PRODUCT AND BENEFIT RULES
OLD MUTUAL PROTECT FUNCTIONAL IMPAIRMENT 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 Functional Impairment Cover. It pays the cover amount when the insured person becomes functionally impaired. 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 replacement owner?

A replacement owner is a person who will take over the ownership of the contract if it continues after your death. You must nominate him/her. Any nominated replacement owner's name will appear on Personal, product and benefit details. You may change the replacement owner at any time. We will not act on any replacement owner nomination that we receive after your death. If you have not named a replacement owner or the replacement owner you have named is no longer alive when you die, the executor of your estate must appoint the new owner in terms of your will or, if you do not have a will, the law of succession will apply.

The **executor** is the person who finalises your estate (what you owe and own) after your death. He/she may be appointed in your will or by a court.

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 is cashback and who is the cashback beneficiary?

On each cashback anniversary, we will pay a percentage, as shown on Personal, product and benefit details of all the premiums that we have received for the contract since the previous cashback anniversary and while cashback existed on your contract, to the cashback beneficiary. The name of the cashback beneficiary is shown on Personal, product and benefit details. You may remove cashback from the contract at any time. Cashback will not be paid if the contract has been cancelled for any reason including where we pay a claim that results in the contract terminating.

Its premium is included in the premium for the product on Personal, product and benefit details. The cashback premium changes whenever the contract premium changes or at its review date. The next cashback review date is shown on Personal, product and benefit details.

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.

A **cashback anniversary** is every fifth anniversary of the date on which the cashback was first added to the contract. If there is less than five years to the contract end date, cashback will be paid on the contract end date. The date of the next cashback anniversary is shown on Personal, product and benefit details.

When cashback is payable - if you added cashback to your contract on 1 July 2017, the first cashback anniversary will be on 1 July 2022. If you remove cashback from your contract on 30 June 2019, you will still receive cashback on 1 July 2022 if your contract has not been cancelled by this date, for the 2 years during which cashback existed on your contract (between 1 July 2017 and 30 June 2019).

Cancelled includes where we cancel the contract because you stopped paying premiums and where we cancel the contract on your instruction.

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.

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><td>Age</td><td>Yearly premium increase</td></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, no premium is payable on the contract and the premium would have increased, we will decrease the cover amount instead.

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, the cover amount will automatically increase every year on the scheduled yearly 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.
Currency-linked	the currency exchange rate as set by us and as adjusted by a percentage you have chosen. If you have chosen to adjust the currency exchange rate by an inflation linked percentage, it is the foreign inflation as set by us.

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, no premium is payable on the contract and the premium would have increased, we will decrease the cover amount instead.

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.

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.

Cessions affect you, the replacement owner and 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 or replacement owners.

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).

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.

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 FUNCTIONAL IMPAIRMENT COVER BENEFIT

What is it?

This benefit pays the cover amount when the insured person (whose name appears on Personal, product and benefit details) becomes functionally impaired after the cover started and if the survival period is met.

Functionally impaired means that the insured person has permanently and irreversibly suffered and met the requirements of a qualifying functional impairment. See the list of functional impairments that qualify at the end of this document

Permanent and irreversible means that the insured person cannot recover from the sickness or injury despite following reasonable medical advice, adequate medical treatment and having achieved maximum medical improvement as confirmed by our medical officer.

Reasonable medical advice means the medical opinion provided by a health professional that the insured person can reasonably be expected to follow to improve or preserve 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.

Maximum medical improvement means that the insured person's condition cannot be improved any further. It can mean that the insured person has fully recovered from his medical condition or that his/her medical condition has stabilised to the point that no major medical or emotional change can be expected despite continuing medical treatment or rehabilitative programs.

What is a survival period?

A survival period is the number of consecutive days or months the insured person must survive after becoming functionally impaired before we will pay the cover amount. It starts on the date of the functional impairment as confirmed by our medical officer. The survival period is 10 days. You must continue to pay your premiums during the survival period and while we decide if your claim is valid. If your contract is cancelled before the survival period ends, we will not pay the cover amount.

How much and when does Old Mutual pay?

The cover amount for the insured person can be claimed when he/she becomes functionally impaired. The starting cover amount is shown on Personal, product and benefit details.

We will pay 100% of the cover amount that applies on the date of the functional impairment as confirmed by our medical officer.

