



BUSINESS PERSON ELECT

POLICY TERMS AND CONDITIONS

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1. Introducing your policy

We will pay out the benefits given on your schedule as long as:

- you pay the premiums set out in this policy, and
- you comply with the terms and conditions of this policy.

1.1. Key words used in this policy

- *We, us* and *our* refer to Lombard Life Ltd.
 - *You* and *your* refer to the life insured
 - *The administrator* refers to Financial Management International Limited
- The plural of these words is used where appropriate.

1.2. Refer to your schedule to see what you are covered for

You must refer to the schedule to see what you are covered for. The fact that certain benefits are explained in this document does not mean that you are covered for them.

1.3. We decide if you qualify

You understand and agree that we decide whether your inability to earn income, your death, your injury, or your illness, qualifies for these benefits, and, if so, in which category it belongs.

1.4. Maximum amounts

You may not claim more than 100% of the sum insured for any one injury or illness.

1.5. Tax and interest

No amounts paid under this policy earn or pay interest.

It is your responsibility to disclose and pay the tax owing on any amounts paid under this policy.

2. Outline of benefits

Here is an outline of benefits paid monthly.

2.1. Outline of benefits

Benefit	When you can claim	When we payout	How much?
<i>To provide an income for an initial period</i> Temporary Income Protector benefit (TIP)	If you cannot work in your own occupation	Monthly for a maximum of 6, 12 or 24 months (depending on what option you chose)	Cover may be chosen from R1,000 to R120,000 per month. Cover selected is reflected on policy schedule.
<i>To provide an income in the longer-term</i> Permanent Income Protector benefit (PIP)	If you cannot work in your own or suited occupation which you could reasonably be expected to do	Monthly after a waiting period of 6, 12 or 24 months (depending on what option you chose)	Cover may be chosen from R1,000 to R120,000 per month. Cover selected is reflected on policy schedule.
<i>To cover certain overhead expenses</i> Business Overhead Protector benefit (BOP)	If you cannot work in your own occupation	Monthly for a maximum of 6, 12 or 24 months (depending on what option you chose)	Cover may be chosen from R1,000 to R100,000 per month. Cover selected is reflected on policy schedule.
<i>To provide an income for an initial period</i> TIP Dread Disease Enhancer	If your claim on the Temporary Income Protector Benefit is due to a listed dread disease	Monthly for a maximum of the lesser of 6 months or actual payout of your TIP benefit	This benefit pays an additional 20% of the cover selected on the Temporary Income Protector Benefit
<i>To cover your spouse & dependent children</i> Family Cover	If your spouse is disabled due to injury or illness; and if your child is diagnosed with a dread disease from the list	Monthly for a maximum of 2 months Lump sum on diagnosis of a dread disease	Maximum of R15,000 per month (limited to one claim) R20,000 per claim. (pays up to 2 claims for policy)

2.2. Definitions

Work: perform the daily duties of your full-time job.

Own occupation: the nominated occupation that you do to earn income as set out on your application.

Own or suited occupation: Either your own or any suited occupation that you would be able to do, taking into account your experience, training and skill.

Income:

- **Salaried Employees:**

Cost to company income which consists of gross taxable income including the employer's contributions to a medical scheme, provident fund or pension fund, and the cost of any other benefits paid for by the life insured's employer that forms part of the life insured's remuneration package and are reflected in the employer's financial statements. Salaried employees do not qualify for the Primary Waiting Period on TIP and BOP.

- Self-employed / Business owner – non Professional:
Income or benefits receivable on account of the life insured's employment, or any services rendered by the life insured, plus the life insured share of profit in the business over the last 12 months.
- Self-employed/Business owner – Professional:
Gross professional income for professionals who charge a fee for services is equal to the sum of professional fees and net income from trading activities, after deducting business overhead expense.
- Passive income:
Passive income (for example rental income, interest, etc.) is specifically excluded from the definition of income for the purposes of this policy

2.3. How the benefits are paid

The administrator pays the benefits directly into the bank account given on the claim forms.

2.4. Age Limitations

Please refer to your schedule to see the respective benefits' termination ages.

2.5. Special Limited Benefits

These special conditions are covered if they meet the certain criteria.

Pregnancy and childbirth

We will pay you one month's Temporary Income Protector benefit and Business Overhead Protector benefit after you have given birth to a child. The benefit will not be paid if your date of conception is before the commencement date of your policy.

