# PRODUCT AND BENEFIT RULES
## OLD MUTUAL PROTECT BUSINESS EXPENSES COVER

**CONTRACT NUMBER: 123456789**

**How to read these product and benefit rules**

**We/us/our** means Old Mutual, which is the short form of our full name, Old Mutual Life Assurance Company (South Africa) Limited. Our registration number is 1999/004643/06. We are the insurer.

**You/your/I** means the owner – the person who took out the contract with us and who may give us instructions relating to it. The names of the owners are shown on Personal, product and benefit details.

In the rest of this pack, where we use insurance words that may be difficult to understand, look out for the definitions, examples and notes on the right hand side of the page:


indicates a definition


indicates an example


indicates a note or more information.

Your completed application (including the accepted quote), other information (for example about the insured person's health) that has been provided to us in any form including in writing and verbally, these Product and benefit rules and the Personal, product and benefit details included in this pack, form the contract between you and us. The other documents in this pack do not form part of the contract but are provided to you to help you understand it better.

These Product and benefit rules have been written in the form of questions that you may want to ask us and our answers to them. If this pack does not fully answer your questions, you may contact us as described under "HOW DO I...?".

## ABOUT YOU AND THE PRODUCT

**What have I bought?**

You have bought Old Mutual Protect Business Expenses Cover. It pays the cover amount monthly if the insured person becomes occupationally disabled, functionally impaired or suffers a fracture. The name of the insured person is shown on the Personal, product and benefit details and the rules that apply are explained in these Product and benefit rules. In return for cover, you must pay its price, called premiums. You may have further customised the product to meet your needs by choosing other features and benefits.

**What is a beneficiary?**

A beneficiary is a person who will receive the cover amount when it becomes payable. Any beneficiary's name will appear on Personal, product and benefit details. If you are still alive at that time, you may choose whether we will pay the cover amount to you or the beneficiary.

If you are no longer alive at that time, we will pay the beneficiary who is alive at that time. If none of the beneficiaries are alive at the time, we will pay the cover amount to your estate.

If some of the beneficiaries are not alive at the time, we will divide the shares of the deceased beneficiaries between the beneficiaries that are still alive at the time in the same proportion as the remaining beneficiaries' shares.

We may allow you to name one or more beneficiaries or to change the beneficiary at any time. We will not act on any beneficiary nomination that we receive after your death. Unless you have indicated otherwise, all beneficiaries will receive equal shares of the cover amount.

**What and when do I pay?**

Until the premium end date, you must pay all premiums on their due dates. The Personal, product and benefit details shows the starting premium, first premium due date, name of the premium payer, frequency of premiums and the premium end date.

You have 45 days (a grace period) from its premium due date to pay each premium. If we do not receive your first premium within 45 days from the first premium due date, your application will be cancelled. As the contract does not start until the first premium has been received, you may not apply to have it restarted. If a premium becomes due and we do not receive it within 45 days from the due date or another premium becomes due within the 45 days, we will cancel the contract. If we receive a claim and there is any premium outstanding, we will deduct it from the claim payment.

If we have cancelled the contract because you have not paid your premiums, you may, within six months from the date on which the contract was cancelled, apply to have it restarted. We may ask for further information before we agree to restart the contract. If we agree to restart the contract, it may be on different terms and you must restart your premiums. You will not have cover from when your contract was cancelled until we have agreed to restart it. If we have cancelled your contract again because you have not paid your premiums, you may only apply to have it restarted if we have received your premiums for at least six months from the time the contract was previously restarted.

When your premiums will/may change

Your premiums will/may change under any of the circumstances described below. If your premium changes, we will notify you of the new premium.

**Dividing deceased beneficiaries' shares between those that are alive when the cover amount becomes payable** - Abel, Ben and Craig have been nominated to receive 50%, 25% and 25% of the cover amount respectively. Craig had passed away at the time that the cover amount becomes payable. His 25% share will be divided between Abel and Ben. Abel will receive 16.67% (two thirds of 25%) and Ben will receive 8.33% (one third of 25%) in addition to their original 50% and 25% shares.

**Different terms** could include the following examples:

- a premium increase,
- additional circumstances under which we will not pay,
- the insured person may no longer qualify for the existing benefit but may qualify for another benefit, or
- a cover decrease.

**Compulsory yearly premium increases and scheduled yearly cover increases and their impact on the cover amount and premium** – Joe has chosen a 10% compulsory yearly premium increase and chose a 10% scheduled yearly cover increase. His starting cover is R100 000 and his starting premium is R200. After 1 year, his new cover is R110 000 (R100 000 + R10 000 (10% * R100 000)). The premium increase for the additional cover is R22. The premium increase because of the compulsory yearly premium increase is R20 (10% * R200). His new premium is R242 (R200 + R22 + R20). Every year, if no other changes are made, the cover amount will change because of scheduled yearly cover increases and his premium will change because of both scheduled yearly cover increases and compulsory yearly premium increases.

Compulsory yearly premium increases

Until the premium end date and for any compulsory yearly premium increase other than 0%, your premium will automatically increase every year on the compulsory yearly premium increase date as shown on Personal, product and benefit details. The compulsory yearly premium increase you have chosen is shown on Personal, product and benefit details and the different compulsory yearly premium increases are explained below.

<table>
<tr><th>Compulsory yearly premium increase</th><th>How the premium will increase</th></tr>
<tr><td>Fixed rate</td><td>Your premium will increase every year by the percentage you have chosen.</td></tr>
<tr><td>Age-linked</td><td>The yearly premium increase depends on the age of the insured person at his/her next birthday after the increase date:
<table>
<tr><th>Age</th><th>Yearly premium increase</th></tr>
<tr><td>Younger than 31</td><td>0%</td></tr>
<tr><td>31 to 35</td><td>4%</td></tr>
<tr><td>36 to 40</td><td>6%</td></tr>
<tr><td>41 to 50</td><td>8%</td></tr>
<tr><td>51 to 60</td><td>9%</td></tr>
<tr><td>Older than 60</td><td>10%</td></tr>
</table></td></tr>
</table>

This is necessary to keep the cover amount constant and the cover amount will not increase because of the compulsory yearly premium increase. You may change the compulsory yearly premium increase at any time.

Review at the end of each guarantee term

Premiums are based on our expectations of future conditions and we expect them to be sufficient for the full term of the contract. However, future conditions are uncertain and may be different to our expectations. For this reason, we will review your premium or the cover amount at the end of each guarantee term. The first review date is shown on Personal, product and benefit details. At such a review, we may:

- keep the premium or the cover amount the same,
- increase the premium, or
- change the cover amount.

Different benefits may have different guarantee terms as shown in Personal, product and benefit details. If, at a review, the premium is increased while no premium is payable on the contract because the benefit is in payment, you must pay the increased premium if the contract continues after we have stopped making payments.

Changes to the cost of cover because of changes in law

We may change the premium at any time, even before the next review date, if the cost of providing cover changes significantly because of changes in tax or other laws.

Contract changes

Some contract changes (for example if you decide to increase or decrease the cover amount), may also change your premium.

Scheduled yearly cover increases

Your premium will also change every year if you have chosen a scheduled yearly cover increase other than 0% scheduled yearly cover increase, to pay for the increased cover amount. If you have chosen a compulsory yearly premium increase other than 0% and a scheduled yearly cover increase other than 0%, your premiums will increase by the compulsory yearly premium increase rate and by the cost of the increased cover amount bought by the scheduled yearly cover increase.

**Can I miss premiums?**

No, you must pay your premiums when they are due.

**Why and how will the cover amount change?**

The starting cover amount for each benefit is shown on Personal, product and benefit details.

When the cover amount will/may change

The cover amount will/may change under any of the circumstances described below. If the cover amount changes, we will notify you of the new cover amount.

Scheduled yearly cover increases

Until the premium end date, even if we are making monthly payments, the cover amount will automatically increase every year on the scheduled yearly cover increase date as shown on Personal, product and benefit details. The scheduled yearly cover increase you have chosen is shown on Personal, product and benefit details and the different scheduled yearly cover increases are explained below.

| **Scheduled yearly cover increase** | **The cover amount will increase every year by:** |
|---|---|
| Fixed rate | the percentage you have chosen. |
| Inflation-linked | the inflation rate as set by us and as adjusted by a percentage you have chosen. |

The impact of the scheduled yearly cover increase is explained under “What and when do I pay?”.

If you do not want the cover amount to increase in a particular year, you need to inform us before the scheduled yearly cover increase date in that year. If you refuse the scheduled yearly cover increase three years in a row, we will change the scheduled yearly cover increase to a fixed rate 0% increase. You may later apply to change it again. We may ask for further information. We may or may not agree to the change.

Review at the end of each guarantee term

Premiums are based on our expectations of future conditions and we expect them to be sufficient for the full term of the contract. However, future conditions are uncertain and may be different to our expectations. For this reason, we will review your premium or the cover amount at the end of each guarantee term. The first review date is shown on Personal, product and benefit details. At such a review, we may:

- keep the premium or the cover amount the same,
- increase the premium, or
- change the cover amount.

Different benefits may have different guarantee terms as shown in Personal, product and benefit details. If, at a review, the premium is increased while no premium is payable on the contract because the benefit is in payment, you must pay the increased premium if the contract continues after we have stopped making payments.

Changes to the cost of cover because of changes in law

We may change the cover at any time, even before the date of the next cover review, if the cost of providing cover changes significantly because of changes in tax or other laws.

If you make any contract changes

Some contract changes you make (for example you decide to increase the cover amount), may also change the cover amount.

**Why is it important that Old Mutual must always have up to date contact details for the persons who play a role in the contract?**

We need your contact details to be up to date so that we can communicate with you about the contract. We need the beneficiaries' latest contact details so that we can pay the cover amount when it becomes payable. You must inform us if any contact details for any person who plays a role in the contract, changes.

Unclaimed benefits

We will try to find the persons who have the right to the cover amount or any other benefit under this contract when it becomes payable.

We will search our internal database, a database outside of Old Mutual like that of the Department of Home Affairs or use a tracing agent.

If we use a tracing agent, we will deduct the cost of tracing from the cover amount or benefit before we pay it. The cost of tracing will change over time.

