compulsory yearly premium increase	· 0% fixed rate · 5% fixed rate · Age-linked	· 0% fixed rate · 5% fixed rate · Age-linked	· 0% fixed rate · 5% fixed rate · Age-linked
Guarantee term	· 1 year · 5 years	· 1 year · 5 years	· 1 year · 5 years
Minimum cover amount	R6 000 monthly	R3 000 monthly	R6 000 monthly

Maximum cover amount	Smaller of: · 100% of average monthly earning net of tax AND · R250 000 monthly for term cover · R60 000 monthly for whole-life cover	Smaller of: · 100% of average monthly earning net of tax AND · R250 000 monthly for term cover · R60 000 monthly for whole-life cover · Home executives: R15 000 monthly · Students: R15 000 monthly	Smaller of: · 100% of average monthly earning AND · R250 000 monthly for term cover · R60 000 monthly for whole-life cover
Benefit term	· Whole-life · Term (minimum of 5 years)	· Whole-life · Term (minimum of 5 years)	· Whole-life · Term (minimum of 5 years)
Minimum cover end age for term cover	70 next birthday	70 next birthday	70 next birthday
Scheduled yearly cover increase	· 0% fixed rate · 5% fixed rate · Inflation-linked	· 0% fixed rate · 5% fixed rate · Inflation-linked	· 0% fixed rate · 5% fixed rate · Inflation-linked
Underwriting method	· No medical tests, only questions · Medical tests, questions or both	· No medical tests, only questions · Medical tests, questions or both	· No medical tests, only questions · Medical tests, questions or both
Waiting period	· 7 days · 1 month · 3 months · 6 months · 12 months · 24 months	· 1 month · 3 months · 6 months · 12 months · 24 months	· 7 days · 1 month · 3 months

31.1.3.2 Disability Insurance single amount

COVER	DISABILITY COVER	FUNCTIONAL IMPAIRMENT COVER	PHYSICAL IMPAIRMENT COVER	ACCIDENTAL DISABILITY AND DEATH COVER
Payout	Single amount	Single amount	Single amount	Single amount
Other benefits	· Own Occupation Benefit · Partial Functional Impairment Benefit · Child Impairment Benefit	· Partial Functional Impairment Benefit · Child Impairment Benefit	-	-
Add-ons	· Premium Protection Death · Premium Protection Disability · Premium Protection Functional Impairment · Premium Protection Retrenchment · Cashback	· Premium Protection Death · Premium Protection Disability · Premium Protection Functional Impairment · Premium Protection Retrenchment · Cashback	· Premium Protection Death · Premium Protection Disability · Premium Protection Functional Impairment · Premium Protection Retrenchment · Cashback	· Premium Protection Death · Premium Protection Disability · Premium Protection Functional Impairment · Premium Protection Retrenchment · Cashback
Eligible lives	· Only specific occupations and employment types · Unemployed lives at entry will not be eligible for cover	All lives (subject to entry age limits and underwriting)	All lives (subject to entry age limits and underwriting)	· Only specific occupations and employment types · Students, home executives and unemployed lives at entry will not be eligible for cover
Relationship to owner	There must be an insurable interest if the owner and insured person aren't the same person			

Maximum number of insured persons	· One	· One	· One	· One
Minimum entry age	· 15 next birthday	· 15 next birthday	· 15 next birthday	· 15 next birthday
Maximum entry age	· 60 next birthday	· 65 next birthday	· 65 next birthday	· 60 next birthday
Premium frequency	· Monthly · Monthly with option to skip a month · Yearly	· Monthly · Monthly with option to skip a month · Yearly	· Monthly · Monthly with option to skip a month · Yearly	· Monthly · Monthly with option to skip a month · Yearly
Premium term	· Benefit term · Retirement (minimum premium term of 10 years)	· Benefit term · Retirement (minimum premium term of 10 years)	· Benefit term · Retirement (minimum premium term of 10 years)	· Benefit term · Retirement (minimum premium term of 10 years)
Compulsory yearly premium increase	· 0% fixed rate · 5% fixed rate · Age-linked	· 0% fixed rate · 5% fixed rate · Age-linked	· 0% fixed rate · 5% fixed rate · Age-linked	· 0% fixed rate · 5% fixed rate · Age-linked
Guarantee term	· 5 years · 10 years	· 5 years · 10 years	· 5 years · 10 years	· 5 years · 10 years · 15 years
Minimum cover amount	· R100 000	· R100 000	· R100 000	· R100 000
Maximum cover amount	· R30 000 000 for term cover · R6 000 000 for whole-life cover	· Employed: – R30 000 000 for term cover – R6 000 000 for whole-life cover · Home executives: R2 500 000 · Students: R2 000 000 · Unemployed: R1 250 000	· Employed: R4 000 000 · Home executives: R2 500 000 · Students: R1 250 000 · Unemployed: R1 250 000	R2 000 000 (subject to salary)
Benefit term	· Whole-life · Term (minimum of 5 years)	· Whole-life · Term (minimum of 5 years)	· Whole-life · Term (minimum of 5 years)	· Term (minimum of 5 years)
Maximum cover end age for term cover	· 70 next birthday	· 70 next birthday	· 70 next birthday	· 65 next birthday

