General Terms and Conditions

These are the General Terms and Conditions that relate to your Policy. They set out what you are required do to, what we are required to do and all other legalities.

What you need to do

Check Information and Declarations made are correct

We assess a life insured's risk based on the information supplied and declarations made by you and other parties when you apply for cover. We need to be able to trust that the information provided and that all declarations made are honest and complete.

Omitting to disclose information asked for, or providing false information at any time, either by accident or on purpose is misrepresentation which could lead to your Policy being cancelled.

In the worst-case scenario, you could lose all your Benefits as well as the Premiums you've paid, so please make sure that you check all the information in this Policy document as well as your original Application and notify us of any omissions or inaccurate information you find.

If at any time we find misrepresentation, whether intentional or otherwise, we will reassess your application on the complete and correct facts and if we would have come to a different decision had we known the complete and correct information we will either :

- cancel your Policy, decline your claim and retain all, or a proportion of your premiums, or
- at our discretion, we may offer you revised terms and a revised benefit amount

If we reassess your application for a benefit you are claiming, you will be charged a misrepresentation penalty of 10% of the revised benefit amount to be deducted from any payments that may be due to you. If we discover misrepresentation that is relevant to a claim we have already paid, we can request that you return the money paid to you.

If the incorrect or incomplete information would not have affected the decision we made when we originally assessed your application, it will not affect the terms or benefits of your policy or our assessment of your claim.

We will also not make any payment of any benefit amount, or any other amount due to any party, if any fraudulent documentation or information is provided at application or claim stage.

Keep us informed

It is your responsibility to make sure that we have up to date information on record at all times. Please advise us if any of the following details change:

- Contact details of the Policyholders, Life Insureds, and Beneficiaries;
- Bank account details from which Premiums are paid;
- Any changes to the Beneficiaries; and
- Any specific notifiable changes set out in the Benefit Specific Terms and Conditions.

Update your Beneficiary

Your Policy schedule sets out the details of the Beneficiaries you have nominated. You are free to change your beneficiaries at any time. You must notify us in writing to change a beneficiary and we will issue a revised Policy schedule. Your change in beneficiaries will only be effective after we have issued a revised Policy schedule.

The beneficiaries shall have no interests or rights in the Policy during the lifetime of the Policyholder.

If you have ceded your Policy to a Cessionary any Benefit Amount payable will first be paid out to the Cessionary, to fulfil the terms of your agreement with the Cessionary. Any remaining Benefit Amount not due the Cessionary will be paid to you or, if you are deceased, to your nominated Beneficiaries.

Pay your Premiums on time

Your first premium falls due on the day your Policy commences, and thereafter on the 1st day of each following month, in other words, in advance.

You are required to pay your first premium on or before the first debit order date you selected on your application form. If after the first debit order date we have not received the first premium due, we will suspend cover from your first debit order date until you pay the outstanding premium.

If premiums other than the first premium are not paid by the due date, then:

- We will give you 30 days grace, from the due date, to make the outstanding premium payment. If you choose a debit order date other than the 1st of the month, then you accept you are using the grace period to pay your premiums.
- If you don't pay your premium within the 30 day grace period, your cover will cease and you will not be covered for any of the benefits on your Policy. This means, if there is a claim after the grace period, we will not pay the claim.
- If your unpaid premiums are more than the equivalent of two monthly premiums, your Policy will lapse and your Benefits will cease. The lapse date is calculated as the last day of the month for which the last premium was paid in full.
- If your policy lapses you can, within 12 months from the date the Policy Lapsed, request that your Policy be reinstated to provide the benefits that was provided prior to the lapse. Once we receive your request we may agree to this reinstatement, subject to the terms and conditions that we set at that time.

At each policy anniversary your premiums will be adjusted as set out in your Policy schedule.

Keep your Policy document in a safe place

It is a good idea to tell your Beneficiaries, or someone else you trust, where to find your Policy document.

What we will do

Free cover

The free cover will start from the date we originally issued your Policy, as set out in your welcome letter, until the date your Policy commences, subject to a maximum of 30 days. If this period is longer than 30 days, the free cover will start 30 days prior to the date your policy commences. During this period you will be covered for the benefits on your Policy, but you won't have to pay any premiums.

If you choose to change the date your Policy commences on your application form no free cover will apply.

Adjust your Premium from time to time

Level Premium

You have chosen a "level" Premium pattern. This means your Premium will not increase as long as you keep the same level of cover. However, after the Guarantee Period, as set out in your Policy schedule, we may review the Premiums and the Terms and Conditions of the Benefit. If this results in any change to your Premium, you will be notified in writing.

Voluntary Increases

Your Policy schedule sets out the level of voluntary escalation you have selected. At each Policy anniversary your Premium will be increased by the amount needed to pay for the increased benefit. This is calculated using the rating information and premium rates applicable at the time the voluntary increase is applied.

The voluntary increase is not compulsory and, at each Policy anniversary, you have the option to cancel that voluntary increase. If you cancel the voluntary increase for three years in a row, the option will be cancelled and there will be no further automatic increase to the Benefit amount.

You may send us a request in writing to add a voluntary increase to your Policy if the voluntary increase was cancelled, or if it was not included in your original application. We will review your request in line with the Terms and Conditions at that time of your request.

Pay your claims

We will pay your claim as described in the benefit terms, if we are satisfied that all the following conditions are met:

- The Premiums have been paid up to date;
- The claim is valid in terms of the Benefit conditions;
- The person making the claim is entitled to receive the Benefit amount or a share of it; and
- All the information provided to us, including supporting documents is complete and true.

Pay interest on a claim payment

A benefit amount payable will start to earn interest 60 days after we decided your claim is valid until it is paid. Interest will be earned at the daily rate earned on the 90 day Treasury bill, issued by the Namibian Government.

Get in touch about an unclaimed Benefit

If we become aware, through a source other than a Beneficiary, that a Life Insured has died, we will:

- Contact the Beneficiary or Cessionary to let them know claim payment is due to them; and
- If we are unable to contact the Beneficiary or Cessionary, we will:
  - Use an external database and/or tracing company to try contact them;
  - Repeat this process three years later, on the anniversary of the date the claim decision was reached;
  - Repeat this process again, ten years later.
- If we are still unable to contact them or, if the Benefit amount is less than N$1 000 or the cost of tracing exceeds the claim value, then we will make no further attempt to do so.

Any associated costs, administrative, tracing and management fees will be deducted from the claim payment.

Review the Terms and Conditions of your Policy

The terms and conditions of your Policy are guaranteed for the period specified in your Policy schedule. This guarantee applies for each benefit from the date the benefit commenced.

Once the guarantee term has expired we may review the terms and conditions for a benefit, including the premium charged for the benefit. This review will be carried out on all policies that have the benefit being

reviewed. In the review we will look at various factors, for example, our expected future experience of claims, expenses, lapses and investment returns for the benefit being reviewed. If we decide to change the terms and conditions of the benefit or premium, the change will apply to all policies within the portfolio with the benefit that is being reviewed, where the guarantee period has expired.

Any increase or decrease in the benefit premium, following a review, will not be greater than 15%. We will inform you in writing of the increase in premium. You may decline to accept the increase in premium, in which case we will reduce your benefit amount accordingly so that your benefit premium remains that same prior to the review.

Other Legal Requirements

Law
Your Policy is subject to the laws of the Republic of Namibia and, if there are any changes to the law that impact this Policy, we will review them and may have to change the Terms and Conditions.

Good Faith
We will act in good faith in our dealings with our Policyholders and Life Insureds. If we inadvertently make an administrative error, it will not affect the cover to which your Policy entitles you to.

Cession
A cession allows you to give up some, or all, of your rights to the Benefits of your Policy to another party (a Cessionary) by means of a formal agreement. You may opt either:

- An outright cession, in which you transfer all your rights from the Policy to the Cessionary. The full Benefit amount due on any valid claim is payable to the Cessionary; or
- A collateral or security cession, in which the Cessionary's claim on the Benefit amount will be limited to the extent of your agreement with the Cessionary on the date of the claim event.

If you have ceded your Policy to a Cessionary, you are required to notify us in writing immediately, so the Policy Parties and Policy Schedule documents can be amended accordingly. We will accept no liability if a Benefit amount is paid to the Beneficiaries, as per the Policy Schedule, if we did not receive the formal notification in writing of the Cession.

We will require written consent from the Cessionary to amend the Policy if it has been ceded, including cancelling the cession.

Currency
Any premium payments you make to us, and benefit amounts we pay to you, shall be made in the currency of the Republic of Namibia. All claims will be paid into Namibian bank accounts.

Complaints
We work very hard to keep our Policyholders happy but if you, or any other party to the Policy (listed in the Policy Parties schedule) is dissatisfied with a decision we have made or any aspect of our service, please let us know. There is always a better way to do things and you will be helping us, as well as yourself, if you outline your complaint in an email and send it to either:

- our customer services team;
- our complaints department; or
- our compliance officer.

In the unlikely event that you are unhappy with our response, your next step is to submit your complaint to the Namibian Financial Institutions Supervisory Authority (NAMFISA):

We have set out the required contact details of all the above parties in the Contact Details page.

Once our claim department has assessed the claim request, they send out a letter to confirm their decision (a claim letter). You, a beneficiary or an executor has 90 days from the date of the claim letter to send a written request/complaint for us to reconsider the claim decision. If we have not received the complaint within 90 days of the date of the claim letter, we are not obliged to reconsider the claim decision.

If a complainant elects to take legal action, a summons must be served within 270 days of the date of the claim letter.

Privacy

We respect the confidentiality of the Policyholder(s) and Life Insured(s) personal information. It is however essential for insurance companies to share claims and underwriting information with outside parties for the fair assessment and underwriting of risks, and to reduce the number of fraudulent claims. We may communicate your personal information relating to assessment of claims, medical information and insurance history to other insurance companies, and to our service providers who assist us in managing your cover and our relationship with you. This will always be done as permitted by the relevant privacy legislation.

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If you choose to change the date your Policy commences on your application form no free cover will apply.

Adjust your Premium from time to time

Age Rated Premium Pattern

You have chosen an "age- rated" premium pattern. This means that your Premium will automatically increase, at each Policy anniversary, by a pre-defined rate based on your age, without an increase in the Benefit. The rates of increase are set out in the table below:

Age-rated Increase Percentages	
Age Band (defined as Life Insured's Age next birthday on the Policy anniversary)	**Increase Percentages**
0 to 34	2.5%
35 to 44	5.0%
45 to 54	7.5%
Over 55	8.25%

Voluntary Increases

Your Policy schedule sets out the level of voluntary escalation you have selected. At each Policy anniversary your Premium will be increased by the amount needed to pay for the increased benefit. This is calculated using the rating information and premium rates applicable at the time the voluntary increase is applied.

The voluntary increase is not compulsory and, at each Policy anniversary, you have the option to cancel that voluntary increase. If you cancel the voluntary increase for three years in a row, the option will be cancelled and there will be no further automatic increase to the Benefit amount.

You may send us a request in writing to add a voluntary increase to your Policy if the voluntary increase was cancelled, or if it was not included in your original application. We will review your request in line with the Terms and Conditions at that time of your request.

Pay your claims

We will pay your claim as described in the benefit terms, if we are satisfied that all the following conditions are met:

- The Premiums have been paid up to date;
- The claim is valid in terms of the Benefit conditions;
- The person making the claim is entitled to receive the Benefit amount or a share of it; and
- All the information provided to us, including supporting documents is complete and true.

Pay interest on a claim payment

A benefit amount payable will start to earn interest 60 days after we decided your claim is valid until it is paid. Interest will be earned at the daily rate earned on the 90 day Treasury bill, issued by the Namibian Government.

Get in touch about an unclaimed Benefit

If we become aware, through a source other than a Beneficiary, that a Life Insured has died, we will:

- Contact the Beneficiary or Cessionary to let them know claim payment is due to them; and
- If we are unable to contact the Beneficiary or Cessionary, we will:
  - Use an external database and/or tracing company to try contact them;
  - Repeat this process three years later, on the anniversary of the date the claim decision was reached;
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Review the Terms and Conditions of your Policy

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Once the guarantee term has expired we may review the terms and conditions for a benefit, including the premium charged for the benefit. This review will be carried out on all policies that have the benefit being reviewed. In the review we will look at various factors, for example, our expected future experience of claims, expenses, lapses and investment returns for the benefit being reviewed. If we decide to change the terms and conditions of the benefit or premium, the change will apply to all policies within the portfolio with the benefit that is being reviewed, where the guarantee period has expired.

Any increase or decrease in the benefit premium, following a review, will not be greater than 15%. We will inform you in writing of the increase in premium. You may decline to accept the increase in premium, in which case we will reduce your benefit amount accordingly so that your benefit premium remains that same prior to the review.

Other Legal Requirements

Law

Your Policy is subject to the laws of the Republic of Namibia and, if there are any changes to the law that impact this Policy, we will review them and may have to change the Terms and Conditions.

Good Faith

We will act in good faith in our dealings with our Policyholders and Life Insureds. If we inadvertently make an administrative error, it will not affect the cover to which your Policy entitles you to.

Cession

A cession allows you to give up some, or all, of your rights to the Benefits of your Policy to another party (a Cessionary) by means of a formal agreement. You may opt either:

- An outright cession, in which you transfer all your rights from the Policy to the Cessionary. The full Benefit amount due on any valid claim is payable to the Cessionary; or
- A collateral or security cession, in which the Cessionary's claim on the Benefit amount will be limited to the extent of your agreement with the Cessionary on the date of the claim event.

If you have ceded your Policy to a Cessionary, you are required to notify us in writing immediately, so the Policy Parties and Policy Schedule documents can be amended accordingly. We will accept no liability if a Benefit amount is paid to the Beneficiaries, as per the Policy Schedule, if we did not receive the formal notification in writing of the Cession.

We will require written consent from the Cessionary to amend the Policy if it has been ceded, including cancelling the cession.

Currency

Any premium payments you make to us, and benefit amounts we pay to you, shall be made in the currency of the Republic of Namibia. All claims will be paid into Namibian bank accounts.

Complaints

We work very hard to keep our Policyholders happy but if you, or any other party to the Policy (listed in the Policy Parties schedule) is dissatisfied with a decision we have made or any aspect of our service, please let us know. There is always a better way to do things and you will be helping us, as well as yourself, if you outline your complaint in an email and send it to either:

- our customer services team;
- our complaints department; or
- our compliance officer.

In the unlikely event that you are unhappy with our response, your next step is to submit your complaint to the Namibian Financial Institutions Supervisory Authority (NAMFISA):

We have set out the required contact details of all the above parties in the Contact Details page.

Once our claim department has assessed the claim request, they send out a letter to confirm their decision (a claim letter). You, a beneficiary or an executor has 90 days from the date of the claim letter to send a written request/complaint for us to reconsider the claim decision. If we have not received the complaint within 90 days of the date of the claim letter, we are not obliged to reconsider the claim decision.

If a complainant elects to take legal action, a summons must be served within 270 days of the date of the claim letter.

Privacy

We respect the confidentiality of the Policyholder(s) and Life Insured(s) personal information. It is however essential for insurance companies to share claims and underwriting information with outside parties for the fair assessment and underwriting of risks, and to reduce the number of fraudulent claims. We may communicate your personal information relating to assessment of claims, medical information and insurance history to other insurance companies, and to our service providers who assist us in managing your cover and our relationship with you. This will always be done as permitted by the relevant privacy legislation.

Benefit Specific Terms and Conditions:
Life Cover

How does Life Cover work?
The Life Cover Benefit will become payable if the Life Insured dies while the Life Cover Benefit is inforce.

The Benefit amount payable is set out on your Policy Schedule, at the date of the claim event, and will include any voluntary increases you have selected and any benefit endorsements accepted and confirmed in writing by us.

Terminal Illness Benefit
The Terminal Illness benefit allows you to claim the Life Cover benefit if the Life Insured suffers a terminal illness which, in our opinion, results in the Life Insured likely to have less than 12 months to live. The Benefit will end once the Terminal Illness Benefit has been claimed.

Payment of the Benefit
On receipt of a valid claim the Benefit amount will be paid to one or more of the nominated beneficiaries, subject to any cession. In the absence of a nominated beneficiary and where the Life Insured is the Policyholder, the benefit amount will be paid to the deceased Life Insured's estate.

The payment of a funeral claim does not automatically result in a valid Life cover claim. The validity of the Life Cover claim will be assessed independently.

We will not make any claim payment if any fraudulent documentation or information is provided.

When does the Life Cover benefit end (no longer inforce)?
The Life Cover benefit will end when the first of the following happens:

- The Life Cover benefit term, as specified in your Policy schedule, expires;
- You cancel the Life Cover benefit;
- Your Policy lapses. The Life cover Benefit will cease on the last day of the month for which you last paid your premiums in full;
- Terminal Illness Benefit is paid out; or
- On the death of the Life Insured.

Suicide Exclusion Period
The Life Cover benefit will end and no benefit amount will be payable if the Life Insured dies as a result of their own deliberate actions and in our opinion committed suicide within two years of the Policy commencing or being reinstated. This is known as the suicide exclusion. We will not make any payment if the illness or incident that gives rise to a claim event was directly or indirectly caused by, brought about by, accelerated by or aggravated by self-inflicted injuries or if the life assured takes any substance / medication to induce a condition

If there was an endorsement on the Policy to increase the benefit amount, the two year suicide exclusion will apply to the increased portion of the benefit amount from the date the endorsement is accepted by us.

In determining the two year suicide exclusion period we will give recognition of prior insurance when a previous life cover benefit is replaced with a new Hollard Life policy and if all of the following conditions are met:

- the policy that was replaced, was issued by a Namibian registered insurer;
- the Life Insured and Policyholder are the same under this Policy and the one being replaced;
- the Life Insured had uninterrupted Life Cover under both the policy that was replaced and this Policy.

When applying the recognition of prior insurance clause, the Benefit Amount will be limited to the amount of the

previous life cover if it is lower than the Life cover from this Policy.

Benefit Specific Terms and Conditions:
Family Funeral

How does Family Funeral Benefit work?

The Family Funeral benefit is part of the Life Cover benefit. On the death of the Life Insured, the spouse insured or child insured, as set out in the Policy Schedule, the following benefit amounts will be payable:

- Life Insured: N$40 000;
- Spouse Insured: N$20 000, subject to a maximum of N$40 000 from all funeral benefits on all Hollard Life policies;
- Child Insured: N$10 000. The maximum we will pay in respect of all funeral benefits on Hollard Life policies on the death of a child is the lower of N$20 000 and the maximum specified in applicable legislation

If a family funeral benefit claim is made for two or more of the lives insured at the same time, and their deaths are a direct or as an indirect consequence of the same event, the total maximum claim amount payable will be N$70 000.

This Benefit covers a maximum of one spouse and four children at any one time. The benefit in respect of the death of a spouse or child may not be ceded.

Who can be covered as the Spouse Insured?

A person who meets the definition of a spouse at the date of death, may be covered by the Family Funeral Benefit. The spouse is defined as a person who is the permanent life partner* of the Policyholder (whether in a heterosexual or homosexual partnership) or spouse by marriage, civil union, customary law, or the tenants of any Asiatic religion

* To qualify as a permanent life partner, in terms of this Policy, the Life Insured and life partner must have lived together for at least 12 months before the death of the Life Insured.

Who can be covered as the Child insured?

A person who meets the definition of a child at the date of death, may be covered by the Family Funeral Benefit. A Child means an unmarried, financially dependent *child* of the *main insured person* or *spouse* and will include a biological child, a posthumous *child*, a grandchild, a step*child*, a legally fostered *child* and an adopted *child*

When does the Family Funeral benefit end?

The Family Funeral benefit will end when the first of the following happens:

- The Life Cover benefit term, as specified in your Policy schedule, expires;
- You cancel the Life Cover benefit;
- Your Policy lapses. The Life cover Benefit will then cease on the last day of the month for which you last paid your premiums in full;
- Terminal Illness Benefit is paid out; or
- The Life Insured dies.

When does the Spouse's Cover end?

The benefit for the Spouse will end when the first of these happens:

- Family Funeral benefit ends; or
- On the Spouse's 65th birthday.

When does the Child Cover end?

The benefit for the Child will end when the first of these happens:

- Family Funeral benefit ends;
- the Child's 25th birthday, provided the Child is a full-time student at a recognised educational institution or permanently and totally disabled; or
- the Child's 21st birthday.

Payment of the Benefit

On receipt of a valid claim the benefit amount payable on the death of the Life Insured will be paid to one or more of the nominated beneficiaries, subject to any cession. In the absence of a nominated beneficiary and where the Life Insured is the Policyholder, the benefit amount will be paid to the deceased Life Insured's estate.

On receipt of a valid claim the benefit amount payable on the death of a Spouse or Child will be paid to one or more of the nominated beneficiaries.

Effect of a Claim on the Life Cover Benefit

On the death of the Life insured, the Life Cover benefit amount is not reduced by the Funeral benefit that is paid. This means the Funeral Benefit for the Life Insured is not an acceleration of the Life Cover Benefit.

On the death of the Spouse or a Child the Life Cover benefit amount remains unchanged. The Funeral benefit for the Spouse and a Child is paid out as an additional amount.

Instances when Family Funeral benefit is not payable:

The Family Funeral benefit will not be paid in any of the following circumstances:

- The death of the Life insured would not be a valid claim under the Life Cover Benefit;
- The death of a child occurs in the first month after birth;
- The Policyholder and Life Insured are not the same person, unless the Policyholder is the spouse or child of the Life Insured;
- during the first 12 months following the date of nomination of the Spouse or Child, unless the death of the nominated Spouse or Child is as a result of accident*;
- Death of the Life insured in the suicide exclusion period (as detailed in the Life Cover benefit); or
- A claim being notified more than six months after the date of death.
- If any fraudulent documentation or information is provided

*An accident means a specific identifiable event that is unplanned and unexpected by the Life Insured and is external and violent in nature and directly and solely causes grievous bodily harm independently of all other causes.

Benefit Specific Terms and Conditions: Comprehensive Disability

How does Comprehensive Disability Benefit work?

