GAP COVER UNIVERSAL POLICY SCHEDULE

This policy schedule in conjunction with the policy terms and conditions form the basis of the insurance contract.

Policy Number

Policyholder

Postal or physical address

Identity number

Date of birth

Starting date of policy

Debit order collection date

If the policy was issued on or after this date, then an automatic double deduction will take place on your next debit order due date.

Type of cover	Medical Expense Shortfall Health Insurance benefits (For terms and conditions, see relevant sections in policy wording attached.)
Policy option	Universal
Optional Extended Dentistry Cover chosen	No
Optional Extended Lump Sum Cancer Cover chosen	No
Optional Extended Lump Sum Cancer Cover amount	0

Split of total monthly premium payable	R	(including VAT)

Split of total monthly premium payable

Medical Expense Shortfall	R	(including VAT)
Health Insurance Benefits	R	(including VAT)

The total monthly premium includes the following:

Commission	R	(excluding VAT
Binder fee	R	(including VAT)
Broker fee	0	(including VAT)

You are on a premium applicable to lives insured younger than 65. If you or any of the lives covered by this policy are 65 years or older at the start of their cover you need to notify us, as your premium will be determined taking this into account and will be higher.

The binder fee represents the amount payable by the insurer to Zestlife for performance of the following tasks on behalf of the insurer:

- Determining the policy terms and conditions every year subject to approval by the Insurer.
- Determining the policy premium and benefit structures subject to approval by the Insurer.
- Processing new business applications.
- Issuing policy documents to clients and intermediaries.
- Issuing annual policy renewals and client communications and cancelling policies.
- Processing claims and dealing with client and intermediary queries.
- Keeping financial records of the policy and an effective system for managing the policy and making sure that internal controls are in place to support an effective administration system.
- Establish and maintain a complaints procedure and system meeting the minimum requirements as specified in the applicable legislation, including the requirements relating to compliance officers, disclosures and providing a complaints escalation process.
- Provide the Insurer with all the relevant information and documents to assist in all complaints lodged with the Ombudsman of Short-Term Insurance, or the FAIS Ombudsman.

I hereby authorise Zestlife to issue payment instructions to its bank to collect the monthly premium due by debit order from my bank account on condition that the sum of such payment instruction will never exceed my obligation in terms of this application.

I acknowledge that all payment instructions issued by Zestlife shall be treated by my bank as if the instructions have been issued by me personally.

The debit order will be collected every month on the debit order collection date selected. In the event that this collection day falls on a Sunday or a recognised South African public holiday, the collection day will automatically be the previous ordinary business day.

I acknowledge that this authority may be assigned to a third party only if the policy is transferred to another Insurer or administrator.

I understand that the payment instruction will be processed through a computerised system provided by the South African Banks.

I shall not be entitled to any refund of amounts which Zestlife has collected while this debit order authority was in force, if such amounts were legally owed to Zestlife.

This authority may be cancelled by giving Zestlife notice of not less than 31 days and such cancellation will not necessary cancel my policy.

Zestlife followed by a unique reference number will be reflected on my bank statement as the payment reference.

Issue date:

Gap Cover Universal Policy Terms and Conditions

Important Information

These are your policy terms and conditions which is the agreement between you and us. This document explains all the details of your benefits including when benefits will be paid. This document also details our responsibilities to each other.

If you pay us the premium due in respect of this policy, we will pay you the benefits that you are entitled to in terms of this policy. Benefits will either be paid to you or directly to the medical practitioner or service provider, at the discretion of the Insurer.

This policy is renewed annually on 1 January. If your policy with us begins after 1 January, your first period of cover may be less than 12 months. This is because we may align your policy renewal with the medical aid industry's annual renewal period of 1 January to 31 December each year and enable you to enjoy our new benefits from 1 January each year. This also means that your premium may change on 1 January each year and not 12 months after your cover with us begins.

Only the laws of the Republic of South Africa apply to this policy, and as a result any legal proceedings arising from this policy will only take place in the courts of the Republic of South Africa.

If any terms of this policy contradict the law of the Republic of South Africa, the terms of the law will take priority over the policy.

Benefit Summary

These terms and conditions are divided into two sections each containing a separate policy.

Section 1 describes your Medical Expense Shortfall or Gap benefits.

The purpose of the Medical Expense Shortfall benefit is to cover the difference or part of the difference between the cost of certain health services and the amount paid by your medical aid.

The Medical Expense Shortfall benefit provides cover for:

- Benefits to cover medical practitioner shortfalls for in hospital procedures and certain out-of-hospital procedures.
- Co-payments charged by your medical aid for certain procedures.
- Co-payments charged by your medical aid for using non-designated service provider hospitals and medical practitioners.
- Co-payments charged by your medical aid for oncology treatment programmes.
- Where a cancer treatment cost limit is imposed and where no further treatment is funded by the medical aid, a benefit of 20% of the ongoing treatment costs to cover general treatment and the costs of biological drugs and other specialised treatments.
- Cosmetic breast reconstruction as a result of cancer.
- Benefit for emergency treatment in a hospital casualty facility as a result of an accident.
- Shortfall benefit if your internal prosthesis costs more than the limit imposed by your medical aid.
- Shortfall benefit if your robotic procedure costs more than the limit imposed by your medical aid.

Section 2 describes your other Health Insurance benefits.

The purpose of these Health Insurance benefits is to assist you financially if you suffer from one of the health events covered by the policy.

The Health Insurance benefits provide cover for:

- Lump sum benefit for first time stage 2 cancer diagnosis
- Lump sum benefit for personal accidental death and disability
- Trauma counselling benefit

- Fixed benefit for tooth repairs due to accidental injury
- Medical Premium Waiver benefit on accidental death and accidental disability

Under Section 2 there are additional optional benefits for Extended Cancer and Extended Dentistry.