Scheduled yearly cover increase	· 0% fixed rate · 5% fixed rate · 10% fixed rate · Inflation-linked · Currency-linked	· 0% fixed rate · 5% fixed rate · 10% fixed rate · Inflation-linked · Currency-linked	· 0% fixed rate · 5% fixed rate · 10% fixed rate · Inflation-linked · Currency-linked	· 0% fixed rate · 5% fixed rate · 10% fixed rate · Inflation-linked · Currency-linked
Underwriting method	· No medical tests, only questions · Medical tests, questions or both	· No medical tests, only questions · Medical tests, questions or both	· No medical tests, only questions · Medical tests, questions or both	· Medical tests, questions or both
Survival period	10 days	10 days	Six months	10 days

31.1.4 Illness Insurance

COVER	SEVERE ILLNESS COVER
Payout	Single amount
Other benefits	· Top-up Benefit · Mild Illness Benefit · For Women Benefit · Child Illness Benefit · Returning Illness Benefit (only if Severe Illness Cover is taken on its own)
Add-ons	· Premium Protection Death · Premium Protection Disability · Premium Protection Functional Impairment · Premium Protection Retrenchment · Cashback
Eligible lives	All lives (subject to entry age limits and underwriting)
Relationship to owner	There must be an insurable interest if the owner and insured person aren't the same person
Maximum number of insured persons	One
Minimum entry age	15 next birthday
Maximum entry age	70 next birthday
Premium frequency	· Monthly · Monthly with option to skip a month · Yearly
Premium term	· Benefit term · Retirement (minimum premium term of 10 years)
Compulsory yearly premium increase	· 0% fixed rate · 5% fixed rate · Age-linked
Guarantee term	· 5 years · 10 years
Minimum cover amount	R100 000
Maximum cover amount	· Employed: R6 000 000 (subject to salary) · Home executives: R2 000 000 · Students: R2 000 000 · Unemployed: R2 000 000

Benefit term	· Whole-life · Term (minimum of 5 years)
Maximum cover end age for term cover	100 next birthday
Scheduled yearly cover increase	· 0% fixed rate · 5% fixed rate · 10% fixed rate · Inflation-linked · Currency-linked
Underwriting method	· No medical tests, only questions · Medical tests, questions or both
Survival period	· Severe Illness Cover: 10 days on specified illnesses · Severe Illness Cover add-on to Life Cover or Business Life Cover: No survival period

31.1.5 Future Insurance

COVER	FUTURE LIFE COVER
Other benefits	Disability and Illness Benefit
Add-ons	· Premium Protection Death · Premium Protection Disability · Premium Protection Functional Impairment · Premium Protection Retrenchment · Cashback
Eligible lives	All lives (subject to entry age limits and underwriting)
Relationship to owner	There must be an insurable interest if the owner and insured person aren't the same person
Maximum number of insured persons	One
Minimum entry age	15 next birthday
Maximum entry age	55 next birthday
Premium frequency	· Monthly · Monthly with option to skip a month · Yearly
Premium term	· Benefit term · Retirement (minimum premium term of 10 years)
Compulsory yearly premium increase	0% fixed rate
Guarantee term	1 year
Minimum cover amount	R400 000
Maximum cover amount	· Employed: R15 000 000 · Home executives: R2 500 000 · Students: R2 500 000 · Unemployed: R2 500 000
Benefit term	Term (minimum of 5 years)
Maximum cover end age	65 next birthday