The Comprehensive Disability Benefit will become payable if the Life Insured suffers an Occupational Disability or an Impairment claim event while the Policy is inforce.

What is the Benefit Amount?

The Benefit amount payable is set out on your Policy Schedule, at the date of the claim event, and will include any voluntary increases you have selected and any benefit endorsements accepted and confirmed in writing by us.

The Benefit amount set out in your Policy Schedule, together with voluntary increases is the maximum that can be paid out under this benefit. Where a partial payment is made, the Benefit amount will be reduced by the amount paid. The remaining Benefit amount will be available for future claims. Once 100% of the Benefit amount has been paid the benefit will cease.

At the policy anniversary after the Life Insured's 65th birthday, the Benefit amount for an Occupational Disability, and certain Impairment claims, will be reduced to the percentage specified below:

Policy Anniversary after	Percentage of Benefit Amount
65th birthday	80%
66th birthday	60%
67th birthday	40%
68th birthday	20%
69th birthday	0%

Where "**" (asterisks) appear next to the definition of Impairment claim events means that reduced benefit amount will apply.

General Conditions

You are required to notify us, in writing, of a claim within six months after the date of disability or impairment. Until the claim is admitted by us, you will be required to continue paying the premiums in respect of the Comprehensive Disability benefit.

The benefit will only be payable once Hollard Life is satisfied that the Life Insured is permanently disabled or impaired, and that life insured has followed all medical advice and treatment as recommended by their own medical practitioner or Hollard Life's Chief Medical Officer.

We will make only one claim payment if a claim for two or more claims events are made at the same time. In such a case, the highest claim payment for the relevant claim events will be made.

Claim Events

The table below sets out the claim events covered under this Policy and the percentage of the Benefit Amount payable for the claim event.

Occupational disability The benefit will only be payable on confirmed diagnosis and once Hollard Life is satisfied that the Life Insured is permanently disabled and the disability is total and irreversible - that is not correctable by treatment or operation.	
Claim Event	**Definition of Claim Event**
Occupational disability	Total and irreversible (not correctable by treatment or operation) inability of the Life Insured, due to a sickness, injury, disease, illness or a surgical operation, to perform their occupation, provided the Life insured had been gainfully employed for a period of not less than six months before the onset of the disability.
	Benefit: 100% of Benefit Amount**

Impairment Claim Events The impairment benefit will only be payable on confirmed diagnosis to the satisfaction of Hollard Life	
Claim Event	**Definition of Claim Event**
Loss of one limb	Total and irreversible (not correctable by treatment or operation) loss or loss of use of a limb, where a limb is defined as an arm including the elbow or a leg including the knee.
	Benefit: 50% of Benefit Amount
Loss of two more limbs	Total and irreversible (not correctable by treatment or operation) loss or loss of use of any two limbs, where a limb is defined as an arm including the elbow or a leg including the knee.
	Benefit: 100% of Benefit Amount
Loss of one foot, or one hand	Total and irreversible (not correctable by treatment or operation) loss or loss of use of a foot or a hand, where a foot is defined as the extremity of the leg below the ankle and a hand the extremity of the arm beyond the wrist. Radiological evidence of irreversible joint destruction must be provided.
	Benefit: 50% of Benefit Amount
Loss of both hands, or both feet, or one hand and one foot	Total and irreversible (not correctable by treatment or operation) loss or loss of use of both hands, both feet or one hand and one foot. Radiological evidence of irreversible joint destruction must be provided.
	Benefit: 100% of Benefit Amount
Loss of dominant hand	Loss or Loss of use of dominant hand.
	Benefit: 100% of Benefit Amount
Loss of Fingers	Loss or Loss of use of more than three fingers on the dominant hand (must include the thumb or index finger).
	Benefit: 50% of Benefit Amount

Impairment of upper limbs	• 60% impairment of dominant upper limb as measured using the AMA guidelines*; or • 90% impairment of non-dominant upper limb as measured using the AMA guidelines*
	Benefit: 50% of Benefit Amount
	• 80% impairment of dominant upper limb as measured using the AMA guidelines*
	Benefit: 100% of Benefit Amount
	*American Medical Association's "Guidelines to the Evaluation of Permanent impairment"
Loss of sight in one eye	Total and irreversible (not correctable by treatment or operation) loss of sight in one eye. Permanent visual acuity impairment (not correctable by operation) resulting in a Snellen rating of less than 20/200 or worse. The blindness must be certified through an Ophthalmologist's report and cataracts are specifically excluded.
	Benefit: 50% of Benefit Amount
Loss of sight in both eyes	Total and irreversible (not correctable by treatment or operation) loss of sight in both eyes. Permanent visual acuity impairment (not correctable by operation) resulting in a Snellen rating of less than 20/200 or worse bilaterally. The blindness must be certified through an Ophthalmologist's report and cataracts are specifically excluded.
	Benefit: 100% of Benefit Amount
Loss of hearing	Greater than 75% total and irreversible (not correctable by treatment or operation) binaural hearing loss.
	Benefit: 50% of Benefit Amount
	Total and irreversible (not correctable by treatment or operation) loss of hearing in both ears as a result of chronic sickness or an accident. Total loss of hearing means the average hearing levels, tested with hearing aids when applicable, at audible frequencies, is more than 90 decibels. Medical evidence in the form of audiometric and sound-threshold tests must be provided.
	Benefit: 100% of Benefit Amount
Loss of speech or Aphasia	Inability to perform the Communication daily activity.
	Benefit: 50% of Benefit Amount
	Total aphasia, or the total and irreversible (not correctable by treatment or operation) inability to speak.
	Benefit: 100% of Benefit Amount

Spine	Radiculopathy and significant extremity impairment as indicated by 3 or more of the following: • Atrophy; • Loss of reflexes; • Numbness on an anatomical basis; • Loss of spine motion integrity as documented by neurological or motor compromise (AMA guidelines*); • Inability to perform two daily activities.
	Benefit: 50% of Benefit Amount
	Radiculopathy and significant extremity impairment as indicated by 3 or more of the following: • Cauda equina syndrome; • Loss of bowel or bladder integrity resulting in incontinence as confirmed by specialist assessment; • Paraplegia, quadriplegia; • Inability to perform three or more daily activities.
	Benefit: 100% of Benefit Amount
Hemiplegia	Persistent disabling hemiplegia or monoplegia resulting in the inability to perform two Daily Activities.
	Benefit: 50% of Benefit Amount
	Persistent disabling hemiplegia resulting in the inability to perform three Daily Activities.
	Benefit: 100% of Benefit Amount
Traumatic head injury	A traumatic injury to the brain caused by an external physical force, with a Glasgow Coma Scale score of less than or equal to 8 on admission and persisting for more than 96 hours. This must result in significant and irreversible (not correctable by treatment or operation) impairment of cognitive abilities and/or physical functioning.
	Benefit: 50% of benefit amount The diagnosis must be confirmed by a Neurosurgeon or Specialist Neurologist
	A traumatic injury to the brain, caused by an external physical force, resulting in total and irreversible (not correctable by treatment or operation) impairment of cognitive abilities and/or physical functioning and resulting in a need for continual care or supervision in a recognised institution.
	Benefit: 100% of benefit amount The diagnosis must be confirmed by a Neurosurgeon or Specialist Neurologist.
Permanent mental or Cognitive Impairment	Irreversible cognitive deterioration, or loss of cognitive capacity which results from an identifiable organic cause and is evidenced by MMSE (Mini Mental Test) scores of less than 18 in tests conducted at least two months apart.
	Benefit: 100% of Benefit Amount
Impairment of Consciousness and Awareness or Coma	Irreversible unconsciousness/coma of an organic nature and not amenable to therapy.
	Benefit: 100% of benefit amount**

Cranial nerve impairments	• Total and irreversible (not correctable by treatment or operation) nerve damage with equilibrium and or hearing impairment resulting in the inability to perform three or more daily activities; or • Total and irreversible (not correctable by treatment or operation) paralysis with severe inability to swallow requiring regular assistance and suctioning
	Benefit: 100% of benefit amount**
Mental and behavioural disorders	• The inability to perform two daily activities; or • Institutionalization for a period longer than six months
	Benefit: 50% of benefit amount**
	• The inability to perform three or more daily activities; or • Permanent institutionalization; or • Permanent GAF (Global Assessment of Functioning Scale) score of less than 40.
	Benefit: 100% of benefit amount**
Ischaemic heart disease or myocardial infarction or coronary artery disease or cardiac arrhythmias or valvular heart disease or congenital heart disease or cardiomyopathy	• At least one sign or symptom of congestive heart failure persisting for six months and refractory to treatment; or • NYHA Classification II or III, with ejection fraction less than 45% or METS less than 3. **Benefit: 50% of benefit amount****
	• At least two signs or symptoms of congestive heart failure persisting for six months and refractory to treatment; or • NYHA Classification III or IV, with ejection fraction less than 30% or METS less than 2; or • Awaiting cardiac transplantation.
	Benefit: 100% of benefit amount**
	Signs of congestive heart failure: ○ 3+ pedal oedema; ○ Paroxysmal nocturnal dyspnoea; ○ Rales in the lung/lungs; ○ Presence of S3.
Peripheral artery or Venous disease	• Total and irreversible (not correctable by treatment or operation) abnormal, diminished pulse on Doppler readings, cold leg, dependent rubor and pain on exercise; or • Severe and deep widespread vascular ulceration.
	Benefit: 50% of benefit amount**
	• Severe vascular ulceration; or • Gangrene or amputation; or • Persistent ischaemia with no detectable pulse on Doppler.
	Benefit: 100% of benefit amount**
Pericardial Heart Disease	At least one sign or symptom of congestive heart failure persisting for six months and refractory to treatment (including surgery) with significant pericardial thickening/calcification.
	Benefit: 50% of benefit amount**

	At least two signs or symptoms of congestive heart failure persisting for six months and refractory to treatment (including surgery) with signs of congestion of lungs or other organs.
	Benefit: 100% of benefit amount**
	Signs of congestive heart failure: ○ 3+ pedal oedema; ○ Paroxysmal nocturnal dyspnoea; ○ Rales in the lung/lungs; ○ Presence of S3.
Hypertension	Diastolic pressure higher than 100 mm/Hg on optimal treatment and complicated by at least one of the following: • Renal dysfunction (BU>12mmol/l, SCR>200mmol/l); • CVA; • Grade III retinopathy; • Congestive heart failure (at least one symptom).
	Benefit: 50% of benefit amount**
	Diastolic pressure higher than 105 mm/Hg on optimal treatment and complicated by at least two of the following: • Renal dysfunction (BU>15mmol/l, SCR>200mmol/l); • CVA; • LVH (Septal wall thickness to posterior LV wall thickness 1:1.3) on echocardiogram; • Grade IV retinopathy; • Congestive heart failure (at least two symptoms).
	Benefit: 100% of benefit amount**
Respiratory system	• FEV1 40% - 49% of expected value; or • FVC 40% - 49% of expected value; or • DLCO 40% - 49% of expected value.
	Benefit: 50% of benefit amount**
	• FEV1 less than 40% of expected value; or • FVC less than 40% of expected value; or • DLCO less than 40% of expected value; or • Requiring the constant use of oxygen; or • Where there is no capacity for spontaneous respiration.
	Benefit: 100% of benefit amount**
	The above respiratory system events must be total and irreversible (not correctable by treatment or operation) and must be confirmed by two tests at least one month apart.
Diseases involving the upper and lower digestive tract	• Anatomical loss and alteration in gastrointestinal tract with medical evidence of organic disease and more than 15% weight loss below desirable weight with minimal response to medical therapy; or • Ongoing nutritional deficiency with BMI less than 16 despite optimal treatment; or • Partial faecal incontinence; or • Irreparable hernia with ongoing bowel dysfunction.

	Benefit: 50% of benefit amount**
	• Anatomical loss and alteration in gastrointestinal tract with medical evidence of organic disease and more than 25% weight loss below desirable weight with no response to medical therapy; or • Ongoing nutritional deficiency with BMI less than 14 despite optimal treatment; or • Complete faecal incontinence; or • Total and irreversible (not correctable by treatment or operation) stoma (such as colostomy or ileostomy).
	Benefit: 100% of benefit amount**
Liver and biliary disease	Progressive chronic liver disease with S-bilirubin in the range 34-51 micromol/dl and one of the following: • S-albumin in the range 30-35 g/dl; • Prothrombin time: four to six seconds prolonged; • Irreparable biliary tract obstruction with recurrent cholangitis and S-bilirubin in the range 34-51 micromol/dl.
	Benefit: 50% of benefit amount**
	Progressive chronic liver disease with S-bilirubin more than 51 micromol/dl and one of the following: • S-albumin less than 30 g/dl; • Hepatic encephalopathy; • Prothrombin time: more than six seconds prolonged; • Irreparable biliary tract obstruction with cholangitis and S-bilirubin more than 51 micromol/dl.
	Benefit: 100% of benefit amount**
Endocrine system, urological system and renal disease	Renal disease with a creatinine clearance of 30-42ml/min
	Benefit: 50% of benefit amount**
	• End stage renal disease with a creatinine clearance below 30 ml/min, or • Impaired renal function that requires either on-going peritoneal dialysis or haemodialysis; or • Life insured has no reflex regulation or voluntary control of the bladder due to a total and irreversible (not correctable by treatment or operation) impairment.
	Benefit: 100% of benefit amount**
Soft tissue	15% body surface burns
	Benefit: 50% of benefit amount**
	25% body surface burns
	Benefit: 100% of benefit amount**
Cancer	A malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. • Stage 4 cancer; or • Stage 3 cancer requiring ongoing adjuvant treatment (in-patient or out-patient) for more than six months

	Benefit: 100% of benefit amount**

Haemopoietic System or Leukaemia	Leukaemia (white blood cell and red blood cell cancer) with the inability to perform three or more Daily Activities
	Benefit: 100% of benefit amount
Advanced AIDS	Advanced AIDS, confirmed by a positive HIV antibody test, a CD4 cell count of less than 200 despite optimal treatment and the diagnosis of at least one of the following diseases: • Kaposi's sarcoma; • Pneumocystis carinii pneumonia; • Progressive multifocal leukoencephalopathy; • Extrapulmonary tuberculosis; or • Pulmonary cryptococcus. **Benefit: 100% of benefit amount****
Daily activities	Totally and irreversibly (not correctable by treatment or operation) unable, because of illness or accidental injury, to perform two or more of the tests listed below without the help of another person, but with the use of appropriate assistive or corrective aids and appliances. This must be confirmed in a report from the life insured's doctor, and an examination by a specialist of Hollard Life's choice. The assessment of Activities of Daily Living must be done as part of a comprehensive assessment by an Occupational Therapist.
	Before the policy anniversary immediately after the life insured's 65th birthday:
	• The ability to bend to get into or out of a standard car, being able to bend or kneel to pick up something from the floor and straighten up without suffering severe discomfort or being unable to walk 200 meters on a flat surface without having to stop. • The ability to lift, carry objects for example a kettle of water, bags of shopping or a briefcase. • Communicating, being the ability to talk to another person and being the ability to answer the telephone. • Reading, meaning having the eyesight required to be able to read, for example reading a daily newspaper or emails. • Manual Dexterity, being the ability to use hands and fingers with precision, including the ability to pick up and manipulate small objects, such as pens or cutlery and take a message.
	After the policy anniversary immediately after the life insured's 65th birthday
	• Washing: The ability to wash in a bath or shower (including getting into and out of a bath or shower). • Dressing: The ability to put on, take off, secure and unfasten all garments. • Feeding: The ability to cut meat, butter bread and to get food and drink into the mouth using fingers or utensils. • Toileting: The ability to use the lavatory and to recognize the need to void the bladder or bowel. • Mobility: The ability to move indoors from room to room on level surfaces. • Transferring: The ability to move from a bed to a chair or wheelchair and vice versa.

	• Communicating: The ability to answer the telephone and take a message.
	Benefits:
	Inability to perform 2 daily activities: 50% of benefit amount **Inability to perform 3 or more daily activities: 100% of benefit amount**

An accident means a specific identifiable event that is unplanned and unexpected by the Life Insured, is external and violent in nature, and is directly and solely responsible for the grievous bodily harm caused.

Waiting Period

A waiting period is the specific period of time that is required to pass from the date of the claim event until the claim is admitted and assessed. During the waiting period no claim is payable.

We will impose a 3-month waiting period from the date of the event before a claim will be admitted by us under this benefit.

If the Life Insured has both a Life Cover benefit and a Comprehensive Disability benefit on the Policy, we may, at our discretion pay a claim under this benefit before the required 3-month waiting period has expired. If the Life insured dies within the 3-month waiting period, we will reduce the Life Cover benefit amount by the amount paid under this benefit in the 3-month waiting period.

Impact of a Claim on other Benefits

If we pay a claim under this benefit before the required 3-month waiting period has expired and the Life insured dies within the 3-month waiting period, we will reduce the Life Cover benefit amount by the amount paid under this benefit.

What is the effect of a Claim on the Comprehensive Disability Benefit?

When a Claim is paid under this benefit:

- The Benefit Amount will be reduced by the amount of the payment made; and
- the premiums payable for this benefit will be reduced.

Once 100% of the benefit amount has been paid, the Comprehensive Disability benefit will cease and cannot be reinstated.

When does the Comprehensive Disability benefit end?

The Comprehensive Disability benefit will end when the first of these happens:

- The Comprehensive Disability benefit term, as specified in your Policy schedule, expires;
- The full benefit amount has been paid;
- You cancel the Comprehensive Disability benefit;
- Your Policy lapses. The Comprehensive Disability Benefit will then cease on the last day of the month for which you last paid your premiums in full; or
- The Life Insured dies.

What are Notifiable Changes?

You are required to notify us in writing if there are any changes to the following:

- Occupation or the Duty Split of the Life Insured;
- Involvement of the Life Insured in Hazardous Activities, as defined below.

What is the effect of a Change in Occupation or Duty Spilt?

When we are notified of changes in the occupation or duty split of the (from that set out in the Policy Schedule), we may:

- adjust the benefits or premiums; or,
- if the Life Insured's new occupation or duties mean they no longer qualify for the original Benefit,
  - we may offer to replace this benefit with another Benefit the Life Insured qualifies for; or
  - any claim will be assessed on the Daily Activities assessment criteria, where such a benefit is included in the benefit definitions.

If we are not notified in writing of a change in occupation or duty split, the benefit will be reassessed at the claims stage (in line with our prevailing underwriting practice) and this may result in a claim being reduced or rejected. In addition a 10% penalty on the claim amount will be applied.

What is defined as a Hazardous Activity?
Below is the list of activities that are defined as a hazardous activity:

- Big game hunting;
- Competitive body building or weight lifting;
- Boxing or mixed martial arts;
- Cage fighting;
- Motorcar or motorcycle racing (excluding vintage racing and local endurance races other than the Castrol Winterburg Enduro);
- Mountaineering (excluding hiking, rock climbing, trail climbing and canoeing/kloofing, at heights below 3 000 metres;
- Microlighting, hang-gliding or gyrocopter flying;
- Private flying (including fixed wing and helicopter);
- Competitive Quad-Biking (excluding participation in less than 10 events a year);
- Skydiving or parachuting (excluding static line/automatic opening and/or tandem jumps with a qualified skydiving instructor only);
- Underwater diving (excluding snorkelling, free diving less than 25 meters or a certified diver at depths less than 40 metres in a group, as long as there is no involvement in either wreck or cave diving)

What is the effect of a Change in Hazardous Activities?
When we are notified of a change in Hazardous Activities we may adjust the premium or benefits as necessary, and advise you of any additional premium or exclusion/s added to the Policy.

If we are not notified in writing of a change in hazardous activities, the benefit will be reassessed at the claims stage (in line with our prevailing underwriting practice for the specific hazardous activity) and this may result in a claim being reduced or rejected. In addition, a penalty of 10% on the claim amount will be applied.

Exclusions
We will not make any payment if the illness or incident that gives rise to a claim event was directly or indirectly caused by, brought about by, accelerated by or aggravated by self-inflicted injuries or if the life assured takes any substance / medication to induce a condition.
We will not make any payment if any fraudulent documentation or information is provided at application or claim stage.

Benefit Specific Terms and Conditions: Comprehensive Disability

How does Comprehensive Disability Benefit work?

The Comprehensive Disability Benefit will become payable if the Life Insured suffers an Occupational Disability or an Impairment claim event while the Policy is inforce.

What is the Benefit Amount?

The Benefit amount payable is set out on your Policy Schedule, at the date of the claim event, and will include any voluntary increases you have selected and any benefit endorsements accepted and confirmed in writing by us.

The Benefit amount set out in your Policy Schedule, together with voluntary increases is the maximum that can be paid out under this benefit. Where a partial payment is made, the Benefit amount will be reduced by the amount paid. The remaining Benefit amount will be available for future claims. Once 100% of the Benefit amount has been paid the benefit will cease.

At the policy anniversary after the Life Insured's 65th birthday, the Benefit amount for an Occupational Disability, and certain Impairment claims, will be reduced to the percentage specified below:

Policy Anniversary after	Percentage of Benefit Amount
65th birthday	80%
66th birthday	60%
67th birthday	40%
68th birthday	20%
69th birthday	0%

Where "**" (asterisks) appear next to the definition of Impairment claim events means that reduced benefit amount will apply.

General Conditions

You are required to notify us, in writing, of a claim within six months after the date of disability or impairment. Until the claim is admitted by us, you will be required to continue paying the premiums in respect of the Comprehensive Disability benefit.

The benefit will only be payable once Hollard Life is satisfied that the Life Insured is permanently disabled or impaired, and that life insured has followed all medical advice and treatment as recommended by their own medical practitioner or Hollard Life's Chief Medical Officer.

We will make only one claim payment if a claim for two or more claims events are made at the same time. In such a case, the highest claim payment for the relevant claim events will be made.

Claim Events

The table below sets out the claim events covered under this Policy and the percentage of the Benefit Amount payable for the claim event.