- Extended Lump Sum Cancer Cover (see Appendix B). **You have not selected this benefit.**
- Extended Dentistry Cover (see Appendix C). **You have not selected this benefit.**

You will only qualify for cover under this policy if you are a member of a registered medical aid. We will require your medical aid details or proof of your medical aid cover.

The policy is written under a Short-Term Insurance license as an accident and health insurance product.

The policy premium is not tax deductible and we do not issue tax deduction (IT3) certificates for the premiums that you pay in respect of this policy.

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

Age Limits

People of all ages can be covered. However older people are likely to claim more benefits than younger people and therefore premium amounts are age related and differentiated based on age at the start of the policy.

Who is covered by the policy?

The policy covers you and all your registered dependents on your medical aid which could include your spouse, children and additional adult dependents.

If your spouse to whom you are legally married is a principal member of another medical aid in their own right they will also be covered by the policy including any of your mutual children who are registered as dependents on your spouse's medical aid. We may ask for proof of marriage if we need to do so.

Only one spouse can be covered under this policy. If you have more than one spouse registered as a dependent on your medical aid, you must let us know in writing which spouse will be covered under your policy before the starting date of your cover.

What is the meaning of certain key words and phrases?

a) **"accident"** means a sudden, unexpected, violent, and visible external event, which is inflicted on you by something other than yourself at an identifiable time and place and that independently of any other cause directly results in bodily injury.

b) **"cancer"** means the presence of one or more malignant tumours that have invaded normal tissue. Hodgkinsons disease and leukaemia are included in this definition. All skin tumours (including, but not limited to, Basal Cell Carcinoma and Melanoma) and/or in situ carcinomas (cancers that are contained and have not spread to normal tissue) are excluded.

c) **"claim incident"** means a medical or surgical procedure that leads to a claim under this policy. A claim incident will be viewed as one claim incident for all treatments received from the date on which you are admitted to hospital and the date on which you are discharged. In the case of out-of-hospital procedures, a claim for a listed procedure will be viewed as one claim incident.

d) **"hospital"** means an institution in South Africa and other countries that meets all the following criteria:
   1. Has diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of medical practitioners.
   2. Provides nursing services supervised by registered nurses.
   3. Is not, other than incidentally, either a mental institution or a convalescent home.
   4. Is not an institution that treats people for drug addiction, alcoholism, eating disorders or any other form of addictive behaviour.
   5. Is not a health hydro, or natural cure clinic, or similar establishment.
   6. Is not an institution providing long-term care for the blind, deaf, dumb or other handicapped persons.
   7. Is not a step-down facility (also called a medical rehabilitation centre).

e) **"illness"** means any illness or disease of the body that appears during the period of insurance. It includes premature senile degenerative changes but not an illness that cannot be diagnosed on the grounds of objective medical evidence or that can be diagnosed but has not been diagnosed.

f) **"insured incident"** means any accident or Illness for which you have to go to hospital and have to get certain medical or surgical procedures or a health event that is covered by the policy.

g) **"insured person"** means any person who qualifies for cover under this policy.

h) **"medical and surgical procedure"** means any procedure listed in your medical aid's tariff which is covered by your medical aid.

i) **"medical practitioner"** means a legally qualified medical practitioner who is registered with the Health Professionals Council of South Africa (HPSCA) and who is authorised to practise in the Republic of South Africa.

j) **"medical aid"** means a medical aid registered by the Registrar of Medical Aids in terms of the Medical Aid Act 131 of 1998, or a sick fund as defined in the Labour Relations 66 of 1995.

k) **"medical aid tariff"** (also called MST) means 100% of the specific amount that your medical aid has determined as being payable for a specific procedure. You may be on a medical aid option that covers more than 100% of the medical aid tariff but when we refer to medical aid tariff in this policy we are referring to 100% of the medical aid tariff. Your medical aid calculates this amount based on what it can afford to pay for the procedure, not on the actual costs to the medical practitioner for performing the procedure. Your medical aid will have a tariff for every procedure that it covers and these tariffs can be requested from your medical aid. If your medical aid cannot provide or does not have a medical aid tariff for a certain procedure we may calculate an industry-related tariff that we will use to calculate the amount payable to you.

l) **"policyholder"** means the natural person named in the policy schedule.

m) **"treatment"** means any form of investigation, examination, consultation or treatment by a medical practitioner in order to treat or monitor an insured person's medical condition arising from an insured incident.

n) **"we", "us"** and **"our"** refers to Guardrisk Life Ltd (Registration number 1999/013922/06 FSP No 76), who is the insurer of this policy.

o) **"you"** and **"your"** refers to the person who has cover under this insurance policy and includes every person who qualifies for cover under this policy. Only you have rights in terms of this policy and may claim against this policy. You may not pass your rights on to anyone else.

q) **"total and permanent disability"** means an insured person's continuous, total and permanent inability due to an accident to perform the material and substantial duties of any occupation in the open labour market for which they are qualified or suited or could reasonably be expected to become qualified or suited, taking into account their degree of disability and knowledge, training, education, ability and experience.

Section 1

Medical Expense Shortfall Benefit

What is covered under the Medical Expense Shortfall Benefit

Medical Practitioner Shortfalls

Medical Practitioners may charge you more than what your medical aid will pay for medical procedures performed in and out-of-hospital.

This benefit will pay the difference between the total costs charged by medical practitioners and the higher of the amount payable or paid by your medical aid or one times the medical aid tariff for in hospital procedures and for certain procedures performed out-of-hospital.

The total costs charged by the medical practitioner are limited to five times the medical aid tariff and so you will not be covered for any amount charged by the medical practitioner in excess of five times the medical aid tariff.

If your medical aid cannot provide or does not have a medical aid tariff for a certain procedure, we may use an industry- related tariff when we calculate the amount we have to pay you.

The list of out-of-hospital procedures that are covered is set out in Appendix A. The shortfalls in respect of these out-of-hospital procedures are not covered unless the procedures are covered by your medical aid hospital benefit or major medical benefit.