Scheduled yearly cover increase	· 0% fixed rate · 5% fixed rate · 10% fixed rate · Inflation-linked
Underwriting method	· No medical tests, only questions · Medical tests, questions or both

31.1.6 Retrenchment Insurance

COVER	RETRENCHMENT COVER
Linked to	· Life Cover · Life Income Cover · Last Survivor Cover · Accidental Death Cover · Disability Income Cover · Functional Impairment Income Cover · Disability Cover · Functional Impairment Cover · Physical Impairment Cover · Accidental Disability and Death Cover · Severe Illness Cover
Payout	Monthly amount
Other benefits	None
Add-ons	· Premium Protection Death · Premium Protection Disability · Premium Protection Functional Impairment · Cashback
Eligible lives	All lives (subject to entry age limits and underwriting)
Relationship to owner	There must be an insurable interest if the owner and insured person aren't the same person
Maximum number of insured persons	One
Minimum entry age	18 next birthday
Maximum entry age	60 next birthday

Premium frequency	Monthly
Premium term	Benefit term
Compulsory yearly premium increase	0% fixed rate
Guarantee term	1 year
Minimum cover amount	R3 000 monthly
Maximum cover amount	Smaller of: · R30 000 monthly or · 60% of average monthly income If linked to single amount product the cover is limited to the cover amount of the product it is linked to, divided by 12. If linked to a monthly payment product, the cover will be the cover amount of the product it is linked to.
Benefit term	· Term (minimum 5 years) · The benefit term must be equal to or less than the cover it's linked to
Cover end age	65 next birthday
Scheduled yearly cover increase	· 0% fixed rate · 5% fixed rate · Inflation-linked
Underwriting method	No medical tests, only questions
Exclusion period	· Cover start date: six months · Following a claim: 12 months
Waiting period	One month

31.2 Business Protection

31.2.1 Buy and Sell Insurance

COVER	BUSINESS LIFE COVER	BUSINESS DISABILITY COVER	BUSINESS FUNCTIONAL IMPAIRMENT COVER
Add to	-	Business Life Cover	Business Life Cover
Payout	Single amount	Single amount	Single amount
Other benefits	· Business Disability Cover · Business Functional Impairment Cover	-	-
Add-ons	-	Own Occupation Benefit	-
Eligible lives	All lives (subject to entry age limits and underwriting)	· Only specific occupations and employment types · Unemployed lives at entry are not be eligible for cover	All lives (subject to entry age limits and underwriting)
Relationship to owner	There must be an insurable interest if the owner and insured person aren't the same person	There must be an insurable interest if the owner and insured person aren't the same person	There must be an insurable interest if the owner and insured person aren't the same person
Maximum number of insured persons	One	One	One
Minimum entry age	15 next birthday	15 next birthday	15 next birthday
Maximum entry age	80 next birthday	60 next birthday	65 next birthday
Premium frequency	· Monthly · Monthly with option to skip a month · Yearly	Same premium frequency as Business Life Cover	Same premium frequency as Business Life Cover
Premium term	Benefit term	Benefit term	Benefit term
Compulsory yearly premium increase	· 0% fixed rate · 5% fixed rate · Age-linked	Same compulsory yearly premium increase as Business Life Cover	Same compulsory yearly premium increase as Business Life Cover
Guarantee term	· 5 years · 10 years · 15 years	· 5 years · 10 years	· 5 years · 10 years

Minimum cover amount	R100 000	R100 000	R100 000
Maximum cover amount	None (subject to financial underwriting)	· R30 000 000 for term cover · R6 000 000 for whole-life cover Cover amount must be less than or equal to the cover amount of Business Life Cover	· R30 000 000 for term cover · R6 000 000 for whole-life cover Cover amount must be less than or equal to the cover amount of Business Life Cover
Benefit term	· Whole-life · Term (minimum of 5 years)	· Whole-life · Term (minimum of 5 years) Benefit term must be less than or equal to the benefit term of Business Life Cover	· Whole-life · Term (minimum of 5 years) Benefit term must be less than or equal to the benefit term of Business Life Cover
Maximum cover end age for term cover	100 next birthday	70 next birthday	70 next birthday
Scheduled yearly cover increase	· 0% fixed rate · 5% fixed rate · 0% fixed rate · Inflation-linked · Currency-linked	Same scheduled yearly cover increase as Business Life Cover	Same scheduled yearly cover increase as Business Life Cover
Underwriting method	· No medical tests, only questions · Medical tests, questions or both	· No medical tests, only questions · Medical tests, questions or both	· No medical tests, only questions · Medical tests, questions or both