Occupational disability The benefit will only be payable on confirmed diagnosis and once Hollard Life is satisfied that the Life Insured is permanently disabled and the disability is total and irreversible - that is not correctable by treatment or operation.	
Claim Event	**Definition of Claim Event**
Occupational disability	Total and irreversible (not correctable by treatment or operation) inability of the Life Insured, due to a sickness, injury, disease, illness or a surgical operation, to perform their occupation, provided the Life insured had been gainfully employed for a period of not less than six months before the onset of the disability.
	Benefit: 100% of Benefit Amount**

Impairment Claim Events The impairment benefit will only be payable on confirmed diagnosis to the satisfaction of Hollard Life	
Claim Event	**Definition of Claim Event**
Loss of one limb	Total and irreversible (not correctable by treatment or operation) loss or loss of use of a limb, where a limb is defined as an arm including the elbow or a leg including the knee.
	Benefit: 50% of Benefit Amount
Loss of two more limbs	Total and irreversible (not correctable by treatment or operation) loss or loss of use of any two limbs, where a limb is defined as an arm including the elbow or a leg including the knee.
	Benefit: 100% of Benefit Amount
Loss of one foot, or one hand	Total and irreversible (not correctable by treatment or operation) loss or loss of use of a foot or a hand, where a foot is defined as the extremity of the leg below the ankle and a hand the extremity of the arm beyond the wrist. Radiological evidence of irreversible joint destruction must be provided.
	Benefit: 50% of Benefit Amount
Loss of both hands, or both feet, or one hand and one foot	Total and irreversible (not correctable by treatment or operation) loss or loss of use of both hands, both feet or one hand and one foot. Radiological evidence of irreversible joint destruction must be provided.
	Benefit: 100% of Benefit Amount
Loss of dominant hand	Loss or Loss of use of dominant hand.
	Benefit: 100% of Benefit Amount
Loss of Fingers	Loss or Loss of use of more than three fingers on the dominant hand (must include the thumb or index finger).
	Benefit: 50% of Benefit Amount

Impairment of upper limbs	• 60% impairment of dominant upper limb as measured using the AMA guidelines*; or • 90% impairment of non-dominant upper limb as measured using the AMA guidelines*
	Benefit: 50% of Benefit Amount
	• 80% impairment of dominant upper limb as measured using the AMA guidelines*
	Benefit: 100% of Benefit Amount
	*American Medical Association's "Guidelines to the Evaluation of Permanent impairment"
Loss of sight in one eye	Total and irreversible (not correctable by treatment or operation) loss of sight in one eye. Permanent visual acuity impairment (not correctable by operation) resulting in a Snellen rating of less than 20/200 or worse. The blindness must be certified through an Ophthalmologist's report and cataracts are specifically excluded.
	Benefit: 50% of Benefit Amount
Loss of sight in both eyes	Total and irreversible (not correctable by treatment or operation) loss of sight in both eyes. Permanent visual acuity impairment (not correctable by operation) resulting in a Snellen rating of less than 20/200 or worse bilaterally. The blindness must be certified through an Ophthalmologist's report and cataracts are specifically excluded.
	Benefit: 100% of Benefit Amount
Loss of hearing	Greater than 75% total and irreversible (not correctable by treatment or operation) binaural hearing loss.
	Benefit: 50% of Benefit Amount
	Total and irreversible (not correctable by treatment or operation) loss of hearing in both ears as a result of chronic sickness or an accident. Total loss of hearing means the average hearing levels, tested with hearing aids when applicable, at audible frequencies, is more than 90 decibels. Medical evidence in the form of audiometric and sound-threshold tests must be provided.
	Benefit: 100% of Benefit Amount
Loss of speech or Aphasia	Inability to perform the Communication daily activity.
	Benefit: 50% of Benefit Amount
	Total aphasia, or the total and irreversible (not correctable by treatment or operation) inability to speak.
	Benefit: 100% of Benefit Amount
Spine	Radiculopathy and significant extremity impairment as indicated by 3 or more of the following: • Atrophy; • Loss of reflexes; • Numbness on an anatomical basis; • Loss of spine motion integrity as documented by neurological or motor compromise (AMA guidelines*); • Inability to perform two daily activities.
	Benefit: 50% of Benefit Amount

	Radiculopathy and significant extremity impairment as indicated by 3 or more of the following: • Cauda equina syndrome; • Loss of bowel or bladder integrity resulting in incontinence as confirmed by specialist assessment; • Paraplegia, quadriplegia; • Inability to perform three or more daily activities.
	Benefit: 100% of Benefit Amount
Hemiplegia	Persistent disabling hemiplegia or monoplegia resulting in the inability to perform two Daily Activities.
	Benefit: 50% of Benefit Amount
	Persistent disabling hemiplegia resulting in the inability to perform three Daily Activities.
	Benefit: 100% of Benefit Amount
Traumatic head injury	A traumatic injury to the brain caused by an external physical force, with a Glasgow Coma Scale score of less than or equal to 8 on admission and persisting for more than 96 hours. This must result in significant and irreversible (not correctable by treatment or operation) impairment of cognitive abilities and/or physical functioning.
	Benefit: 50% of benefit amount The diagnosis must be confirmed by a Neurosurgeon or Specialist Neurologist
	A traumatic injury to the brain, caused by an external physical force, resulting in total and irreversible (not correctable by treatment or operation) impairment of cognitive abilities and/or physical functioning and resulting in a need for continual care or supervision in a recognised institution.
	Benefit: 100% of benefit amount The diagnosis must be confirmed by a Neurosurgeon or Specialist Neurologist.
Permanent mental or Cognitive Impairment	Irreversible cognitive deterioration, or loss of cognitive capacity which results from an identifiable organic cause and is evidenced by MMSE (Mini Mental Test) scores of less than 18 in tests conducted at least two months apart.
	Benefit: 100% of Benefit Amount
Impairment of Consciousness and Awareness or Coma	Irreversible unconsciousness/coma of an organic nature and not amenable to therapy.
	Benefit: 100% of benefit amount**
Cranial nerve impairments	• Total and irreversible (not correctable by treatment or operation) nerve damage with equilibrium and or hearing impairment resulting in the inability to perform three or more daily activities; or • Total and irreversible (not correctable by treatment or operation) paralysis with severe inability to swallow requiring regular assistance and suctioning
	Benefit: 100% of benefit amount**
Mental and behavioural disorders	• The inability to perform two daily activities; or • Institutionalization for a period longer than six months
	Benefit: 50% of benefit amount**

	• The inability to perform three or more daily activities; or • Permanent institutionalization; or • Permanent GAF (Global Assessment of Functioning Scale) score of less than 40.
	Benefit: 100% of benefit amount**
Ischaemic heart disease or myocardial infarction or coronary artery disease or cardiac arrhythmias or valvular heart disease or congenital heart disease or cardiomyopathy	• At least one sign or symptom of congestive heart failure persisting for six months and refractory to treatment; or • NYHA Classification II or III, with ejection fraction less than 45% or METS less than 3. **Benefit: 50% of benefit amount****
	• At least two signs or symptoms of congestive heart failure persisting for six months and refractory to treatment; or • NYHA Classification III or IV, with ejection fraction less than 30% or METS less than 2; or • Awaiting cardiac transplantation.
	Benefit: 100% of benefit amount**
	Signs of congestive heart failure: ○ 3+ pedal oedema; ○ Paroxysmal nocturnal dyspnoea; ○ Rales in the lung/lungs; ○ Presence of S3.
Peripheral artery or Venous disease	• Total and irreversible (not correctable by treatment or operation) abnormal, diminished pulse on Doppler readings, cold leg, dependent rubor and pain on exercise; or • Severe and deep widespread vascular ulceration.
	Benefit: 50% of benefit amount**
	• Severe vascular ulceration; or • Gangrene or amputation; or • Persistent ischaemia with no detectable pulse on Doppler.
	Benefit: 100% of benefit amount**
Pericardial Heart Disease	At least one sign or symptom of congestive heart failure persisting for six months and refractory to treatment (including surgery) with significant pericardial thickening/calcification.
	Benefit: 50% of benefit amount**
	At least two signs or symptoms of congestive heart failure persisting for six months and refractory to treatment (including surgery) with signs of congestion of lungs or other organs.
	Benefit: 100% of benefit amount** Signs of congestive heart failure: ○ 3+ pedal oedema; ○ Paroxysmal nocturnal dyspnoea; ○ Rales in the lung/lungs; ○ Presence of S3.

Hypertension	Diastolic pressure higher than 100 mm/Hg on optimal treatment and complicated by at least one of the following: • Renal dysfunction (BU>12mmol/l, SCR>200mmol/l); • CVA; • Grade III retinopathy; • Congestive heart failure (at least one symptom).
	Benefit: 50% of benefit amount**
	Diastolic pressure higher than 105 mm/Hg on optimal treatment and complicated by at least two of the following: • Renal dysfunction (BU>15mmol/l, SCR>200mmol/l); • CVA; • LVH (Septal wall thickness to posterior LV wall thickness 1:1.3) on echocardiogram; • Grade IV retinopathy; • Congestive heart failure (at least two symptoms).
	Benefit: 100% of benefit amount**
Respiratory system	• FEV1 40% - 49% of expected value; or • FVC 40% - 49% of expected value; or • DLCO 40% - 49% of expected value.
	Benefit: 50% of benefit amount**
	• FEV1 less than 40% of expected value; or • FVC less than 40% of expected value; or • DLCO less than 40% of expected value; or • Requiring the constant use of oxygen; or • Where there is no capacity for spontaneous respiration.
	Benefit: 100% of benefit amount**
	The above respiratory system events must be total and irreversible (not correctable by treatment or operation) and must be confirmed by two tests at least one month apart.
Diseases involving the upper and lower digestive tract	• Anatomical loss and alteration in gastrointestinal tract with medical evidence of organic disease and more than 15% weight loss below desirable weight with minimal response to medical therapy; or • Ongoing nutritional deficiency with BMI less than 16 despite optimal treatment; or • Partial faecal incontinence; or • Irreparable hernia with ongoing bowel dysfunction.
	Benefit: 50% of benefit amount**
	• Anatomical loss and alteration in gastrointestinal tract with medical evidence of organic disease and more than 25% weight loss below desirable weight with no response to medical therapy; or • Ongoing nutritional deficiency with BMI less than 14 despite optimal treatment; or • Complete faecal incontinence; or • Total and irreversible (not correctable by treatment or operation) stoma (such as colostomy or ileostomy).

	Benefit: 100% of benefit amount**

Liver and biliary disease	Progressive chronic liver disease with S-bilirubin in the range 34-51 micromol/dl and one of the following: • S-albumin in the range 30-35 g/dl; • Prothrombin time: four to six seconds prolonged; • Irreparable biliary tract obstruction with recurrent cholangitis and S-bilirubin in the range 34-51 micromol/dl.
	Benefit: 50% of benefit amount**
	Progressive chronic liver disease with S-bilirubin more than 51 micromol/dl and one of the following: • S-albumin less than 30 g/dl; • Hepatic encephalopathy; • Prothrombin time: more than six seconds prolonged; • Irreparable biliary tract obstruction with cholangitis and S-bilirubin more than 51 micromol/dl.
	Benefit: 100% of benefit amount**
Endocrine system, urological system and renal disease	Renal disease with a creatinine clearance of 30-42ml/min
	Benefit: 50% of benefit amount**
	• End stage renal disease with a creatinine clearance below 30 ml/min, or • Impaired renal function that requires either on-going peritoneal dialysis or haemodialysis; or • Life insured has no reflex regulation or voluntary control of the bladder due to a total and irreversible (not correctable by treatment or operation) impairment.
	Benefit: 100% of benefit amount**
Soft tissue	15% body surface burns
	Benefit: 50% of benefit amount**
	25% body surface burns
	Benefit: 100% of benefit amount**
Cancer	A malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. • Stage 4 cancer; or • Stage 3 cancer requiring ongoing adjuvant treatment (in-patient or out-patient) for more than six months
	Benefit: 100% of benefit amount**
Haemopoietic System or Leukaemia	Leukaemia (white blood cell and red blood cell cancer) with the inability to perform three or more Daily Activities
	Benefit: 100% of benefit amount
Advanced AIDS	Advanced AIDS, confirmed by a positive HIV antibody test, a CD4 cell count of less than 200 despite optimal treatment and the diagnosis of at least one of the following diseases: • Kaposi's sarcoma; • Pneumocystis carinii pneumonia; • Progressive multifocal leukoencephalopathy;

	• Extrapulmonary tuberculosis; or • Pulmonary cryptococcus. **Benefit: 100% of benefit amount****

Daily activities	Totally and irreversibly (not correctable by treatment or operation) unable, because of illness or accidental injury, to perform two or more of the tests listed below without the help of another person, but with the use of appropriate assistive or corrective aids and appliances. This must be confirmed in a report from the life insured's doctor, and an examination by a specialist of Hollard Life's choice. The assessment of Activities of Daily Living must be done as part of a comprehensive assessment by an Occupational Therapist.
	Before the policy anniversary immediately after the life insured's 65th birthday:
	• The ability to bend to get into or out of a standard car, being able to bend or kneel to pick up something from the floor and straighten up without suffering severe discomfort or being unable to walk 200 meters on a flat surface without having to stop. • The ability to lift, carry objects for example a kettle of water, bags of shopping or a briefcase. • Communicating, being the ability to talk to another person and being the ability to answer the telephone. • Reading, meaning having the eyesight required to be able to read, for example reading a daily newspaper or emails. • Manual Dexterity, being the ability to use hands and fingers with precision, including the ability to pick up and manipulate small objects, such as pens or cutlery and take a message.
	After the policy anniversary immediately after the life insured's 65th birthday
	• Washing: The ability to wash in a bath or shower (including getting into and out of a bath or shower). • Dressing: The ability to put on, take off, secure and unfasten all garments. • Feeding: The ability to cut meat, butter bread and to get food and drink into the mouth using fingers or utensils. • Toileting: The ability to use the lavatory and to recognize the need to void the bladder or bowel. • Mobility: The ability to move indoors from room to room on level surfaces. • Transferring: The ability to move from a bed to a chair or wheelchair and vice versa. • Communicating: The ability to answer the telephone and take a message.
	Benefits:
	Inability to perform 2 daily activities: 50% of benefit amount **Inability to perform 3 or more daily activities: 100% of benefit amount**

An accident means a specific identifiable event that is unplanned and unexpected by the Life Insured, is external and violent in nature, and is directly and solely responsible for the grievous bodily harm caused.

Impact of a Claim on other Benefits

The Comprehensive Disability benefit is an acceleration of the Life Cover benefit. When a valid claim is paid:

- The amount payable on the Life Cover benefit will be reduced by the amount paid;
- Any other benefit that is an Accelerator benefit will also be reduced to an amount that does not exceed the Life Cover benefit; and
- If the Comprehensive Disability benefit paid out to you is the same as the Life Cover benefit, the Comprehensive Disability benefit and Life Cover benefit will cease, together with any other accelerated benefits on the Policy.

What is the effect of a Claim on the Comprehensive Disability Benefit?

When a Claim is paid under this benefit:

- The Benefit Amount will be reduced by the amount of the payment made; and
- the premiums payable for this benefit will be reduced.

Once 100% of the benefit amount has been paid, the Comprehensive Disability benefit will cease and cannot be reinstated.

When does the Comprehensive Disability benefit end?

The Comprehensive Disability benefit will end when the first of these happens:

- The Comprehensive Disability benefit term, as specified in your Policy schedule, expires;
- The full benefit amount has been paid;
- You cancel the Comprehensive Disability benefit;
- Your Policy lapses. The Comprehensive Disability Benefit will then cease on the last day of the month for which you last paid your premiums in full; or
- The Life Insured dies.

What are Notifiable Changes?

You are required to notify us in writing if there are any changes to the following:

- Occupation or the Duty Split of the Life Insured;
- Involvement of the Life Insured in Hazardous Activities, as defined below.

What is the effect of a Change in Occupation or Duty Spilt?

When we are notified of changes in the occupation or duty split of the (from that set out in the Policy Schedule), we may:

- adjust the benefits or premiums; or,
- if the Life Insured's new occupation or duties mean they no longer qualify for the original Benefit,
  - we may offer to replace this benefit with another Benefit the Life Insured qualifies for; or
  - any claim will be assessed on the Daily Activities assessment criteria, where such a benefit is included in the benefit definitions.

If we are not notified in writing of a change in occupation or duty split, the benefit will be reassessed at the claims stage (in line with our prevailing underwriting practice) and this may result in a claim being reduced or rejected. In addition a 10% penalty on the claim amount will be applied.

What is defined as a Hazardous Activity?
Below is the list of activities that are defined as a hazardous activity:

- Big game hunting;
- Competitive body building or weight lifting;
- Boxing or mixed martial arts;
- Cage fighting;
- Motorcar or motorcycle racing (excluding vintage racing and local endurance races other than the Castrol Winterburg Enduro);
- Mountaineering (excluding hiking, rock climbing, trail climbing and canoeing/kloofing, at heights below 3 000 metres;
- Microlighting, hang-gliding or gyrocopter flying;
- Private flying (including fixed wing and helicopter);
- Competitive Quad-Biking (excluding participation in less than 10 events a year);
- Skydiving or parachuting (excluding static lineautomatic opening and/or tandem jumps with a qualified skydiving instructor only);
- Underwater diving (excluding snorkelling, free diving less than 25 meters or a certified diver at depths less than 40 metres in a group, as long as there is no involvement in either wreck or cave diving)

What is the effect of a Change in Hazardous Activities?
When we are notified of a change in Hazardous Activities we may adjust the premium or benefits as necessary, and advise you of any additional premium or exclusion/s added to the Policy.

If we are not notified in writing of a change in hazardous activities, the benefit will be reassessed at the claims stage (in line with our prevailing underwriting practice for the specific hazardous activity) and this may result in a claim being reduced or rejected. In addition, a penalty of 10% on the claim amount will be applied.

Exclusions
We will not make any payment if the illness or incident that gives rise to a claim event was directly or indirectly caused by, brought about by, accelerated by or aggravated by self-inflicted injuries or if the life assured takes any substance / medication to induce a condition.
We will not make any payment if any fraudulent documentation or information is provided at application or claim stage.

Benefit Specific Terms and Conditions: Comprehensive Impairment Benefit

How does the Impairment Benefit work?

The Impairment Benefit will become payable if the Life Insured suffers an Impairment claim event while the Policy is inforce.

What the Benefit Amount?

The Benefit amount payable is set out on your Policy Schedule, at the date of the claim event, and will include any voluntary increases you have selected and any Benefit endorsements accepted and confirmed in writing by us. The benefit is the maximum that can be paid out under this benefit. Where a partial payment is made, the Benefit amount will be reduced by the amount paid. The remaining Benefit amount will be available for future claims. Once 100% of the Benefit amount has been paid the benefit will cease.

At the policy anniversary's after the Life Insured's 65th birthday, the Benefit for certain Impairment claims, will be reduced by the percentage specified below:

Policy Anniversary after	Percentage of Benefit Amount
65th birthday	80%
66th birthday	60%
67th birthday	40%
68th birthday	20%
69th birthday	0%

Where "**" (asterisks) appear next to the definition of Impairment claim events means that reduced benefit amount will apply.

General Conditions

You are required to notify us, in writing, of a claim within six months after the date of impairment. Until the claim is admitted by us, you will be required to continue paying the premiums in respect of the Impairment benefit.

The benefit will only be payable once Hollard Life is satisfied that the Life Insured is totally and permanently impaired, and that life insured has followed all medical advice and treatment as recommended by their own medical practitioner or Hollard Life's Chief Medical Officer.

We will make only one claim payment if a claim for two or more claims events are made at the same time. In such a case, the highest claim payment for the relevant claim events will be made.

Claim Events

The table below sets out the claim events covered under this Policy and the percentage of the Benefit Amount payable for the claim event.