This benefit will only be paid if the treatment you receive is covered in terms of the rules of your medical aid under your major medical or hospital benefit. The policy benefits will not be paid if the treatment you receive is only covered from your medical aid savings account.

Co-payments

Procedure co-payments
Your medical aid may impose a co-payment for hospital admissions or for certain specified medical procedures which may be expressed in the medical aid rules as a fixed rand amount or as a percentage of costs. This is an amount that you need to pay. We will refund the co-payment that you have paid for in hospital procedures and for the out-of-hospital procedures listed in Appendix A. The co-payment must be paid before you claim.

Penalty co-payment
A penalty co-payment imposed by your medical aid for not following the rules of the medical aid will not be covered. Examples of these penalties are amounts due as a result of not obtaining a pre-authorisation from the medical aid for a procedure or consulting a specialist without first obtaining a referral from a general practitioner.

Non-designated hospital or medical practitioner co-payment

You may be admitted to a hospital or be treated by a medical practitioner that is not part of your medical aids designated provider network due to the fact that your medical aid has not negotiated a fee arrangement with the hospital or medical practitioner. Under these circumstances your medical aid may impose a co-payment that you need to pay to the hospital or medical practitioner which may be expressed as a rand amount or as a percentage of the hospital or medical practitioner costs. We will refund the co-payment to you, or part thereof subject to a maximum of R10 000 and limited to one claim for each policy each calendar year. The co-payment must be paid before you claim.

Oncology treatment programme co-payment

Your medical aid may impose a co-payment that you have to pay for any oncology or cancer- related treatment after using up the specific limit or threshold defined in your medical aid option. This benefit will cover this amount that you have to pay subject to a maximum co-payment of 25% for any claim per insured person in any one calendar year.

Medical Aid Cancer Cover Limit Extender

Where a cancer treatment cost limit is imposed and where no further treatment is funded by the medical aid, this benefit will subsidise 20% of the of the ongoing treatment costs. This benefit can be used to cover general treatment and the costs of biological drugs and other specialised treatments.

Cosmetic breast reconstruction

If you undergo a single mastectomy due to breast cancer diagnosed after your cover start date, your medical aid may not cover the cost of the cosmetic reconstruction of the non-affected breast or it may only be covered partially by your medical aid. This benefit will cover the amount not covered by the medical aid up to a maximum of R20 000. Any subsequent reconstructions or replacements required after the first one are not covered.

Treatment in hospital casualty facility

If you are treated in the emergency room at a registered hospital casualty facility your medical aid may not cover this cost at all or it may only be covered partially by your medical aid. This benefit will cover this cost less any amount paid by your medical aid provided that the treatment required is for an injury due to an accident. This means that you will not be covered for treatment required as a result of a disease or illness. This benefit will include the facility fee, consultations, medications, ward stock, radiology and pathology and it is limited to R20 000 for each policy each calendar year. Prescribed medication obtained after leaving the emergency room and subsequent follow ups to the emergency room and the cost of any prosthetic products such as crutches, limb guards or braces or any fees charged by Prosthetists or Orthotists, will not be covered. In order to qualify for this benefit you must use the casualty facility within 48 hours of the accident.

Shortfall benefit for internal prosthesis

An internal prosthesis is a device that is placed inside a person's body during a procedure to permanently replace a body part.

Examples of internal prostheses include joint replacements and spinal fusions.

Intraocular lenses and devices that are placed inside a body to help a functioning body part (for example, a pacemaker or a stent) are specifically excluded from cover.

This benefit will cover the shortfall if the medical aid does not cover the full cost of an internal prosthesis because you have exceeded the medical aid annual limit or because the medical aid has levied a co payment. This benefit will only pay up to a maximum of R35 000 for each policy each calendar year.

We will only cover you for any shortfall under this benefit if the medical aid option you have chosen includes cover under your major medical benefit for the internal prosthesis that you are claiming for. If your medical aid option does not include cover for this, we will not provide cover for any shortfall.

Robotic Procedures

Procedures performed with the use of robotic machinery where any shortfall being claimed is directly related to the use of such robotic machinery by a medical practitioner will be covered subject to a maximum of R30 000 per policy per calendar year.

Circumstances when your Medical Expense Shortfall benefit will not be paid

Your Medical Expense Shortfall benefit will not pay you for the following:

- Hospital fees including theatre charges, ward charges or any other hospital costs.
- Day-to-day medical practitioner costs.
- Specialist consultations not billed as part of the hospital or out-of-hospital procedure such as pre and post procedure consultations.
- Materials or medication used during your stay in hospital, at a day clinic or during your procedure (whether it is in hospital or out-of-hospital).
- Any external prosthesis or dental implants. A dental implant is an artificial tooth root that is placed into your jaw to hold a replacement tooth or bridge.
- Out-of-hospital dental procedures.
- Home and private nursing.
- Procedures for cosmetic purposes (unless this is covered under the Cosmetic Breast Reconstruction Benefit or the cosmetic procedure is necessary because of an illness or an injury).
- Exploratory procedures or procedures that are paid for by your medical aid on an exception or ex-gratia basis.
- Any procedure or procedure tariff code not covered by your medical aid or your spouse's medical aid if your spouse that you are legally married to in terms of South African law, is on a different medical aid.
- Procedures for the treatment of obesity or treatment that is required as a result of obesity.
- Elective or routine procedures and physical examinations including laboratory tests, x-rays, colonoscopies, other scopes, electrocardiograms (ECG's), pap smears, annual check-ups, etc. which are not required as a result of a specific medical condition or diagnosis (for example elective circumcision or scopes due to family history). Female surgical and non-surgical permanent sterilisation and a vasectomy are not excluded and will be covered.
- Anxiety disorders (such as phobias, excessive compulsive disorders, etc.), mood disorders (such as depression, bipolar disorder, etc), psychotic disorders (such as schizophrenia, delusions, etc), dementias (such as Alzheimers, substance-induced dementia, etc) eating disorders (such as anorexia nervosa, binge eating disorder, etc) and sleeping disorders such as sleep apnea.
- Any cancer treatment or planned procedures received outside the Republic of South Africa. If you require treatment outside the Republic of South Africa due to an accident or illness whilst you are travelling, this will be covered provided you have not been outside the Republic of South Africa for more than 60 consecutive days.
- Transportation costs (including resuscitation) in an emergency vehicle or aircraft and emergency medical service costs.