31.2.2 Business Contingency Insurance

COVER	BUSINESS LIFE COVER	BUSINESS DISABILITY COVER	BUSINESS FUNCTIONAL IMPAIRMENT COVER	BUSINESS SEVERE ILLNESS COVER
Add to	-	Business Life Cover	Business Life Cover	Business Life Cover
Payout	Single amount	Single amount	Single amount	Single amount
Other benefits	· Business Disability Cover · Business Functional Impairment Cover	-	-	-
Add-ons	-	Own Occupation Benefit	-	Top-up Benefit
Eligible lives	All lives (subject to entry age limits and underwriting)	· Only specific occupations and employment types · Unemployed lives at entry are not be eligible for cover	All lives (subject to entry age limits and underwriting)	All lives (subject to entry age limits and underwriting)
Relationship to owner	There must be an insurable interest if the owner and insured person aren't the same person	There must be an insurable interest if the owner and insured person aren't the same person	There must be an insurable interest if the owner and insured person aren't the same person	There must be an insurable interest if the owner and insured person aren't the same person
Maximum number of insured persons	One	One	One	One
Minimum entry age	15 next birthday	15 next birthday	15 next birthday	15 next birthday
Maximum entry age	80 next birthday	60 next birthday	65 next birthday	70 next birthday
Premium frequency	· Monthly · Monthly with option to skip a month · Yearly	Same premium frequency as Business Life Cover	Same premium frequency as Business Life Cover	· Monthly · Monthly with option to skip a month · Yearly

Premium term	Benefit term	Benefit term	Benefit term	Benefit term
Compulsory yearly premium increase	· 0% fixed rate · 5% fixed rate · Age-linked	Same compulsory yearly premium increase as Business Life Cover	Same compulsory yearly premium increase as Business Life Cover	Same compulsory yearly premium increase as Business Life Cover
Guarantee term	· 5 years · 10 years · 15 years	· 5 years · 10 years	· 5 years · 10 years	· 5 years · 10 years
Minimum cover amount	R100 000	R100 000	R100 000	R100 000
Maximum cover amount	None (subject to financial underwriting)	· R30 000 000 for term cover · R6 000 000 for whole-life cover Cover amount must be less than or equal to the cover amount of Business Life Cover	· R30 000 000 for term cover · R6 000 000 for whole-life cover Cover amount must be less than or equal to the cover amount of Business Life Cover	· R6 000 000 Cover amount must be less than or equal to the cover amount of Business Life Cover
Benefit term	· Whole-life · Term (minimum of 5 years)	· Whole-life · Term (minimum of 5 years) Benefit term must be less than or equal to the benefit term of Business Life Cover	· Whole-life · Term (minimum of 5 years) Benefit term must be less than or equal to the benefit term of Business Life Cover	· Whole-life · Term (minimum of 5 years) Benefit term must be less than or equal to the benefit term of Business Life Cover
Maximum cover end age for term cover	100 next birthday	70 next birthday	70 next birthday	100 next birthday
Scheduled yearly cover increase	· 0% fixed rate · 5% fixed rate · 10% fixed rate · Inflation-linked · Currency-linked	Same scheduled yearly cover increase as Business Life Cover	Same scheduled yearly cover increase as Business Life Cover	Same scheduled yearly cover increase as Business Life Cover
Underwriting method	· No medical tests, only questions · Medical tests, questions or both	Same as Business Life Cover	Same as Business Life Cover	Same as Business Life Cover