If we do not pay the benefit within 15 working days of all the requirements to confirm the validity and acceptance of the claim having been met, we will make up for the late payment by increasing the claim payment amount at our discretion.

**Why must Old Mutual know about changes to the circumstances of the insured person?**

You must tell us in writing about certain changes to the circumstances of the insured person as it may affect the contract and its terms. Please see "CHANGES TO THE CIRCUMSTANCES OF THE INSURED PERSON" at the end of this document for details.

**Why is it important that I always provide honest and correct information to Old Mutual?**

We use all the information you and the insured person provide to us and rely on it to make decisions about accepting your application, what cover we will provide and the premium you must pay. If the information we receive is untruthful, incorrect or incomplete, this may affect our decision-making.

If we find out that any information was untruthful, incomplete or withheld, we may make changes to your contract (such as the premium or the cover amount) or cancel it. If we cancel your contract, we will not refund your premiums.

We may investigate any claim. If you, the insured person or the claimant gave us incorrect, fraudulent or incomplete information at any time (including during application), we may refuse to pay the claim or cancel your contract. If we cancel your contract, we will not refund your premiums.

**Why must I make sure that the cover amount is never more than the part of the business expenses that the insured person is responsible for?**

It is your responsibility to make sure that the cover amount is never more than the part of the business expenses that the insured person is responsible for. If it is, we will reduce the cover amount and the payments. If we reduce the cover amount, we will not refund any premiums you have paid.

If you have chosen scheduled yearly cover increases other than fixed rate 0%, you need to take particular care that the cover amount is not more than the part of the business expenses that the insured person is responsible for.

**Business expenses** are those monthly costs incurred in the day-to-day running of a business and as recognised by us. The business expenses that we will recognise are:

- rent
- interest portion of repayments on debt for example a mortgage bond or loan
- property taxes
- electricity, water and telephone
- regular maintenance services
- equipment leasing costs
- insurance premiums
- accounting fees or
- remuneration payable to staff who
  - do not directly impact on or contribute to turnover or
  - directly impact on or contribute to turnover but who are unable to do so because of the insured person's occupational disability, functional impairment or fracture.

The business expenses that we will not recognise are:

- any provision, for example, for depreciation or bad debt
- remuneration payable to the insured person
- remuneration payable to staff who directly impact on or contribute to turnover but who are still able to so despite the insured person's occupational disability, functional impairment or fracture.
- cost of trading stock or merchandise
- any expenses of a personal nature and not related to the business of the owner
- any capital expenses
- capital portion of repayments on debt for example a mortgage bond or loan or
- expenses not related directly to the continued functioning of the business.

We will assume that the part of the business expenses that the insured person is responsible for, expressed as a percentage, is the same as his/her contribution to the total monthly turnover.

**Remuneration payable to staff included in business expenses** – Hair-we-go salon employs a receptionist, two hair dressers and one hairdresser assistant. Hair-we-go salon takes out Business Expenses Cover for one of the hair dressers, Edward Scissorhands. In determining the cover amount, the staff that can be included in the remuneration payable to staff for business expenses are:

- the receptionist (because she does not directly impact on or contribute to turnover)
- the hairdresser assistant (because she does directly impact on or contribute to turnover but she is unable to do so because of the insured person's occupational disability, functional impairment or fracture).

The staff that cannot be included are:

- the second hair dresser (because she does directly impact on or contribute to turnover and is still able to do so despite the insured person's occupational disability, functional impairment or fracture).

**Overinsurance** – Peter is the insured person on the Business Expenses Cover benefit – his contribution to business expenses was R100 000 when the benefit was bought so the cover amount chosen was R100 000 and fixed rate 10% scheduled yearly cover increase was chosen to ensure that the cover amount increased each year. At the first scheduled yearly cover increase date, we automatically changed the cover amount to R110 000. However, Peter's contribution to business expenses was only R105 000 which means that if Peter were to become occupationally disabled, we would not pay more than R105 000. This means that Peter is over insured and the cover amount should be decreased to R105 000 to bring it in line with his contribution to business expenses.

**Will I get money from the contract if I or Old Mutual cancel it?**

No, the contract does not have a cash value and because you enjoyed cover before it was cancelled, you cannot claim back the premiums you have paid.

**Can I loan money from the contract?**

Because the contract does not have a cash value, you cannot loan from it.

**Can I transfer my rights to the contract?**

We refer to the transferring of rights as cession.

You may transfer your rights by giving ownership to someone else (outright cession) and as security for a loan (security cession).

We will change our records to reflect the cessionary's name once all our requirements have been met including that you have informed us of the cession.

The **cessionary** is the person to whom rights to (in the case of a security cession) or the ownership of the contract (in the case of an outright cession), has been transferred. In the case of an outright cession, this person becomes the new owner.

Cessions affect you and the beneficiaries

An outright cession transfers all your rights to the contract to the cessionary. He/she can make any contract changes including to change the beneficiaries.

A security cession limits your rights or ability to make contract changes. Until the security cession is cancelled, you may need the permission of the cessionary to make certain contract changes and your nominated beneficiaries will only receive any benefits after the cessionary has received what they are owed.

**What can I do if I have chosen term cover and that benefit reaches or nears its cover end date?**

We may allow you to apply for a similar benefit within 90 days before or after the cover end date if:

- the premiums on this contract are up to date at the time,
- the insured persons on the new and this benefit are the same,
- the cover amount on the new benefit is not more than the cover amount on this benefit, and
- all our requirements at the time are met (for example completing an application).

## WHAT ELSE DO I NEED TO KNOW?

**Replacing an existing financial product**

It may not be in your best interest to cancel or change existing financial products to take out other ones. For example: you may not be able to get cover for the same premium you previously paid and the new product may have more exclusions, restrictions or waiting periods.

**Cooling-off period**

You may ask us to cancel this contract within 31 days of receiving this pack. You may only cancel this contract if you have not claimed and we have not paid any benefits. After we have deducted the cost of the cover you have enjoyed, we will refund any premiums we have received before you instructed us to cancel the contract. You may also cancel any contract change within 31 days of giving us the instruction.

## ABOUT THE BENEFITS

Information about the benefits, including the names of the insured person and the benefits, is shown on Personal, product and benefit details.  The rules of each benefit are further described below.

## ABOUT THE BUSINESS EXPENSES COVER BENEFIT

**What is it?**

This benefit pays up to 100% of the cover amount monthly if the insured person (whose name appears on Personal, product and benefit details) becomes:

- occupationally disabled,
- functionally impaired or
- suffers a fracture

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

**Occupationally disabled** means that the insured person is, in part or completely and despite following reasonable medical advice and adequate medical treatment, unable to perform the main duties of his/her occupation as stated on Personal, product and benefit details, because of a sickness or injury.

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

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

**Functionally impaired** means that the insured person has suffered and meets the requirements of a qualifying functional impairment, despite following reasonable medical advice and adequate medical treatment. See the list of functional impairments that qualify at the end of this document

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

**What is a waiting period?**

A waiting period is the number of consecutive days or months for which the insured person's occupational disability or functional impairment must have continued or from the date of the fracture that must have passed before we will start the monthly payments. It starts on the date of the occupational disability, functional impairment or the fracture as confirmed by our medical officer. The waiting period you have chosen is shown on Personal, product and benefit details. You must continue to pay your premiums during the waiting period and while we decide if your claim is valid but can stop paying your premiums when we start the monthly payments. If your contract is cancelled before the waiting period ends, we will not start the monthly payments.

We may decide not to apply the waiting period if the insured person was occupationally disabled or functionally impaired for at least one month, recovers and then becomes occupationally disabled or functionally impaired from a related event within three months after his/her recovery.

If we decide not to apply the waiting period, we will start the monthly payments from the date of the occupational disability or functional impairment.

**Waiting period end** – Frank chose a 7-day waiting period. He suffers a fracture on 1 January 2016. The waiting period starts on 1 January and ends at midnight on 7 January 2016.

If Frank chose a 1-month waiting period, the waiting period would end at midnight on 31 January 2016.

**Cancelled** may include because you have instructed us to cancel the contract or we have cancelled it (including because we have discovered that you or the insured person withheld information or deliberately disclosed inaccurate information and we have relied on this information in our decision to issue the contract).

**Related event and the waiting period only applies once** – Sally is diagnosed with chronic gastrointestinal disease and is functionally impaired. She is the insured person under the Business Expenses Cover benefit that has a 1-month waiting period so she qualified for a monthly payment from month two. She recovers three months after her diagnosis and we stop making monthly payments. Two months later she is diagnosed with chronic liver disease and is again functionally impaired. Because we consider her chronic liver and gastrointestinal diseases to be related conditions and because her second condition happened within three months of her recovery from the first condition, we will not apply another 1-month waiting period and will start making monthly payments immediately.

**Unrelated event and the waiting period is applied again** - Sally is diagnosed with chronic gastrointestinal disease and is functionally impaired. She is the insured person under the Business Expenses Cover benefit that has a 1-month waiting period so she qualified for a monthly payment from month two. She recovers three months after her diagnosis and we stop making monthly payments. Two months later she is diagnosed with hypertension and is again functionally impaired. Because we consider her chronic gastrointestinal disease to be unrelated to her hypertension and despite the short time between her recovery from the first condition and her diagnosis with the second, we will apply another 1-month waiting period and will start making monthly payments from month two.

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

**What is a waiting period?**

A waiting period is the number of consecutive days or months for which the insured person's occupational disability or functional impairment must have continued or from the date of the fracture that must have passed before we will start the monthly payments. It starts on the date of the occupational disability, functional impairment or the fracture as confirmed by our medical officer. The waiting period you have chosen is shown on Personal, product and benefit details. You must continue to pay your premiums during the waiting period and while we decide if your claim is valid but can stop paying your premiums when we start the monthly payments. If your contract is cancelled before the waiting period ends, we will not start the monthly payments.

We may decide not to apply the waiting period if the insured person qualified for at least one payment after he/she was occupationally disabled or functionally impaired, recovers and then becomes occupationally disabled or functionally impaired from a related event within the length of the chosen waiting period after his/her recovery.

If we decide not to apply the waiting period, we will start the monthly payments from the date of the occupational disability or functional impairment.