- Shortfalls in respect of fees charged by Allied Health Professionals for example
  - Audiologist
  - Acupuncturist
  - Biokineticist
  - Chiropracter
  - Clinical technologist
  - Dietician
  - Occupational Therapist
  - Physiotherapists
  - Podiatrist
  - Nurses
  - Scientist
  - Speech Therapist
  - Technologist

Pre-existing condition waiting period for the Medical Expense Shortfall benefit

You will not be entitled to claim a benefit for a period of 12 months from the start date of your policy in respect of a medical condition for which in the 12 months preceding the start date of your policy medical advice, diagnosis, care or treatment was received or would reasonably have been recommended.

If you fall pregnant before the start date of your policy this will be regarded as a pre-existing condition and any pregnancy and birth related claims will be excluded for a period of 12 months from the start date of your policy.

If, immediately before the start date of this policy, you were insured under a medical expense shortfall policy with similar benefits to this policy, then the pre-existing condition waiting period will only be applied to the unexpired part of the pre- existing condition waiting period in the previous policy. The pre-existing condition waiting period will apply for a period of 12 months for any benefit not provided under your previous medical expense shortfall policy.

In the event where a single member upgraded their cover to cover a spouse and/or dependents, then the pre-existing condition waiting period will apply to these new lives insured covered by this policy from the start of their cover under this policy.

If you stop being a dependant on the policyholder's medical scheme and immediately join another medical scheme on your own and take out your own Gap cover policy without a break in cover, then the date on which cover under this policy starts will be used to determine the pre-existing condition exclusion under the new policy. This will only apply for all benefits provided under this policy.

Limit applicable to the Medical Expense Shortfall benefit

The benefits payable may not exceed R165 000 for each insured person for any 12 month period. This limit will increase each year in accordance with the Consumer Price Index.

Section 2

Heath Insurance benefits

Your benefits described in this Section 2 of the policy are separate from the Medical Expense Shortfall benefits described in Section 1.

What are the Health Insurance benefits?

Lump sum cancer benefit

A benefit of R30 000 is payable if, after cover has started and after the 12-month applicable waiting period you are diagnosed for the first time as having at least stage 2 regional and malignant cancer, as long as this diagnosis is made by a registered medical practitioner and is supported by clinical, histological, radiological and laboratory evidence that we are satisfied with. This is a once-off benefit for each insured person, payable when cancer is diagnosed for the first time (excluding a skin cancer diagnosis), and no further benefit will be payable if cancer is diagnosed again thereafter or comes back after it has gone into remission.

In order to qualify for this benefit you must be registered on your medical aid's oncology programme.

There is a 12-month waiting period applicable to this benefit meaning that you cannot claim for a cancer diagnosis that occurs within the first 12 months from the start of this cover.

Medical premium waiver benefit

If you as the policyholder die or become permanently disabled as a result of an accident you or your beneficiaries may require financial assistance to pay your medical aid contributions and your premiums for this policy. This benefit will pay you a lump sum amount equal to twelve months' payment of your medical aid contributions and your premiums for this policy at the time of the claim incident, up to a maximum of R100 000. The benefit ends when you turn 65.

This benefit will be paid in addition to any similar benefit paid under a freestanding medical premium waiver policy.

Accidental dentistry benefit

This benefit will pay up to R19 250 each calendar year for each insured person, up to a maximum of R2 750 for each tooth, for an accidental tooth fracture due to an external blow to the mouth where the likely treatment is a crown, splinting or a bridge. Deciduous teeth are excluded.

Accidental death and permanent disability benefit

This is a lump sum benefit of R50 000 payable on the death or total and permanent disability of an insured person as a result of an accident. The maximum benefit payable for the accidental death of a minor child younger than six years old is R10 000 and after he or she attains the age of six years but before he or she attains the age of fourteen years the maximum benefit is R30 000, in accordance with Section 50 of the Short-Term Insurance Act 53 of 1998. Permanent disability cover ends when the insured person turns 65.

Trauma counselling

- If you are subjected to, or a witness of, an act of violence or a traumatic accident, we will refund you for medical practitioner counselling fees paid by you as a result of the violence or traumatic accident.
- An act of violence includes events such as murder, assault, robbery, rape, kidnapping or hijack which is reported to the police and for which you have a case number.
- The maximum that we will pay under this benefit is R750 for each counselling session for a maximum period of six months and up to R25 000 for each policy each year.
- The counselling must commence within six months from the date of the incident giving rise to the need for counselling.

General conditions applicable to sections 1 and 2 of this policy

1.1 You will not be entitled to receive a benefit, under any circumstances, for any disease or bodily injury that is caused either directly or indirectly by, or is as a result of:

1.1.1 Your willful participation in war, invasion, terrorist activity, rebellion, active military duty, police duty, police reservist duty, civil commotion, labour disturbances, riot, strike or the activities of locked out workers.

1.1.2 Nuclear weapons, nuclear material, ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the burning of nuclear fuel, including any self-sustaining process of nuclear fission (the splitting of an atomic nucleus into small parts).

1.1.3 Your taking of any legal drug unless it has been prescribed by a registered medical practitioner (other than you) and you are following the instructions of the medical practitioner in your taking of the drug. A legal drug is a substance that is used as a medicine and is registered in terms of the Medicines and Related Substances Control Act No. 101 of 1965.