Minor infections

No claim will be paid for minor infections e.g. influenza, bronchitis, sinusitis, pneumonia, tuberculosis or laryngitis unless the life insured adheres to medical treatment protocol, and meets one of the following:-

1. Undergo diagnostic testing
2. Diagnosed with minor infection by a specialist
3. Admitted to hospital

Reconstructive and cosmetic surgery

If, as a direct result of a medical condition or accident your doctor recommends that you have to undergo cosmetic or reconstructive surgery, we will pay your benefit. However, we will not pay out anything if you are unable to work because of any treatments, examinations or operations for purely cosmetic purposes. We will not pay out anything for breast reductions or reconstructions – except if cancer related.

2.6. Increasing your sums insured

Option of automatic benefit increase each year

This applies to the Temporary Income Protector, Permanent Income Protector, Business Overhead Protector, Life Cover, Capital Disability and Dread Disease Benefits.

Refer to your schedule to see whether you have chosen an automatic benefit increase. If you have, your sum insured goes up each year by the amount shown on the schedule. Your premium also goes up according to a rate appropriate to your age.

You cannot add an automatic benefit increase after the policy start date. Once a year, the administrator sends you a letter stating the amount of the benefit increase for the following year. You have the choice to:

- accept the amount, in which case your premiums and benefits are increased
- refuse the amount, in which case your premiums and benefits stay the same.

You can remove this benefit by refusing the amount in writing three times in a row. Once you have removed the benefit, you cannot add it again.

Annual Review Benefit

This applies to the Temporary Income Protector, Permanent Income Protector and Business Overhead Protector Benefits.

Benefit Increases

You have the option of increasing your cover by 20% each year on anniversary of date of commencement of your policy ("Anniversary Date"). You will not have to provide proof that you are medically insurable, but you may have to prove that you are financially insurable; for example we will not request medical reports but may request you to provide proof of income.

This benefit ends on your 56th birthday.

Benefit Reductions

You may decrease cover by any percentage on any Anniversary Date.

Re-Instatement Benefit

This applies to the Temporary Income Protector, Permanent Income Protector and Business Overhead Protector Benefits.

On Anniversary Date you have the option to re-instate benefits to the cover amount at which they were before the benefit reduction effected on previous Anniversary Date. You will not have to provide proof that you are medically insurable, but you may have to prove that you are financially insurable. Re-instating benefits will affect your premium.

Definition of <i>insurable</i>: the circumstances and risk factors that make it possible for you to get insurance.

(See section 'changing your policy' for other ways to increase cover.)

The option exercised on this benefit will automatically include any underwriting conditions as stipulated in the original application.

There are maximum amounts we pay out

Once the maximum is reached, you cannot apply an automatic benefit increase or annual review benefit increase.

Repeated periods of illness or injury are treated as one

If there are repeated periods where you are off work for the same illness or injury, we add up all the periods and count them as one unless they are separated by 24 months. This means that, after the waiting period has run its term uninterrupted, you will not have another waiting period imposed if you have another claim for the same illness or injury within 24 months of the first claim.

For example, Mr. Jones has a 30-day waiting period and misses work because of illness or injury for the months of January and February 2007. In July 2007 he suffers from the same condition and misses work again for two months. In January 2008 he misses work yet again for the month because of the same condition. We will pay out the benefit for a total of four months.
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2.7. About your premium

Five-yearly guarantees

Every five years from commencement of benefit cover, we review your premiums. Between the reviews, we guarantee that the amounts will not go up, except for amounts included in the automatic benefit increase, annual review benefit increase, premium patterns, changes in benefit cover amounts and changes that result from a change to material information – for example, a change in your occupation, the nature of your occupation, or smoker status.

Waiver of Premium - *no premiums if you receive the monthly payouts*

While you are in claim and receiving any monthly payouts on a benefit, you do not have to pay the premiums due for that specific benefit.

Option of automatic premium increase - *premium pattern*

Refer to your schedule to see the option you have chosen for an automatic premium increase.

The three options are:

- **Level Premium Pattern** – the premiums on the policy remain the same throughout the policy, subject to any other options you may have chosen, for example the automatic benefit increase.
- **5% Escalation Pattern** – the premiums on the policy will increase by 5%.
- **Age Rated** – the premiums on the policy will increase when you enter a new age. This means that every year your premium will increase according to the rate for that age.

Premium increases will be effected on Anniversary Date.

This increase will be over and above any other increase that may occur as a result of any other options (for example the automatic benefit increase) that you may have selected.

Example:

Mr. Jones chooses the 5% premium pattern. He also chooses an automatic benefit increase of 10%. Mr. Jones's benefit will increase by 10% each year and he will pay a corresponding premium to the new benefit. Because he also selected a 5% premium pattern his premium for the benefit will increase by an additional 5% on Anniversary Date.

2.8. Freeze Period

What is a Freeze Period?