**Waiting period end** – Frank chose a 7-day waiting period. He suffers a fracture on 1 January 2016. The waiting period starts on 1 January and ends at midnight on 7 January 2016.

If Frank chose a 1-month waiting period, the waiting period would end at midnight on 31 January 2016.

**Cancelled** may include because you have instructed us to cancel the contract or we have cancelled it (including because we have discovered that you or the insured person withheld information or deliberately disclosed inaccurate information and we have relied on this information in our decision to issue the contract).

**Related event and the waiting period only applies once** – Sally is diagnosed with chronic gastrointestinal disease and is functionally impaired. She is the insured person under the Business Expenses Cover benefit that has a 12-month waiting period so she qualified for a monthly payment from month 13. She recovers 18 months after her diagnosis and we stop making monthly payments. Two months later she is diagnosed with chronic liver disease and is again functionally impaired. Because we consider her chronic liver and gastrointestinal diseases to be related conditions and because her second condition happened within three months of her recovery from the first condition, we will not apply another 12-month waiting period and will start making monthly payments immediately.

**Unrelated event and the waiting period is applied again** - Sally is diagnosed with chronic gastrointestinal disease and is functionally impaired. She is the insured person under the Business Expenses Cover benefit that has a 12-month waiting period so she qualified for a monthly payment from month 13. She recovers 18 months after her diagnosis and we stop making monthly payments. Two months later she is diagnosed with hypertension and is again functionally impaired. Because we consider her chronic gastrointestinal disease to be unrelated to her hypertension and despite the short time between her recovery from the first condition and her diagnosis with the second, we will apply another 12-month waiting period and will start making monthly payments from month 13.

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

**When will a 1-month waiting period apply?**

Even though you chose a seven-day waiting period, a waiting period of one month will apply if the insured person's occupational disability or functional impairment is directly or indirectly caused by:

- cosmetic surgery or procedures, unless reconstructive in nature, following an accident or illness which happened after the cover start date,
- fertility treatments to facilitate pregnancy,
- non-surgical treatment to cure impotence or to improve potency,
- uncomplicated pregnancy,
- uncomplicated birth including caesarean sections,
- any spinal conditions unless
    - diagnosed by a specialist orthopaedic or neurosurgeon,
    - supported by medical evidence of spinal pathology and
    - for which he/she was hospitalised for at least 24 hours,
- any mechanical musculoskeletal disorder primarily causing pain, decreased range of motion or loss of sensation unless
    - diagnosed by a specialist orthopaedic or neurosurgeon and
    - for which he/she was hospitalised for at least 24 hours,
- all psychiatric disorders unless diagnosed by a psychiatrist and for which he/she was hospitalised for at least 24 hours,
- headaches and migraines unless diagnosed by a neurologist and for which he/she was hospitalised for at least 24 hours,
- the common cold (coryza), rhinitis, sinusitis, influenza, bronchitis, pharyngitis, laryngitis, pneumonia or any combination of these, unless he/she was hospitalised for at least 24 hours, or
- any functional pain disorders including
    - chronic fatigue syndrome,
    - fibromyalgia, or
    - myalgic encephalopathy (Yuppie Flu),

  unless diagnosed by a specialist orthopaedic or neurosurgeon or rheumatologist and for which he/she was hospitalised for at least 7 days.

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

**How much does Old Mutual pay?**

The cover amount for the insured person can be claimed when he/she becomes occupationally disabled, functionally impaired or suffers a fracture. The starting cover amount is shown on Personal, product and benefit details. Each monthly payment is equal to a percentage of the cover amount that applies on the payment day.

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

- the insured person's ability as determined by us, to continue doing some of the material and substantial duties of his/her occupation,
- the part of the business expenses that the insured person continues to be responsible for while being occupationally disabled and
- any payments received from any product provider, including us, for the specific purpose of covering continuing business expenses that the insured person is responsible for while he/she is occupationally disabled.

For functional impairment, the percentage of the cover amount depends on:

- the severity of the functional impairment. The functional impairments, their requirements and the percentage of the cover amount payable in each case are shown at the end of this document,
- the part of the business expenses that the insured person continues to be responsible for while being functionally impairment and
- any payments received from any product provider, including us, for the specific purpose of covering continuing business expenses that the insured person is responsible for while he/she is functionally impaired.

If the insured person is occupationally disabled or functionally impaired for part of a month when the monthly payment is payable, we will pay a proportion of the monthly payment that would have applied for that month.

The percentage of the cover amount that is paid for occupational disability or functional impairment may change over time as the insured person's condition worsens or improves or the part of the business expenses that the insured person continues to be responsible for changes.

If the insured person qualifies for more than one claim at the same time, we will pay the claim that results in the highest percentage of the cover amount.

If the insured person suffers a fracture, each monthly payment will be equal to 100% of the cover amount. We will not pay for a fracture if you have chosen a waiting period of longer than one month or if you suffer a fracture while we are already making monthly payments for occupational disability or functional impairment.

The cover amount will only be paid once our requirements have been met and if the claim is valid. We will pay the cover amount into a South African bank account.

**Will there be any payment for the waiting period?**

No, there will not be a payment for the waiting period.

**When does cover start?**

The cover starts on the cover start date for this benefit as shown on Personal, product and benefit details.

The **payment day** is the day of the month on which you have chosen to receive the monthly payments. When you claim, you can choose the payment day. If you did not choose a day of the month, the payment day will be the last day of the month. If any payment day is not a working day, we will make the monthly payment on the next working day.

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

Examples of a **product provider** include us and other insurers.

**When will the monthly payments start?**

Once all our requirements have been met, the monthly payments for a valid claim will start after the end of the waiting period. When you claim, you may choose the payment day.

If all our requirements are met before the waiting period has passed, we will pay the first monthly payment on the payment day immediately after the end of the waiting period to cover the time after the end of the waiting period and up to the date of the first monthly payment.

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

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

We will not pay interest on any of these amounts. If your contract is cancelled before the waiting period ends, we will not start the monthly payments.

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

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

**When will the monthly payments stop?**

The monthly payments will stop:

- if the insured person dies,
- if we no longer recognise the insured person's functional impairment or occupational disability (as explained under "When will Old Mutual not recognise the insured person's ..." under the heading "When will Old Mutual not pay the cover amount?"),
- if the insured person fails to meet our requirements for following reasonable medical advice or adequate medical treatment,
- if the insured person fails to meet our requirements for regular evaluation of his/her occupational disability or functional impairment,
- when we have made the last monthly payment that the insured person qualifies for (as explained under "How many monthly payments will Old Mutual make?"),
- if the insured person no longer qualifies for the benefit because of changes to his/her circumstances (as explained under "CHANGES TO THE CIRCUMSTANCES OF THE INSURED PERSON"),
- if your contract is cancelled, or
- when his/her occupational disability cover stops (as explained below under "When does occupational disability cover stop?") while we are making monthly payments because of occupational disability,

whichever happens first.

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

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

If the monthly payments stop and cover continues, you must start paying your premiums again.

We may need the insured person to prove that he/she still qualifies for payments by undergoing regular evaluation. When you claim, we will tell you how often the insured person must be evaluated.

**When will the monthly payments stop?**

The monthly payments will stop:

- if the insured person dies,
- on the cover end date shown on Personal, product and benefit details,
- if we no longer recognise the insured person's functional impairment or occupational disability (as explained under "When will Old Mutual not recognise the insured person's ..." under the heading "When will Old Mutual not pay the cover amount?"),
- if the insured person fails to meet our requirements for following reasonable medical advice or adequate medical treatment,
- if the insured person fails to meet our requirements for regular evaluation of his/her occupational disability or functional impairment,
- when we have made the last monthly payment that the insured person qualifies for (as explained under "How many monthly payments will Old Mutual make?"),
- if the insured person no longer qualifies for the benefit because of changes to his/her circumstances (as explained under "CHANGES TO THE CIRCUMSTANCES OF THE INSURED PERSON"),
- if your contract is cancelled, or
- when his/her occupational disability cover stops (as explained below under "When does occupational disability cover stop?") while we are making monthly payments because of occupational disability,

whichever happens first.

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

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

If the monthly payments stop and cover continues, you must start paying your premiums again.

We may need the insured person to prove that he/she still qualifies for payments by undergoing regular evaluation. When you claim, we will tell you how often the insured person must be evaluated.

**How many monthly payments will Old Mutual make?**

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

You can claim more than once if:

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

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

For functional impairment, we will determine the number of monthly payments that we make, in line with the period of time the insured person continuously meets all the requirements of the functional impairment, as evidenced by sufficient specialist reports or test results from the treating doctor. Any supporting medical proof that we need will be at your own cost.

The number of monthly payments we make for fractures is specified in the table "FRACTURES THAT QUALIFY FOR PAYMENT UNDER THE BUSINESS EXPENSES COVER BENEFIT".

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

A **full monthly payment** is 100% of the cover amount.

**How the monthly payments work on occupational disability and functional impairment** – Jenna suffers from chronic liver failure at the highest severity and receives six full monthly payments (or 100% of the cover amount) for her functional impairment. She recovers but is later diagnosed with chronic gastrointestinal disease at the highest severity. Because our medical officer considered her chronic liver failure and chronic gastrointestinal disease as related, she will only qualify for up to 18 more full monthly payments for this functional impairment. If she is later diagnosed with a functional impairment that is unrelated to chronic liver failure and chronic gastrointestinal disease, she can qualify for up to 24 full monthly payments.

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

**Insured person suffers a fracture while receiving monthly payments for another fracture** – Mark is the insured person under an Old Mutual Protect Business Expenses Cover contract that has a 7-day waiting period. He was in an accident and fractured his shoulder blade. Mark qualified for 2 monthly payments. Before receiving the second payment, he falls and fractures the shaft of his thigh bone. This qualifies him for 3 monthly payments, but because we are still making monthly payments for his previous fracture, we will pay the number of monthly payments that applies to the fracture with the highest number of payments, which is the fracture to the shaft of the thigh bone. We will make 2 more monthly payments (in total 3 monthly payments).