Impairment Claim Events The impairment benefit will only be payable on confirmed diagnosis to the satisfaction of Hollard Life	
Claim Event	**Definition of Claim Event**
Loss of one limb	Total and irreversible (not correctable by treatment or operation) loss or loss of use of a limb, where a limb is defined as an arm including the elbow or a leg including the knee.
	Benefit: 50% of Benefit Amount
Loss of two more limbs	Total and irreversible (not correctable by treatment or operation) loss or loss of use of any two limbs, where a limb is defined as an arm including the elbow or a leg including the knee.
	Benefit: 100% of Benefit Amount
Loss of one foot, or one hand	Total and irreversible (not correctable by treatment or operation) loss or loss of use of a foot or a hand, where a foot is defined as the extremity of the leg below the ankle and a hand the extremity of the arm beyond the wrist. Radiological evidence of irreversible joint destruction must be provided.
	Benefit: 50% of Benefit Amount
Loss of both hands, or both feet, or one hand and one foot	Total and irreversible (not correctable by treatment or operation) loss or loss of use of both hands, both feet or one hand and one foot. Radiological evidence of irreversible joint destruction must be provided.
	Benefit: 100% of Benefit Amount
Loss of dominant hand	Loss or Loss of use of dominant hand.
	Benefit: 100% of Benefit Amount
Loss of Fingers	Loss or Loss of use of more than three fingers on the dominant hand (must include the thumb or index finger).
	Benefit: 50% of Benefit Amount
Impairment of upper limbs	• 60% impairment of dominant upper limb as measured using the AMA guidelines*; or • 90% impairment of non-dominant upper limb as measured using the AMA guidelines*
	Benefit: 50% of Benefit Amount
	• 80% impairment of dominant upper limb as measured using the AMA guidelines*
	Benefit: 100% of Benefit Amount
	*American Medical Association's "Guidelines to the Evaluation of Permanent impairment"
Loss of sight in one eye	Total and irreversible (not correctable by treatment or operation) loss of sight in one eye. Permanent visual acuity impairment (not correctable by operation) resulting in a Snellen rating of less than 20/200 or worse. The blindness must be certified through an Ophthalmologist's report and cataracts are specifically excluded.
	Benefit: 50% of Benefit Amount

Loss of sight in both eyes	Total and irreversible (not correctable by treatment or operation) loss of sight in both eyes. Permanent visual acuity impairment (not correctable by operation) resulting in a Snellen rating of less than 20/200 or worse bilaterally. The blindness must be certified through an Ophthalmologist's report and cataracts are specifically excluded.
	Benefit: 100% of Benefit Amount
Loss of hearing	Greater than 75% total and irreversible (not correctable by treatment or operation) binaural hearing loss.
	Benefit: 50% of Benefit Amount
	Total and irreversible (not correctable by treatment or operation) loss of hearing in both ears as a result of chronic sickness or an accident. Total loss of hearing means the average hearing levels, tested with hearing aids when applicable, at audible frequencies, is more than 90 decibels. Medical evidence in the form of audiometric and sound-threshold tests must be provided.
	Benefit: 100% of Benefit Amount
Loss of speech or Aphasia	Inability to perform the Communication daily activity.
	Benefit: 50% of Benefit Amount
	Total aphasia, or the total and irreversible (not correctable by treatment or operation) inability to speak.
	Benefit: 100% of Benefit Amount
Spine	Radiculopathy and significant extremity impairment as indicated by 3 or more of the following: • Atrophy; • Loss of reflexes; • Numbness on an anatomical basis; • Loss of spine motion integrity as documented by neurological or motor compromise (AMA guidelines*); • Inability to perform two daily activities.
	Benefit: 50% of Benefit Amount
	Radiculopathy and significant extremity impairment as indicated by 3 or more of the following: • Cauda equina syndrome; • Loss of bowel or bladder integrity resulting in incontinence as confirmed by specialist assessment; • Paraplegia, quadriplegia; • Inability to perform three or more daily activities.
	Benefit: 100% of Benefit Amount
Hemiplegia	Persistent disabling hemiplegia or monoplegia resulting in the inability to perform two Daily Activities.
	Benefit: 50% of Benefit Amount
	Persistent disabling hemiplegia resulting in the inability to perform three Daily Activities.
	Benefit: 100% of Benefit Amount

Traumatic head injury	A traumatic injury to the brain caused by an external physical force, with a Glasgow Coma Scale score of less than or equal to 8 on admission and persisting for more than 96 hours. This must result in significant and irreversible (not correctable by treatment or operation) impairment of cognitive abilities and/or physical functioning.
	Benefit: 50% of benefit amount The diagnosis must be confirmed by a Neurosurgeon or Specialist Neurologist
	A traumatic injury to the brain, caused by an external physical force, resulting in total and irreversible (not correctable by treatment or operation) impairment of cognitive abilities and/or physical functioning and resulting in a need for continual care or supervision in a recognised institution.
	Benefit: 100% of benefit amount The diagnosis must be confirmed by a Neurosurgeon or Specialist Neurologist.
Permanent mental or Cognitive Impairment	Irreversible cognitive deterioration, or loss of cognitive capacity which results from an identifiable organic cause and is evidenced by MMSE (Mini Mental Test) scores of less than 18 in tests conducted at least two months apart.
	Benefit: 100% of Benefit Amount
Impairment of Consciousness and Awareness or Coma	Irreversible unconsciousness/coma of an organic nature and not amenable to therapy.
	Benefit: 100% of benefit amount**
Cranial nerve impairments	• Total and irreversible (not correctable by treatment or operation) nerve damage with equilibrium and or hearing impairment resulting in the inability to perform three or more daily activities; or • Total and irreversible (not correctable by treatment or operation) paralysis with severe inability to swallow requiring regular assistance and suctioning
	Benefit: 100% of benefit amount**
Mental and behavioural disorders	• The inability to perform two daily activities; or • Institutionalization for a period longer than six months
	Benefit: 50% of benefit amount**
	• The inability to perform three or more daily activities; or • Permanent institutionalization; or • Permanent GAF (Global Assessment of Functioning Scale) score of less than 40.
	Benefit: 100% of benefit amount**

Ischaemic heart disease or myocardial infarction or coronary artery disease or cardiac arrhythmias or valvular heart disease or congenital heart disease or cardiomyopathy	• At least one sign or symptom of congestive heart failure persisting for six months and refractory to treatment; or • NYHA Classification II or III, with ejection fraction less than 45% or METS less than 3. **Benefit: 50% of benefit amount****
	• At least two signs or symptoms of congestive heart failure persisting for six months and refractory to treatment; or • NYHA Classification III or IV, with ejection fraction less than 30% or METS less than 2; or • Awaiting cardiac transplantation. **Benefit: 100% of benefit amount**** Signs of congestive heart failure: ○ 3+ pedal oedema; ○ Paroxysmal nocturnal dyspnoea; ○ Rales in the lung/lungs; ○ Presence of S3.
Peripheral artery or Venous disease	• Total and irreversible (not correctable by treatment or operation) abnormal, diminished pulse on Doppler readings, cold leg, dependent rubor and pain on exercise; or • Severe and deep widespread vascular ulceration. **Benefit: 50% of benefit amount****
	• Severe vascular ulceration; or • Gangrene or amputation; or • Persistent ischaemia with no detectable pulse on Doppler. **Benefit: 100% of benefit amount****
Pericardial Heart Disease	At least one sign or symptom of congestive heart failure persisting for six months and refractory to treatment (including surgery) with significant pericardial thickening/calcification. **Benefit: 50% of benefit amount****
	At least two signs or symptoms of congestive heart failure persisting for six months and refractory to treatment (including surgery) with signs of congestion of lungs or other organs. **Benefit: 100% of benefit amount**** Signs of congestive heart failure: ○ 3+ pedal oedema; ○ Paroxysmal nocturnal dyspnoea; ○ Rales in the lung/lungs; ○ Presence of S3.
Hypertension	Diastolic pressure higher than 100 mm/Hg on optimal treatment and complicated by at least one of the following: • Renal dysfunction (BU>12mmol/l, SCR>200mmol/l); • CVA; • Grade III retinopathy; • Congestive heart failure (at least one symptom). **Benefit: 50% of benefit amount****

	Diastolic pressure higher than 105 mm/Hg on optimal treatment and complicated by at least two of the following: • Renal dysfunction (BU>15mmol/l, SCR>200mmol/l); • CVA; • LVH (Septal wall thickness to posterior LV wall thickness 1:1.3) on echocardiogram; • Grade IV retinopathy; • Congestive heart failure (at least two symptoms).
	Benefit: 100% of benefit amount**
Respiratory system	• FEV1 40% - 49% of expected value; or • FVC 40% - 49% of expected value; or • DLCO 40% - 49% of expected value.
	Benefit: 50% of benefit amount**
	• FEV1 less than 40% of expected value; or • FVC less than 40% of expected value; or • DLCO less than 40% of expected value; or • Requiring the constant use of oxygen; or • Where there is no capacity for spontaneous respiration.
	Benefit: 100% of benefit amount**
	The above respiratory system events must be total and irreversible (not correctable by treatment or operation) and must be confirmed by two tests at least one month apart.
Diseases involving the upper and lower digestive tract	• Anatomical loss and alteration in gastrointestinal tract with medical evidence of organic disease and more than 15% weight loss below desirable weight with minimal response to medical therapy; or • Ongoing nutritional deficiency with BMI less than 16 despite optimal treatment; or • Partial faecal incontinence; or • Irreparable hernia with ongoing bowel dysfunction.
	Benefit: 50% of benefit amount**
	• Anatomical loss and alteration in gastrointestinal tract with medical evidence of organic disease and more than 25% weight loss below desirable weight with no response to medical therapy; or • Ongoing nutritional deficiency with BMI less than 14 despite optimal treatment; or • Complete faecal incontinence; or • Total and irreversible (not correctable by treatment or operation) stoma (such as colostomy or ileostomy).
	Benefit: 100% of benefit amount**
Liver and biliary disease	Progressive chronic liver disease with S-bilirubin in the range 34-51 micromol/dl and one of the following: • S-albumin in the range 30-35 g/dl; • Prothrombin time: four to six seconds prolonged; • Irreparable biliary tract obstruction with recurrent cholangitis and S-bilirubin in the range 34-51 micromol/dl.

	Benefit: 50% of benefit amount**

	Progressive chronic liver disease with S-bilirubin more than 51 micromol/dl and one of the following: • S-albumin less than 30 g/dl; • Hepatic encephalopathy; • Prothrombin time: more than six seconds prolonged; • Irreparable biliary tract obstruction with cholangitis and S-bilirubin more than 51 micromol/dl.
	Benefit: 100% of benefit amount**
Endocrine system, urological system and renal disease	Renal disease with a creatinine clearance of 30-42ml/min
	Benefit: 50% of benefit amount**
	• End stage renal disease with a creatinine clearance below 30 ml/min, or • Impaired renal function that requires either on-going peritoneal dialysis or haemodialysis; or • Life insured has no reflex regulation or voluntary control of the bladder due to a total and irreversible (not correctable by treatment or operation) impairment.
	Benefit: 100% of benefit amount**
Soft tissue	15% body surface burns
	Benefit: 50% of benefit amount**
	25% body surface burns
	Benefit: 100% of benefit amount**
Cancer	A malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. • Stage 4 cancer; or • Stage 3 cancer requiring ongoing adjuvant treatment (in-patient or out-patient) for more than six months
	Benefit: 100% of benefit amount**
Haemopoietic System or Leukaemia	Leukaemia (white blood cell and red blood cell cancer) with the inability to perform three or more Daily Activities
	Benefit: 100% of benefit amount
Advanced AIDS	Advanced AIDS, confirmed by a positive HIV antibody test, a CD4 cell count of less than 200 despite optimal treatment and the diagnosis of at least one of the following diseases: • Kaposi's sarcoma; • Pneumocystis carinii pneumonia; • Progressive multifocal leukoencephalopathy; • Extrapulmonary tuberculosis; or • Pulmonary cryptococcus. **Benefit: 100% of benefit amount****

Daily activities	Totally and irreversibly (not correctable by treatment or operation) unable, because of illness or accidental injury, to perform two or more of the tests listed below without the help of another person, but with the use of appropriate assistive or corrective aids and appliances. This must be confirmed in a report from the life insured's doctor, and an examination by a specialist of Hollard Life's choice. The assessment of Activities of Daily Living must be done as part of a comprehensive assessment by an Occupational Therapist.
	Before the policy anniversary immediately after the life insured's 65th birthday:
	• The ability to bend to get into or out of a standard car, being able to bend or kneel to pick up something from the floor and straighten up without suffering severe discomfort or being unable to walk 200 meters on a flat surface without having to stop. • The ability to lift, carry objects for example a kettle of water, bags of shopping or a briefcase. • Communicating, being the ability to talk to another person and being the ability to answer the telephone. • Reading, meaning having the eyesight required to be able to read, for example reading a daily newspaper or emails. • Manual Dexterity, being the ability to use hands and fingers with precision, including the ability to pick up and manipulate small objects, such as pens or cutlery and take a message.
	After the policy anniversary immediately after the life insured's 65th birthday
	• Washing: The ability to wash in a bath or shower (including getting into and out of a bath or shower). • Dressing: The ability to put on, take off, secure and unfasten all garments. • Feeding: The ability to cut meat, butter bread and to get food and drink into the mouth using fingers or utensils. • Toileting: The ability to use the lavatory and to recognize the need to void the bladder or bowel. • Mobility: The ability to move indoors from room to room on level surfaces. • Transferring: The ability to move from a bed to a chair or wheelchair and vice versa. • Communicating: The ability to answer the telephone and take a message.
	Benefits:
	Inability to perform 2 daily activities: 50% of benefit amount **Inability to perform 3 or more daily activities: 100% of benefit amount**

An accident means a specific identifiable event that is unplanned and unexpected by the Life Insured, is external and violent in nature, and is directly and solely responsible for the grievous bodily harm caused.

Waiting Period

A waiting period is the specific period of time, as set out in your Policy Schedule, that is required to pass from the date of the claim event until the claim is admitted and assessed. During the waiting period no claim is payable.

We will impose a 3-month waiting period from the date of event before a claim will be admitted by us under this benefit. We may, at its discretion, waive this waiting period.

If the Life Insured has both a Life Cover benefit and an Impairment benefit on the Policy, we may, at our discretion pay a claim under this benefit before the required 3-month waiting period has expired. If the Life insured dies within the 3-month waiting period, we will reduce the Life Cover benefit amount by the amount paid under this benefit in the 3-month waiting period.

What is the effect of a Claim on the Impairment Benefit?
When a Claim is paid under this benefit:

- The Benefit Amount will be reduced by the amount of the payment made; and
- the premiums payable for this benefit will be reduced.

Once 100% of the benefit amount has been paid, the Impairment benefit will cease and cannot be reinstated.

When does the Impairment benefit end?
The Impairment Benefit will end when the first of these happens:

- The Impairment benefit term, as specified in your Policy schedule, expires;
- The full Benefit amount has been paid;
- You cancel the Impairment benefit;
- Your Policy lapses. The Impairment Benefit will then cease on the last day of the month for which you last paid your premiums in full; or
- The Life Insured dies.

What are Notifiable Changes?
You are required to notify us in writing if there are any changes to the following:

- Occupation or the Duty Split of the Life Insured;
- Involvement of the Life Insured in Hazardous Activities, as defined below.

What is the effect of a Change in Occupation or Duty Spilt?
When we are notified of changes in the occupation or duty split of the (from that set out in the Policy Schedule), we may:

- adjust the benefits or premiums; or,
- if the Life Insured's new occupation or duties mean they no longer qualify for the original Benefit,
    - we may offer to replace this benefit with another Benefit the Life Insured qualifies for; or
    - any claim will be assessed on the Daily Activities assessment criteria, where such a benefit is included in the benefit definitions.

If we are not notified in writing of a change in occupation or duty split, the benefit will be reassessed at the claims stage (in line with our prevailing underwriting practice) and this may result in a claim being reduced or rejected. In addition, a 10% penalty on the claim amount will be applied.

What is defined as a Hazardous Activity?
Below is the list of activities that are defined as a hazardous activity:

- Big game hunting;
- Competitive body building or weight lifting;

- Boxing or mixed martial arts;
- Cage fighting;
- Motorcar or motorcycle racing (excluding vintage racing and local endurance races other than the Castrol Winterburg Enduro);
- Mountaineering (excluding hiking, rock climbing, trail climbing and canoeing/kloofing, at heights below 3 000 metres;
- Microlighting, hang-gliding or gyrocopter flying;
- Private flying (including fixed wing and helicopter);
- Competitive Quad-Biking (excluding participation in less than 10 events a year);
- Skydiving or parachuting (excluding static line/automatic opening and/or tandem jumps with a qualified skydiving instructor only);
- Underwater diving (excluding snorkelling, free diving less than 25 meters or a certified diver at depths less than 40 metres in a group, as long as there is no involvement in either wreck or cave diving)

What is the effect of a Change in Hazardous Activities?
When we are notified of a change in Hazardous Activities we may adjust the premium or benefits as necessary, and advise you of any additional premium or exclusion/s added to the Policy.

If we are not notified in writing of a change in hazardous activities, the benefit will be reassessed at the claims stage (in line with our prevailing underwriting practice for the specific hazardous activity) and this may result in a claim being reduced or rejected. In addition, a penalty of 10% on the claim amount will be applied.

Exclusions
We will not make any payment if the illness or incident that gives rise to a claim event was directly or indirectly caused by, brought about by, accelerated by or aggravated by self-inflicted injuries or if the life assured takes any substance / medication to induce a condition .

We will not make any payment if any fraudulent documentation or information is provided at application or claim stage.

Benefit Specific Terms and Conditions: Comprehensive Severe Illness

How does Comprehensive Severe Illness work?

The Comprehensive Severe Illness benefit has been divided into 16 Benefit categories. Each benefit category sets out the criteria for the Claim Events and the proportion of the Benefit Amount payable under the Comprehensive Severe Illness benefit, subject to any limits and conditions within each benefit category. A benefit under the Comprehensive Severe Illness Benefit will become payable if the Life Insured meets the criteria of a Claim Event, and the Policy is inforce.

What are the Benefit Categories?

The benefit categories are as follows:

- Cancer Benefit Category;
- Early Cancer Benefit Category;
- Cardiac Benefit Category;
- Cardiovascular Benefit Category;
- Nervous Benefit Category;
- Cerebrovascular Benefit Category;
- Gastrointestinal Benefit Category;
- Kidney and Urogenital Benefit Category;
- Respiratory Benefit Category;
- Connective Tissue Benefit Category;
- Sensory Benefit Category;
- Trauma and Musculoskeletal;
- Endocrine Benefit Category;
- HIV Benefit Category;
- Children Benefit Category; and
- A Catch-all Benefit Category.

What is the Benefit Amount?

The maximum Benefit Amount payable for each benefit category, subject to any specified maximum, is specified in the Policy schedule, at date of event, and will include any benefit endorsements and any voluntary increases. The Benefit Amount for certain Benefit Categories are subject to an overall maximum, set out below under Benefit Categories and Claim Events.

The Benefit Amount for any Benefit Category will reduce by the amount of any payment made with respect to that Benefit Category. The remaining Severe Illness Benefit Amount (if any) will be available for further claims in that Benefit category. The Benefit Amount payable for any Benefit Category is subject to a maximum of 100%.

If the illness for which you have previously claimed has progressed to a more severe level, as per the Benefit Category, an additional payment will be made. This additional payment will be the current benefit minus the previous payment.

How does the Reinstatement of Benefit Amount work?

After 100% of the Benefit Amount has been paid in respect of a Benefit Category, the Benefit Amount for that Benefit Category will automatically reinstate 90 days after the last claim event date for that Benefit Category on the following basis:

- Claims for conditions prior to 75th birthday, 25% of the original Benefit Amount plus any benefit increases;
- Claims for conditions on or after 75th birthday, 15% of the original Benefit Amount plus any benefit increases.

The reinstated Benefit Amount will only be payable for a claim event that occurs more than 90 days after the last claim event that resulted in a total of 100% of the Benefit Amount for a particular Benefit Category being paid.

The reinstatement of the benefit, as described above, will not apply in the event of a recurrence, progression, or complication of a condition for which all or part of the Benefit Amount was paid prior to reinstatement.

What happens if two or more Claims are made at the same time?

Only one payment will be made if claims for two or more of the contingent claim events are made at the same time. Contingent claim events are any claim events occurring within 30 days of each other. We will pay the highest benefit payment that would have been made for any one of the individual claims.

General Conditions

The claim must be proved to Hollard Life's satisfaction within three months of the injury or onset of the illness or disease.

We reserve the right to call for appropriate investigations and tests in order to confirm the diagnosis to the satisfaction of Hollard Life.

Cancer Benefit Category

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, multiple myeloma and sarcoma. Unless stated otherwise, the levels are correlated to the general classification used by the American Joint Committee for Cancer for the type of cancer involved.
The following conditions are excluded from this definition:
(1) All skin cancers other than malignant melanoma that have been histologically classified as having caused invasion beyond the epidermis unless specifically mentioned; and
(2) Diagnosis made by liquid biopsy will not be acceptable proof of a cancer diagnosis.

Claim Event	**% Payable – Max Benefit Option**
Myeloproliferative disorders : Polycythaemia Vera, Essential thrombocytosis	5%
Carcinoid Syndrome	100%
Myelodysplastic syndrome or Myelofibrosis	10%
Borderline Ovarian Tumours Stage I	25%
Bone marrow aplasia	25%
Basal Cell or Squamous Cell Carcinoma Stage III	50%
Malignant Melanoma Stage IB	100%
Prostate cancer T1N0M0 Gleason ≥7	25%
Prostate cancer T2N0M0	100%
Chronic Lymphocytic Leukaemia (Stage 0 or 1 on the RAI classification)	100%
Hairy cell leukaemia	100%
Hodgkin's / Non Hodgkin's Lymphoma Stage 1 on Ann Arbor classification	100%
Any other stage 1 Carcinoma not covered elsewhere	100%
Prostate cancer T3N0M0	100%
Chronic Lymphocytic Leukaemia (Stage II on the Rai classification)	100%
Acute Lymphocytic Leukaemia (children)	100%
Chronic Myeloid Leukaemia (no bone barrow transplantation)	100%
Hodgkin's / Non Hodgkin's lymphoma Stage II on Ann Arbor classification system	100%
Multiple Myeloma Stage I and II on the Durie-Salmon scale	100%
Malignant melanoma Stage II	100%
WHO Grade II Brain Tumour	100%
Borderline Ovarian Tumours Stage II	50%
Hairy cell leukaemia with myelofibrosis transformation	100%
Any other stage 2 Carcinoma not specified above	100%
Prostate cancer T4N0M0	100%
WHO Grade III or IV Brain Tumour	100%
Any other stage 3 cancer not covered above	100%
Prostate cancer any T, N1 - 3, M0	100%
Acute Myeloid Leukaemia	100%
Chronic Lymphocytic Leukaemia (stage III or IV on Rai classification)	100%
Chronic Myeloid Leukaemia (with bone barrow transplantation)	100%
Acute Lymphocytic Leukaemia (adults)	100%
Hodgkin's / Non Hodgkin's lymphoma Stage III or IV on Ann Arbor classification system	100%

Multiple Myeloma Stage III on the Durie-Salmon scale	100%
Any other stage 4 cancer not covered above	100%
Aplastic anaemia with total aplasia of the bone marrow as confirmed by a haematologist, with either blood transfusion or a bone marrow transplant.	100%
The actual undergoing of a bone marrow transplant for haematological malignancy	100%
A condition including any of the following: Unilateral or bilateral mastectomy for carcinoma-in-situ, or prophylactic unilateral or bilateral mastectomy performed upon clinical recommendation by the attending specialist, where any of the following apply for the prophylactic mastectomy: • Breast and/or ovarian cancer in either mother or sister before the age of 50 years; • Bilateral breast cancer in either mother or sister; • Confirmed BRCA 1 or 2 carrier status.	25%
A 12 month waiting period applies for the claim events set out below.	
Prophylactic partial colectomy or hysterectomy for confirmed diHNPCC	25%
Prophylactic total colectomy for confirmed diHNPCC	100%
Prophylactic partial colectomy or hysterectomy for confirmed diagnosis of HNPCC or Lynch syndrome	25%
Prophylactic total colectomy for confirmed diagnosis of HNPCC or Lynch syndrome	100%

Early Cancer Benefit Category

No payment will be made under this benefit if an amount is payable for the same event on the Severe Illness benefit to which this Early Cancer Cover benefit is an ancillary or the event does not meet the definitions covered under this Early Cancer Benefit.