If you are unable to pay the full premium on a policy you have the option of requesting a Freeze Period from us in order to avoid the lapsing of your policy. During a Freeze Period you will not be required to pay any premiums on your policy for a pre-determined period, being three or six months.

You will not be able to claim on your policy during this Freeze Period.

No changes may be made to benefits during a Freeze Period.

How many Freeze Periods are allowed on a policy?

Each policy is only allowed one Freeze Period during its existence.

How do I request a Freeze Period on my policy?

Contact the Administrator on 086 010 1119.

What happens after the Freeze Period expires?

After expiry of the Freeze Period your cover and premiums will revert to the amounts pre-Freeze Period and your obligation to pay premiums will continue.

2.9. Accident Only Cover

Accident only benefits provide cover for claim events that result from accidents only. An accident is defined as a sudden, unplanned, unexpected unusual and fortuitous event occasioned by visible, violent, physical and external means which result in bodily injury as defined below.

Your schedule will reflect whether your benefit is accident only cover.

In the event that you are less than 32 years old, are not a substandard life and have chosen accident only cover at commencement, your cover will automatically upgrade to full cover and your premiums will double on the third Anniversary Date.

3. Temporary Income Protector - Protecting you for an initial period

3.1. What is your Temporary Income Protector benefit?

The Temporary Income Protector benefit covers you for an initial period if you cannot work in your own occupation because of illness or injury. This benefit is compulsory – you cannot choose cover on any other benefit if you do not choose this benefit.

Own occupation: what you submitted on your application as the full-time job that you do to earn an income.

3.2. Periods needed to qualify

There are three options for how long your illness or injury has to last before it qualifies for this benefit. Refer to your schedule to see which option you selected.

- 3.2.1. **Primary Benefit - Qualify after 7 days:** If you have this option your injury or illness must last at least 7 days in order to qualify. Note that once the illness or injury has qualified, your benefit will be back-dated to day one. This applies to the Primary Benefit only. Salaried Employees do not qualify for the Primary Benefit.
- 3.2.2. **Monthly Benefit -Qualify after 30 days:** With this option, you do not receive any amounts for the first 30 days that you are ill or injured. Your benefit starts on the 31st day after the date of the injury or the start of the illness.
- 3.2.3. **Quarterly Benefit - Qualify after 90 days:** With this option, you do not receive any amounts for the first 90 days that you are ill or injured. Your benefit starts on the 91st day after the date of the injury or the start of the illness.

3.3. When does the benefit end?

The maximum period we pay out for this benefit is shown on your schedule. You have chosen 6, 12 or 24 months.

However the payouts may stop before the maximum period has expired. We payout only until the first of these events takes place:

- Your full recovery
- The day we consider you are able to go back to your own occupation
- Your death
- The Anniversary Date following your chosen termination age.
- The end date of your benefit term. If on expiry of chosen benefit term you do not return to work the benefit will end and be removed from your policy. However, if you have fully resumed your nominated occupation before the end of the benefit term, then the benefit will not be removed from your policy and any subsequent disability claims for the same or related conditions must be separated by 24 months.

End Date of Benefit. This is the last day of the benefit period you have chosen. Example: If you have a 6 month benefit period and your claim payout is for the entire 6 months (inclusive of any waiting period), your benefit will end at the end of the 6 months.

3.4. Amount of payout

The amount that is paid out depends on how severely the illness or injury affects your ability to work. If you cannot do:

- 75% or more of your work, the benefit will be the total amount stated for such benefit on the policy schedule
- Between 25% and 75% of your work, the benefit will be a proportion of the total amount stated for such benefit on the policy schedule. The proportion paid is based on the proportion of your work you cannot perform.
- Less than 25%, no benefit is paid.

3.5. Maximum amounts we will pay out

The maximum we will pay is R120 000 monthly.

The maximum for the full period of cover will be (depending on the benefit you chose)

24 months of cover	R 2 880 000
12 months of cover	R 1 440 000
6 months of cover	R 720 000

3.6. Option of increasing payout– *Claims escalation*

You have the option at application stage of adding annual escalation to amounts paid to you in claim.

If this option is shown on your schedule, the amount we pay out during a claim goes up each year at the lower of:

- the rate you have chosen as per your application form (see schedule); and
- the Consumer Price Index (CPI).

The increase is applied on the anniversary of the claim.

3.7. Driver's Extension - *Cost of driver if you cannot drive*

We pay up to R250 per day towards the cost of employing a driver if:

- you are able to work in your own occupation in all aspects except driving
- your injury or illness makes it impossible for you to drive the vehicle you need for your own occupation
- with a driver's help, you would be able to continue with your own occupation.