**When does cover stop?**

The insured person's cover stops:

- if he/she dies,
- if he/she no longer qualifies for the benefit because of changes to his/her circumstances (as explained under "CHANGES TO THE CIRCUMSTANCES OF THE INSURED PERSON"),
- if the insured person refuses to follow reasonable medical advice or adequate medical treatment,
- if we do not receive your premiums and the grace period has passed, or
- if your contract is cancelled,

whichever happens first.

**When does cover stop?**

The insured person's cover stops:

- if he/she dies,
- on the cover end date shown on Personal, product and benefit details,
- if he/she no longer qualifies for the benefit because of changes to his/her circumstances (as explained under "CHANGES TO THE CIRCUMSTANCES OF THE INSURED PERSON"),
- if the insured person refuses to follow reasonable medical advice or adequate medical treatment,
- if we do not receive your premiums and the grace period has passed, or
- if your contract is cancelled,

whichever happens first.

**When does cover for occupational disability stop?**

In addition to the reasons listed under "When does cover stop?", the insured person's occupational disability cover stops on the:

- date on which he/she retires or
- on his/her 69th birthday,

whichever happens first.

**When will Old Mutual not pay the cover amount?**

We will not pay the cover amount:

- if the insured person's occupational disability, functional impairment or fracture is before this benefit's cover start date,
- if we do not recognise the insured person's occupational disability, functional impairment or fracture (as explained below),
- if the insured person's occupational disability, functional impairment or fracture is because of an excluded event, activity or condition (as explained below), or
- if the waiting period is not met.

When will Old Mutual not recognise the insured person's ...

occupational disability?

We will not recognise the insured person's occupational disability if:

- he/she does not qualify for at least 25% of the cover amount or
- he/she is able to do more than 75% of the main duties of his/her occupation.

functional impairment?

We will not recognise the insured person's functional impairment if he/she suffers a functional impairment:

- that is not on the list of functional impairments,
- at the severity that the contract does not cover, or
- that does not meet all the requirements that the functional impairment must meet to qualify.

fracture?

We will not recognise the insured person's fracture if:

- he/she suffers a fracture that is not on the list of fractures that the contract covers or
- if you chose a waiting period longer than one month.

**Retires** means to stop following any occupation that provides an income.

Examples of **unrest** are riot, civil commotion, insurrection and rebellion.

Excluded events, activities or conditions

We will not recognise the insured person's occupational disability, functional impairment or fracture if it is directly or indirectly caused by an event, activity or condition that is specifically or generally excluded.

Specific exclusions apply only to certain insured persons and not to others. Any specific exclusions that apply to the insured person on this benefit, are shown on Personal, product and benefit details.

General exclusions apply to all insured persons. We will not pay if:

- you fail to meet our requirement to tell us about changes to the circumstances of the insured person (as set out under "CHANGES TO THE CIRCUMSTANCES OF THE INSURED PERSON"),
- the insured person refuses to follow reasonable medical advice or adequate medical treatment,
- the insured person's occupational disability, functional impairment or fracture is caused by:
    - unrest, war or terrorist activity,
    - radioactivity or nuclear explosion,
    - him/her provoking, committing or attempting to commit a crime for example murder, assault, housebreaking, theft, robbery, the forceful detention of another person or any similar crime or
    - self-inflicted injury.

## ABOUT OTHER FEATURES AND BENEFITS

You have other features and benefits in your contract. Details are shown on Personal, product and benefit details where relevant and the rules are explained below.

**Old Mutual Rewards**

You may choose to become a member of the Old Mutual Rewards Programme ("the Programme"). As a member of the Programme and in terms of its rules, you will earn points.

By taking part in the Programme, you enable us, on an ongoing basis, to re-assess the costs and risks associated with this policy. Any saving realised as a result of such re-assessment, is made available to you in the form of points that you can use as part of the Programme.

You cannot ask us to pay you the value of the reallocated portion of the premium or to reduce the premium you pay rather than allocating points in the Programme. You must continue paying this policy's premium as agreed with us and as explained under "What and when do I pay?".

The reallocation of the value of the portion of the reallocated premium is in our sole discretion and we may stop it at any time.

The Programme is owned and operated by Old Mutual Rewards (Pty) Ltd, a company in the Old Mutual group. Visit www.oldmutual.co.za/rewards to access the rules of the Programme and the number of points (including the value of the reallocated premiums).

## HOW DO I...?

**How do I contact Old Mutual?**

Use any of these contact details to contact us

| | |
|---|---|
| **By phone** | 076 0535 TBC<br>Monday – Friday between 7:30am and 5pm<br>excluding public holidays |
| **In person** | Visit a branch during office hours. |
| **By email** | <include correct servicing postal address once finalised > |
| **By post** | <include correct servicing postal address once finalised > |
| **Our website** | www.oldmutual.co.za |

**How do I complain?**

If you disagree with us on any matter about your contract, you can use our internal dispute resolution process. We use this process to deal with complaints and to solve disagreements between you and us quickly, fairly and at no additional cost to you. For further information about the complaints handling process (including the times within which your complaint must be addressed), you may call 0860 60 70 00 or visit a branch.

For complaints about your contract or Old Mutual

Contact us in any of the ways described under "How do I contact Old Mutual?". If, after you have contacted us, your complaint is not satisfactorily addressed, you can contact any of:

| Who | Send a fax | Send an email | Write a letter |
|---|---|---|---|
| OMSTA Complaints management | (021) 509 0506 | complaintadmin@oldmutual.com | PO Box 201<br>Mutualpark<br>7451 |
| Compliance officer | (021) 509 1193 | RMMcompliance@oldmutual.com | PO Box 73<br>Cape Town<br>8000 |
| Old Mutual Internal Arbitrator | (021) 504 7700 | arbitrator@oldmutual.com | PO Box 80<br>Mutualpark<br>7451 |

You can at any time contact:

| Who | Send a fax | Send an email | Write a letter |
|---|---|---|---|
| Ombudsman for Long-term Insurance | (021) 674 0951 | info@ombud.co.za | Private Bag X45<br>Claremont<br>7735 |

For complaints about the advice you received or the adviser:

| Who | Send a fax | Send an email | Write a letter |
|---|---|---|---|
| Ombudsman for Financial Services Providers | (012) 470 9097 or<br>(012) 348 3447 | info@faisombud.co.za | PO Box 74571<br>Lynwood Ridge<br>0040 |

The courts

You can always refer your dispute to a South African court. In this case, you will need the help of an attorney and the process may take long and be expensive. For this reason, we encourage you to first follow our internal dispute resolution process in order to bring a speedy solution to your complaint.

**How do I exercise my right to cool off?**

You must give us an instruction in writing when you want to exercise your right to cool off. In writing means by email or sending us a letter.

**How do I make a contract change or cancel my contract?**

You must give us an instruction in writing when you want to make a contract change (for example to name or change a beneficiary) or cancel your contract. In writing means by email or sending us a letter. When we receive your email or letter, we will inform you which information and documents we require.

**How do I claim?**

The claimant must claim by completing the claim forms and providing us with the necessary information and documents through an adviser or at one of our branches. At the point of claim, we will inform the claimant which claim form he/she needs to complete and which information and documents we require.

We may also request other information or documents from any person (including directly from a doctor or clinic) to help us to decide if the claim is valid.

You must pay the costs related to satisfying our requirements for your Business Expenses Cover benefit. This includes:

- the cost of obtaining expert evidence that must be submitted in South Africa by persons or businesses that operate in South Africa,
- if the insured person is not in South Africa, the cost to travel to South Africa to undergo evaluation to help us to decide whether the claim is valid, and
- the cost of reasonable medical advice or adequate medical treatment as determined by our medical officer.

Once all our claims requirements have been met, we will consider the claim and pay it if it is valid.

If your claim is fraudulent, we will cancel your contract and will not refund any premiums you have paid.

If all our requirements are not met, we cannot consider the claim and will not pay it until these requirements have been met.

## CHANGES TO THE CIRCUMSTANCES OF THE INSURED PERSON ON THE BUSINESS EXPENSES COVER BENEFIT

The table below sets out what changes to the circumstances of the insured person you must tell us about. The actions we may or will take depends on whether you told us about the change or whether we found out about it and if we are making payments at the time of the change. Some changes in circumstances will only affect the payments being made or the contract itself, while other changes may affect both. Any change to the insured person's circumstances while we are not making payments will affect only the contract itself.

| **What changes about the insured person** | **Actions we can take while we are making monthly payments** | | **Actions we can take when we are not making monthly payments** | |
|---|---|---|---|---|
| | **You tell us about the change** | **You don't tell us about the change** | **You tell us about the change** | **You don't tell us about the change** |
| The insured person starts to regularly (more than on a once-off basis) participate in a risky activity or sport* that may expose him/her to a higher than average risk of accident or injury (for example motor racing, climbing, aviation, combat sports, water sports) | Impacts on the payments being made<br><br>None<br><br>Impacts on the contract itself<br><br>We may:<br>• change the premium or<br>• offer different terms** | Same as under "You tell us about the change" on the left | We may:<br>• change the premium,<br>• offer different terms**,<br>• remove the benefit*** or<br>• recover benefit payments we had already made but that the insured person did not qualify for, from you | In addition to what is listed under "You tell us about the change" on the left, we may:<br>• reject your claim*** |
| The insured person changes his/her occupation* (this includes when he/she was unemployed or retired and then starts working again or he/she worked and then becomes unemployed) or any detail of his/her occupation (this includes where the insured person's employer changes) | Impacts on the payments being made<br><br>We may:<br>• change the benefit payments,<br>• stop the benefit payments or<br>• recover benefit payments we had already made but that the insured person did not qualify for, from you<br><br>Impacts on the contract itself<br><br>We may:<br>• change the premium,<br>• offer different terms** or<br>• remove any benefits that you no longer qualify for*** | Same as under "You tell us about the change" on the left | We may:<br>• change the premium,<br>• offer different terms**,<br>• remove any benefits you no longer qualify for*** or<br>• recover benefit payments we had already made but that the insured person did not qualify for, from you | In addition to what is listed under "You tell us about the change" on the left, we may:<br>• reject your claim*** |