After we have paid a claim under this benefit, the cover under it will stop.

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.

When does cover start?

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

When does cover stop?

The insured person's cover stops:

- if he/she dies,
- if we do not receive your premiums and the grace period has passed,
- if 100% of the cover amount is paid,
- 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"), 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 we do not receive your premiums and the grace period has passed,
- if 100% of the cover amount is paid,
- 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"), or
- if your contract is cancelled,

whichever happens first.

When will Old Mutual not pay the cover amount?

We will not pay the cover amount:

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

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).

Payment of claim on Functional Impairment Cover benefit reduces Functional Impairment Cover benefit's cover amount to R0 and stops the benefit – Zane has an Old Mutual Protect Functional Impairment benefit with R500 000 cover. Zane becomes functionally impaired and qualifies for a payment of R500 000 (R500 000 * 100%) under the Functional Impairment Cover benefit. Because the full cover amount under the Functional Impairment Cover benefit has been paid, cover under this benefit stops.

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

When will Old Mutual not recognise the insured person's 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 permanently and irreversibly meet all the requirements that the functional impairment must meet to qualify.

Excluded events, activities or conditions

We will not recognise the claim if it is directly or indirectly caused by an event, activity or condition that is specifically or generally excluded.

Specific exclusions apply to certain contracts but not to others. Any specific exclusions that apply to this benefit, are shown on Personal, product and benefit details.

General exclusions always apply. 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 functional impairment 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).

ABOUT THE PARTIAL FUNCTIONAL IMPAIRMENT BENEFIT

What is it?

The Functional Impairment Cover benefit pays on functional impairment at 100% of the cover amount when the insured person has permanently and irreversibly suffered any of that benefit's qualifying functional impairments and if the survival period is met. The Partial Functional Impairment Benefit will pay on functional impairment at a percentage, that will be less than 100%, of the Functional Impairment Cover benefit's cover amount when the insured person has permanently and irreversibly suffered any of this benefit's qualifying functional impairments and if the survival period is met. See the list of functional impairments that qualify at the end of this document. The percentage of the Functional Impairment Cover benefit's cover amount depends on the severity of the functional impairment. Its premium is included in the starting premium for the product on Personal, product and benefit details.

What is a survival period?

This is explained under the same heading earlier under "ABOUT THE FUNCTIONAL IMPAIRMENT COVER BENEFIT".

How much and when does Old Mutual pay?

We will pay a percentage of the Functional Impairment Cover benefit's cover amount that applies on the date of the functional impairment as confirmed by our medical officer. The percentage of the Functional Impairment Cover benefit's cover amount depends on the severity of the functional impairment. The functional impairments, their requirements and the percentage of the Functional Impairment Cover benefit's cover amount payable in each case are shown in the list of functional impairments that qualify at the end of this document.

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

You can claim for the same functional impairment if it is more severe than was previously claimed for.

Each time we pay a claim under this benefit, the Functional Impairment Cover benefit's cover amount will decrease by the amount paid and the benefit will continue unless the amount paid was 100% of the cover amount.

The cover 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.

Claim for the same functional impairment if it is more severe than was previously claimed for - John has a Functional Impairment Cover benefit with R500 000 cover and a Partial Functional Impairment Benefit. John suffers loss of sight in one eye and qualifies for a payment equal to 25% of the cover amount. We pay R125 000 (R500 000 * 25%) and we decrease John's Functional Impairment Cover benefit's cover amount to R375 000 (R500 000 – R125 000). One year later, John suffers loss of sight in the other eye and qualifies for a payment equal to 100% of the cover amount. The cover amount at the date of the functional impairment was R375 000. John receives R375 000 (R375 000 * 100%) and we decrease John's Functional Impairment Cover benefit's cover amount to R0 and John's Functional Impairment Cover benefit stops.

Cover decreases after a claim is paid - Jack has a Functional Impairment Cover benefit with R500 000 cover and a Partial Functional Impairment Benefit. Jack's house burns down and he suffers major burns and qualifies for a payment equal to 50% of the cover amount. We pay R250 000 (R500 000 * 50%) and we decrease Jack's Functional Impairment Cover benefit's cover amount to R250 000 (R500 000 – R250 000).

Two months later, Jack suffers loss of hearing in one ear and qualifies for a payment equal to 25% of the cover amount. The cover amount at the date of the functional impairment was R250 000. We pay R62 500 (R250 000 * 25%) and we decrease Jack's Functional Impairment Cover benefit's cover amount to R187 500 (R250 000 – R62 500).