No claim will be payable for any tumour (as defined below) diagnosed in the first 6 months following the commencement of this benefit.

A malignant tumour positively diagnosed with histological confirmation and characterised by the growth of malignant cells without the invasion of surrounding tissue. Unless otherwise specified the tumour must be classified as tumour in situ (Tis) according to the TNM classification system.

Only one claim will be paid under any specific definition below. Where less than 100% of the Benefit Amount is paid for a claim, the balance is available for future claims on claim events not previously claimed for. Once 100% of the Benefit Amount has been paid the benefit will cease to provide cover.

Maximum Benefit Amount for Early Cancer is N$100 000

Claim Event	**% Payable – Max Benefit Option**
Bladder carcinoma in situ (Tis) with excision	5%
Cervical Intraepithelial Neoplasia Grade III (CIN III) with excision	5%
T1N0M0 melanoma (lentigo maligna melanoma, nodular melanoma, superficial spreading melanoma or acral lentiginous melanoma) with excision	25%

T1N0M0 melanoma (lentigo maligna melanoma, nodular melanoma, superficial spreading melanoma or acral lentiginous melanoma) with excision of the tumour with a skin flap or skin graft	25%
Stage I or II basal cell carcinoma, squamous cell carcinoma, keratoacanthoma, epidermoid carcinoma, malignant epithelioma or verrucous carcinoma with excision	5%
Stage I or II basal cell carcinoma, squamous cell carcinoma, keratoacanthoma, epidermoid carcinoma, malignant epithelioma or verrucous carcinoma with excision of the tumour with a skin flap or skin graft	10%
Trichilemmal carcinoma, pilomatrix carcinoma, sebaceous carcinoma, apocrine carcinoma, eccrine gland carcinoma, adenoid cystic carcinoma or Merkel cell carcinoma with excision	5%
Trichilemmal carcinoma, pilomatrix carcinoma, sebaceous carcinoma, apocrine carcinoma, eccrine gland carcinoma, adenoid cystic carcinoma or Merkel cell carcinoma with excision of the tumour with a skin flap or skin graft	10%
Prostate carcinoma T1N0M0, Gleason Score <7 with external beam radiotherapy, brachytherapy or excision	5%
Colon adenoma with increasing polyp size >1cm or high grade dysplasia treated with polypectomy (removal of the polyp)	5%
Diagnosis of any in situ or borderline malignant cancer, not specified above, having undergone medical and/or surgical treatment in keeping with current best medical practice	10%

Cardiac Benefit Category

Only one payment will be made per cardiovascular event. A single event is defined as all cardiovascular conditions or procedures that occur within a 30 day period.

	Claim Event	**% Payable – Max Benefit Option**
Cardiomyopathy	Confirmed diagnosis of dilated, restrictive or hypertrophic obstructive cardiomyopathy with ongoing treatment on optimal treatment and with the following irreversible functional impairment criteria as confirmed by a cardiologist with two measurements done six weeks apart.	
	Definite diagnosis of Takosubo Cardiomyopathy	25%
	Ejection Fraction <50% and NYHA = 3	75%
	Ejection Fraction <30% and NYHA =4	100%
Heart valve surgery	The undergoing of heart valve surgery, performed to replace or repair one or more heart valves	
	Minimally invasive (such as catheter or keyhole surgery) heart valve repair	25%
	Open heart (thoracotomy) valve repair	100%
	Heart Valve replacement	100%
Heart transplant	Having undergone a heart transplant	100%
Cardio-Pulmonary Dysfunction	On confirmed diagnosis of cardio-pulmonary dysfunction, including	
	Diagnosis of irreversible Cor Pulmonale on optimal treatment	100%
	Confirmed diagnosis of pulmonary hypertension with a peak pulmonary pressure of >40 mmHg	100%

Arrhythmia	This is defined as abnormal electrical activity in the heart, with the life insured having undergone pathway ablation, permanent pacemaker insertion or defibrillator insertion.	
	Cardiac Arrhythmia having undergone pathway ablation or a permanent pacemaker insertion (one payment only)	25%
	Cardiac Arrhythmia having undergone defibrillator insertion (one payment only)	50%
Heart Surgery*	Minimally invasive (such as catheter or keyhole) heart surgery not specified above	25%
	Undergoing of open heart (thoracotomy) surgery for any condition not specified above such as Atrial Septal Defect, Ventricular Septal Defect and Ventricular aneurysm	100%

*This definition occurs in more than one benefit category. Any benefits payable as a result of this definition will only be paid from the benefit category originally claimed from for that condition. i.e. A maximum of up to 100% of the sum insured will be paid for a condition that meets the requirements of the definition.

Cardiovascular Benefit Category		
Only one payment will be made per cardiovascular event. A single event is defined as all cardiovascular conditions or procedures that occur within a 30 day period		
	Claim Event	**% Payable – Max Benefit Option**
NSTMI and acute coronary syndrome	Acute coronary syndrome confirmed by raised hs -Troponin T level >0,1 ng/ml with angiographic evidence of coronary artery disease at the time of the event. This specifically includes Non-STEMI events	10%
	Mild: This is defined as the death of heart muscle, due to inadequate blood supply, as evidenced by all three of the following criteria: 1. Compatible clinical symptoms 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 > 0,5 ng/ml, or • Trop I > 0,25 ng/ml, or • Raised CK-MB mass ○ Up to 2 times normal values in acute presentation phase, or ○ Up to 4 times normal values post-intervention, or • Total CPK elevation of up to 2x 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	100%

	angina and takatsubo are not covered by this definition.	

Heart attack	**Moderate:** This is defined as the death of heart muscle, due to inadequate blood supply, as evidenced by two of the following three criteria: 1. Compatible clinical symptoms 2. Characteristic ECG changes, which can be either of the following: • New pathological Q-waves, or • ST-segment and T-wave changes indicative of myocardial injury, but only when accompanied by raised cardiac markers as described hereafter. 3. Raised cardiac markers: • Trop T > 1,0 ng/ml, or • Trop I > 0,5 ng/ml, or • Raised CK-MB mass ○ More than 2 times normal values in acute presentation phase, or ○ More than 4 times normal values post-intervention, • Total CPK elevation of more than 2x normal values, with at least 6% being CK-MB.	100%
	Meeting the moderate heart attack definition with irreversible functional impairment measured 30 days post-infarction: Ejection Fraction < 50%	100%
	Meeting the moderate heart attack definition with irreversible functional impairment measured 30 days post-infarction: Ejection Fraction < 40%	100%
Angioplasty / stent	Angioplasty with or without stent	10%
Coronary Artery Disease	The undergoing of surgery to correct the narrowing of, or blockage to, one or more coronary arteries by means of a bypass graft.	
	Bypass graft in 1 coronary artery, including the left main or proximal left anterior descending coronary artery	100%
	Bypass grafts in 2 coronary arteries	100%
	Bypass grafts in 3 or more coronary arteries	100%
Surgery of the Aorta	Having undergone surgery to the thoracic or abdominal aorta to repair an aneurysm, or dissection. This does not include the branches of the aorta or endovascular procedures.	100%
Endovascular procedures to aorta	Endovascular repair of established disease, atheroma, aneurysm and dissection, by means of keyhole or catheter techniques or any other minimally invasive surgical procedure.	
	Endovascular procedures to repair the aorta or any of its immediate branches: Iliac, femoral, renal, splenic, subclavian and superior mesenteric arteries. All other branches are excluded.	25%

Carotid Arterial Disease (only one payment under each category of this condition will be considered)	Carotid artery stenosis in one or both carotid arteries, having undergone angioplasty and/or stenting	25%
	Carotid artery stenosis in one carotid artery, having undergone open endarterectomy	75%
	Carotid artery stenosis in two carotid arteries, having undergone open endarterectomy	100%
Peripheral Arterial disease	Peripheral arterial disease resulting in gangrene or amputation of a limb or part of a limb	100%
	Peripheral arterial disease resulting in an ABI <0.7 resulting in persistent claudication or ulceration	75%
	Surgical repair of the following occluded major peripheral arteries: Iliac, Femoral, Popliteal, Tibial, Peroneal, Splenic, Subclavian, Superior Mesenteric, Brachial. All other branches are excluded.	25%

Nervous System Benefit Category		
	Claim Event	**% Payable – Max Benefit Option**
Multiple Sclerosis	The diagnosis of Multiple Sclerosis confirmed by a specialist neurologist. The diagnosis must be supported by: • Two separate clinical events must have occurred resulting in neurological deficit, and • Supporting radiological evidence	25%
	The diagnosis of Multiple Sclerosis confirmed by a specialist neurologist. The diagnosis must be supported by: • Two separate clinical events must have occurred resulting in neurological deficit, and • supporting radiological evidence, and • permanent failure of 6 advanced ADLs	75%
	The diagnosis of Multiple Sclerosis confirmed by a specialist neurologist. The diagnosis must be supported by: • Two separate clinical events must have occurred resulting in neurological deficit, and • supporting radiological evidence, and • permanent failure of 3 basic ADLs.	100%
Parkinson's Disease	The definite diagnosis of Parkinson's Disease confirmed with appropriate imaging, excluding other conditions that present similarly and/or drug induced conditions that are reversible	25%
	The diagnosis of Parkinson's Disease by a neurologist with permanent failure of 6 advanced ADLs	100%
	The diagnosis of Parkinson's Disease by a neurologist with permanent failure of 3 basic ADLs	100%

Motor Neurone Disease	Definite diagnosis of Motor Neurone Disease by a specialist neurologist, confirmed by appropriate testing and investigations. There must be irreversible, objective clinical impairment of motor functions.	100%

Muscular Dystrophy	Confirmed diagnosis of Muscular Dystrophy resulting in the permanent inability to perform 6 or more advanced ADL's	75%
	Confirmed diagnosis of Muscular Dystrophy resulting in the permanent failure of 3 or more basic ADLs	100%
Alzheimer's Disease	The unequivocal diagnosis of the current symptoms of Alzheimer's Disease, confirmed by a neurologist and radiological investigations.	25%
	The unequivocal diagnosis of Alzheimer's Disease confirmed by a neurologist where dementia has resulted in permanent, significant memory and cognitive impairment for which no other recognisable cause has been identified. Memory and cognitive impairment must result in an MMSE score of ≤ 18	100%
Benign Brain Tumour	The diagnosis of a symptomatic non-cancerous tumour of the brain or meninges confirmed by a neurologist	
	The diagnosis of a symptomatic benign tumour of the brain or meninges confirmed by a neurologist and having undergone any form of surgery or radiotherapy.	50%
	Resulting in failure of 3 or more basic activities of daily living	100%
Bacterial Meningitis	The diagnosis of bacterial meningitis confirmed by a Neurologist with supporting medical evidence	25%
Cerebral Malaria	The diagnosis of cerebral malaria confirmed by a specialist physician	25%
Myasthenia Gravis	Myasthenia Gravis is a neuromuscular disease characterised by weakness and fatigability of the skeletal muscles. The diagnosis must be confirmed by a neurologist. A positive antiacetylcholine receptor antibody test must support the diagnosis.	
	Definite diagnosis of Myasthenia Gravis confirmed with positive serology and electrophysiological testing	25%
	With failure of 6 or more Advanced ADLs	75%
	With failure of 3 or more Basic ADLs	100%
Guillain-Barre syndrome	Guillain-Barre syndrome is an acute, inflammatory, post infectious polyneuropathy resulting in progressive and ascending paralysis. The diagnosis must be confirmed by a neurologist, have been treated with plasma exchange or intravenous immunoglobulin, and must be of a severity to have documented evidence of persistent neurological symptoms lasting for a period of at least six months from the time of diagnosis. Cases of Guillain-Barre syndrome that present with or progress to bulbar weakness and respiratory dysfunction with resultant ventilation or tracheostomy will be paid on diagnosis.	
	Guillain-Barre syndrome that present with respiratory dysfunction treated with mechanical ventilation, or with persistent neurological symptoms lasting at least 6 months	25%
	Guillain-Barre syndrome with persistent total and irreversible neurological symptoms lasting at least 12 months, with the inability to perform 6 or more Advanced Activities of Daily Living	75%

	Guillain-Barre syndrome with persistent total and irreversible neurological symptoms lasting at least 12 months, with the inability to perform 3 or more Basic Activities of Daily Living	100%

Permanent mental or cognitive impairment	An organic brain condition resulting in a permanent, irreversible MMSE score of < 24 and a failure to perform 3 or more Advanced ADLs. All Psychiatric conditions are excluded.	50%
	An organic brain condition resulting in a permanent, irreversible MMSE score of ≤ 18 and where curatorship is required. Psychiatric conditions are excluded.	100%
Neuro Catch-All	Failure of 6 or more Advanced ADLs for any neurological condition not specified above	75%
	Failure of 3 or more Basic ADLs for any neurological condition not specified above	100%
Paralysis	Paraplegia, hemiplegia, diplegia or quadriplegia	100%
Hydrocephalus	Insertion of a shunt for the treatment of hydrocephalus	25%
Brain Abscess	Diagnosis of brain abscess treated without surgery	25%
	Diagnosis of brain abscess treated with surgery	50%
Stereotactic Brain Surgery	Stereotactic brain surgery for any condition not specified above	10%
Open Brain Surgery*	Having undergone open brain surgery for a medical condition due to illness or trauma	50%
	Having undergone open brain surgery for a medical condition due to illness or trauma with permanent failure of 6 or more Advanced ADLs	75%
	Having undergone open brain surgery for a medical condition due to illness or trauma with permanent failure of 3 or more basic ADLs	100%

Cerebrovascular Benefit Category		
	Claim Event	**% Payable – Max Benefit Option**
Stroke	Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in motor deficit or neurological deficit lasting at least 24 hours consistent with the area of the brain affected, and confirmed with 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 full neurological examination by a specialist neurologist any time after three months	
	Diagnosis of stroke	25%
	Stroke with irreversible motor or neurological deficit, defined as	100%

	the permanent inability to perform 3 or more advanced activities of daily living.	
	Stroke resulting in the permanent inability to perform 6 or more advanced activities of daily living	100%
	Stroke resulting in the permanent inability to perform 3 or more basic activities of Daily living	100%
Sub-Arachnoid Haemorrhage	Diagnosis of sub-arachnoid haemorrhage	25%
Sinus thrombosis	Diagnosis of a sagittal or cavernous sinus thrombosis	25%
Arteriovenous Malformation	Arteriovenous malformation treated with radiological intervention	25%

*This definition occurs in more than one benefit category. Any benefits payable as a result of this definition will only be paid from the benefit category originally claimed from for that condition. i.e. A maximum of up to 100% of the sum insured will be paid for a condition that meets the requirements of the definition.

Gastrointestinal Benefit Category

Only one payment will be made per gastrointestinal category event. A single event is defined as all gastrointestinal system conditions that occur within a 30 day period.

For this benefit group no benefit will be paid where a claim is, in the opinion of Hollard Life, directly or indirectly occasioned by or accelerated by alcohol or substance abuse.

	Claim Event	**% Payable – Max Benefit Option**
Liver failure	Chronic Liver disease classified as Child Pugh class C	100%
	Chronic Liver disease classified as Child Pugh class B	75%
	Chronic Liver disease classified as Child Pugh class A	50%
Liver or Kidney Pancreas transplant	Having undergone a complete liver or pancreas transplant	100%
Pancreatectomy	Partial pancreatectomy. Non-therapeutic procedures such as biopsies and organ donation are specifically excluded.	25%
	Complete pancreatectomy	100%
Hepatectomy	Partial hepatectomy. Non-therapeutic procedures such as biopsies and organ donation are specifically excluded.	25%
Chronic Pancreatitis	Chronic pancreatitis resulting in diabetes or malabsorption syndrome. Diabetes has to be clinically diagnosed with relevant medical tests	50%
Crohn's Disease	Ulcerative colitis or Crohn's disease on optimal medical treatment for at least 6 months. The diagnosis must be confirmed by a gastroenterologist and the disease must be treated with either steroids or immunomodulatory medication for a period of at least six months.	25%
Ulcerative Colitis	Ulcerative colitis or Crohn's disease having undergone more than one surgery. Non-therapeutic procedures such as biopsies are specifically excluded. The diagnosis must be confirmed by a gastroenterologist and the disease must be treated with either steroids or immunomodulatory medication for a period of at	50%

	least six months.	
Hepato-biliary	Primary Sclerosing Cholangitis	100%
	Fulminant hepatic failure	100%
	Primary biliary cirrhosis	100%
	Portal hypertension with varices, or refractory ascites and splenomegaly, or refractory pancytopenia	100%

	Diagnosis of portal hypertension	25%
	Chronic persistent Hepatitis B on optimal treatment for 12 months or more without complete viral suppression	25%
Colon	Total colectomy, permanent colostomy or permanent ileostomy	75%
	Hemicolectomy, not due to Ulcerative Colitis or Crohn's Disease	10%
	Chronic rectal fistula despite surgical repair	10%
General	Tracheal-oesophageal fistula	10%
	Proven acute bacterial peritonitis having undergone laparotomy. Non-perforated appendicitis is specifically excluded.	10%
	Drainage of pancreatic cyst or abscess	10%

Kidney and Liver Urogenital Benefit Category

Only one payment will be made per kidney and urogenital event. A single event is defined as all kidney or urogenital conditions or procedures that occur within a 30 day period.

	Claim Event	**% Payable – Max Benefit Option**
Kidney and Renal disease	Diagnosis of Renal abscess	5%
	Chronic tubulo-interstitial nephritis	10%
	Confirmed diagnosis of nephritic syndrome	15%
	Confirmed diagnosis of nephrotic syndrome with a proteinuria of 3g per 24 hours and a GFR of <60 mls per minute present for 6 months	15%
	Renal cortical necrosis involving >2/3 of the renal cortex	50%
	Acute renal failure having undergone 5 treatments of haemodialysis	50%
	Chronic irreversible renal disease with the GFR of 31-55ml/min and a documented decline in the GFR of greater than 5ml/min within the last 12 months despite optimal treatment by an appropriate specialist	50%
	Chronic irreversible renal failure with a GFR of 16-30ml/min/1.73m2 and a documented decline in the GFR of greater than 5ml/min within the last 12 months despite	75%

	optimal treatment by an appropriate specialist	
	Chronic irreversible renal failure with GFR <15 ml/min/m2 or continuous permanent regular dialysis confirmed by nephrologist	100%
	Having undergone a kidney transplant	100%
Nephrectomy Renal Surgery	Endoscopic or minimally invasive renal surgery (excluding biopsy* or any surgery for renal stones)	10%
	The actual undergoing of a partial nephrectomy due to illness, disease or accident. Non-therapeutic procedures such as biopsies* and organ donation are specifically excluded.	25%
	The actual undergoing of a complete nephrectomy due to illness, disease or accident. Non-therapeutic procedures such as biopsies and organ donation are specifically excluded.	50%
Cystectomy	Partial cystectomy	25%
	Radical cystectomy resulting in the need for permanent external stoma bag or permanent catheterisation	100%
Penile Amputation	Partial amputation of the penis. This specifically excludes biopsies*, circumcision, gender reassignment surgery and gender dysphonia.	25%
	Total amputation of the penis. This excludes surgery for gender reassignment or gender dysphonia.	50%
General	Unilateral or bilateral orchidectomy	25%
	Open kidney surgery for renal or renovascular disease or injury	25%
	Rectovaginal or vesicovaginal fistula	25%
	Urethral fistula	10%
	Surgical repair of urethral or ureteric stricture (Restricted to one payment only)	5%
*A biopsy is a medical test commonly performed by a surgeon, interventional radiologist, or an interventional cardiologist involving extraction of sample cells or tissues for examination to determine the presence or extent of a disease.		

Respiratory Benefit Category

Only one payment will be made per respiratory event. A single event is defined as all respiratory conditions or procedures that occur within a 30 day period.

	Claim Event	**% Payable – Max Benefit Option**
Lung Transplant	The actual undergoing of a transplant as a recipient of a complete lung	100%
Cor Pulmonale	Irreversible cor pulmonale	100%

Pulmonary Hypertension	Confirmed diagnosis of pulmonary hypertension with a peak pulmonary pressure of >40 mmHg	100%
Pulmonary Embolism	Recurrent pulmonary emboli having undergone insertion of a veno-caval filter	100%
	Diagnosis of pulmonary embolism confirmed with relevant imaging. Subject to a maximum of 2 payments	25%
Respiratory Failure	Chronic obstructive or restrictive lung disease with a permanent FEV1 or FVC or DLCO of 45% or less than predicted on 2 separate occasions at least one month apart	100%
	Chronic obstructive or restrictive lung disease with permanent FEV1 or FVC or DLCO of 46% to 49% of predicted	50%
Lung Surgery	Removal of one lobe of a lung due to disease or injury	25%
	Removal of more than one lobe of the lung or removal of an entire lung due to disease or injury	50%
Status Asthmaticus	Status asthmaticus having undergone intubation and ICU admission	25%
General	Diagnosis of a lung abscess	25%
	Diagnosis of a bronchopleural fistula	25%
	Pleurectomy, decortication, drainage of empyema, or other open lung surgery not specified elsewhere. This excludes lung biopsy* and any procedures purely for diagnostic purposes.	25%
	On confirmed diagnosis of any of the following: bronchiectasis, fibrosing alveolitis, pneumoconiosis, or interstitial lung diseases	10%
	Drainage of pleural effusion by intercostal drainage	10%
*A biopsy is a medical test commonly performed by a surgeon, interventional radiologist, or an interventional cardiologist involving extraction of sample cells or tissues for examination to determine the presence or extent of a disease.		

Connective Tissue Disease's Benefit Category

Only one payment will be made per connective tissue disease event.

Confirmed diagnosis of Rheumatoid arthritis, Systemic lupus Erythematosus, Progressive Systemic Sclerosis, Sarcoidosis, Polyarteritis nodosa, Giant cell arteritis, Wegener's granulomatosis, dermatomyositis, polymyositis. Diagnosis is to be confirmed according to specific criteria defined by the American College of Rheumatology.