1.1.4 Your using alcohol or your taking of any illegal drug. An illegal drug is any chemical substance that affects a physical, mental, emotional or behavioral change in an individual and is listed in the South African Drugs and Drug Trafficking Act 140 of 1992.

1.1.5 Any behaviour that breaks the laws of the Republic of South Africa.

1.1.6 Your attempted suicide, intentional self-injury or reckless exposure to danger.

1.1.7 Aviation except if you are on a commercial flight as a fare-paying passenger.

1.1.8 Participation in any form of race or speed test, involving any mechanically propelled vehicle, vessel, craft or aircraft.

1.2 Changes, cancelling or continuing your cover:

1.2.1 We may make changes to your policy by giving you 31 days' written notice to your last known postal address or email address.

1.2.2 We may cancel your Policy if you fail to pay your premiums or you submit a fraudulent claim or you commit a fraudulent act.

1.2.3 If we decide to discontinue the product line comprising your policy we may give you 90 days' notice of cancellation of your policy.

1.2.4 You may cancel your policy with us at any time by giving us 31 calendar days' written notice either by email, post or telephone.

1.2.5 Your cover and all benefits under this policy will be cancelled from the date of cancellation of your policy.

1.2.6 We will also only cover you for events that have happened on or after your cover start date and before midnight on the date on which your cover is cancelled.

1.2.7 There is no cash value to this policy if it is cancelled.

1.2.8 If you change your mind about taking up the policy, you may let us know either by email, post or telephone within 31 days of the start date of the policy and we will cancel the policy and refund you your first (and only) premium paid.

Premium

The premium must be paid monthly in advance on the due date given in the schedule.

You may pay your premium in equal monthly instalments over the policy year. This monthly premium must be paid to us on the due date given in the schedule.

Your policy will be renewed on 1 January each year (unless we have specifically agreed to another date). At this time we will calculate a new premium and we may revise the policy terms and conditions. When we do this, we will give you at least 31 days' notice of the new terms, conditions and premium payable.

If we do not get your first premium on the first date on which the premium is payable, your policy will not start and you will not have any cover.

It is your responsibility to make sure that we get your first premium or that your first premium is deducted and paid to us. It is also your responsibility to make sure that you continue to pay your premium so that you remain covered under this policy.

If we collect your premium through a debit order deduction from your bank account:

- Your premium will be payable every month on your agreed premium due date.
- We will always try to collect your premium on the agreed date. If for any reason we are unable to collect your premium on this date – for example, because the date falls on a weekend or a public holiday – we will collect your premium as close as possible to this date. You will be responsible for all bank charges.
- It is your responsibility to make sure that there are funds in your account on the date we submit your debit order.
- If you miss a debit order you have 31 days to pay the first outstanding premium.
- If we are unable to collect your premium by the due date, we will try to deduct a double premium during the next monthly debit order run.
- If we are again unable to collect your outstanding premium, we will cancel your policy and your cover will end as at midnight on the day before your outstanding premium was due.
- If you cancel the direct debit order that pays your premium for this policy, your policy will automatically be cancelled from the date that your premium had to be paid.

If your policy is in a grace period, it means that you are a month behind with your premium payments. If you submit a claim during this period, we will not process your claim until you have paid us the premium you owe us. When you have paid us the outstanding premium, we will process your claim.

Your premium can only be paid to us in South African Rand.

If we change the premiums for your cover under this policy, we will give you 31 days' written notice.

How to claim

a) If you have a claim you need to let the administrator know as soon as possible but not later than six months from the date of admission to hospital or the date of the out-of-hospital procedure or casualty procedure or the date diagnosed in the event of a lump sum cancer claim. Please note that we will not accept the claim unless we receive such notification within the six months.
b) You will need to provide us with the required claim form and the claim documentation that we request as proof of the validity of your claim.
c) If required you may need to give us permission to inspect all current and/or past medical or other information, including the results of any blood tests, and undergo a medical examination when we ask you to do so. We will pay for the examination.

d) Any claim under this policy will become invalid after 12 calendar months from the date when the insured incident took place if the claim is not the subject of a pending court case where court proceedings have been instituted.
e) Any benefit where we have to pay for a stay in hospital will only be paid at the end of the period spent in hospital. But, payments on account can be made to you after you have spent 31 days in hospital if we decide to do so.
f) All benefits we have to pay will be paid to you or your legal representative or to the medical aid practitioner or service provider at the discretion of the Insurer. Our liability ends when one of these parties gets the payment.
g) No benefit that we have to pay carries interest.
h) We will not process any claims if your premium payments are not up to date.

If you do not agree with (dispute) our repudiation of a claim, you have 90 days from the date of the repudiation letter to tell us why you dispute our decision. If the dispute is not resolved by the end of this period, you can, within a further 180 days, take legal action by serving us with a summons. If you do not do so, you will not be able to hold us liable for the claim.

How we protect your privacy

You are sharing your information with Zestlife and Guardrisk Insurance Company Ltd and its subsidiaries and their subsidiaries. All the companies in the Group, including all subsidiaries, are committed to protecting your information.

What information we collect and how we collect it:

When you conclude a transaction with us, we have to collect some personal information to make it possible for us to provide our services and to comply with our legal obligations.

What do we mean by 'personal information'?

Personal information is information relating to an identifiable, living individual or an existing business ('juristic person') and includes the following:

- Identifiers such as name, identity number, staff number, account number, customer number, company registration number, tax number, photos and videos or any other 'assignment' to the person used to identify them.
- Demographic information such as race, gender, pregnancy, marital status, national, ethnic or social origin, colour, sexual orientation, age, physical or mental health or well-being, disability, religion, principles, beliefs, culture, language and date and place of birth.
- Contact details such as physical, postal and email addresses, telephone numbers, online identifiers (e.g. a person's Twitter handle) and location information.
- Financial information such as bank and other account numbers, bank statements, salary information and financial statements.
- Usernames and passwords.
- Background information such as education, financial, employment, medical, criminal or credit history.
- Biometric information: This is connected to techniques of identification that are based on physical, physiological or behavioural characterisation such as blood typing, fingerprinting, DNA analysis, retinal scanning and voice recognition.
- A person's personal opinions, views and preferences.
- Correspondence sent by the person that is of a private or confidential nature and any further correspondence that would reveal the contents of the original correspondence.
- Views or opinions about a person (such as interview notes and trade references).