| | | | | |
|---|---|---|---|---|
| The insured person changes the industry* he/she works in (for example he/she was working in the building industry and changed to the mining industry) | Impacts on the payments being made<br><br>We may:<br>• change the benefit payments,<br>• stop the benefit payments or<br>• recover benefit payments we had already made but that the insured person did not qualify for, from you<br><br>Impacts on the contract itself<br><br>We may:<br>• change the premium,<br>• offer different terms** or<br>• remove any benefits that you no longer qualify for*** | Same as under "You tell us about the change" on the left | We may:<br>• change the premium,<br>• offer different terms**,<br>• remove any benefits you no longer qualify for*** or<br>• recover benefit payments we had already made but that the insured person did not qualify for, from you | In addition to what is listed under "You tell us about the change" on the left, we may:<br>• reject your claim*** |
| The insured person changes how much time of his/her day is spent doing administrative or manual tasks and travelling* | Impacts on the payments being made<br><br>We may:<br>• change the benefit payments,<br>• stop the benefit payments or<br>• recover benefit payments we had already made but that the insured person did not qualify for, from you<br><br>Impacts on the contract itself<br><br>We may:<br>• change the premium,<br>• offer different terms** or<br>• remove any benefits that you no longer qualify for*** | Same as under "You tell us about the change" on the left | We may:<br>• change the premium,<br>• offer different terms**,<br>• remove any benefits you no longer qualify for*** or<br>• recover benefit payments we had already made but that the insured person did not qualify for, from you | In addition to what is listed under "You tell us about the change" on the left, we may:<br>• reject your claim*** |
| The insured person changes his/her employment type* (for example changing from a full time employee to a part time worker or becoming self-employed) | Impacts on the payments being made<br><br>We may:<br>• change the benefit payments,<br>• stop the benefit payments or<br>• recover benefit payments we had already made but that the insured person did not qualify for, from you<br><br>Impacts on the contract itself<br><br>We may:<br>• change the premium,<br>• offer different terms** or<br>• remove any benefits that you no longer qualify for*** | Same as under "You tell us about the change" on the left | We may:<br>• change the premium,<br>• offer different terms**,<br>• remove any benefits you no longer qualify for*** or<br>• recover benefit payments we had already made but that the insured person did not qualify for, from you | In addition to what is listed under "You tell us about the change" on the left, we may:<br>• reject your claim*** |

| | | | | |
|---|---|---|---|---|
| The insured person starts/ stops a second occupation* or changes the number of hours per week that he/she works | Impacts on the payments being made<br><br>We may:<br>• change the benefit payments,<br>• stop the benefit payments or<br>• recover benefit payments we had already made but that the insured person did not qualify for, from you<br><br>Impacts on the contract itself<br><br>We may:<br>• change the premium,<br>• offer different terms** or<br>• remove any benefits that you no longer qualify for*** | Same as under "You tell us about the change" on the left | We may:<br>• change the premium,<br>• offer different terms**,<br>• remove any benefits you no longer qualify for*** or<br>• recover benefit payments we had already made but that the insured person did not qualify for, from you | In addition to what is listed under "You tell us about the change" on the left, we may:<br>• reject your claim*** |
| The insured person's part of the business expenses that he/she is responsible for decreases while we are making payments | Impact on the payments being made<br><br>We may:<br>• change the benefit payments or<br>• recover benefit payments we had already made but that the insured person did not qualify for, from you<br><br>Impacts on the contract itself<br><br>None | Same as under "You tell us about the change" on the left | None | Same as under "You tell us about the change" on the left |
| The insured person's health/medical status changes (he/she recovers or his/her condition improves) while we are making payments | Impact on the payments being made<br><br>We may:<br>• change the benefit payments,<br>• stop the benefit payments or<br>• recover benefit payments we had already made but that the insured person did not qualify for, from you<br><br>Impacts on the contract itself<br><br>None | In addition to what is listed under "You tell us about the change" on the left, we may:<br>• remove the benefit*** | None | Same as under "You tell us about the change" on the left |

| | | | | |
|---|---|---|---|---|
| The insured person dies | Impact on the payments being made<br><br>We may:<br>• stop the benefit payments or<br>• recover benefit payments we made after the insured person's death, from you<br><br>Impacts on the contract itself<br><br>We will remove the benefit from your contract*** | Same as under "You tell us about the change" on the left | We will remove the benefit from your contract*** | Same as under "You tell us about the change" on the left |

* Any details that you have provided to us, will appear on the Personal, product and benefit details. It is your responsibility to let us know if any of these details change.

** Different terms include the following examples:

- a premium increase,
- additional circumstances under which we will not pay,
- the insured person may no longer qualify for the existing benefit but may qualify for another benefit, or
- a cover decrease.

*** If we remove benefits from your contract or reject your claim, we will not pay back the premiums we have received. If a removed benefit was the last active benefit on the contract, the contract will be cancelled and you will no longer have any cover.

## FUNCTIONAL IMPAIRMENTS THAT QUALIFY UNDER THE BUSINESS EXPENSES COVER BENEFIT

| Body system | Functional impairment | Requirements that the functional impairment must meet to qualify | Percentage of the cover amount payable |
|---|---|---|---|
| Cardiovascular | Arrhythmia | The diagnosis of an arrhythmia by a medical specialist.<br><br>With evidence of the following, despite adequate medical treatment:<br><br>• Shortness of breath so severe that symptoms are present at rest (NYHA, Class IV), and<br>• Symptoms of palpitations and syncope or dizziness correlating with ECG evidence of serious arrhythmia are present daily. | 100% |
| | | The diagnosis of an arrhythmia by a medical specialist.<br><br>With evidence of the following, despite adequate medical treatment:<br><br>• Marked limitation in activity due to symptoms, even during less-than-ordinary activity, e.g. walking short distances (NYHA Class III), and<br>• Symptoms of palpitations and syncope or dizziness correlating with ECG evidence of serious arrhythmia are present frequently with at least 3 episodes per week. | 50% |
| | Congestive Cardiac Failure | The diagnosis of Congestive cardiac failure by a specialist cardiologist or physician as a result of coronary artery disease or valvular heart disease or diseases of the aorta or pericardial disease.<br><br>With evidence of the following:<br><br>• Ejection fraction (EF) consistently less than 40% after adequate medical treatment, and shortness of breath so severe that symptoms are present during less than ordinary activity or at rest (NYHA Class lll - IV), or<br>• Awaiting cardiac transplantation. | 100% |
| | | The diagnosis of Congestive cardiac failure by a specialist cardiologist or physician as a result of coronary artery disease or valvular heart disease or diseases of the aorta or pericardial disease.<br><br>With evidence of the following:<br><br>• Ejection fraction (EF) consistently less than 45% after adequate medical treatment, and marked limitation in activity due to symptoms, even during ordinary or less than ordinary activity e.g. walking short distances (NYHA Class ll - III). | 50% |

| | | | |
|---|---|---|---|
| Cardiovascular (continued) | Hypertension | The diagnosis of uncontrolled hypertension confirmed by a medical specialist.<br><br>With evidence of diastolic pressure greater than or equal to 110mmHg on adequate treatment and complicated by 2 or more of the following:<br><br>• Stage 4 Kidney dysfunction<br>• Cerebrovascular incident (excluding transient ischaemic attacks) confirmed by neuroimaging<br>• Echocardiogram evidence of LVH (septal wall<br>• thickness to posterior LV wall thickness 1.3:1)<br>• Grade IV retinopathy<br>• Congestive Cardiac Failure with evidence of an ejection fraction (EF) consistently less than 45% after adequate medical treatment, and marked limitation in activity due to symptoms, even during ordinary or less than ordinary activity e.g. walking short distances (NYHA Class II - III). | 100% |
| | | The diagnosis of uncontrolled hypertension confirmed by a medical specialist.<br><br>With evidence of diastolic pressure greater than 105mmHg on adequate treatment and complicated by 1 of the following:<br><br>• Stage 3 Kidney dysfunction, or<br>• Cerebrovascular incident (excluding transient ischaemic attacks) confirmed by neuroimaging, or<br>• Grade III retinopathy. | 50% |
| | Peripheral Arterial Disease | The diagnosis of peripheral arterial disease of the lower limbs by a vascular surgeon.<br><br>With evidence of no recordable pulse on Doppler readings, and 1 of the following:<br><br>• Severe Vascular Ulceration, or<br>• Gangrene secondary to peripheral arterial disease. | 100% |
| | | The diagnosis of peripheral arterial disease of the lower limbs by a vascular surgeon.<br><br>With evidence of the following:<br><br>• Abnormal diminished pulse on Doppler readings, and<br>• Ankle-brachial index (ABI) < 0.9 and<br>• Pain on exercise as a result of peripheral arterial disease with claudication on walking less than 500m. | 50% |
| | Peripheral Venous Disease | The diagnosis of veno-occlusive disease of the lower limbs by a vascular surgeon.<br><br>With evidence of the following:<br><br>• Severe deep and widespread vascular ulceration, and<br>• Oedema of the lower limbs | 50% |

| | | | |
|---|---|---|---|
| Respiratory | Chronic Respiratory Failure | The diagnosis of a chronic respiratory failure by a pulmonologist.<br><br>With persistent evidence of at least 1 of the following, despite adequate medical treatment:<br><br>• Impaired airflow with FEV1 less than or equal to 40%, or<br>• FVC less than or equal to 50%, or<br>• DLCO of less than or equal to 40%. | 100% |
| | | The diagnosis of a chronic respiratory failure by a pulmonologist.<br><br>With persistent evidence of at least 1 of the following, despite adequate medical treatment:<br><br>• Impaired airflow with FEV1 less than or equal to 50%, or<br>• FVC less than or equal to 60%, or<br>• DLCO of less than or equal to 50%. | 50% |
| | Pulmonary Arterial Hypertension | The diagnosis of pulmonary hypertension by a medical specialist.<br><br>With evidence of a Systolic Pulmonary Artery Pressure greater than 70mmHg and complicated by at least 1 of the following:<br><br>• Right sided heart failure, or<br>• Shortness of breath so severe that symptoms are present at rest (NYHA Class IV). | 100% |
| | | The diagnosis of pulmonary hypertension by a medical specialist.<br><br>With evidence of a Systolic Pulmonary Artery Pressure of 40-70 mmHg and complicated by at least 1 of the following:<br><br>• Right sided heart failure, or<br>• Marked limitation in activity due to symptoms, even during less-than-ordinary activity, e.g. walking short distances (NYHA Class III). | 50% |