31.2.3 Keyperson Insurance

COVER	BUSINESS LIFE COVER	BUSINESS DISABILITY COVER	BUSINESS FUNCTIONAL IMPAIRMENT COVER	BUSINESS SEVERE ILLNESS COVER
Add to	-	Business Life Cover	Business Life Cover	Business Life Cover
Payout	Single amount	Single amount	Single amount	Single amount
Other benefits	· Business Disability Cover · Business Functional Impairment Cover	-	-	-
Other benefits	-	Own Occupation Benefit	-	Top-up Benefit
Eligible lives	All lives (subject to entry age limits and underwriting)	· Only specific occupations and employment types · Unemployed lives at entry are not be eligible for cover	All lives (subject to entry age limits and underwriting)	All lives (subject to entry age limits and underwriting)
Relationship to owner	There must be an insurable interest if the owner and insured person aren't the same person	There must be an insurable interest if the owner and insured person aren't the same person	There must be an insurable interest if the owner and insured person aren't the same person	There must be an insurable interest if the owner and insured person aren't the same person
Maximum number of insured persons	One	One	One	One
Minimum entry age	15 next birthday	15 next birthday	15 next birthday	15 next birthday
Maximum entry age	80 next birthday	60 next birthday	65 next birthday	70 next birthday
Premium frequency	· Monthly · Monthly with option to skip a month · Yearly	Same premium frequency as Business Life Cover	Same premium frequency as Business Life Cover	· Monthly · Monthly with option to skip a month · Yearly

Premium term	Benefit term	Benefit term	Benefit term	Benefit term
Compulsory yearly premium increase	· 0% fixed rate · 5% fixed rate · Age-linked	Same compulsory yearly premium increase as Business Life Cover	Same compulsory yearly premium increase as Business Life Cover	Same compulsory yearly premium increase as Business Life Cover
Guarantee term	· 5 years · 10 years · 15 years	· 5 years · 10 years	· 5 years · 10 years	· 5 years · 10 years
Minimum cover amount	R100 000	R100 000	R100 000	R100 000
Maximum cover amount	None (subject to financial underwriting)	· R30 000 000 for term cover · R6 000 000 for whole-life cover Cover amount must be less than or equal to the cover amount of Business Life Cover	· R30 000 000 for term cover · R6 000 000 for whole-life cover Cover amount must be less than or equal to the cover amount of Business Life Cover	· R6 000 000 Cover amount must be less than or equal to the cover amount of Business Life Cover
Benefit term	· Whole-life · Term (minimum of 5 years)	· Whole-life · Term (minimum of 5 years) Benefit term must be less than or equal to the benefit term of Business Life Cover	· Whole-life · Term (minimum of 5 years) Benefit term must be less than or equal to the benefit term of Business Life Cover	· Whole-life · Term (minimum of 5 years) Benefit term must be less than or equal to the benefit term of Business Life Cover
Maximum cover end age for term cover	100 next birthday	70 next birthday	70 next birthday	100 next birthday
Scheduled yearly cover increase	· 0% fixed rate · 5% fixed rate · 10% fixed rate · Inflation-linked · Currency-linked	Same scheduled yearly cover increase as Business Life Cover	Same scheduled yearly cover increase as Business Life Cover	Same scheduled yearly cover increase as Business Life Cover
Underwriting method	· No medical tests, only questions · Medical tests, questions or both	Same as Business Life Cover	Same as Business Life Cover	Same as Business Life Cover

31.2.4 Business Expenses Insurance

COVER	BUSINESS EXPENSES COVER
Payout	Monthly amount
Other benefits	-
Add-ons	-
Eligible lives	Only owners, partners or key persons in a business
Relationship to owner	There must be an insurable interest if the owner and insured person aren't the same person
Maximum number of insured persons	One
Minimum entry age	18 next birthday
Maximum entry age	60 next birthday
Premium frequency	Monthly
Premium term	Benefit term
Compulsory yearly premium increase	· 0% fixed rate · 5% fixed rate · Age-linked
Guarantee term	1 year 5 years
Minimum cover amount	R6 000 monthly
Maximum cover amount	Smaller of: · 100% of average monthly earning AND · R250 000 monthly for term cover · R60 000 monthly for whole-life cover
Benefit term	· Whole-life · Term (minimum of 5 years)
Cover end age	70 next birthday
Scheduled yearly cover increase	· 0% fixed rate · 5% fixed rate · Inflation-linked

Underwriting method	· No medical tests, only questions · Medical tests, questions or both
Waiting period	· 7 days · 1 month · 3 months