One year later, Jack suffers loss of sight and qualifies for a payment equal to 100% of the cover amount. The cover amount at the date of the functional impairment was R206 250 (R187 500 + 10% scheduled yearly cover increase of R18 750). We pay R206 250 (R206 250 * 100%) and we decrease Jack's Functional Impairment Cover benefit's cover amount to R0 and Jack's Functional Impairment Cover benefit stops.

When does cover start?

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

When does cover stop?

This is explained under the same heading earlier under "ABOUT THE FUNCTIONAL IMPAIRMENT COVER BENEFIT". In addition, cover under this benefit stops if it is removed from your contract.

When will Old Mutual not pay the cover amount?

We will not pay the cover amount:

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

When will Old Mutual not recognise the insured person's 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 permanently and irreversibly meet all the requirements that the functional impairment must meet to qualify.

Excluded events, activities or conditions

We will not recognise the claim if it is directly or indirectly caused by an event, activity or condition that is specifically or generally excluded.

Specific exclusions apply to certain contracts but not to others. Any specific exclusions that apply to this benefit, are shown on Personal, product and benefit details.

General exclusions always apply. 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 functional impairment 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 THE CHILD IMPAIRMENT BENEFIT

What is it?

This benefit pays up to 10% of the cover amount on the Functional Impairment Cover benefit if the child qualifies for an insured event as confirmed by our medical officer and if the survival period is met. Its premium is included in the starting premium for the product on Personal, product and benefit details.

The **child** is the biological, step or legally adopted child of the insured person on the Functional Impairment Cover benefit.

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

Insured event means:

- congenital birth defects of biological children; and
- child impairments.

See the list of congenital birth defects and child impairments that qualify at the end of this document.

What is a survival period?

A survival period is the number of consecutive days or months the child must survive after the insured event happened before we will pay the cover amount. It starts on the date of the insured event as confirmed by our medical officer. The survival period is 10 days. You must continue to pay your premiums during the survival period and while we decide if your claim is valid. If your contract is cancelled before the survival period ends, we will not pay the cover amount.

How much and when does Old Mutual pay?

A percentage of the Child Impairment Benefit's cover amount can be claimed when an insured event happens.

The Child Impairment Benefit's cover amount is the smaller of:

- 10% of the Functional Impairment Cover benefit's cover amount on the date of the insured event; and
- R500 000.

The percentage of the cover amount depends on the severity of the insured event. The insured events, their requirements and the percentage of the cover amount payable in each case are shown at the end of this document.

We will never pay more than R500 000 per child across all Child Impairment Benefits across all Functional Impairment Cover benefits for the same insured person.

We will pay a maximum of one claim per child for up to two children. If more than one insured event happens to the same child at the same time, we will pay the claim that results in the highest cover amount.

The Child Impairment Benefit's 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.

The **date of the insured event** will be:

- date of birth for congenital birth defects and
- date of child impairment as confirmed by our medical officer.

Multiple Child Impairment Benefits taken out by the same insured person and the cover amount is limited to R500 000 - Abulela takes out two Old Mutual Protect Functional Impairment Cover contracts both with a Child Impairment Benefit. Cover on the Functional Impairment Cover benefits are R5 000 000 and R1 000 000 respectively. A year later, his child Zinhle meets the criteria for total loss of hearing, which qualifies for 100% of the cover amount under the Child Impairment Benefit.

Abulela's total cover is R6 000 000. If we considered his two contracts separately, he would be able to claim for R500 000 [10% of R5 000 000] and R100 000 [10% of R1 000 000] or a total of R600 000 for Zinhle.

However, a maximum of R500 000 applies per child and per insured person, across all Child Impairment Benefits and a percentage of this amount will be paid based on the severity of the insured event. In this case, the insured event qualifies for 100% so 100% x R500 000 = R500 000 will be paid.

Multiple Child Impairment Benefits taken out by two different insured persons and the cover amount is limited to R500 000 for each insured person's Child Impairment Benefits – Abulela's wife, Ntombi, also has two Old Mutual Protect Functional Impairment Cover contracts with Child Impairment Benefits. Cover on the Functional Impairment Cover benefits are R2 000 000 and R2 500 000 respectively. Ntombi also claims for Zinhle's total loss of hearing.