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| Gastrointestinal | Ano-rectal impairment | Faecal incontinence<br>• With evidence of complete faecal incontinence despite adequate medical and/or surgical treatment by a gastroenterologist or equivalent specialist. | 100% |
| | | A stoma in situ created by a gastroenterologist or equivalent specialist due to a gastrointestinal disorder. | 50% |
| | Biliary Tract Disease | The diagnosis of a biliary tract disease by a liver specialist, gastroenterologist or equivalent medical specialist.<br>With evidence of the following:<br>• Persistent biliary tract obstruction with recurrent cholangitis, and<br>• Persistent jaundice | 75% |
| | Chronic Gastrointestinal Disease | The diagnosis of a chronic gastrointestinal disease by a gastroenterologist or equivalent specialist, as a result of a medical condition.<br>With evidence of the following:<br>• Medical findings confirming organic disease, and<br>• Significant unintentional weight loss resulting in a BMI of less than 15 or 25% weight loss below the lower limit of the normal range for the individual, and<br>• Symptoms uncontrolled by medical or surgical treatment.<br>Psychiatric conditions are excluded. | 100% |
| | | The diagnosis of a chronic gastrointestinal disease by a gastroenterologist or equivalent specialist, as a result of a medical condition.<br>With evidence of the following:<br>• Medical findings confirming organic disease, and<br>• Significant unintentional weight loss resulting in a BMI between 15 and 16.1 or 20% weight loss below the lower limit of the normal range for the individual, and<br>• Symptoms uncontrolled by medical or surgical treatment.<br>Psychiatric conditions are excluded. | 75% |
| | | The diagnosis of a chronic gastrointestinal disease by a gastroenterologist or equivalent specialist, as a result of a medical condition.<br>With evidence of the following:<br>• Medical findings confirming organic disease, and<br>• Significant unintentional weight loss resulting in a BMI between 16.2 and 17 or 15% weight loss below the lower limit of the normal range for the individual, and<br>• Symptoms uncontrolled by medical or surgical treatment.<br>Psychiatric conditions are excluded. | 50% |
| | Chronic Liver Failure | The diagnosis of chronic end-stage liver failure, with a Child Pugh Classification of class C, by a gastroenterologist or equivalent specialist. | 100% |
| | | The diagnosis of progressive chronic liver disease, with a Child Pugh Classification of class B, by a gastroenterologist or equivalent specialist. | 50% |
| | Irreducible Hernia | The diagnosis of an irreducible hernia, following unsuccessful surgical repair of the hernia, by a gastroenterologist or equivalent specialist.<br>With evidence of bowel dysfunction which impacts on activities of daily living, such that the insured person is unable to perform 2 of the Basic Activities of Daily Living and 2 of the Advanced Activities of Daily Living. | 50% |

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| Urogenital | Bladder Impairment | The diagnosis of a bladder impairment despite adequate surgical and medical treatment by a nephrologist or urologist.<br><br>With evidence of 1 of the following:<br><br>• No detectable reflex or voluntary urine control as a result of organic pathology, resulting in urinary incontinence, or<br>• Total bladder resection, or<br>• Chronic disorders of the bladder and its structures that require a permanent indwelling catheter. | 100% |
| | Chronic Kidney Failure | The diagnosis of chronic renal failure despite adequate medical treatment by a nephrologist or urologist.<br><br>With evidence of 1 of the following:<br><br>• End-stage renal disease with an estimated GFR less than 24ml/min, or<br>• Creatinine clearance of less than 28 ml per minute, or<br>• Renal function deterioration that requires life-long peritoneal dialysis or lifelong haemodialysis. | 100% |
| | | The diagnosis of chronic renal failure despite adequate medical treatment by a nephrologist or urologist.<br><br>With evidence of 1 of the following:<br><br>• Chronic renal disease with an estimated GFR between 24-40ml/min, or<br>• Creatinine clearance of 28 to 42 ml per minute. | 50% |

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| Central Nervous System | Impaired consciousness | The diagnosis of a coma of a specified severity by a neurologist or neurosurgeon. Medically induced comas are excluded.<br><br>With evidence of the following for 14 days or more:<br><br>• A decreased level of consciousness, with a Glasgow Coma Scale of less than 9, and<br>• Requiring total medical support including intubation and assisted ventilation. | 100% |
| | | The diagnosis of a coma of a specified severity by a neurologist or neurosurgeon. Medically induced comas are excluded.<br><br>With evidence of the following:<br><br>• Decreased level of consciousness, with a Glasgow Coma Scale of less than 9, which is constant and present for greater than 96hrs. | 50% |
| | Aphasia | The diagnosis of aphasia by a neurologist or neurosurgeon.<br><br>With evidence of the following:<br><br>• A total inability to express oneself or communicate (through speech, writing, or signs), or to comprehend spoken or written language, due to injury or disease of the brain, and<br>• Deficits in the formal aspects of language such as naming, word choice, comprehension, spelling and syntax, and<br>• Objective medical findings supporting the diagnosis of aphasia.<br><br>Psychiatric conditions are excluded. | 100% |
| | Cranial Nerve V (Trigeminal Neuralgia) | The diagnosis of severe unilateral or bilateral facial neuralgic pain by a neurologist due to an affliction of the Trigeminal Nerve.<br><br>With evidence of the following:<br><br>• Resistance to pharmacological treatment, and<br>• Has resulted in decompression surgery. | 50% |
| | Cranial Nerve VII | The diagnosis of facial nerve paralysis confirmed by a neurologist or neurosurgeon.<br><br>With persistent evidence of the following:<br><br>• Slight or no movement of the face, and<br>• An inability to actively close the eyelids, and<br>• Slight or no movement of the mouth. | 100% |
| | | The diagnosis of facial nerve paralysis confirmed by a neurologist or neurosurgeon.<br><br>With persistent evidence of the following:<br><br>• Slight or no movement of one half of the face with asymmetry at rest, and<br>• An inability to actively close the eyelid on the affected side, and<br>• Slight or no movement of the mouth. | 50% |

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| Central Nervous System (continued) | Cranial Nerve VIII | The diagnosis of Vestibulocochlear nerve paralysis confirmed by a neurologist or neurosurgeon.<br><br>With evidence of the following:<br><br>• Nerve damage with severe imbalance resulting in limitation of activities of daily living such that the insured person is unable to perform 3 of the Basic Activities of Daily Living or 4 of the Advanced Activities of Daily Living. | 100% |
| | | The diagnosis of Vestibulocochlear nerve paralysis confirmed by a neurologist or neurosurgeon.<br><br>With evidence of the following:<br><br>• Nerve damage with moderately-severe imbalance resulting in limitation of activities of daily living such that the insured person is unable to perform 2 of the Basic Activities of Daily Living and 2 of the Advanced Activities of Daily Living. | 50% |
| | Cranial Nerves IX, X, XII | The diagnosis of Cranial Nerve IX, X, XII paralysis confirmed by a neurologist or neurosurgeon.<br><br>With evidence of the following:<br><br>• An inability to swallow or process oral secretions without choking, and<br>• Need for external suctioning device, and<br>• Medical findings confirming organic disease. | 100% |
| | | The diagnosis of Cranial Nerve IX, X, XII paralysis confirmed by a neurologist or neurosurgeon.<br><br>With evidence of the following:<br><br>• Severe dysarthria or dysphagia, and<br>• Nasal regurgitation, and<br>• Aspiration of liquids or semi-solid foods, and<br>• Medical findings confirming organic disease. | 50% |
| | Epilepsy | The diagnosis of epilepsy by a neurologist or neurosurgeon supported by objective medical findings and resistant to optimal therapy as confirmed by drug serum-level testing.<br><br>With evidence of the following:<br><br>• 3 or more generalised seizures per week for at least 3 consecutive months, and<br>• An inability to perform 3 of the Basic Activities of Daily Living or 4 of the Advanced Activities of Daily Living. | 100% |
| | | The diagnosis of epilepsy by a neurologist or neurosurgeon supported by objective medical findings and resistant to optimal therapy as confirmed by drug serum-level testing.<br><br>With evidence of the following:<br><br>• 6 or more generalised seizures per month for at least 3 consecutive months, and<br>• An inability to perform 2 of the Basic Activities of Daily Living and 2 of the Advanced Activities of Daily Living. | 50% |

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| Central Nervous System (continued) | Gait disorders / Poor motor coordination | The diagnosis of a cerebellar disorder by a neurologist or neurosurgeon correlating with objective medical findings.<br><br>With evidence of the following:<br><br>• Needs assistive devices or mechanical support for daily functions, or<br>• An inability to perform 2 of the Basic Activities of Daily Living and 2 of the Advanced Activities of Daily Living, or<br>• Documented previous falls and inability to stand, walk, stoop, squat, kneel, climb stairs, or<br>• Inability to grasp and pincer grip and a complete loss of fine or gross motor coordination or grip strength. | 50% |
| | | The diagnosis of a cerebellar disorder by a neurologist or neurosurgeon.<br><br>The diagnosis of a cerebellar disorder by a neurologist or neurosurgeon correlating with objective medical findings.<br><br>With evidence of the following:<br><br>• Difficulty with standing or maintaining a standing position, without assistive devices,<br>• and needs assistance with walking, or<br>• Difficulty with fine or gross motor coordination or grip strength. | 25% |
| | Hemiplegia | The total loss of the functioning of one side of the body due to an injury or disease of the brain as confirmed by a neurologist or neurosurgeon and correlating with objective medical findings. | 100% |
| | Dementia (incl. Alzheimer's Disease) | The diagnosis of dementia by a neurologist, physician or neurosurgeon<br><br>With evidence of the following:<br><br>• A diminished intellectual ability (may include personality changes and episodes of confusion), and<br>• A score of 2 under the 5 point Clinical Dementia Rating scale, and<br>• Needs constant supervision. | 100% |
| | | The diagnosis of dementia by a neurologist, physician or neurosurgeon<br><br>With evidence of the following:<br><br>• A diminished intellectual ability (may include a personality change and episodes of confusion), and<br>• A score of 1 under the 5 point Clinical Dementia Rating scale, and<br>• Needs some supervision with everyday duties. | 50% |
| | Paraplegia / Diplegia | The total loss of the functioning of both legs or both arms due to an injury or disease of the brain or spinal cord.<br><br>This must be confirmed by a neurologist or neurosurgeon and correlate with objective medical findings. | 100% |
| | Quadriplegia | The total loss of the functioning of both legs and both arms due to an injury or disease of the brain or spinal cord.<br><br>This must be confirmed by a neurologist or neurosurgeon and correlate with objective medical findings. | 100% |