If you receive this amount, you will not receive any other amount under the Temporary Income Protector benefit.

4. Permanent Income Protector - *protecting you in the longer term*

4.1. What is the Permanent Income Protector benefit?

The Permanent Income Protector benefit covers you in the longer term if you cannot work either in:

- your own occupation, or
- your own occupation or any other suited occupation that you can reasonably be expected to do because of your training, skills or experience.

You can choose between own occupation **or** own or suited occupation. Please refer to your policy schedule to see the option you have chosen.

4.2. When does the benefit start?

You selected a waiting period at application stage. The waiting period is reflected on the schedule as six months, 12 months or 24 months.

The waiting period starts on the day you were unable to earn an income because of the injury or illness.

4.3. When does the benefit end?

The payouts end on the earliest of:

- The date you have fully recovered
- The date you are able to work in your own occupation or any suited occupation you can be expected to do because of your training, skills or experience
- Your death
- The Anniversary Date following your chosen termination age

4.4. Amount of payment

Maximum amounts we will pay out

The sum insured is limited to R120 000 per month.

4.5. Option of increasing payout during a claim – *claims escalation*

You have the option at application stage of adding annual escalation to payouts.

If this option is shown on your schedule, the amount we pay out during a claim goes up each year at the lower of:

- the rate you have chosen as per your application form (see schedule)
- the Consumer Price Index (CPI).

The increase is applied on the anniversary of the claim.

4.6 How payouts can be reduced

The payouts can be reduced by:

- Payments from other income benefits
- Compensation schemes (whether for loss of income or not)
- Sick leave payments
- Lump sum disability payments.

We deduct the amounts according to the most recent guidelines given by ASISA.

5. **Business Overhead Protector** – offering cover for overhead expenses

5.1. About your Business Overhead Protector benefit

We will only pay Business Overhead Protector benefits if you qualify for the Temporary Income Protector benefit. If you have selected this benefit and have been accepted the following will be considered:

- Rent or mortgage of business premises only (This does not include business premises based on private residence of policyholder).
- Property rates and taxes
- Electricity, water, telephone
- Equipment and vehicle leasing costs
- Insurance premiums
- Legal, accounting fees and auditing fees
- Remuneration of non-income producing staff
- Business cleaning and laundry
- Other maintenance costs that are directly related to the business and deemed necessary expenses in running the business
- Advertising
- Postage
- Bank charges
- Subscriptions to Professional Associations.

5.2. Periods needed to qualify

There are three options for how long your illness or injury has to last before it qualifies for this benefit. Refer to your schedule to see which option you selected.

5.2.1. **Primary Benefit** - Qualify after seven days: If you have this option your injury or illness must last at least seven days to qualify. Note that once the illness or injury has qualified, your benefit will be back-dated to day one. This applies to the Primary Benefit only. Salaried Employees do not qualify for the Primary Benefit.

5.2.2. **Monthly Benefit** - Qualify after 30 days: With this option, you do not receive any amounts for the first 30 days that you are ill or injured. Your benefit starts on the 31st day after the date of the injury or the start of the illness.

5.2.3. **Quarterly Benefit** - Qualify after 90 days: With this option, you do not receive any amounts for the first 90 days that you are ill or injured. Your benefit starts on the 91st day after the date of the injury or the start of the illness.

5.3. When does the benefit end?

The maximum period we pay out for this benefit is shown on your schedule. You have chosen six, 12 or 24 months.

However the payouts may stop before the maximum period has expired. We pay out only until the first of these events takes place:

- Your full recovery
- The day we consider you are able to go back to your own occupation
- Your death
- The Anniversary Date following your chosen termination age
- Your business stops operating or you sell the business
- The end date of your benefit term. If on expiry of chosen benefit term you do not return to work the benefit will end and be removed from your policy. However, if you have fully resumed your nominated occupation before the end date of the benefit term, then the benefit will not be removed from your policy and any subsequent disability claims for the same or related conditions must be separated by 24 months.

5.4. Amount of payout

Maximum amounts we will pay out

The maximum we will pay is R100 000 monthly. The maximum for the full period of cover will be (depending on the benefit you chose):

24 months of cover	R 2 400 000
12 months of cover	R 1 200 000
6 months of cover	R 600 000

The amount that is paid out depends on how severely the illness or injury affects your ability to work. If you cannot do:

- 75% or more of your work, the benefit will be the total amount stated for such benefit on the policy schedule
- Between 25% and 75% of your work, the benefit will be a proportion of the total amount stated for such benefit on the policy schedule. The proportion paid is based on the proportion of your work you cannot perform.
- Less than 25%, no benefit is paid.