Ntombi's total cover is R4 500 000. If we considered her two contracts separately, she would be able to claim for R200 000 [10% of R2 000 000] and R250 000 [10% of R2 500 000] or a total of R450 000 for Zinhle. We will pay a percentage, based on the severity of the insured event, of the R450 000. In this case, the insured event qualifies for 100% so 100% x R450 000 = R450 000 will be paid. In total we pay R950 000 [R500 000 from Abulela's contracts and R450 000 from Ntombi's ones]. The claim for Zinhle will also stop her cover under both her parents' Child Impairment Benefits because we will only pay one valid claim for her.

When does cover start?

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

When does cover stop?

Cover under this benefit stops:

- if we do not receive your premiums and the grace period has passed,
- if your contract is cancelled,
- once we have paid two valid claims under this benefit, or
- if this benefit is removed from your contract,

whichever happens first.

When does cover stop?

Cover under this benefit stops:

- on the cover end date shown on Personal, product and benefit details,
- if we do not receive your premiums and the grace period has passed,
- if your contract is cancelled,
- once we have paid two valid claims under this benefit, or
- if this benefit is removed from your contract,

whichever happens first.

When does cover for a child stop?

In addition to the reasons listed under "When does cover stop?", cover for a child under this benefit stops:

- at his/her 18th birthday,
- once we have paid one valid claim for him/her, or
- once we have paid R500 000 for him/her across all Child Impairment Benefits across all Functional Impairment Cover benefits for the same insured person,

whichever happens first.

When will Old Mutual not pay the cover amount?

We will not pay the cover amount:

- if the insured event is before the cover start date,
- if we do not recognise the insured event (as explained below),
- if the insured event is because of an excluded event, activity or condition (as explained below), or
- if the survival period is not met.

When will Old Mutual not recognise the insured event?

We will not recognise the insured event if the child suffers an insured event:

- that is not on the list of congenital birth defects and child impairments,
- at the severity that the contract does not cover, or
- that does not meet all the requirements that the insured event must meet to qualify.

Excluded events, activities or conditions

We will not recognise the claim if it is directly or indirectly caused by an event, activity or condition that is excluded.

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"),
- if the claim is because of:
    - unrest, war or terrorist activity,
    - radioactivity or nuclear explosion,
- if the claim for a child impairment is because of:
    - a self-inflicted injury,
    - you or the child provoking, committing or attempting to commit a crime for example murder, assault, housebreaking, theft, robbery, the forceful detention of another person or any similar crime,
    - the use of alcohol, poison, drugs or non-prescribed medication,
    - a condition that was diagnosed:
        - before or within six months after this benefit's benefit start date,
        - before the child was legally adopted or became the stepchild of the insured person under the Functional Impairment Cover benefit,
- the claim for a congenital birth defect if the child was born before or within nine months after this benefit's <benefit start date> or if it is because of:
    - a self-inflicted injury by the biological mother of the child, you or the biological mother provoking, committing or attempting to commit a crime, or
    - the use of alcohol, poison, drugs or non-prescribed medication by the biological mother of the child.

ABOUT THE PREMIUM PROTECTION DEATH BENEFIT

What is it?

This benefit waives the contract's premiums when the insured person dies. The name of the insured person for this benefit is shown on Personal, product and benefit details. Its premium is included in the starting premium for the product on Personal, product and benefit details. The premium for this benefit is reviewed every year.

How does the cover amount or premium on the contract change while Old Mutual is waiving its premiums?

If you have chosen currency-linked scheduled yearly cover increases, the cover amount and premium will still increase yearly, but:

- the percentage cover increase is limited to the inflation rate as set by us, and
- we will waive the increased premium.

Your premium will increase each year with the compulsory yearly increase you have chosen and we will waive this increased premium.

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

When does cover start?

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

When will Old Mutual start waiving the contract's premiums?

Once all our requirements have been met, we will start waiving the contract's premiums for a valid claim from the date of death of the insured person. If we have received any premiums after the date of death, we will refund those premiums. We will not pay interest on this refund.

When will Old Mutual stop waiving the contract's premiums?

We will stop waiving the contract's premiums:

- on this benefit's cover end date shown on Personal, product and benefit details,
- if your contract is cancelled, or
- if this benefit is removed from the contract,

whichever happens earlier.