For CTD or Autoimmune Disorders with major organ involvement, the severity of involvement will be assessed under the relevant system which will be capped at a 100% payout. Should multiple organs be involved, the organ with the most severe impairment will qualify for the highest payout. (are we limiting to brain and kidney)

Claim Event	**% Payable – Max Benefit Option**
Confirmed diagnosis and ongoing treatment with DMARDS or biologics for the listed connective tissue disease, above.	25%
Confirmed diagnosis and ongoing treatment of Ehlers-Danlos Syndrome	10%
Any listed CTD or autoimmune disease having undergone major joint replacement or arthrodesis of the Spine, shoulder, elbow, wrist, hip, knee or ankle	100%
Connective tissue disorder or autoimmune disorder with permanent failure of 6 or more Advanced ADLs	75%

Connective tissue disorder or autoimmune disorder with permanent failure of 3 or more basic ADLs	100%

Sensory Benefit Category Only one payment will be made per sensory disease event. A single event is defined as all sensory conditions or procedures that occur within a 30 day period.		
	Claim Event	**% Payable – Max Benefit Option**
Blindness	Total and irreversible (not correctable by treatment or operation) loss of sight in both eyes. Permanent visual acuity impairment (not correctable by operation) resulting in a Snellen rating of less than 20/200 or worse bilaterally. The blindness must be certified through an ophthalmologist's report and cataracts are specifically excluded.	100%

	Irreversible homonymous hemianopia in both eyes	100%
	Irreversible Diabetic retinopathy (grade IV)	100%
	Enucleation of eye	75%
	Optic nerve atrophy	50%
	Irreversible hemianopia in one eye	50%
	Complete and permanent blindness in one eye due to injury or disease	50%
	Diagnosis of Retinitis Pigmentosa	25%
	The undergoing of a corneal transplant	15%
	On diagnosis of Optic neuritis	10%
	On diagnosis of Retinal Detachment	10%
Deafness	Permanent Hearing loss of more than 90 decibels (in both ears) at frequencies of 500, 1000, 2000, and 3000Hz despite use of a hearing aid	100%
	Binaural hearing loss >75% as per the American Medical Association Guide To Impairment (latest edition), despite the use of a hearing aid	75%
	Permanent Hearing loss between 70-89 decibels (in both ears) at frequencies of 500, 1000, 2000, and 3000Hz (PPS) despite use of a hearing aid	50%
	Acoustic neuroma I would suggest including "that is causing neurological deficit" to avoid paying for incidental findings	25%
	Mastoiditis having undergone surgery	25%
	Tympanosclerosis with hearing loss	10%
	Otosclerosis	10%
	On diagnosis of Mastoiditis	5%
	Having undergone a cochlear implant (any payments received for hearing loss)	25%

Loss of Speech	A certified physician must make the definite diagnosis of loss of speech where there is total and permanent loss of the ability to produce intelligible speech as a result of irreversible damage to the larynx or its nerve supply from the speech centres of the brain. Medical evidence must be supplied to confirm laryngeal dysfunction and that the loss of speech has lasted for a continuous period of at least 12 months. For the above definition, the following are not covered: • All psychiatric causes of loss of speech.	100%

Trauma and Musculoskeletal Benefit Group For this benefit group, no payment shall be made if the incident or illness giving rise to such claim was directly or indirectly caused, occasioned, accelerated or aggravated by self-inflicted injuries whether the life insured is of sound mind or not**.**		
	Claim Event	**% Payable – Max Benefit Option**
Coma	ICU admission with mechanical ventilation for 48 hours due to illness or injury. A coma which is medically induced or results directly from alcohol or drug use is excluded.	50%
	ICU admission with mechanical ventilation for 96 hours due to illness or injury. A coma which is medically induced or results directly from alcohol or drug use is excluded.	100%
Major Head Trauma	A traumatic injury to the brain, caused by an external physical force, resulting in significant irreversible neurological deficit measured by the inability to perform 6 Advanced Activities of Daily Living. The inability to perform ADLs will be assessed with a functional capacity evaluation performed by an occupational therapist, in conjunction with a neurological examination by the treating neurologist.	75%
	A traumatic injury to the brain, caused by an external physical force, resulting in significant irreversible neurological deficit measured by the inability to perform 3 basic Activities of Daily Living. The inability to perform ADLs will be assessed with a functional capacity evaluation performed by an occupational therapist, in conjunction with a neurological examination by the treating neurologist.	100%
Paralysis	Permanent paraplegia, hemiplegia, diplegia or quadriplegia	100%
Major Burns	Full thickness burns covering at least 20% of the body surface area	100%
Loss of use of limbs	For loss of use of, or for amputation, arm is defined as any loss from the wrist and higher, and leg is defined as any loss from the ankle joint and higher. The amputation of, or the total and irreversible loss of motor function of: • one arm or • one leg	50%
	For loss of use of, or for amputation, arm is defined as any loss from the wrist and higher, and leg is defined as	100%

	any loss from the ankle joint and higher. The amputation of, or the total and irreversible loss of motor function of: • both arms, • both legs, or • one arm and one leg	
Pregnancy Complications	For this benefit there is a 12 month waiting period from the benefit commencement date until the benefits are available. This benefit covers a female life insured against the following: • Stillbirth in the third trimester; • Birth weight of less than 1.5 kg with two or more days in ICU for the new-born baby of the female Life Insured • Birth defect or congenital anomaly in the new-born baby of the female life insured with surgery in the 90 days following birth Pregnancy complications where the female life insured: • Spends two or more days in ICU; or • Spends one day in ICU and three or more consecutive days in a general hospital ward/ high care ward, or; • Spends more than five consecutive days in a general hospital ward/high care ward	5%

General	Total replacement of any of the Hip, Knee, Ankle or shoulder joint. Subject to a maximum of 2 events.	10%
	Chronic (more than 6 months) Osteomyelitis confirmed by the treating specialist.	10%
	Definite diagnosis of Paget's disease of the bone	5%
	Surgical repair of any of the musculocutaneous, median, ulnar, radial, sciatic, femoral, tibial or fibular nerves after complete severance. Subject to a maximum of 2 events	10%

Endocrine Conditions Benefit Group
(one payout per distinct endocrine disorder)

Only one payment will be made per endocrine disease event. A single event is defined as all endocrine conditions or procedures that occur within a 30 day period.

Claim Event	**% Payable – Max Benefit Option**
On diagnosis of a Thyroid storm	10%
On diagnosis of Diabetes insipidus	10%
On diagnosis of an Acute adrenal crisis	10%
On diagnosis of Addison's disease	10%
On diagnosis of Sheehan's syndrome or Simmonds' disease	10%
On diagnosis of Conn's syndrome	10%
On diagnosis of Cushing's syndrome	10%

On diagnosis of any Glycogen storage disease	10%
Endocrine tumours having undergone surgical excision: adrenal adenoma (or adrenalectomy), pheochromocytoma, carcinoid tumour, pancreatic tumour, insulinoma, parathyroid tumour and thyroid adenoma, pituitary tumour.	10%

AIDS / HIV Benefit Group		
	Claim Event	**% Payable – Max Benefit Option**
Advanced AIDS	Advanced AIDS, confirmed by a positive HIV antibody test and a CD4 count <200 despite compliance with Antiretroviral treatment, with confirmed drug resistance to first, second and third line ART resulting in a persistently high viral load of >10000 copies/ml	100%
Accidental HIV Infection	An HIV test, done at a SANAS or NSI accredited lab, must be done within 72 hours after the event leading to HIV exposure to confirm prior HIV negative status. A full course of post exposure prophylaxis must have been taken by the client for at least 28 consecutive days after the incident or event. Accidental HIV infection as a result of one of the following incidents: • Accidental needle-stick injury acquired in the course of professional duties as a medical or dental practitioner or registered nurse. The practitioner must be registered with the appropriate professional council. A negative HIV test must be performed within 24 hours to confirm a HIV negative status at the time of the needle-stick injury. Proof should also be supplied that the person has been started on a course of anti-retroviral drugs, or • Rape or indecent assault. The offence must have been reported to the Namibian Police Force (NAMPOL) and a criminal case opened. An HIV test must have been performed within 24 hours of the assault to confirm an HIV negative status at the time of the assault. A medical examination of the victim must have been performed within 24 hours after the incident. Proof should also be supplied that the patient has been started on a course of anti-retroviral drugs; or • Undergoing an organ transplant at an institution recognised by Hollard Life where the transplanted organ was infected with the HIV virus. The organ donor service must admit liability for the incident, or; • The transfusion of infected blood or blood products from a transfusion service recognised by Hollard Life, occurring after the starting date of the policy. The transfusion service must admit liability for the incident, or; • Involvement in a road traffic accident. The incident must have been reported to the Namibian Police Force (NAMPOL). An HIV test must have been performed within 24 hours of the accident to confirm an HIV negative status at the time of the accident. Proof should also be supplied	100%

	that the patient has been started on a course of anti-retroviral drugs, or; • Being the victim of a violent crime. The incident must have been reported to the Namibian Police Force (NAMPOL) and a criminal case opened. An HIV test must have been performed within 24 hours of the accident to confirm an HIV negative status at the time of the accident. Proof should also be supplied that the patient has been started on a course of anti-retroviral drugs.	

Children's Benefit	
Claim Event	**% Payable – Max Benefit Option**
All children of the life insured, up to a maximum of 4, are covered in terms of the children's benefit for the conditions defined in this policy wording. A child is defined as a natural or legal child of the life insured. The cover will start when each child is six months old and ends on their 21st birthday (24 if the child is a full-time student at a recognised tertiary educational institution). The benefit amount for each child will be 15% of the benefit amount payable to the life insured for that event or condition, subject to a maximum of N$300 000. Where a child could claim under two or more Hollard Life policies with a children's benefit, then the benefit amount shall be restricted to the greater of the amount on any individual policy. This benefit is only payable once for each child and once two claims have been paid under the children's benefit, the children's benefit cover will end. A survival period of 14 days will be imposed before a claim is admitted. Should the child die within the survival period, then no claim will be payable under the children's benefit. Hollard Life may, at its discretion, waive the survival period. Congenital, familial and pre-existing conditions are specifically excluded from this benefit and on the Status Epilepticus Benefit, febrile seizures are excluded. Any payments made under the children's benefit will not reduce the benefit amount for the life insured.	15% (max N$300 000)

Catch-All Benefit

For this benefit group, payment shall be made if the incident or illness giving rise to such claim meets one of the definitions below but not any other definition covered under the Comprehensive Severe Illness benefit. Pre-existing medical conditions and injuries suffered by the life insured will be specifically excluded from this benefit. Pre-existing conditions are defined as medical conditions, injuries and events suffered by the life insured prior to the commencement date of the policy, as well as any event related to these medical conditions, injuries or events that occur after the policy commencement date.

Life saving Emergency Surgical Procedure	Emergency, open surgical procedure, performed in response to and within 24 hours of a life-threatening event, confirmed by clinical and laboratory or radiological evidence. Appendectomies and tonsillectomies are specifically excluded from this definition	The lesser of N$500 000 and 20% of the benefit amount
Intensive Care Unit Stay	Continuous ICU stay for longer than 24 hours. The benefit amount is paid out per day with a day being a completed period of 24 hours from admittance to an Intensive Care Unit. All psychiatric admissions and elective stays are	4% of benefit amount per day, subject to a maximum of the lesser of N$500 000 and 20% of the benefit amount

	specifically excluded from this definition.	
Hospitalisation Benefit:	Continuous hospitalisation for more than 10 days. This includes back traction, spinal fusion and spinal / back surgery, but excludes elective cosmetic surgery. The benefit amount is paid out per day with a day being a completed period of 24 hours from admittance to hospital. All psychiatric admissions and elective stays are specifically excluded from this definition.	2% of benefit amount per day, subject to a maximum of the lesser of N$500 000 and 20% of the benefit amount

Definition of Activities of Daily Activities The cause, must be confirmed in a report from the life insured's doctor, and an examination by a specialist of Hollard Life's choice. The assessment of Activities of Daily Living must be done as part of a comprehensive assessment by an Occupational Therapist.	
Basic	• The ability to bend to get into or out of a standard car, being able to bend or kneel to pick up something from the floor and straighten up without suffering severe discomfort or being unable to walk 200 meters on a flat surface without having to stop; • The ability to lift, carry objects for example a kettle of water, bags of shopping or a briefcase; • Communicating, being the ability to talk to another person, communicate via technology and, being the ability to answer the telephone; • Reading, meaning having the eyesight required to be able to read, for example reading a daily newspaper or emails; • Manual Dexterity, being the ability to use hands and fingers with precision, including the ability to pick up and manipulate small objects, such as pens or cutlery and take a message
Advanced	• Driving a car – the ability to open a car door, change gears or use a steering wheel; • Medical care: the ability to prepare and take the correct medication; • Money management – the ability to do one's own banking and to make rational financial decisions; • Communicative activities: - the ability to communicate either verbally or written; • Shopping: - the ability to choose and lift groceries from shelves as well as carry them in bags; • Food preparation – the ability to prepare food for cooking as well as using kitchen utensils; • Housework – the ability to clean a house or iron clothing; • Community ambulation with or without assistive device, not requiring a mobility device- the ability to walk around in public places using a walking stick, if necessary.

What is the Survival Period?

If a policy has life cover, a survival period of 14 days will be imposed before a claim is admitted. Should the Life insured or a child covered under the Children's Benefit die within the survival period, then no claim will be payable.

When does the Comprehensive Severe Illness Benefit end?

The Comprehensive Severe Illness benefit will end when the first of these happens:

- The Comprehensive Severe Illness benefit term, as specified in your Policy schedule, expires;
- You cancel the Comprehensive Severe Illness benefit;
- Your Policy lapses. The Comprehensive Severe Illness Benefit will then cease on the last day of the month for which you last paid your premiums in full;
- The Life Insured dies;
- After the full benefit amount has been paid for every benefit category.

Exclusions

We will not make any payment if the illness or incident that gives rise to a claim event was directly or indirectly caused by, brought about by, accelerated by or aggravated by self-inflicted injuries or if the life assured takes any substance / medication to induce a condition.

We will not make any payment if any fraudulent documentation or information is provided at application or claim stage.

Benefit Specific Terms and Conditions: Comprehensive Severe Illness

How does Comprehensive Severe Illness work?

The Comprehensive Severe Illness benefit has been divided into 16 Benefit categories. Each benefit category sets out the criteria for the Claim Events and the proportion of the Benefit Amount payable under the Comprehensive Severe Illness benefit, subject to any limits and conditions within each benefit category. A benefit under the Comprehensive Severe Illness Benefit will become payable if the Life Insured meets the criteria of a Claim Event, and the Policy is inforce.

What are the Benefit Categories?

The benefit categories are as follows:

- Cancer Benefit Category;
- Early Cancer Benefit Category;
- Cardiac Benefit Category;
- Cardiovascular Benefit Category;
- Nervous Benefit Category;
- Cerebrovascular Benefit Category;
- Gastrointestinal Benefit Category;
- Kidney and Urogenital Benefit Category;
- Respiratory Benefit Category;
- Connective Tissue Benefit Category;
- Sensory Benefit Category;
- Trauma and Musculoskeletal;
- Endocrine Benefit Category;
- HIV Benefit Category;
- Children Benefit Category; and
- A Catch-all Benefit Category.

What is the Benefit Amount?

The maximum Benefit Amount payable for each benefit category, subject to any specified maximum, is specified in the Policy schedule, at date of event, and will include any benefit endorsements and any voluntary increases. The Benefit Amount for certain Benefit Categories are subject to an overall maximum, set out below under Benefit Categories and Claim Events.

The Benefit Amount for any Benefit Category will reduce by the amount of any payment made with respect to that Benefit Category. The remaining Severe Illness Benefit Amount (if any) will be available for further claims in that Benefit category. The Benefit Amount payable for any Benefit Category is subject to a maximum of 100%.

If the illness for which you have previously claimed has progressed to a more severe level, as per the Benefit Category, an additional payment will be made. This additional payment will be the current benefit minus the previous payment.

How does the Reinstatement of Benefit Amount work?

After 100% of the Benefit Amount has been paid in respect of a Benefit Category, the Benefit Amount for that Benefit Category will automatically reinstate 90 days after the last claim event date for that Benefit Category on the following basis:

- Claims for conditions prior to 75th birthday, 25% of the original Benefit Amount plus any benefit increases;
- Claims for conditions on or after 75th birthday, 15% of the original Benefit Amount plus any benefit increases.

The reinstated Benefit Amount will only be payable for a claim event that occurs more than 90 days after the last claim event that resulted in a total of 100% of the Benefit Amount for a particular Benefit Category being paid.

The reinstatement of the benefit, as described above, will not apply in the event of a recurrence, progression, or complication of a condition for which all or part of the Benefit Amount was paid prior to reinstatement.

What happens if two or more Claims are made at the same time?

Only one payment will be made if claims for two or more of the contingent claim events are made at the same time. Contingent claim events are any claim events occurring within 30 days of each other. We will pay the highest benefit payment that would have been made for any one of the individual claims.

General Conditions

The claim must be proved to Hollard Life's satisfaction within three months of the injury or onset of the illness or disease.

We reserve the right to call for appropriate investigations and tests in order to confirm the diagnosis to the satisfaction of Hollard Life.

Cancer Benefit Category

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, multiple myeloma and sarcoma. Unless stated otherwise, the levels are correlated to the general classification used by the American Joint Committee for Cancer for the type of cancer involved.
The following conditions are excluded from this definition:
(1) All skin cancers other than malignant melanoma that have been histologically classified as having caused invasion beyond the epidermis unless specifically mentioned; and
(2) Diagnosis made by liquid biopsy will not be acceptable proof of a cancer diagnosis.

Claim Event	**% Payable – Severity benefit option**
Myeloproliferative disorders : Polycythaemia Vera, Essential thrombocytosis	5%
Carcinoid Syndrome	10%
Myelodysplastic syndrome or Myelofibrosis	10%
Borderline Ovarian Tumours Stage I	25%
Bone marrow aplasia	25%
Basal Cell or Squamous Cell Carcinoma Stage III	50%
Malignant Melanoma Stage IB	25%
Prostate cancer T1N0M0 Gleason ≥7	25%
Prostate cancer T2N0M0	25%
Chronic Lymphocytic Leukaemia (Stage 0 or 1 on the RAI classification)	25%

Hairy cell leukaemia	25%
Hodgkin's / Non Hodgkin's Lymphoma Stage 1 on Ann Arbor classification	25%
Any other stage 1 Carcinoma not covered elsewhere	25%
Prostate cancer T3N0M0	50%
Chronic Lymphocytic Leukaemia (Stage II on the Rai classification)	50%
Acute Lymphocytic Leukaemia (children)	50%
Chronic Myeloid Leukaemia (no bone barrow transplantation)	50%
Hodgkin's / Non Hodgkin's lymphoma Stage II on Ann Arbor classification system	50%
Multiple Myeloma Stage I and II on the Durie-Salmon scale	50%
Malignant melanoma Stage II	50%
WHO Grade II Brain Tumour	50%
Borderline Ovarian Tumours Stage II	50%
Hairy cell leukaemia with myelofibrosis transformation	50%
Any other stage 2 Carcinoma not specified above	50%
Prostate cancer T4N0M0	100%
WHO Grade III or IV Brain Tumour	100%
Any other stage 3 cancer not covered above	100%
Prostate cancer any T, N1 - 3, M0	100%
Acute Myeloid Leukaemia	100%
Chronic Lymphocytic Leukaemia (stage III or IV on Rai classification)	100%
Chronic Myeloid Leukaemia (with bone barrow transplantation)	100%
Acute Lymphocytic Leukaemia (adults)	100%
Hodgkin's / Non Hodgkin's lymphoma Stage III or IV on Ann Arbor classification system	100%
Multiple Myeloma Stage III on the Durie-Salmon scale	100%
Any other stage 4 cancer not covered above	100%
Aplastic anaemia with total aplasia of the bone marrow as confirmed by a haematologist, with either blood transfusion or a bone marrow transplant.	100%
The actual undergoing of a bone marrow transplant for haematological malignancy	100%
A condition including any of the following: Unilateral or bilateral mastectomy for carcinoma-in-situ, or prophylactic unilateral or bilateral mastectomy performed upon clinical recommendation by the attending specialist, where any of the following apply for the prophylactic mastectomy: • Breast and/or ovarian cancer in either mother or sister before the age of 50 years; • Bilateral breast cancer in either mother or sister; • Confirmed BRCA 1 or 2 carrier status.	25%
A 12 month waiting period applies for the claim events set out below.	
Prophylactic partial colectomy or hysterectomy for confirmed diHNPCC	25%
Prophylactic total colectomy for confirmed diHNPCC	100%
Prophylactic partial colectomy or hysterectomy for confirmed diagnosis of HNPCC or Lynch syndrome	25%
Prophylactic total colectomy for confirmed diagnosis of HNPCC or Lynch syndrome	100%

Early Cancer Benefit Category

No payment will be made under this benefit if an amount is payable for the same event on the Severe Illness benefit to which this Early Cancer Cover benefit is an ancillary or the event does not meet the definitions covered under this Early Cancer Benefit.

No claim will be payable for any tumour (as defined below) diagnosed in the first 6 months following the commencement of this benefit.

A malignant tumour positively diagnosed with histological confirmation and characterised by the growth of malignant cells without the invasion of surrounding tissue. Unless otherwise specified the tumour must be classified as tumour in situ (Tis) according to the TNM classification system.

Only one claim will be paid under any specific definition below. Where less than 100% of the Benefit Amount is paid for a claim, the balance is available for future claims on claim events not previously claimed for. Once 100% of the Benefit Amount has been paid the benefit will cease to provide cover.