5.5. Option of increasing payout during a claim – *claims escalation*

You have the option at application stage of adding annual escalation to amounts paid to you in claim.

If this option is shown on your schedule, the amount we pay out during a claim goes up each year at the lower of:

- the rate you have chosen as per your application form (see schedule); and
- the Consumer Price Index (CPI).

The increase is applied on the anniversary of the claim.

6. Family Cover - offering cover for your spouse and dependent children

6.1. Spouse Benefit – what is your Spouse Benefit?

This benefit covers your spouse if he / she cannot work in his / her own occupation because of illness or injury. At date of entry of this benefit your spouse must be able to work in his / her own occupation.

Definition of Spouse: A spouse may be any one of the following:

- married to you by law, tribal custom or under the beliefs of any Asian religion. If there is a marriage under African traditions, it must be accepted by a tribal council. The tribal council is a person who the tribal chief recognises as a legal partner and who has written proof that lobola has been paid.
- a common-law spouse. A common law spouse is a person that we recognise as a spouse. To qualify as a spouse, a common law spouse must live with you for at least six months in a committed relationship akin to marriage.

A spouse may be of the same gender as you.

You must give all details of common law spouses to us at the date of commencement or within one month of the common law spouse becoming eligible for cover.

We will cover a maximum of one spouse.

Divorced spouses are not covered. Divorced spouses are people who do not fall under the above definition of a spouse anymore.

6.1.1. Periods needed to qualify

Your spouse's injury or illness must last at least 30 days in order to qualify.

Note that once the illness or injury has qualified, the benefit will be back-dated to day one.

6.1.2. When does the benefit end?

Only one claim will be paid on this benefit, after which the benefit will be removed from the policy.

The maximum period we pay out for this benefit is 2 months.

However the payouts may stop before the maximum period has expired. We pay out only until the first of these events takes place:

- Your spouse's full recovery
- The day we consider your spouse to be able to go back to his / her own occupation
- The Anniversary Date following the chosen termination date

This means that:

If a claim is only 30 days the benefit will terminate. You will not be able to claim again for another 30 days at a later date even though your initial claim did not last a full 2 months.

6.1.3. Amount of Payout

The amount that is paid out depends on how severely the illness or injury affects your spouse's ability to work. If your spouse cannot do:

- 75% or more of your spouse's work, the benefit will be the total amount stated for such benefit on the policy schedule

- Between 25% and 75% of your spouse's work, the benefit will be a proportion of the total amount stated for such benefit on the policy schedule. The proportion paid is based on the proportion of your spouse's work he / she cannot do.
- Less than 25%, no benefit is paid.

6.1.4. Maximum amounts we will pay out

The maximum we will pay is R15,000 per month.

In the event that the claim does not last for the full second month a pro rata amount will be paid.

The Spouse Benefit Cover amount will remain constant throughout the existence of the benefit.

6.1.5. Driver's Extension – Cost of driver if your spouse cannot drive

We pay up to R250 per day towards the cost of employing a driver if:

- Your spouse is able to work in all aspects except driving
- your spouse's injury or illness makes it impossible for them to drive the vehicle they need for their occupation
- with a driver's help, your spouse would be able to continue with their occupation.

If we pay this amount, we will not pay any other amount on the Spouse Benefit.

6.1.6. No cover for illness or injuries that existed before

Your spouse cannot claim in the first 12 months from the entry date for illnesses or injuries that existed in the 6 months before your spouse's entry date. If your spouse is injured or becomes ill in the first 12 months after their entry date, they may have to prove that the illness or injury did not exist in the 6 months before the entry date. We will only pay the benefit if we have enough proof that the illness or injury did not exist before.

6.2. Child Cover - What is your Child Dread Disease Benefit?

We will pay you if your dependant eligible child is diagnosed with a dread disease as detailed hereunder. This benefit will pay for new Dread Disease Events that occur after the date of commencement of this benefit for each dependent child, up to a maximum of two claims during the lifetime of your policy. The diagnosis of the dread disease must be before date of death.

To be eligible for cover, the child must be unmarried and:

- Under 21 years old, or
- Under 25 years old if the child is still a full-time student at a recognised institution, or
- Any age for as long as the member's cover continues if the child has become mentally or totally and permanently disabled before age 21, or
- Under 19 if the child is financially dependent on the member and the member is the child's guardian (and not their parent).

This may include a legally adopted child, a stepchild and an illegitimate child.

6.2.1. Dread Diseases covered

CARDIOVASCULAR

Heart Attack:

This is defined as the death of heart muscle, due to inadequate blood supply, as evidenced by all 3 (three) of the following criteria:

1. Compatible clinical symptoms; and
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 > 0,5ng/ml or Trop > 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 times 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.