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| Cancer | Cancer | The diagnosis of an advanced stage of cancer as confirmed by an oncologist with supporting documentation.<br><br>With evidence of the following:<br><br>• Diagnosis of at least a stage III cancer, and the insured person is unable to perform 2 of the Basic Activities of Daily Living or 3 of the Advanced Activities of Daily Living, or<br>• Stage IV cancer or<br>• Cancer which has resulted in organ failure will be assessed under the affected organ.<br><br>Organ failure will only be assessed under the following definitions:<br><br>Congestive Cardiac Failure or<br><br>Chronic respiratory failure or<br><br>Chronic liver failure or<br><br>Chronic kidney failure or<br><br>Organic Brain Disorders/ Dementia | 100% |

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| Senses | Loss of sight | Confirmed diagnosis of bilateral loss of sight by an ophthalmologist. The loss of sight cannot be improved through refractive correction or medication.<br><br>With evidence of 1 of the following:<br><br>• A reading of 6/60 or worse (or equivalent measure on a non-metric scale) in each eye after best correction, or<br>• Severe proliferative diabetic retinopathy, or<br>• Grade IV hypertensive retinopathy, or<br>• Permanent Hemianopia in both eyes, or<br>• A visual field loss to a 10˚ radius in the better eye.<br><br>Loss of sight due to cataracts is excluded, unless there is evidence of failed cataract surgery or contraindications to cataract surgery. | 100% |
| | | Confirmed diagnosis of bilateral loss of sight by an ophthalmologist. The loss of sight cannot be improved through refractive correction or medication.<br><br>With evidence of 1 of the following:<br><br>• A reading of 6/36 or worse (or equivalent measure on a non-metric scale) in each eye after best correction, or<br>• Severe non-proliferative diabetic retinopathy, or<br>• Grade III hypertensive retinopathy, or<br>• A visual field loss to a 20˚ radius in the better eye.<br><br>Loss of sight due to cataracts is excluded, unless there is evidence of failed cataract surgery or contraindications to cataract surgery. | 50% |
| | | Confirmed diagnosis of loss of sight in one eye by an ophthalmologist. The loss of sight cannot be improved through refractive correction or medication.<br><br>With evidence of the following:<br><br>• A reading of 6/60 or worse (or equivalent measure on a non-metric scale) in one eye after best correction, or<br>• The diagnosis of a hemianopia in one eye, or<br>• A visual field loss to a 10˚ radius.<br><br>Loss of sight due to cataracts is excluded, unless there is evidence of failed cataract surgery or contraindications to cataract surgery. | 25% |
| | Loss of hearing | Total loss of hearing in both ears as confirmed by an ear, nose and throat surgeon.<br><br>With evidence of the following:<br><br>• Audiometry measurements, done with the use of hearing aids, with an average loss of greater than 87dB. | 100% |
| | | Total loss of hearing in both ears as confirmed by an ear, nose and throat surgeon.<br><br>With evidence of the following:<br><br>• Audiometry measurements, done with the use of hearing aids, averaging between 70-87dB. | 50% |
| | | Total loss of hearing in one ear as confirmed by an ear, nose and throat surgeon.<br><br>With evidence of the following:<br><br>• Audiometry measurements, done with the use of hearing aids, with an average loss of greater than 70dB. | 25% |

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| Senses (continued) | Loss of speech | The total loss of the ability to produce intelligible and audible speech due to injury or disease, as confirmed by an ear, nose and throat surgeon, neurologist or neurosurgeon.<br>• Objective medical evidence of an ear, nose and throat disorder causing the impairment must be provided.<br>Loss of speech due to psychiatric causes are excluded. | 100% |
| | | The loss of 50% of speech, as confirmed by an ear, nose and throat surgeon, neurologist or neurosurgeon.<br>Objective medical evidence of an ear, nose and throat disorder causing the impairment must be provided, with clinical evidence of 2 of the following requirements:<br>• Audibility: while whisper may be present, there is no audible voice.<br>• Intelligibility: while single words may be recognisable, most words are unintelligible.<br>• Function: speech is impractically slow and laboured.<br>Loss of speech due to psychiatric causes are excluded. | 50% |
| Endocrine | Endocrine Disorders | The diagnosis of an endocrine disorder, which despite adequate medical and surgical treatment, has resulted in organ failure, as confirmed by a medical specialist.<br>• Organ failure will only be assessed under the following definitions:<br>Congestive Cardiac Failure or<br>Chronic respiratory failure or<br>Chronic liver failure or<br>Chronic kidney failure or<br>Organic Brain Disorders/ Dementia | 100% |
| Psychiatric | Psychiatric Disorder | The diagnosis of a psychiatric disorder, as confirmed by a specialist psychiatrist.<br>Resulting in continuous institutionalisation and<br>With evidence of the following:<br>• persistent GAF score of 40 or less certified under the DSM IV classification, or<br>• persistent WHODAS average domain score of 4 certified under the DSM 5 classification | 100% |
| | | The diagnosis of a psychiatric disorder, as confirmed by a specialist psychiatrist.<br>Requires constant supervision and<br>With evidence of the following:<br>• persistent GAF score of 40 or less certified under the DSM IV classification, or<br>• persistent WHODAS average domain score of 4 certified under the DSM 5 classification | 75% |

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| Trauma | Facial Disorders or Disfigurement | Total facial disfigurement as confirmed by a maxillofacial specialist or related specialist.<br><br>There should be destruction or loss of skin, bone, or muscles that requires reconstructive surgery. | 100% |
| | Major Burns | The diagnosis of third degree burns (full thickness burns) by a plastic surgeon or trauma specialist.<br><br>With evidence of at least:<br><br>• 30% of total body surface affected as measured on the Lund and Browder Chart or equivalent scale, or<br>• more than 50% of the combined surface area of the bilateral upper limbs affected including involvement of at least 60% of combined surface area of the palms of both hands; and restriction of joint mobility of at least two of the following: 3 fingers, wrist or elbow. | 100% |
| | | The diagnosis of third degree burns (full thickness burns) by a plastic surgeon or trauma specialist.<br><br>With evidence of:<br><br>• at least 20% of total body surface affected as measured on the Lund and Browder Chart or equivalent scale, or<br>• more than 50% of the combined surface area of the bilateral lower limbs including involvement of at least 60% of the combined surface area of the soles of both feet; or<br>• more than 50% of the combined surface area of an upper and lower limb including involvement of at least 60% of the combined surface area of the sole of one foot and the palm of one hand. | 50% |
| | Inhalational Burn | Inhalational burns resulting in a tracheostomy. | 50% |

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| Haematology | Clotting Disorders | The diagnosis of a clotting disorder, which despite adequate medical and surgical treatment, has resulted in organ failure, as confirmed by a medical specialist.<br>• Organ failure will only be assessed under the following definitions:<br>Congestive Cardiac Failure or<br>Chronic respiratory failure or<br>Chronic liver failure or<br>Chronic kidney failure or<br>Organic Brain Disorders/ Dementia | 100% |
| | Red Blood Cell Disorders | The diagnosis of severe chronic anaemia by a physician or haematologist.<br>With evidence of the following:<br>• Hb persistently less than 8g/dL, and<br>• Requiring 2-3U of blood every 2 weeks. | 100% |
| | | The diagnosis of severe chronic anaemia by a physician or haematologist.<br>With evidence of the following:<br>• Hb persistently less than 8g/dL, and<br>• Requiring 2-3U of blood every 4-6 weeks. | 50% |
| | White Blood Cell Disorders | The diagnosis of a severe white blood cell disorder by a physician or haematologist.<br>With evidence of 1 of the following:<br>• An absolute neutrophil count of less than 250, resulting in at least 3 hospitalisations per year for acute bacterial infections, or<br>• Lymphoma or Leukaemia requiring at least 3 chemotherapy regimens per year. | 100% |
| | | The diagnosis of a severe white blood cell disorder by a physician or haematologist.<br>With evidence of 1 of the following:<br>• An absolute neutrophil count of between 250 and 500 , resulting in at least 2 hospitalisations per year for acute bacterial infections, or<br>• Lymphoma or Leukaemia requiring at least 1 chemotherapy regimen per year. | 50% |

<table>
<tr>
<td>Musculoskeletal</td>
<td>Chronic Spinal Column Conditions</td>
<td>
<ul>
<li>A history of chronic pain syndrome due to a chronic spinal condition for a duration of at least two years. It must be treated by a multidisciplinary pain management team with at least three of the four requirements listed below, which must be confirmed by an orthopaedic or neurosurgeon. All these criteria must be present in the same region, as defined below, for a valid claim to be paid. or</li>
<li>Confirmed diagnosis of Cauda equina syndrome resulting in bowel or bladder dysfunction.</li>
</ul>
Spinal Regions:<br><br>
The neck and lower back are part of the spine. The spinal regions are:
<ul>
<li>Cervical region (C1-C7).</li>
<li>Thoracic region (T1-T12) and</li>
<li>Lumbosacral region (L1-S1).</li>
</ul>
The C7 to T1 joint will be classified in the cervical region, and the T12 to L1 joint in the thoracolumbar region.<br><br>
List of four requirements:
<ol>
<li>50% or more compression of a vertebral body or multiple level compression fractures giving rise to kyphotic deformity.</li>
<li>Clinically significant radiculopathy (motor and sensory deficit or muscle atrophy and clinical signs of nerve tension and radiological evidence at the same site as clinically found. NB – We will not accept radiological signs of nerve compression without clinical evidence of neurological involvement as proof of functional impairment.</li>
<li>Alteration of motion segment integrity confirming instability with neurological deficit.</li>
<li>Multiple back or cervical operations (i.e. two or more on separate occasions within a period of 5 years) comprising laminectomy, discectomy or fusion, or a combination thereof.</li>
</ol>
</td>
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<ul>
<li>A history of chronic pain syndrome due to a chronic spinal condition for a duration of at least two years. It must be treated by a multidisciplinary pain management team with at least two of the four requirements listed below, which must be confirmed by an orthopaedic or neurosurgeon. All these criteria must be present in the same region, as defined below, for a valid claim to be paid.</li>
</ul>
Spinal Regions:<br><br>
The neck and lower back are part of the spine. The spinal regions are:
<ul>
<li>Cervical region (C1-C7).</li>
<li>Thoracic region (T1-T12) and</li>
<li>Lumbosacral region (L1-S1).</li>
</ul>
The C7 to T1 joint will be classified in the cervical region, and the T12 to L1 joint in the thoracolumbar region.<br><br>
List of four requirements:
<ol>
<li>50% or more compression of a vertebral body or multiple level compression fractures giving rise to kyphotic deformity.</li>
<li>Clinically significant radiculopathy (motor and sensory deficit or muscle atrophy and clinical signs of nerve tension and radiological evidence at the same site as clinically found. NB – We will not accept radiological signs of nerve compression without clinical evidence of neurological involvement as proof of functional impairment.</li>
<li>Alteration of motion segment integrity confirming instability with neurological deficit.</li>
<li>Multiple back or cervical operations (i.e. two or more on separate occasions within a period of 5 years) comprising laminectomy, discectomy or fusion, or a combination thereof.</li>
</ol>
</td>
<td>50%</td>
</tr>
</table>