We will collect the information directly from you, but in some instances, we may collect it from other sources such as credit bureaux (for information relating to your credit record) or from the police or other government institutions for purposes of fraud prevention or to comply with our legal obligations (e.g. in terms of legislation). We may ask you to provide personal information of other persons (e.g. account signatories, shareholders, executive officers, trustees and your beneficiaries). You must ensure that they have authorised you to provide the information and that you have informed them about the content of this privacy notice. You confirm that you are authorised to give us their information and that you are authorised to consent to the processing of their information and to receive privacy notices on their behalf.

Who we share your information with:

When you share your information, you are sharing it with Zestlife and Guardrisk Insurance Company Ltd. All the companies in the Groups, including all subsidiaries, are committed to protecting your information. We may also share your information with companies who assist us to provide the products and services that you have requested. We only use companies we trust and we require that they promise to keep your information safe and that they follow our privacy policies. We may also have to share your information with companies in other countries. It is possible that these countries may not have the same level of data protection laws as South Africa. In those instances, we require that they promise to keep your information safe and that they follow our privacy policies.
Sometimes, we will be legally required to share your personal information, for instance, if legislation forces us to share personal information with the government or if we are presented with a valid warrant or subpoena.

Your consent:

By using our service, you consent that we may:

- process your personal information to provide our services, to comply with the law and for all other purposes referred to here;
- collect your personal information from third parties such as credit bureaux for credit, fraud and compliance purposes; and
- process your information in other countries who may not have the same level of data protection.

OUR COMPLAINTS RESOLUTION PROCEDURE

Procedure when submitting a complaint to us

If any of our representatives provided you with financial advice or any other intermediary service, and you feel that we or our representative:

- did not comply with the Financial Advisory and Intermediary Services Act and that you suffered financial prejudice as a result;
- intentionally or negligently gave financial advice or rendered an intermediary service to you which caused prejudice or damage or is likely to cause damage; or
- treated you unfairly,

or if your claim is not successful, or if you do not agree with the value of your claim and you have additional evidence that you think we have not considered,

then you must please write us a letter to PostNet Suite 87, Private Bag x1005 Claremont or send us an e-mail to chrism@zestlife.co.za or contact Chris on 021 180 4203 with the following information:

- Your name, surname and contact details.
- A complete description of your complaint.
- The name of the person who provided you with financial advice or an intermediary service.
- The date on which the matter complained about happened.
- All documentation relating to your complaint.

- How you would prefer to receive communication from us regarding your complaint i.e. by e-mail, fax, post and please provide us with the e-mail address, fax number or address where you would prefer to receive such communication.

Our procedure when receiving your complaint

- When we receive your complaint, we will send you an acknowledgement of receipt within 3 working days.
- We will investigate your complaint and provide you with feedback within 5 working days of receipt of your complaint.
- If we are unable to resolve your complaint within 15 working days, or are unable to resolve the complaint to your satisfaction, you have the right to refer your complaint to the Ombud appointed specifically for this purpose. The contact details of the Ombud is provided in the disclosure notice.

APPENDIX A

Out-of-Hospital Procedures

- Arthroscopy
- Bronchoscopy
- Bunionectomy
- Carpal Tunnel Release
- Cataract removal
- Cervical laser ablation
- Chemotherapy or radiotherapy for the treatment of cancer
- Childbirth in a non-hospital setting
- Closure of Colostomy
- Colonoscopy or sigmoidoscopy
- Coronary angiogram
- Coronary angioplasty
- CT Scan – Computer Axial Tomography
- Cystoscopy
- Dilatation and curettage
- Direct laryngscopy
- Endoscopy
- Female surgical and non-surgical permanent sterilisation
- Ganglion surgery
- Gastroscopy and gastrointestinal imaging
- Grommets
- Hernia Repairs, limited to:
  - Inguinal Hernia
  - Femoral Hernia
  - Umbilical Hernia
  - Epigastric Hernia
  - Spigelian Hernia
- Hysteroscopy
- Incision and drainage of Bartholin's cyst
- Ischio-rectal abscess drainage
- Kidney dialysis
- Marsupilisation of Bartholin's cyst
- MRI – Magnetic Resonance Imaging
- Myringotomy
- Needle biopsy of the liver
- Oesophagoscopy
- Orchidopexy
- Surgical Biopsy of Breast Lump
- Surgical Hemorrhoidectomy (excluding sclerotherapy or band ligation)
- Lymph node biopsy
- PET – Positron Emission Tomography
- Prostate biopsy
- Pterygium removal
- Sinus surgery, limited to:
  - Frontal sinus
  - Functional endoscopic sinus
  - Bilateral function endoscopic sinus
- Tonsillectomy
- Trabeculectomy and trabeculoplasty

- Varicose veins
- Vasectomy

APPENDIX B
Extended lump sum cancer cover

Introduction

The extended lump sum cancer cover forms part of the gap policy. The same terms and conditions that apply to the gap policy also apply to the extended lump sum cancer cover. The following additional terms and conditions apply to the extended lump sum cancer cover benefit.

What is the extended lump sum cancer cover benefit?

An additional benefit of R100 000 or R200 000, depending on which amount you chose is payable if you are first diagnosed with cancer during the period of insurance. The diagnosis must be made by a registered medical practitioner and supported to our satisfaction by clinical, histological, radiological and laboratory proof. This is a once-off benefit for each insured person. The benefit is payable on the first diagnosis of cancer. No benefit will be payable if the cancer returns after it has gone into remission.