Maximum Benefit Amount for Early Cancer is N$100 000

Claim Event	**% Payable – Severity benefit option**
Bladder carcinoma in situ (Tis) with excision	0%
Cervical Intraepithelial Neoplasia Grade III (CIN III) with excision	0%
T1N0M0 melanoma (lentigo maligna melanoma, nodular melanoma, superficial spreading melanoma or acral lentiginous melanoma) with excision	0%
T1N0M0 melanoma (lentigo maligna melanoma, nodular melanoma, superficial spreading melanoma or acral lentiginous melanoma) with excision of the tumour with a skin flap or skin graft	0%
Stage I or II basal cell carcinoma, squamous cell carcinoma, keratoacanthoma, epidermoid carcinoma, malignant epithelioma or verrucous carcinoma with excision	0%
Stage I or II basal cell carcinoma, squamous cell carcinoma, keratoacanthoma, epidermoid carcinoma, malignant epithelioma or verrucous carcinoma with excision of the tumour with a skin flap or skin graft	0%
Trichilemmal carcinoma, pilomatrix carcinoma, sebaceous carcinoma, apocrine carcinoma, eccrine gland carcinoma, adenoid cystic carcinoma or Merkel cell carcinoma with excision	0%
Trichilemmal carcinoma, pilomatrix carcinoma, sebaceous carcinoma, apocrine carcinoma, eccrine gland carcinoma, adenoid cystic carcinoma or Merkel cell carcinoma with excision of the tumour with a skin flap or skin graft	0%
Prostate carcinoma T1N0M0, Gleason Score <7 with external beam radiotherapy, brachytherapy or excision	0%
Colon adenoma with increasing polyp size >1cm or high grade dysplasia treated with polypectomy (removal of the polyp)	0%
Diagnosis of any in situ or borderline malignant cancer, not specified above, having undergone medical and/or surgical treatment in keeping with current best medical practice	0%

Cardiac Benefit Category Only one payment will be made per cardiovascular event. A single event is defined as all cardiovascular conditions or procedures that occur within a 30 day period.		
	Claim Event	**% Payable – Severity benefit option**
Cardiomyopathy	Confirmed diagnosis of dilated, restrictive or hypertrophic obstructive cardiomyopathy with ongoing treatment on optimal treatment and with the following irreversible functional impairment criteria as confirmed by a cardiologist with two measurements done six weeks apart.	
	Definite diagnosis of Takosubo Cardiomyopathy	25%
	Ejection Fraction <50% and NYHA = 3	75%
	Ejection Fraction <30% and NYHA =4	100%
Heart valve surgery	The undergoing of heart valve surgery, performed to replace or repair one or more heart valves	
	Minimally invasive (such as catheter or keyhole surgery) heart valve repair	25%
	Open heart (thoracotomy) valve repair	100%
	Heart Valve replacement	100%
Heart transplant	Having undergone a heart transplant	100%
Cardio-Pulmonary Dysfunction	On confirmed diagnosis of cardio-pulmonary dysfunction, including	
	Diagnosis of irreversible Cor Pulmonale on optimal treatment	100%
	Confirmed diagnosis of pulmonary hypertension with a peak pulmonary pressure of >40 mmHg	100%
Arrhythmia	This is defined as abnormal electrical activity in the heart, with the life insured having undergone pathway ablation, permanent pacemaker insertion or defibrillator insertion.	
	Cardiac Arrhythmia having undergone pathway ablation or a permanent pacemaker insertion (one payment only)	25%
	Cardiac Arrhythmia having undergone defibrillator insertion (one payment only)	50%
Heart Surgery*	Minimally invasive (such as catheter or keyhole) heart surgery not specified above	25%
	Undergoing of open heart (thoracotomy) surgery for any condition not specified above such as Atrial Septal Defect, Ventricular Septal Defect and Ventricular aneurysm	100%

*This definition occurs in more than one benefit category. Any benefits payable as a result of this definition will only be paid from the benefit category originally claimed from for that condition. i.e. A maximum of up to 100% of the sum insured will be paid for a condition that meets the requirements of the definition.

Cardiovascular Benefit Category		
Only one payment will be made per cardiovascular event. A single event is defined as all cardiovascular conditions or procedures that occur within a 30 day period		
	Claim Event	**% Payable – Severity benefit option**
NSTMI and acute coronary syndrome	Acute coronary syndrome confirmed by raised hs -Troponin T level >0,1 ng/ml with angiographic evidence of coronary artery disease at the time of the event. This specifically includes Non-STEMI events	10%
	Mild: This is defined as the death of heart muscle, due to inadequate blood supply, as evidenced by all three of the following criteria: 1. Compatible clinical symptoms 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 > 0,5 ng/ml, or • Trop I > 0,25 ng/ml, or • Raised CK-MB mass ○ Up to 2 times normal values in acute presentation phase, or ○ Up to 4 times normal values post-intervention, or • Total CPK elevation of up to 2x 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 and takatsubo are not covered by this definition.	25%
Heart attack	**Moderate:** This is defined as the death of heart muscle, due to inadequate blood supply, as evidenced by two of the following three criteria: 1. Compatible clinical symptoms 2. Characteristic ECG changes, which can be either of the following: • New pathological Q-waves, or • ST-segment and T-wave changes indicative of myocardial injury, but only when accompanied by raised cardiac markers as described hereafter. 3. Raised cardiac markers: • Trop T > 1,0 ng/ml, or • Trop I > 0,5 ng/ml, or • Raised CK-MB mass ○ More than 2 times normal values in acute presentation phase, or ○ More than 4 times normal values post-intervention, • Total CPK elevation of more than 2x normal values,	50%

	with at least 6% being CK-MB.	

	Meeting the moderate heart attack definition with irreversible functional impairment measured 30 days post-infarction: Ejection Fraction < 50%	75%
	Meeting the moderate heart attack definition with irreversible functional impairment measured 30 days post-infarction: Ejection Fraction < 40%	100%
Angioplasty / stent	Angioplasty with or without stent	10%
Coronary Artery Disease	The undergoing of surgery to correct the narrowing of, or blockage to, one or more coronary arteries by means of a bypass graft.	
	Bypass graft in 1 coronary artery, including the left main or proximal left anterior descending coronary artery	50%
	Bypass grafts in 2 coronary arteries	75%
	Bypass grafts in 3 or more coronary arteries	100%
Surgery of the Aorta	Having undergone surgery to the thoracic or abdominal aorta to repair an aneurysm, or dissection. This does not include the branches of the aorta or endovascular procedures.	100%
Endovascular procedures to aorta	Endovascular repair of established disease, atheroma, aneurysm and dissection, by means of keyhole or catheter techniques or any other minimally invasive surgical procedure.	
	Endovascular procedures to repair the aorta or any of its immediate branches: Iliac, femoral, renal, splenic, subclavian and superior mesenteric arteries. All other branches are excluded.	25%
Carotid Arterial Disease (only one payment under each category of this condition will be considered)	Carotid artery stenosis in one or both carotid arteries, having undergone angioplasty and/or stenting	25%
	Carotid artery stenosis in one carotid artery, having undergone open endarterectomy	75%
	Carotid artery stenosis in two carotid arteries, having undergone open endarterectomy	100%
Peripheral Arterial disease	Peripheral arterial disease resulting in gangrene or amputation of a limb or part of a limb	100%
	Peripheral arterial disease resulting in an ABI <0.7 resulting in persistent claudication or ulceration	75%
	Surgical repair of the following occluded major peripheral arteries: Iliac, Femoral, Popliteal, Tibial, Peroneal, Splenic, Subclavian, Superior Mesenteric, Brachial. All other branches are excluded.	25%

Nervous System Benefit Category		
	Claim Event	**% Payable – Severity benefit option**

Multiple Sclerosis	The diagnosis of Multiple Sclerosis confirmed by a specialist neurologist. The diagnosis must be supported by: • Two separate clinical events must have occurred resulting in neurological deficit, and • Supporting radiological evidence	25%

	The diagnosis of Multiple Sclerosis confirmed by a specialist neurologist. The diagnosis must be supported by: • Two separate clinical events must have occurred resulting in neurological deficit, and • supporting radiological evidence, and • permanent failure of 6 advanced ADLs	75%
	The diagnosis of Multiple Sclerosis confirmed by a specialist neurologist. The diagnosis must be supported by: • Two separate clinical events must have occurred resulting in neurological deficit, and • supporting radiological evidence, and • permanent failure of 3 basic ADLs.	100%
Parkinson's Disease	The definite diagnosis of Parkinson's Disease confirmed with appropriate imaging, excluding other conditions that present similarly and/or drug induced conditions that are reversible	25%
	The diagnosis of Parkinson's Disease by a neurologist with permanent failure of 6 advanced ADLs	75%
	The diagnosis of Parkinson's Disease by a neurologist with permanent failure of 3 basic ADLs	100%
Motor Neurone Disease	Definite diagnosis of Motor Neurone Disease by a specialist neurologist, confirmed by appropriate testing and investigations. There must be irreversible, objective clinical impairment of motor functions.	100%
Muscular Dystrophy	Confirmed diagnosis of Muscular Dystrophy resulting in the permanent inability to perform 6 or more advanced ADL's	75%
	Confirmed diagnosis of Muscular Dystrophy resulting in the permanent failure of 3 or more basic ADLs	100%
Alzheimer's Disease	The unequivocal diagnosis of the current symptoms of Alzheimer's Disease, confirmed by a neurologist and radiological investigations.	25%
	The unequivocal diagnosis of Alzheimer's Disease confirmed by a neurologist where dementia has resulted in permanent, significant memory and cognitive impairment for which no other recognisable cause has been identified. Memory and cognitive impairment must result in an MMSE score of ≤ 18	100%
Benign Brain Tumour	The diagnosis of a symptomatic non-cancerous tumour of the brain or meninges confirmed by a neurologist	
	The diagnosis of a symptomatic benign tumour of the brain or meninges confirmed by a neurologist and having undergone any form of surgery or radiotherapy.	50%
	Resulting in failure of 3 or more basic activities of daily living	100%

Bacterial Meningitis	The diagnosis of bacterial meningitis confirmed by a Neurologist with supporting medical evidence	10%
Cerebral Malaria	The diagnosis of cerebral malaria confirmed by a specialist physician	25%

Myasthenia Gravis	Myasthenia Gravis is a neuromuscular disease characterised by weakness and fatigability of the skeletal muscles. The diagnosis must be confirmed by a neurologist. A positive antiacetylcholine receptor antibody test must support the diagnosis.	
	Definite diagnosis of Myasthenia Gravis confirmed with positive serology and electrophysiological testing	25%
	With failure of 6 or more Advanced ADLs	75%
	With failure of 3 or more Basic ADLs	100%
Guillain-Barre syndrome	Guillain-Barre syndrome is an acute, inflammatory, post infectious polyneuropathy resulting in progressive and ascending paralysis. The diagnosis must be confirmed by a neurologist, have been treated with plasma exchange or intravenous immunoglobulin, and must be of a severity to have documented evidence of persistent neurological symptoms lasting for a period of at least six months from the time of diagnosis. Cases of Guillain-Barre syndrome that present with or progress to bulbar weakness and respiratory dysfunction with resultant ventilation or tracheostomy will be paid on diagnosis.	
	Guillain-Barre syndrome that present with respiratory dysfunction treated with mechanical ventilation, or with persistent neurological symptoms lasting at least 6 months	25%
	Guillain-Barre syndrome with persistent total and irreversible neurological symptoms lasting at least 12 months, with the inability to perform 6 or more Advanced Activities of Daily Living	75%
	Guillain-Barre syndrome with persistent total and irreversible neurological symptoms lasting at least 12 months, with the inability to perform 3 or more Basic Activities of Daily Living	100%
Permanent mental or cognitive impairment	An organic brain condition resulting in a permanent, irreversible MMSE score of < 24 and a failure to perform 3 or more Advanced ADLs. All Psychiatric conditions are excluded.	25%
	An organic brain condition resulting in a permanent, irreversible MMSE score of ≤ 18 and where curatorship is required. Psychiatric conditions are excluded.	100%
Neuro Catch-All	Failure of 6 or more Advanced ADLs for any neurological condition not specified above	75%
	Failure of 3 or more Basic ADLs for any neurological condition not specified above	100%
Paralysis	Paraplegia, hemiplegia, diplegia or quadriplegia	100%
Hydrocephalus	Insertion of a shunt for the treatment of hydrocephalus	25%
Brain Abscess	Diagnosis of brain abscess treated without surgery	25%
	Diagnosis of brain abscess treated with surgery	50%
Stereotactic Brain Surgery	Stereotactic brain surgery for any condition not specified above	10%
Open Brain	Having undergone open brain surgery for a medical condition	50%

Surgery*	due to illness or trauma	
	Having undergone open brain surgery for a medical condition due to illness or trauma with permanent failure of 6 or more Advanced ADLs	75%
	Having undergone open brain surgery for a medical condition due to illness or trauma with permanent failure of 3 or more basic ADLs	100%

Cerebrovascular Benefit Category		
	Claim Event	**% Payable – Severity benefit option**
Stroke	Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in motor deficit or neurological deficit lasting at least 24 hours consistent with the area of the brain affected, and confirmed with 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 full neurological examination by a specialist neurologist any time after three months	
	Diagnosis of stroke	25%
	Stroke with irreversible motor or neurological deficit, defined as the permanent inability to perform 3 or more advanced activities of daily living.	50%
	Stroke resulting in the permanent inability to perform 6 or more advanced activities of daily living	75%
	Stroke resulting in the permanent inability to perform 3 or more basic activities of Daily living	100%
Sub-Arachnoid Haemorrhage	Diagnosis of sub-arachnoid haemorrhage	25%
Sinus thrombosis	Diagnosis of a sagittal or cavernous sinus thrombosis	25%
Arteriovenous Malformation	Arteriovenous malformation treated with radiological intervention	25%

*This definition occurs in more than one benefit category. Any benefits payable as a result of this definition will only be paid from the benefit category originally claimed from for that condition. i.e. A maximum of up to 100% of the sum insured will be paid for a condition that meets the requirements of the definition.

Gastrointestinal Benefit Category

Only one payment will be made per gastrointestinal category event. A single event is defined as all gastrointestinal system conditions that occur within a 30 day period.

For this benefit group no benefit will be paid where a claim is, in the opinion of Hollard Life, directly or

indirectly occasioned by or accelerated by alcohol or substance abuse.		
	Claim Event	**% Payable – Severity benefit option**
Liver failure	Chronic Liver disease classified as Child Pugh class C	100%
	Chronic Liver disease classified as Child Pugh class B	75%
	Chronic Liver disease classified as Child Pugh class A	50%
Liver or Kidney Pancreas transplant	Having undergone a complete liver or pancreas transplant	100%

Pancreatectomy	Partial pancreatectomy. Non-therapeutic procedures such as biopsies and organ donation are specifically excluded.	25%
	Complete pancreatectomy	100%
Hepatectomy	Partial hepatectomy. Non-therapeutic procedures such as biopsies and organ donation are specifically excluded.	25%
Chronic Pancreatitis	Chronic pancreatitis resulting in diabetes or malabsorption syndrome. Diabetes has to be clinically diagnosed with relevant medical tests	50%
Crohn's Disease	Ulcerative colitis or Crohn's disease on optimal medical treatment for at least 6 months. The diagnosis must be confirmed by a gastroenterologist and the disease must be treated with either steroids or immunomodulatory medication for a period of at least six months.	25%
Ulcerative Colitis	Ulcerative colitis or Crohn's disease having undergone more than one surgery. Non-therapeutic procedures such as biopsies are specifically excluded. The diagnosis must be confirmed by a gastroenterologist and the disease must be treated with either steroids or immunomodulatory medication for a period of at least six months.	50%
Hepato-biliary	Primary Sclerosing Cholangitis	100%
	Fulminant hepatic failure	100%
	Primary biliary cirrhosis	100%
	Portal hypertension with varices, or refractory ascites and splenomegaly, or refractory pancytopenia	100%
	Diagnosis of portal hypertension	50%
	Chronic persistent Hepatitis B on optimal treatment for 12 months or more without complete viral suppression	25%
Colon	Total colectomy, permanent colostomy or permanent ileostomy	75%
	Hemicolectomy, not due to Ulcerative Colitis or Crohn's Disease	10%
	Chronic rectal fistula despite surgical repair	10%
General	Tracheal-oesophageal fistula	10%
	Proven acute bacterial peritonitis having undergone laparotomy. Non-perforated appendicitis is specifically excluded.	10%
	Drainage of pancreatic cyst or abscess	10%

Kidney and Liver Urogenital Benefit Category

Only one payment will be made per kidney and urogenital event. A single event is defined as all kidney or urogenital conditions or procedures that occur within a 30 day period.

	Claim Event	**% Payable – Severity benefit option**
Kidney and Renal disease	Diagnosis of Renal abscess	5%
	Chronic tubulo-interstitial nephritis	10%
	Confirmed diagnosis of nephritic syndrome	15%
	Confirmed diagnosis of nephrotic syndrome with a proteinuria of 3g per 24 hours and a GFR of <60 mls per minute present for 6 months	15%
	Renal cortical necrosis involving >2/3 of the renal cortex	50%
	Acute renal failure having undergone 5 treatments of haemodialysis	50%
	Chronic irreversible renal disease with the GFR of 31-55ml/min and a documented decline in the GFR of greater than 5ml/min within the last 12 months despite optimal treatment by an appropriate specialist	50%
	Chronic irreversible renal failure with a GFR of 16-30ml/min/1.73m2 and a documented decline in the GFR of greater than 5ml/min within the last 12 months despite optimal treatment by an appropriate specialist	75%
	Chronic irreversible renal failure with GFR <15 ml/min/m2 or continuous permanent regular dialysis confirmed by nephrologist	100%
	Having undergone a kidney transplant	100%
Nephrectomy Renal Surgery	Endoscopic or minimally invasive renal surgery (excluding biopsy* or any surgery for renal stones)	10%
	The actual undergoing of a partial nephrectomy due to illness, disease or accident. Non-therapeutic procedures such as biopsies* and organ donation are specifically excluded.	25%
	The actual undergoing of a complete nephrectomy due to illness, disease or accident. Non-therapeutic procedures such as biopsies and organ donation are specifically excluded.	50%
Cystectomy	Partial cystectomy	25%
	Radical cystectomy resulting in the need for permanent external stoma bag or permanent catheterisation	100%
Penile Amputation	Partial amputation of the penis. This specifically excludes biopsies*, circumcision, gender reassignment surgery and gender dysphonia.	25%
	Total amputation of the penis. This excludes surgery for gender reassignment or gender dysphonia.	50%
General	Unilateral or bilateral orchidectomy	25%
	Open kidney surgery for renal or renovascular disease or injury	25%
	Rectovaginal or vesicovaginal fistula	25%
	Urethral fistula	10%
	Surgical repair of urethral or ureteric stricture (Restricted to	5%

	one payment only)	
*A biopsy is a medical test commonly performed by a surgeon, interventional radiologist, or an interventional cardiologist involving extraction of sample cells or tissues for examination to determine the presence or extent of a disease.		

Respiratory Benefit Category

Only one payment will be made per respiratory event. A single event is defined as all respiratory conditions or procedures that occur within a 30 day period.

***** A biopsy is a medical test commonly performed by a surgeon, interventional radiologist, or an interventional cardiologist involving extraction of sample cells or tissues for examination to determine the presence or extent of a disease.-

	Claim Event	**% Payable – Severity benefit option**
Lung Transplant	The actual undergoing of a transplant as a recipient of a complete lung	100%
Cor Pulmonale	Irreversible cor pulmonale	100%
Pulmonary Hypertension	Confirmed diagnosis of pulmonary hypertension with a peak pulmonary pressure of >40 mmHg	100%
Pulmonary Embolism	Recurrent pulmonary emboli having undergone insertion of a veno-caval filter	100%
	Diagnosis of pulmonary embolism confirmed with relevant imaging. Subject to a maximum of 2 payments	25%
Respiratory Failure	Chronic obstructive or restrictive lung disease with a permanent FEV1 or FVC or DLCO of 45% or less than predicted on 2 separate occasions at least one month apart	100%
	Chronic obstructive or restrictive lung disease with permanent FEV1 or FVC or DLCO of 46% to 49% of predicted	50%
Lung Surgery	Removal of one lobe of a lung due to disease or injury	25%
	Removal of more than one lobe of the lung or removal of an entire lung due to disease or injury	50%
Status Asthmaticus	Status asthmaticus having undergone intubation and ICU admission	25%
General	Diagnosis of a lung abscess	25%
	Diagnosis of a bronchopleural fistula	25%
	Pleurectomy, decortication, drainage of empyema, or other open lung surgery not specified elsewhere. This excludes lung biopsy* and any procedures purely for diagnostic purposes.	25%
	On confirmed diagnosis of any of the following: bronchiectasis, fibrosing alveolitis, pneumoconiosis, or interstitial lung diseases	10%
	Drainage of pleural effusion by intercostal drainage	10%
*A biopsy is a medical test commonly performed by a surgeon, interventional radiologist, or an interventional cardiologist involving extraction of sample cells or tissues for examination to determine the presence or extent of a disease.		

Connective Tissue Disease's Benefit Category

Only one payment will be made per connective tissue disease event.

Confirmed diagnosis of Rheumatoid arthritis, Systemic lupus Erythematosus, Progressive Systemic Sclerosis, Sarcoidosis, Polyarteritis nodosa, Giant cell arteritis, Wegener's granulomatosis, dermatomyositis, polymyositis. Diagnosis is to be confirmed according to specific criteria defined by the American College of Rheumatology.

For CTD or Autoimmune Disorders with major organ involvement, the severity of involvement will be assessed under the relevant system which will be capped at a 100% payout. Should multiple organs be involved, the organ with the most severe impairment will qualify for the highest payout. (are we limiting to brain and kidney)

Claim Event	**% Payable – Severity benefit option**
Confirmed diagnosis and ongoing treatment with DMARDS or biologics for the listed connective tissue disease, above.	25%
Confirmed diagnosis and ongoing treatment of Ehlers-Danlos Syndrome	10%
Any listed CTD or autoimmune disease having undergone major joint replacement or arthrodesis of the Spine, shoulder, elbow, wrist, hip, knee or ankle	50%
Connective tissue disorder or autoimmune disorder with permanent failure of 6 or more Advanced ADLs	75%
Connective tissue disorder or autoimmune disorder with permanent failure of 3 or more basic ADLs	100%

Sensory Benefit Category

Only one payment will be made per sensory disease event. A single event is defined as all sensory conditions or procedures that occur within a 30 day period.