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|---|---|---|---|
| Musculoskeletal (continued) | Chronic Spinal Column Conditions | • A history of chronic pain syndrome due to a chronic spinal condition for a duration of at least two years. It must be treated by a multidisciplinary pain management team with at least one of the four requirements listed below, which must be confirmed by an orthopaedic or neurosurgeon. All these criteria must be present in the same region, as defined below, for a valid claim to be paid.<br><br>Spinal Regions:<br><br>The neck and lower back are part of the spine. The spinal regions are:<br><br>• Cervical region (C1-C7).<br>• Thoracic region (T1-T12) and<br>• Lumbosacral region (L1-S1).<br><br>The C7 to T1 joint will be classified in the cervical region, and the T12 to L1 joint in the thoracolumbar region.<br><br>List of four requirements:<br><br>1. 50% or more compression of a vertebral body or multiple level compression fractures giving rise to kyphotic deformity.<br>2. Clinically significant radiculopathy (motor and sensory deficit or muscle atrophy and clinical signs of nerve tension and radiological evidence at the same site as clinically found. NB – We will not accept radiological signs of nerve compression without clinical evidence of neurological involvement as proof of functional impairment.<br>3. Alteration of motion segment integrity confirming instability with neurological deficit.<br>4. Multiple back or cervical operations (i.e. two or more on separate occasions within a period of 5 years) comprising laminectomy, discectomy or fusion, or a combination thereof. | 25% |
| | Combination of loss of use of an upper and lower limb | The total loss of use of an upper and a lower limb appendage as defined below:<br><br>• a foot at the transverse tarsal joint (Chopart's joint),<br>• a leg at or above the ankle joint up to the hip joint,<br>• a hand (at the metacarpophalangeal joint),<br>• an arm at or above the wrist joint up to the shoulder joint,<br><br>as confirmed by an orthopaedic or neurosurgeon. | 100% |
| | Loss of use of both hands or arms | The total loss of use of:<br><br>• both hands at the metacarpophalangeal joints, or<br>• both arms at or above the wrist joint up to the shoulder joint, or<br>• one hand at the metacarpophalangeal joint and one arm at or above the wrist joint up to the shoulder joint,<br><br>as confirmed by an orthopaedic or neurosurgeon. | 100% |
| | Loss of use of both feet or legs | The total loss of use of:<br><br>• both legs at or above the ankle joint up to the hip joint, or<br>• both feet at the transverse tarsal joint (Chopart's joint), or<br>• one foot at the transverse tarsal joint (Chopart's joint) and one leg at or above the ankle joint up to the hip joint,<br><br>as confirmed by an orthopaedic or neurosurgeon. | 100% |
| | Loss of use of one arm | The total loss of use of one arm at or above the wrist joint up to the shoulder joint, as confirmed by an orthopaedic or neurosurgeon. | 75% |
| | Loss of use of one hand | The total loss of use of one hand at the metacarpophalangeal joint involving more than 3 fingers, one of which includes either the thumb or the index finger, as confirmed by an orthopaedic or neurosurgeon. | 50% |
| | Loss of use of one thumb | The total loss of use of one thumb, as confirmed by an orthopaedic or neurosurgeon. | 25% |
| | Loss of use of one leg | The total loss of use of one leg, at or above the ankle joint up to the hip joint, as confirmed by an orthopaedic or neurosurgeon. | 75% |
| | Loss of use of one foot | The total loss of use of one foot at the transverse tarsal joint (Chopart's joint), as confirmed by an orthopaedic or neurosurgeon. | 50% |

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| HIV/AIDS | AIDS | The clinical manifestation of AIDS/Stage 4 HIV infection, as confirmed by a medical specialist.<br><br>With evidence of the following:<br><br>• Positive HIV antibody test (or other recognised test for the presence of AIDS, acceptable to Old Mutual), and CD4 cell count of less than 200 despite compliance with anti-retroviral treatment as per latest National Guidelines, and either:<br>  • The presence of 3 or more of the following 5 conditions:<br>1. Weight loss of more than 10% body weight in less than 6 months<br>2. Shingles<br>3. Oral thrush<br>4. Chronic diarrhoea<br>5. Active tuberculosis<br><br>Or:<br><br>  • The diagnosis of one or more of the following 8 diseases:<br>1. Kaposi's sarcoma,<br>2. Candidiasis of oesophagus, trachea, bronchi or lungs,<br>3. Oral hairy leukoplakia,<br>4. Pneumocystis carinii pneumonia,<br>5. Extra pulmonary Cryptococcus,<br>6. Cytomegalo virus infection of an internal organ other than the liver,<br>7. Disseminated atypical mycobacteriosis,<br>8. Visceral leischmaniasis | 100% |

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| Activities of Daily Living | Activities of Daily Living | Any illness, condition or event that results in the insured person being unable to perform certain Basic Activities of Daily Living and / or Advanced Activities of Daily Living, as specified below.<br>• An inability to perform 3 of the Basic Activities of Daily Living or 4 of the Advanced Activities of Daily Living.<br>Old Mutual's Medical Officer must confirm that:<br>• The insured person has undergone adequate medical treatment and has reached an adequate level of functioning that can reasonably be expected of a person suffering from the illness, condition or event, and<br>• The insured person does not qualify, as a result of suffering from an illness, condition or event, for the payment of the cover amount for any other listed Functional Impairment under this benefit.<br>Where applicable, the activities listed below must be performed with simple external assistive devices (e.g. walking stick, Zimmer frame), but without complex external assistive devices (e.g. wheelchair, leg prosthesis).<br>• The general meaning of the terms 'simple external assistive devices' and 'complex external assistive devices' is not limited by the specific examples quoted or the class or type of the examples quoted. | 100% |
| | | Any illness, condition or event that results in the insured person being unable to perform certain Basic Activities of Daily Living and / or Advanced Activities of Daily Living, as specified below.<br>• An inability to perform 2 of the Basic Activities of Daily Living and 2 of the Advanced Activities of Daily Living.<br>Old Mutual's Medical Officer must confirm that:<br>• The insured person has undergone adequate medical treatment and has reached an adequate level of functioning that can reasonably be expected of a person suffering from the illness, condition or event, and<br>• The insured person does not qualify, as a result of suffering from an illness, condition or event, for the payment of the cover amount for any other listed Functional Impairment under this benefit.<br>Where applicable, the activities listed below must be performed with simple external assistive devices (e.g. walking stick, Zimmer frame), but without complex external assistive devices (e.g. wheelchair, leg prosthesis).<br>The general meaning of the terms 'simple external assistive devices' and 'complex external assistive devices' is not limited by the specific examples quoted or the class or type of the examples quoted. | 50% |

## ACTIVITIES OF DAILY LIVING UNDER THE BUSINESS EXPENSES COVER BENEFIT

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

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

## FRACTURES THAT QUALIFY FOR PAYMENT UNDER THE BUSINESS EXPENSES COVER BENEFIT

For fractures, the amount we pay depends on the waiting period that you chose.

| Fracture | 7-day waiting period | 1-month waiting period | Other waiting periods |
|---|---|---|---|
| Collar bone (Clavicle) | 1 month's income | No income | No income |
| Facial bones – Le Forte II | 1 month's income | No income | No income |
| Forearm (Radius or ulna or both) | 1 month's income | No income | No income |
| Bones of the hand (includes wrist and fingers) requiring plaster/fibreglass cast or surgery | 1 month's income | No income | No income |
| Hind foot or ankle | 1 month's income | No income | No income |
| Skull | 1 month's income | No income | No income |
| Compression fracture of a vertebral body <10% | 1 month's income | No income | No income |
| Two or less ribs | 1 month's income | No income | No income |
| Three or more ribs | 2 months' income | 1 month's income | No income |
| Knee cap (patella) | 2 months' income | 1 month's income | No income |
| Leg - between the knee and foot (Tibia or fibula or both) | 2 months' income | 1 month's income | No income |
| Shoulder blade (scapula) | 2 months' income | 1 month's income | No income |
| Humerus | 2 months' income | 1 month's income | No income |
| Spinous processes or transverse processes of the spine | 2 months' income | 1 month's income | No income |
| Facial bones – Le Forte III | 3 months' income | 2 months' income | No income |
| Pelvis | 3 month's income | 2 months' income | No income |
| Compression fracture of a vertebral body ≥10% | 3 months' income | 2 months' income | No income |
| Dislocation fracture of the spine requiring surgery | 3 months' income | 2 months' income | No income |
| Depressed fracture of the skull requiring surgery | 3 months' income | 2 months' income | No income |
| Neck of femur (thigh bone) | 3 months' income | 2 months' income | No income |
| Shaft of femur (thigh bone) | 3 months' income | 2 months' income | No income |