Coronary Artery Surgery

The undergoing of surgery to correct the narrowing of, or blockage to, 2 (two) (or more) coronary arteries by means of a by-pass graft.

Aortic Artery Surgery

Undergoing of a laparotomy or thoracotomy to repair or correct an aneurysm, narrowing, obstruction or dissection of a diseased aorta with a graft. For this definition, aorta means the thoracic and abdominal aorta but not its branches. Surgery to treat peripheral vascular disease of the aortic branches is excluded even if a portion of aorta is removed during the operative procedure. Surgery performed using only minimally invasive or intra-arterial techniques such as percutaneous endovascular aneurysm repair are excluded.

Heart Valve Surgery:

The undergoing of open-heart valve surgery with a thoracotomy performed to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The surgery must be considered medically necessary by a consulting cardiologist and supported by appropriate investigations. Catheter based techniques including but not limited to, balloon valvotomy/vulvuloplasty are excluded.

CENTRAL NERVOUS SYSTEM

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 neuro-imaging investigation and appropriate clinical findings by a specialist neurologist. For the above definition, the following are not covered:

- Transient ischaemic attack
- Vascular disease affecting the eye or optic nerve
- Migraine and vestibular disorders
- Traumatic injury to brain tissue or blood vessels

Severity levels will be assessed by a neurological examination by a specialist neurologist any time after three months.

Almost full recovery, with little residual symptoms or signs, as measured by:

- The ability to do all basic and advanced ADL's or
- A WPI of 10% or less

Multiple Sclerosis:

A definite diagnosis by a consultant neurologist of multiple sclerosis must be made which satisfies the following 2 (two) criteria:

1. There must be permanent functional neurological impairment with objective evidence of motor or sensory dysfunction, which must have persisted for a continuous period of at least 6 (six) months;
2. The diagnosis must also be confirmed with objective neurological investigations, such as lumbar puncture, evoked visual responses, evoked auditory responses and MRI evidence of lesions of the central nervous system.

Parkinson's Disease:

The unequivocal diagnosis of idiopathic Parkinson's disease by a consultant neurologist. This diagnosis must be supported by all the following conditions:

1. The disease cannot be controlled with medication; and
2. There is objective signs of progressive deterioration; and
3. There is an inability of the life insured to perform (whether aided or unaided) at least 3 (three) of the following activities of Daily Living, for a continuous period of at least 6 (six) months:
 - a) Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
 - b) Dressing – the ability to put on, take off secure and fasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
 - c) Transferring – the ability to move from a bed to an upright chair or wheelchair and vice versa.
 - d) Toileting – the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
 - e) Feeding – the ability to feed oneself once food has been prepared and made available.

Drug induced or toxic causes of Parkinsonism are excluded.

Alzheimer's Disease:

Progressive and permanent deterioration of memory and intellectual capacity as evidenced by accepted standardised questionnaires and cerebral imaging. The diagnosis of Alzheimer's disease must be confirmed by an appropriate consultant and supported by FMI's appointed doctor. There must be significant reduction in mental and social functioning requiring the continuous supervision of the life insured.

There must also be an inability of the life insured to perform (whether aided or unaided) at least 3 (three) of the following 5 (five) Activities of Daily Living for a continuous period of at least 6 (six) months :

- a) Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
- b) Dressing – the ability to put on, take off secure and fasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

- c) Transferring – the ability to move from a bed to an upright chair or wheelchair and vice versa.
- d) Toileting – the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
- e) Feeding – the ability to feed oneself once food has been prepared and made available.

Psychiatric illnesses and alcohol related brain damage are excluded.

OTHER

Cancer:

A malignant tumour positively diagnosed with histological confirmation and 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 6 (six) or having progressed to at least clinical TNM classification T2N0M0.

All skin cancers, other than malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin).

Renal Failure:

Chronic and irreversible failure of both kidneys, requiring regular renal dialysis.

Major Organ Transplant:

Human to human organ transplantation from a donor to the Life insured of 1 (one) or more of the following organs: kidney, liver, heart, lung, pancreas or the transplantation of bone marrow. If no organ is available, and life insured has been classified as requiring a transplant, the benefit will also be payable.

Paraplegia:

Total and irreversible loss of use of 2 (two) or more limbs through paralysis as a result of injury or disease. The paralysis must be supported by appropriate neurological evidence. A specialist must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 (three) months. Paralysis due to self-harm, partial paralysis, temporary post-viral paralysis or paralysis due to psychological causes are all excluded.

Blindness:

Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident. The diagnosis must be clinically confirmed by an appropriate consultant. The blindness must not be correctable by aides or surgical procedures.