	Claim Event	**% Payable – Severity benefit option**
Blindness	Total and irreversible (not correctable by treatment or operation) loss of sight in both eyes. Permanent visual acuity impairment (not correctable by operation) resulting in a Snellen rating of less than 20/200 or worse bilaterally. The blindness must be certified through an ophthalmologist's report and cataracts are specifically excluded.	100%
	Irreversible homonymous hemianopia in both eyes	100%
	Irreversible Diabetic retinopathy (grade IV)	100%
	Enucleation of eye	75%
	Optic nerve atrophy	50%
	Irreversible hemianopia in one eye	50%
	Complete and permanent blindness in one eye due to injury or disease	50%

	Diagnosis of Retinitis Pigmentosa	25%
	The undergoing of a corneal transplant	15%
	On diagnosis of Optic neuritis	10%
	On diagnosis of Retinal Detachment	10%

Deafness	Permanent Hearing loss of more than 90 decibels (in both ears) at frequencies of 500, 1000, 2000, and 3000Hz despite use of a hearing aid	100%
	Binaural hearing loss >75% as per the American Medical Association Guide To Impairment (latest edition), despite the use of a hearing aid	75%
	Permanent Hearing loss between 70-89 decibels (in both ears) at frequencies of 500, 1000, 2000, and 3000Hz (PPS) despite use of a hearing aid	50%
	Acoustic neuroma I would suggest including "that is causing neurological deficit" to avoid paying for incidental findings	25%
	Mastoiditis having undergone surgery	25%
	Tympanosclerosis with hearing loss	10%
	Otosclerosis	10%
	On diagnosis of Mastoiditis	5%
	Having undergone a cochlear implant (any payments received for hearing loss)	25%
Loss of Speech	A certified physician must make the definite diagnosis of loss of speech where there is total and permanent loss of the ability to produce intelligible speech as a result of irreversible damage to the larynx or its nerve supply from the speech centres of the brain. Medical evidence must be supplied to confirm laryngeal dysfunction and that the loss of speech has lasted for a continuous period of at least 12 months. For the above definition, the following are not covered: • All psychiatric causes of loss of speech.	100%

Trauma and Musculoskeletal Benefit Group

For this benefit group, no payment shall be made if the incident or illness giving rise to such claim was directly or indirectly caused, occasioned, accelerated or aggravated by self-inflicted injuries whether the life insured is of sound mind or not**.**

	Claim Event	**% Payable – Severity benefit option**
Coma	ICU admission with mechanical ventilation for 48 hours due to illness or injury. A coma which is medically induced or results directly from alcohol or drug use is excluded.	50%
	ICU admission with mechanical ventilation for 96 hours due to illness or injury. A coma which is medically induced or results directly from alcohol or drug use is excluded.	100%

Major Head Trauma	A traumatic injury to the brain, caused by an external physical force, resulting in significant irreversible neurological deficit measured by the inability to perform 6 Advanced Activities of Daily Living. The inability to perform ADLs will be assessed with a functional capacity evaluation performed by an occupational therapist, in conjunction with a neurological examination by the treating neurologist.	75%

	A traumatic injury to the brain, caused by an external physical force, resulting in significant irreversible neurological deficit measured by the inability to perform 3 basic Activities of Daily Living. The inability to perform ADLs will be assessed with a functional capacity evaluation performed by an occupational therapist, in conjunction with a neurological examination by the treating neurologist.	100%
Paralysis	Permanent paraplegia, hemiplegia, diplegia or quadriplegia	100%
Major Burns	Full thickness burns covering at least 20% of the body surface area	100%
Loss of use of limbs	For loss of use of, or for amputation, arm is defined as any loss from the wrist and higher, and leg is defined as any loss from the ankle joint and higher. The amputation of, or the total and irreversible loss of motor function of: • one arm or • one leg	50%
	For loss of use of, or for amputation, arm is defined as any loss from the wrist and higher, and leg is defined as any loss from the ankle joint and higher. The amputation of, or the total and irreversible loss of motor function of: • both arms, • both legs, or • one arm and one leg	100%
Pregnancy Complications	For this benefit there is a 12 month waiting period from the benefit commencement date until the benefits are available. This benefit covers a female life insured against the following: • Stillbirth in the third trimester; • Birth weight of less than 1.5 kg with two or more days in ICU for the new-born baby of the female Life Insured • Birth defect or congenital anomaly in the new-born baby of the female life insured with surgery in the 90 days following birth Pregnancy complications where the female life insured: • Spends two or more days in ICU; or • Spends one day in ICU and three or more consecutive days in a general hospital ward/ high care ward, or;	5%

	• Spends more than five consecutive days in a general hospital ward/high care ward	
General	Total replacement of any of the Hip, Knee, Ankle or shoulder joint. Subject to a maximum of 2 events.	10%
	Chronic (more than 6 months) Osteomyelitis confirmed by the treating specialist.	10%
	Definite diagnosis of Paget's disease of the bone	5%
	Surgical repair of any of the musculocutaneous, median, ulnar, radial, sciatic, femoral, tibial or fibular nerves after complete severance. Subject to a maximum of 2 events	10%

Endocrine Conditions Benefit Group
(one payout per distinct endocrine disorder)

Only one payment will be made per endocrine disease event. A single event is defined as all endocrine conditions or procedures that occur within a 30 day period.

Claim Event	**% Payable – Severity benefit option**
On diagnosis of a Thyroid storm	10%
On diagnosis of Diabetes insipidus	10%
On diagnosis of an Acute adrenal crisis	10%
On diagnosis of Addison's disease	10%
On diagnosis of Sheehan's syndrome or Simmonds' disease	10%
On diagnosis of Conn's syndrome	10%
On diagnosis of Cushing's syndrome	10%
On diagnosis of any Glycogen storage disease	10%
Endocrine tumours having undergone surgical excision: adrenal adenoma (or adrenalectomy), pheochromocytoma, carcinoid tumour, pancreatic tumour, insulinoma, parathyroid tumour and thyroid adenoma, pituitary tumour.	10%

AIDS / HIV Benefit Group

	Claim Event	**% Payable – Severity benefit option**
Advanced AIDS	Advanced AIDS, confirmed by a positive HIV antibody test and a CD4 count <200 despite compliance with Antiretroviral treatment, with confirmed drug resistance to first, second and third line ART resulting in a persistently high viral load of >10000 copies/ml	100%
Accidental HIV Infection	An HIV test, done at a SANAS or NSI accredited lab, must be done within 72 hours after the event leading to HIV exposure to confirm prior HIV negative status. A full course of post exposure prophylaxis must have been taken by the client for at least 28 consecutive days after the incident or event. Accidental HIV infection as a result of one of the following incidents: • Accidental needle-stick injury acquired in the course of professional duties as a medical or dental practitioner or	100%

	registered nurse. The practitioner must be registered with the appropriate professional council. A negative HIV test must be performed within 24 hours to confirm a HIV negative status at the time of the needle-stick injury. Proof should also be supplied that the person has been started on a course of anti-retroviral drugs, or • Rape or indecent assault. The offence must have been reported to the South African Police Service (SAPS) and a criminal case opened. An HIV test must have been performed within 24 hours of the assault to confirm an HIV negative status at the time of the assault. A medical examination of the victim must have been performed within 24 hours after the incident. Proof should also be supplied that the patient has been started on a course of anti-retroviral drugs; or • Undergoing an organ transplant at an institution recognised by Hollard Life where the transplanted organ was infected with the HIV virus. The organ donor service must admit liability for the incident, or; • The transfusion of infected blood or blood products from a transfusion service recognised by Hollard Life, occurring after the starting date of the policy. The transfusion service must admit liability for the incident, or; • Involvement in a road traffic accident. The incident must have been reported to the South African Police Service (SAPS). An HIV test must have been performed within 24 hours of the accident to confirm an HIV negative status at the time of the accident. Proof should also be supplied that the patient has been started on a course of anti-retroviral drugs, or; • Being the victim of a violent crime. The incident must have been reported to the South African Police Service (SAPS) and a criminal case opened. An HIV test must have been performed within 24 hours of the accident to confirm an HIV negative status at the time of the accident. Proof should also be supplied that the patient has been started on a course of anti-retroviral drugs.	

Children's Benefit	
Claim Event	**% Payable – Severity benefit option**

All children of the life insured, up to a maximum of 4, are covered in terms of the children's benefit for the conditions defined in this policy wording. A child is defined as a natural or legal child of the life insured. The cover will start when each child is six months old and ends on their 21st birthday (24 if the child is a full-time student at a recognised tertiary educational institution). The benefit amount for each child will be 15% of the benefit amount payable to the life insured for that event or condition, subject to a maximum of N$300 000. Where a child could claim under two or more Hollard Life policies with a children's benefit, then the benefit amount shall be restricted to the greater of the amount on any individual policy. This benefit is only payable once for each child and once two claims have been paid under the children's benefit, the children's benefit cover will end. A survival period of 14 days will be imposed before a claim is admitted. Should the child die within the survival period, then no claim will be payable under the children's benefit. Hollard Life may, at its discretion, waive the survival period. Congenital, familial and pre-existing conditions are specifically excluded from this benefit and on the Status Epilepticus Benefit, febrile seizures are excluded. Any payments made under the children's benefit will not reduce the benefit amount for the life insured.	15% (max N$300 000)

Catch-All Benefit

For this benefit group, payment shall be made if the incident or illness giving rise to such claim meets one of the definitions below but not any other definition covered under the Comprehensive Severe Illness benefit. Pre-existing medical conditions and injuries suffered by the life insured will be specifically excluded from this benefit. Pre-existing conditions are defined as medical conditions, injuries and events suffered by the life insured prior to the commencement date of the policy, as well as any event related to these medical conditions, injuries or events that occur after the policy commencement date.

Life saving Emergency Surgical Procedure	Emergency, open surgical procedure, performed in response to and within 24 hours of a life threatening event, confirmed by clinical and laboratory or radiological evidence. Appendectomies and tonsillectomies are specifically excluded from this definition	The lesser of N$500 000 and 20% of the benefit amount
Intensive Care Unit Stay	Continuous ICU stay for longer than 24 hours. The benefit amount is paid out per day with a day being a completed period of 24 hours from admittance to an Intensive Care Unit. All psychiatric admissions and elective stays are specifically excluded from this definition.	4% of benefit amount per day, subject to a maximum of the lesser of N$500 000 and 20% of the benefit amount
Hospitalisation Benefit:	Continuous hospitalisation for more than 10 days. This includes back traction, spinal fusion and spinal / back surgery, but excludes elective cosmetic surgery.	2% of benefit amount per day, subject to a maximum of the lesser of N$500 000 and 20% of the benefit amount

	The benefit amount is paid out per day with a day being a completed period of 24 hours from admittance to hospital. All psychiatric admissions and elective stays are specifically excluded from this definition.	

Definition of Activities of Daily Activities The cause, must be confirmed in a report from the life insured's doctor, and an examination by a specialist of Hollard Life's choice. The assessment of Activities of Daily Living must be done as part of a comprehensive assessment by an Occupational Therapist.	
Basic	• The ability to bend to get into or out of a standard car, being able to bend or kneel to pick up something from the floor and straighten up without suffering severe discomfort or being unable to walk 200 meters on a flat surface without having to stop; • The ability to lift, carry objects for example a kettle of water, bags of shopping or a briefcase; • Communicating, being the ability to talk to another person, communicate via technology and, being the ability to answer the telephone; • Reading, meaning having the eyesight required to be able to read, for example reading a daily newspaper or emails; • Manual Dexterity, being the ability to use hands and fingers with precision, including the ability to pick up and manipulate small objects, such as pens or cutlery and take a message
Advanced	• Driving a car – the ability to open a car door, change gears or use a steering wheel; • Medical care: the ability to prepare and take the correct medication; • Money management – the ability to do one's own banking and to make rational financial decisions; • Communicative activities: - the ability to communicate either verbally or written; • Shopping: - the ability to choose and lift groceries from shelves as well as carry them in bags; • Food preparation – the ability to prepare food for cooking as well as using kitchen utensils; • Housework – the ability to clean a house or iron clothing; • Community ambulation with or without assistive device, not requiring a mobility device- the ability to walk around in public places using a walking stick, if necessary.

What is the Survival Period?

If a policy has life cover, a survival period of 14 days will be imposed before a claim is admitted. Should the Life insured or a child covered under the Children's Benefit die within the survival period, then no claim will be payable.

When does the Comprehensive Severe Illness Benefit end?

The Comprehensive Severe Illness benefit will end when the first of these happens:

- The Comprehensive Severe Illness benefit term, as specified in your Policy schedule, expires;
- You cancel the Comprehensive Severe Illness benefit;
- Your Policy lapses. The Comprehensive Severe Illness Benefit will then cease on the last day of the month for which you last paid your premiums in full;
- The Life Insured dies;
- After the full benefit amount has been paid for every benefit category.

Exclusions

We will not make any payment if the illness or incident that gives rise to a claim event was directly or indirectly caused by, brought about by, accelerated by or aggravated by self-inflicted injuries or if the life assured takes any substance / medication to induce a condition.

We will not make any payment if any fraudulent documentation or information is provided at application or claim stage.

Benefit Specific Terms and Conditions:
CashBack

How does the CashBack benefit work?

When a Policy is incepted, you have the option to add the CashBack benefit. After the CashBack benefit has been inforce for 5 years, we will pay you a once-off lump sum benefit amount equal to 20% of total premiums paid on the Policy during the five year Cashback benefit term. We will pay the CashBack benefit to the Policyholder. The CashBack benefit is paid even if a claim was made under the Policy, provided all the following conditions are met:

- There are no outstanding premiums;
- No premium concessions have been granted;
- The policy and this benefit have been in force for a continuous period of five years with no break in cover; and
- The policy and this benefit are in force immediately before the expiry of the five year Cashback benefit term.

When does the CashBack benefit end?

The Cashback benefit will end when the first of these happens:

- The Cashback benefit term, as specified in your Policy schedule, expires;
- You cancel the Cashback benefit;
- You cancel the Policy;
- Your Policy lapses. The Cashback Benefit will then cease on the last day of the month for which you last paid your premiums in full; or
- The last surviving Life Insured on the Policy dies.

The Cashback benefit has no maturity or surrender values. If the CashBack benefit ends before the expiry of the CashBack benefit term, all premiums paid for this benefit will be forfeited. Once the benefit ends, it cannot be reinstated.

Benefit Specific Terms and Conditions:
Premium Waiver Benefit

How does the Premium Waiver benefit work?

The Premium Waiver Benefit can be claimed if the Life Insured satisfies the criteria of a Contingent Event when a claim event occurs, and the Premium Waiver Benefit is inforce.

The benefit will only be payable once Hollard Life is satisfied that the Life Insured has met the criteria of a Contingent Event.

What is the Benefit Amount?

The Benefit amount payable is set out on your Policy Schedule, at the date of the claim event, and will include any voluntary increases you have selected and any Benefit endorsements accepted and confirmed in writing by us prior to the claim event.

Following a claim, the Benefit Amount will increase at each subsequent policy anniversary by any Compulsory Premium escalation only. The Benefit amount will not increase by any voluntary increases while the Premium Waiver Benefit is claimed.

What is a Contingent event and the Criteria?

The table below sets out the claim events covered under this Policy.

Contingent Events and Criteria

The benefit will only be payable if the Life Insured satisfies the criteria of one of the Contingent Events, set out below:

Claim Event	Definition of Claim Event
Occupation disability	The premiums due on the policy shall be waived after the expiry of the waiting period while the Life Insured is disabled and unable to perform his/her occupation. A claim will only be admitted once Hollard Life receives proof that the Life Insured has been totally and continuously incapacitated and unable to follow his/her own occupation for remuneration or reward for the duration of the waiting period. Any information or evidence which Hollard Life may require shall be provided by the policy owner at the policy owner's expense. Waiving of premiums shall cease on the earliest date, as determined by Hollard Life, on which the Life Insured: • Becomes able to perform the normal duties of his/her own occupation; • After two years, is able to perform the normal duties of any occupation for which he/she is suited in terms of ability, training, education and experience, even though he/she may not be able to perform the normal duties of his/her own occupation; • Refuses to follow medical treatment as recommended by his/her own medical practitioner or Hollard Life's Chief Medical Officer; • Fails to provide evidence, satisfactory to and as requested by Hollard Life from time to time, of continuance of incapacity justifying the continuance of the claim. The Life Insured shall as often as may be reasonably required submit to physical examinations and tests at the request of and at the expense of Hollard Life;

	• Reaches the benefit cease date as shown in the schedule or dies.
Impairment (alternative to occupation disability)	The premiums due on the policy shall be waived after the expiry of the waiting period if the Life Insured is totally and continuously unable for the duration of the waiting period, as a result of an illness or accidental injury, to perform three or more of the tests listed below without the help of another person, but with the use of appropriate assistive or corrective aids and appliances. This must be confirmed in a report from the Life Insured's doctor, and an examination by a specialist of Hollard Life's choice. • The ability to bend to get into or out of a standard car, being able to bend or kneel to pick up something from the floor and straighten up without suffering severe discomfort or being unable to walk 200 meters on a flat surface without having to stop; • The ability to lift, carry objects for example a kettle of water, bags of shopping or a briefcase; • Communicating, being the ability to talk to another person and being the ability to answer the telephone; • Reading, meaning having the eyesight required to be able to read, for example reading a daily newspaper or emails • Manual Dexterity, being the ability to use hands and fingers with precision, including the ability to pick up and manipulate small objects, such as pens or cutlery and take a message. Payment of a claim shall cease on the earliest date, as determined by Hollard Life, on which the Life Insured: • Ceases to meet the definition of a claim in terms of Activities of Daily Living (ADL); • Refuses to follow medical advice or treatment as recommended by his/her own medical practitioner or Hollard Life's Chief Medical Officer; • Fails to provide evidence, satisfactory to and as requested by Hollard Life from time to time, of the continuance of incapacity justifying the continuance of the claim. The Life Insured shall as often as may be reasonably required submit to physical examinations and tests at the request of and at the expense of Hollard Life; or • Reaches the benefit cease date as shown in the schedule or dies. No Benefit can be claimed if the Premium Payer and the Life Insured is not the same person.

Waiting Period

A waiting period is the specific period of time that is required to pass from the date of the claim event until the claim is admitted and assessed. During the waiting period no claim is payable. We will impose a 1 month waiting period from the date of the event before a claim will be admitted by us under this benefit.

If a new claim for Occupational Disability or an Impairment contingent event arises from a cause or event unrelated to any previous claim payments and within three months of the end of a claim payment, the waiting period on the new claim will be waived and the new claim will be treated as a continuation of the original claim. If a new claim arises from a cause or event related to any previous claim payments, the waiting period will be waived, and the new claim will be treated as a continuation of the original claim.

When does the Premium Waiver Benefit end?

The Premium Waiver benefit ends when the first of these happens:

- The Premium Waiver Benefit term, as specified in your Policy schedule, expires;
- You cancel the Premium Waiver Benefit;
- Your Policy lapses. The Premium Waiver Benefit will then cease on the last day of the month for which you last paid your premiums in full;
- When your Policy ends as a result of a claim; or
- The Life Insured dies.

General Conditions

You are required to notify us, in writing, of a claim within six months after the date of a Premium Waiver Claim event. Until the claim is admitted by us, you will be required to continue paying the premiums in respect of the benefit.

What are Notifiable Changes?

You are required to notify us in writing if there are any changes to the following:

- Occupation or the Duty Split of the Life Insured;
- Involvement of the Life Insured in Hazardous Activities, as defined below.

What is the effect of a Change in Occupation or Duty Spilt?

When we are notified of changes in the occupation or duty split of the (from that set out in the Policy Schedule), we may:

- adjust the benefits or premiums; or,
- if the Life Insured's new occupation or duties mean they no longer qualify for the original Benefit,
  - we may offer to replace this benefit with another Benefit the Life Insured qualifies for; or
  - any claim will be assessed on the Daily Activities assessment criteria, where such a benefit is included in the benefit definitions.

If we are not notified in writing of a change in occupation or duty split, the benefit will be reassessed at the claims stage (in line with our prevailing underwriting practice) and this may result in a claim being reduced or rejected. In addition a 10% penalty on the claim amount will be applied.

What is defined as a Hazardous Activity?

Below is the list of activities that are defined as a hazardous activity:

- Big game hunting;
- Competitive body building or weight lifting;
- Boxing or mixed martial arts;
- Cage fighting;
- Motorcar or motorcycle racing (excluding vintage racing and local endurance races other than the Castrol Winterburg Enduro);
- Mountaineering (excluding hiking, rock climbing, trail climbing and canoeing/kloofing, at heights below 3 000 metres;
- Microlighting, hang-gliding or gyrocopter flying;
- Private flying (including fixed wing and helicopter);
- Competitive Quad-Biking (excluding participation in less than 10 events a year);
- Skydiving or parachuting (excluding static line/automatic opening and/or tandem jumps with a qualified

skydiving instructor only);

- Underwater diving (excluding snorkelling, free diving less than 25 meters or a certified diver a depths less than 40 metres in a group, as long as there is no involvement in either wreck or cave diving)

What is the effect of a Change in Hazardous Activities?
When we are notified of a change in Hazardous Activities we may adjust the premium or benefits as necessary, and advise you of any additional premium or exclusion/s added to the Policy.

If we are not notified in writing of a change in hazardous activities, the benefit will be reassessed at the claims stage (in line with our prevailing underwriting practice for the specific hazardous activity) and this may result in a claim being reduced or rejected. In addition, a penalty of 10% on the claim amount will be applied.

Exclusions
We will not make any payment if the illness or incident that gives rise to a claim event was directly or indirectly caused by, brought about by, accelerated by or aggravated by self-inflicted injuries or if the life assured takes any substance / medication to induce a condition.

We will not make any payment if any fraudulent documentation or information is provided at application or claim stage.