Who is covered?

All insured persons covered by the gap policy are covered for the extended lump sum cancer cover described in this policy document. This includes the principal member and all dependants on the medical aid.

Is there a waiting period?

The cancer benefit extended has a general six-month waiting period. No claims submitted for cancer diagnosed within the first six months from the start of the extended lump sum cancer cover will be payable.

Is there a Pre-existing condition waiting period?

You will not be entitled to claim this benefit for a period of 12 months from the start date of your policy in respect of a medical condition for which in the 12 months preceding the start date of your policy medical advice, diagnosis, care or treatment was received or would reasonably have been recommended.

Does cover end at a certain age?

Cover ends when the insured person reaches the age of 65.

Is there cover for cancer that began before the starting date of this benefit?

You are not covered if the claim is made within 12 months after the start of the extended lump sum cancer cover benefit and is directly or indirectly related to a cancer that showed symptoms in the 12 months before the start of this benefit and would have caused a reasonable and careful person to seek medical advice and/or treatment. This exclusion applies whether or not you actually received treatment.

If you increase your extended lump sum cancer cover amount after the start date of this cover, the 12 month pre-existing condition will apply on the increased portion of cover, from the start date of this benefit amount change.

APPENDIX C
Extended Dentistry Cover

The extended dentistry cover benefit is administered by Denis Insurance Administrators (Pty) Ltd (DIA), an authorised financial services provider (FSP 36026).

Who is covered?

If you chose the extended dentistry cover benefit then all persons insured for medical gap benefits are covered for the dental benefits described in this policy document, including the main member of the medical aid and all their dependants.

Which dental benefits are covered?

The claim events that are covered and the benefit amounts are listed in the table below. Rules apply to each insured condition or event described in this document.
Claims are only valid and may be submitted after a diagnosis has been made by a registered dental practitioner.

Benefits for each insured person

INSURED CONDITION OR EVENT	LIKELY TREATMENT	COVER AMOUNT
Impacted wisdom tooth (teeth in the process of eruption that are not impacted are excluded). Waiting period: six months	Surgical tooth removal	R 1 000 for each tooth
Periodontitis (severe infection of the gums where the attachment of the tooth to the gum has broken down) Waiting period: six months	Gum surgery	R 1 750 for each event
Jaw fracture (substantiated by an X-ray showing that surgical treatment is needed) Waiting period: none	Surgery	R16 500 for each event
Dental emergency (dental pain or infection that needs immediate treatment for relief) Waiting period: none	Emergency root canal, temporary crown, temporary filling	R 1 250 for each event
Accidental tooth fracture (50% of the visible tooth is lost due to an accident and the nerve is permanently damaged) Waiting period: none	Crown, splinting, bridge	R 4 500 for each tooth
Severely decayed or damaged tooth (two thirds of the tooth is lost due to decay or trauma) Waiting period: six months	Crown	R 3 250 for each tooth A maximum of two teeth are covered in 12 months
Impaired function due to loss of tooth/teeth (loss can be due to infection or trauma; 2nd and 3rd molars are excluded) Waiting period: six months	Removable denture(s)	R5 500 for each jaw Paid once for upper or lower jaw in 24 months
Occlusal instability (tooth is lost, which results in adjacent teeth potentially changing position causing the bite to become unstable) Waiting period: six months	Implant or bridge	R10 000 for each tooth Limited to one claim in 12 months

What are the insured events?

The following events are covered and qualify for payment of a benefit.

Specialised dentistry events

a) **Impacted wisdom tooth**

1. This benefit of R1 000 for each tooth is available after a dental professional has made a clinical diagnosis of impacted wisdom tooth or teeth where the likely treatment is surgical removal.
2. Teeth that are in the process of eruption but are not impacted, are excluded.
3. After the diagnosis has been made and the claim settled, the relevant individual impacted tooth is considered to have been properly treated. Therefore no further claims will be paid for this tooth.
4. A waiting period of six months from the start of the dental extended benefit applies to this benefit.

b) **Periodontitis**

This benefit of R1 750 for each event is available on clinical diagnosis of severe infection of the gums where the attachment of the tooth to the gum has broken down and the likely treatment is gum surgery.

1. A CPITN value of 3 or 4 in at least 3 sextants must be measured and reported by the dental professional.
2. A waiting period of six months applies to this benefit from the start of the dental extended benefit.

c) **Severely decayed or damaged tooth**

This benefit of R3 250 for each tooth is available on clinical diagnosis, by a dental professional, of a severely decayed or damaged tooth. Two thirds of the tooth must be lost due to decay or trauma and a crown must be the likely treatment.

1. A maximum of two teeth are covered in a period of 12 months.
2. The administrator may need a diagnostic X-ray to substantiate the claim. (The X-ray must be taken before any treatment is attempted.) Once diagnosed and the claim paid, the tooth is considered properly treated and no claim may be submitted for five years for the same condition and the same tooth.
3. The replacement of existing crowns is subject to a pre-existing condition exclusion period of 12 months.
4. Milk teeth are excluded from benefits.
5. A waiting period of six months applies to this benefit from the start of the dental extended benefit.

d) **Occlusal instability**

This benefit of R10 000 for each tooth is available when a tooth is lost and this loss could result in the adjacent teeth changing position and causing the bite to become unstable. The condition must be diagnosed by a dental professional and the likely treatment must be an implant or a bridge.