Deafness/Loss of Hearing:

Total, bilateral and irreversible loss of hearing for all sounds as a result of sickness or accident. Medical evidence to be supplied by an appropriate specialist and to include audiometric and sound-threshold testing. The deafness must not be correctable by aides or surgical procedures.

Severe Burns:

Third-degree burns with scarring that cover at least 20% of the body's surface area. A certified physician must confirm the diagnosis and the total area involved using standardised, clinically accepted, body surface area charts

6.2.2. When does the benefit end?

- We will pay out a maximum of two claims during the lifetime of your policy.

This means that:

We will pay out up to 2 claims if any of your dependent eligible children have a dread disease (as per the list) i.e. either the same child can have 2 claims or the one child can have a dread disease claim and thereafter a different child has a dread disease claim.

This benefit ends on the earliest of:

- Payment of the second claim on this benefit
- None of your children qualifying for this benefit anymore
- The Anniversary Date of the chosen termination date

6.2.3. Maximum amounts we will pay out

The maximum we will pay is R20,000 per dread disease claim.

The Child Dread Disease Benefit cover amount will remain constant throughout the existence of the benefit.

6.2.4. No cover for illness or injuries that existed before

You cannot claim in the first 12 months from the entry date for illnesses or injuries that existed in the 6 months before your child's entry date. If your child is injured or becomes ill in the first 6 months after their entry date, you may have to prove that the illness or injury did not exist in the 12 months before the entry date. We will only pay the benefit if we have enough proof that the illness or injury did not exist before.

7. TIP Dread Disease Enhancer

7.1. More about your TIP Dread Disease Enhancer

In the event of a TIP (Temporary Income Protector) claim being for a dread disease (see clause 6.2.1 above), this optional benefit will enhance the TIP payout by 20%.

7.2. Periods needed to qualify

The same rules apply as per your TIP benefit (see clause 3.2 above).

7.3. When does the benefit end?

This benefit ends when your TIP benefit ends (refer clause 3.3 above), but has a maximum payout period of the lesser of 6 months or the full TIP payout.

7.4. Amount of Payout

This benefit pays out 20% on top of whatever your TIP benefit pays out for a maximum period of the lesser of 6 months or the full TIP payout.

7.5. Cover Amounts

The minimum available TIP Dread Disease Enhancer is R200 and the maximum is R24 000.

7.6. Increasing your TIP Dread Disease Enhancer

This benefit increases and decreases automatically in line with the TIP benefit and remains at 20% of the TIP benefit.

8. Claiming

8.1. How to claim

Don't delay getting medical help

You must get medical advice right away and follow it. We do not pay out any amounts for claims that resulted from your failure to do this.

Inform the administrator within 30 days

- You must tell the administrator within 30 days of the event which you are going to claim for. If you are claiming for an elective surgery then you must tell the administrator at least 14 days before the date of surgery. Contact them on 086 010 1119.
- The administrator will fax you and, if necessary, your doctor, a claims form which details all the information it needs.
- You must send this information within 30 days.

You will also need to provide:

- Certain medical information. You are responsible for all costs of medical reports, except if we require a second opinion from the same type of medical practitioner you have already seen.
- A certified police report if the claim is a result of criminal activity
- Proof of your inability to work

You may also need to provide proof of income for the 12 months before the claim

This is not standard practice but we reserve the right to request the information.

8.2. During a claim

Give any extra proof we need

We may ask for proof that you are still unable to work. We pay the expenses for you to get this proof. If you do not give us this proof within three months of our request, the benefit ends.

If you are receiving 100% of the income protection benefit, you may need to provide us with proof that you have not returned to work. We may stop payouts until we have received this proof.

Medical conditions that are not properly treated

This benefit is intended to compensate you when you are getting medical advice and following it. We do not pay out anything or will stop paying if you do not get appropriate medical advice and follow any treatment, examination or rehabilitation programme that has been recommended to you.

Unlawful Activity

We do not cover deaths, injuries or illness if caused while you were involved in a crime.

Tell us in advance if you need to extend your claim

If you want to extend a claim, you must tell us within seven days after the end of the period you claimed for.

8.3. We do not accept fraud

If we suffer loss because you (or any person acting for you) lead us to believe any information which is identified to be false and we are negatively affected for relying on this information, we are entitled to:

- Not pay any further benefits
- End the policy
- Refuse any applications you make for another policy offered by us or administered by the administrator.

Fraud: The act of leading a person to believe something which you know to be false in a situation where you know the person will rely on it to their detriment.

We will not pay back any premiums and we may institute proceedings against you to recover any amounts we have paid to you.

9. About this policy

9.1. When this policy applies

From the date that the administrator receives the first premium

The policy applies from the date that the administrator receives the first premium.

You must be working

To claim, you must have been at work in your own occupation immediately prior to a claim on a benefit. This includes times when you are on normal leave.

You must be living in South Africa

You must be ordinarily resident in South Africa at the date of the injury or start of the illness. If you plan to leave South Africa you must tell the administrator, who will have the right to increase your premium or change the benefits. If you are out of South Africa for more than 180 days in a 24 month period, the policy ends on the 180th day of absence.

9.2. Give true and full information

You must give us complete and true information

Our decision to insure you is based on information you give to us, either direct or through an intermediary. If our decision was based on false or incomplete information, we have the right to:

- cancel this policy
- change the premiums and benefits to be appropriate to the true and complete information
- choose not to pay a claim.

This is because, if we had known the true and full information, we may not have agreed to assure you for the amount set out in the schedule and on the terms we have given.

If there is a dispute about material information the decision of our actuary will be final.

Definition of material information: information that affects our decision to offer you assurance according to the terms of this policy

Information you need to give (even if we do not ask for it)

You must tell us within 30 days about any changes to:

- Your occupation and / or duties of the occupation.
- How much you work, for example, changing from full-time to part-time or retiring
- Where you live (whether in South Africa or not)
- Any other information that is material (for example, other details found on your schedule).

Once we have this information, we will tell you if your premium will go up or down.

When changing the smoking status, the insured life must have stopped smoking for at least 12 consecutive months.

The insured life must notify the administrator of this change in writing and the underwriters will then request a serum cotinine test by a pathologist before any changes may be made to the policy.

The insured life will have to pay for the cost of this test.

You must check all information on the schedule

If anything on the schedule is incorrect (for example your age or date of birth) you must tell us immediately.

9.3. Paying

What you must pay

You must pay the premium set out in the schedule each month on the date that you have selected as your premium deduction date on the application form.

Overdue payments

If a premium is not paid on time, we allow a 60-day grace period for you to pay it. If you still do not pay the premium the policy is cancelled on the last day of the grace period. We do however accept premiums paid later, if we did not get the premium because of an error made by the administrator.

We can ask for proof of payment

We have the right to ask for proof of payment at any time. We decide on the form of the proof of payment that we need.

9.4. Changing the policy

If you want to change the policy

To change your benefits or increase your sums insured, you must apply in writing or by telephone or email. Here are the details:

FMI
PO Box 223
Mount Edgecombe
4300
Tel: 086 010 1119
Fax: (031) 5025250
e-mail: fmiclientcare@fmi.co.za

We may need extra information (for example, medical reports) before we can agree to the changes you ask for. We will tell you if this is the case. If we agree to the changes, they come into force on the first day of the month after we agreed to them.

9.5. Ending the policy

How to cancel

You may cancel this policy by giving us written notification.

The policy ends if any of the terms of this policy are not met, or on the earlier of:

- The Anniversary Date following your chosen termination age
- The end date of all benefits attached to the policy. Once a Permanent Income Protector Benefit claim is admitted under this policy, no payouts will be made under the Temporary Income Protector Benefit or the Business Overhead Protector Benefit.

Reinstating the policy after it has been cancelled

If the policy is cancelled, we can reinstate it. However, the terms and conditions may be different to those of the cancelled policy.

No payouts after end dates

We never pay out:

- after the end date given on the application or the schedule, or
- for a period longer than the period of insurance given on the application form or the schedule.

9.6. Exclusions

These exclusions apply to the policy

Illnesses or injuries you caused deliberately

We do not cover injuries or illnesses that are self-inflicted or that you deliberately cause.

War-like or nuclear activities

We do not cover deaths, injuries or illnesses that result from:

- war-like activities, including any war, invasion, terrorism, riots, civil commotions, seizing of power or military rule
- atomic energy, nuclear fission or reaction.

Dangerous pursuits including but not limited to extreme sports

We will not cover deaths, injuries or illnesses resulting from taking part in any dangerous pursuit, including extreme sports, for example, mountaineering, speed competitions or fighting (except in self-defence), or from taking part in any form of aviation other than as a passenger travelling between airfields in a licensed aircraft.

9.7. General conditions

Documents making up the agreement between you and us

This policy, the application, the schedule and any endorsements make up the agreement between you and us. We are not bound by any changes to the agreement unless we agree to them in writing.

The terms of this agreement always apply

If, on any occasion, we allow you to do things differently from the terms of this agreement, it does not mean that we will allow you to do things differently again. The terms of this agreement will apply at all times.

Currency

All premiums and benefits must be paid in South African currency.

Law

South African law governs this policy.