1. In terms of this policy the claim can only be made for teeth lost after the dental extended benefit starting date and which is not as a result of a condition that existed prior to this start date.
2. This benefit is limited to one claim during any 12-month period.
3. A waiting period of six months applies to this benefit from the starting date of the dental extended benefit.

e) **Impaired function because of loss of tooth or teeth**

1. This benefit of R5 500 for each jaw is available if a tooth or teeth are lost because of infection or trauma after the starting date of the dental extended benefit date. The likely treatment as determined by a dental professional must be a removable denture. The benefit is payable once per upper and/or lower jaw every 24 months.
2. The administrator may need a diagnostic X-ray to prove that the claim is valid. (The X-ray must be taken before any treatment is attempted.) After the diagnosis has been made and the claim settled, the jaw is considered properly treated and you will not be able to claim for the same condition for two years.
3. This benefit is available only for tooth positions from the central incisor to the 1st molar position. Dentures in the 2nd and 3rd molar positions are excluded.
4. This benefit may not be claimed at the same time as the benefit for occlusal instability (bridge or implant).
5. Loss of milk teeth is excluded.
6. This benefit is limited to one claim for each prosthesis for each jaw during any 24-.
7. A waiting period of six months applies to this benefit from the start of the dental extended benefit.

Emergency and accidental dental incidents covered by the benefit

a) **Jaw fracture**
1. Insured persons qualify for this benefit of R16 500 for each event after clinical diagnosis of a broken jaw by a dental professional has been confirmed by an X-ray and where surgery is the likely treatment.
2. There is no waiting period for this benefit.

b) **Dental emergency**
1. Insured persons qualify for this benefit of R1 000 for each event if they have dental pain or infection and need immediate treatment to relieve it and where the likely treatment is an emergency root canal, a temporary crown or a temporary filling. Routine visits are expressly excluded from this policy. Benefits are paid for each event.
2. There is no waiting period for this benefit.

c) **Accidental tooth fracture**
1. This benefit of R4 500 for each tooth is available where at least 50% of the visible portion of the tooth is lost due to an accident and where the dental nerve is permanently damaged and the likely treatment is a crown, splinting or a bridge. Milk teeth are excluded.
2. There is no waiting period for this benefit.

What is the meaning of certain key words and phrases related to the dental benefit?

a) **"accident"** means an event where the force that fractures the tooth comes from an external source. For example a fall where forceful contact is made between the teeth and a hard surface, or where a hard object (such as a cricket ball) strikes the teeth, resulting in a fracture. Milk teeth are excluded.
b) **"accidental tooth fracture"** means that at least 50% of the visible portion of the tooth is lost and the dental nerve is permanently damaged. Milk teeth are excluded.
c) **"dental abscess"** means that there is an infection at the tip of the root or another root infection that results from tooth- related pathology such as decay or a fracture.
d) **"dental emergency"** means an event during which the insured person has tooth ache or infection and needs immediate treatment to relieve pain. Routine visits are expressly excluded from this policy. Benefits are paid for each event.
e) **"dental practitioner"** means a legally qualified dental practitioner registered with the South African Medical and Dental Council.
f) **"gingivitis"** means an inflammatory condition that may affect the gums if plaque is not removed by manual brushing.

g) **"impacted"** means a tooth that cannot descend (erupt) into the mouth because it is blocked by the position of another tooth or the jawbone. Cover is given only when there is "pathology" associated with the impacted tooth. In this context, pathology refers to cysts, tooth resorption, recurrent pericoronitis in the case of partially impacted teeth (recurrent pericoronitis is an on-and-off infection of the gum surrounding a tooth that is in the process of eruption. in this context it must have occurred at least two times over a six-month period), or osteomyelitis (a severe infection of the bone) because of the impaction.

h) **"infection"** means an acute infection of the gums or associated with the teeth.

i) **"occlusal instability"** means a tooth has been lost and teeth above or behind the missing tooth are likely to change position because of the missing tooth, resulting in an unstable occlusion (bite).

j) **"periodontitis"** means a severe infection of the gums where the attachment of the gum to the tooth is destroyed. The severity of the disease is determined by measuring the loss of attachment.

k) **"pre-existing condition"** means that the insured was aware of a condition that needed a specific treatment plan before the start of the dental extended benefit. The condtition must have been diagnosed and recorded by a dental practitioner.

l) **"prognosis"** means the likely chance of successful treatment. For example, a poor prognosis for restoring a tooth means that the dentist feels that a tooth is affected too badly by decay or fracture and that there is no point in trying to restore the tooth and it should rather be extracted (pulled).

m) **"rehabilitation"** means the successful rebuilding of a damaged tooth.

n) **"removable prosthesis"** means a device (denture) made in a laboratory to replace missing teeth.

o) **"severely decayed or damaged"** indicates that at least two thirds of the visible tooth structure has been lost to decay or trauma, regardless of the nature of the trauma.

p) **"tooth ache"** means an acute pain for which the insured person must seek immediate relief.

q) **"tooth decay"** (caries) means the bacterial process that weakens the tooth structure and the forming of a hole. For insurance purposes the tooth is regarded as decayed once there is either clinical or radiological proof of a hole. Marginal leakage, which is the visible staining of the margin between an existing filling and the tooth, without proven cavitation is not covered.

Under which circumstances is cover excluded?

Pre-existing conditions are subject to an exclusion period of 12 months from the starting date of the extended dentistry cover benefit.

What claims documents do we need from you?

A diagnostic report that shows that the condition exists. This report has to be compiled by a registered dental practitioner. It may contain an X-ray analysis, or the X-ray itself, or an intra-oral photograph that shows the condition clearly.

The diagnostic report should contain the diagnostic description code (ICD-10) and, if a specific tooth is involved, the relevant FDI tooth number.

A treatment invoice which shows that a procedure was done to treat an existing condition. The invoice usually contains a description of the procedure or the diagnosis.

If the treatment that was given is suitable for both insured and non-insured conditions, then diagnostic proof of the original condition is always needed to support the claim.

What does the claim process involve?

You may only submit a claim after diagnosis by a registered dental health care provider.

You must submit a valid diagnostic report or treatment invoice from a registered dental practitioner.

When claiming for accidental trauma benefit, you must submit a medical certificate that describes the nature of the external blow together with the claim.

We may ask for additional clinical document and/or proof to support the claim.

When does the cover end?

Cover will end on the day that the insured person reaches the age of 65.