When we stop waiving the contract's premiums and the contract continues, you must start paying your premiums again.

Waives the contract's premiums means that the cover continues while no premiums are payable.

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).

Start paying premiums again after we stop waiving premiums - Jane takes out an Old Mutual Protect contract where Johan, her husband is the insured person. The term of that benefit is for life. Jane also takes out a Premium Protection Death benefit on her life. At the time of taking out this benefit, Jane is 60 years old. The term of the Premium Protection Death benefit will be 20 years because the maximum cease age for this benefit is 80. If Jane were to die 2 years after taking out her contract, we will waive the contract's premiums for 18 years, until the Premium Protection Death benefit ends. Thereafter, Jane's replacement owner will need to start paying the contract's premiums.

When does cover stop?

The cover stops:

- on this benefit's cover end date shown on Personal, product and benefit details,
- if we do not receive your premiums and the grace period has passed,
- if your contract is cancelled, or
- if this benefit is removed from the contract,

whichever happens earlier.

When will Old Mutual not waive the contract's premiums?

We will not waive the contract's premiums:

- if the insured person's death is before the cover start date, or
- if the insured person's death is because of an excluded event, activity or condition (as explained below).

Excluded events, activities or conditions

We will not waive the contract's premiums if the insured person's death 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 waive the contract's premiums if the insured person's death is because of:

- 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
- suicide within the first two years from the cover start date.

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

A **suicide** is a self-injury resulting in death, where, in our opinion, the insured person had the intention to take his/her own life. It includes so-called assisted suicide where another person helped him/her to take his/her own life.

ABOUT THE PREMIUM PROTECTION DISABILITY BENEFIT

What is it?

This benefit waives the contract's premiums if the insured person (whose name appears on Personal, product and benefit details) becomes:

- occupationally disabled or
- functionally impaired

after the cover started and if the waiting period is met. Its premium is included in the starting premium for the product on Personal, product and benefit details. The premium for this benefit is reviewed every year.

Waives the contract's premiums means that the cover continues while no premiums are payable.

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 or another occupation for which he/she is reasonably suited, 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.

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

Functionally impaired means that the insured person has suffered and met the requirements of a qualifying functional impairment. See the list of functional impairments that qualify 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 before we will start waiving the contract's premiums. It starts on the date of the occupational disability or functional impairment as confirmed by our medical officer. The waiting period is 6 months. You must continue to pay your premiums during the waiting period and while we decide if your claim is valid. If your contract is cancelled before the waiting period ends, we will not start waiving the contract's premiums.

We may not apply the waiting period if the insured person was occupationally disabled or functionally impaired, recovers and then becomes occupationally disabled or functionally impaired from a related event within six months after his/her recovery.

If we do not apply the waiting period, we will start waiving the contract's premiums from the date of the occupational disability or functional impairment.

Waiting period end –Frank is diagnosed with chronic gastrointestinal disease on 1 January 2016. The waiting period starts on 1 January and ends at midnight on 30 June 2016. We will start waiving the contract's premiums from 1 July 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 functionally impaired for the 6-month waiting period so we will start waiving the contract's premiums from month seven. She recovers twelve months after her diagnosis and we stop waiving the contract's premiums. Two months later she is diagnosed with chronic liver disease and is again functionally impaired. Because we consider chronic liver and gastrointestinal diseases to be related functional impairments and because her second functional impairment happened within six months of her recovery from the first functional impairment, Sally chooses to not apply another 6-month waiting period and we will start waiving the contract's premiums immediately.

Unrelated event and the waiting period is applied again - Sally is diagnosed with chronic gastrointestinal disease and is functionally impaired She is functionally impaired for the 6-month waiting period so we will start waiving the contract's premiums from month seven. She recovers twelve months after her diagnosis and we stop waiving the contract's premiums. Two months later she is diagnosed with hypertension and is again functionally impaired. Because chronic gastrointestinal disease is unrelated to hypertension and despite the short time between her recovery from the first functional impairment and her diagnosis with the second, we will apply another 6-month waiting period and will start waiving the contract's premiums only from month seven.

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.

How does the cover amount or premium on the contract change while Old Mutual is waiving its premiums?

If you have chosen currency-linked scheduled yearly cover increases, the cover amount and premium will still increase yearly, but:

- the percentage cover increase is limited to the inflation rate as set by us, and
- we will waive the increased premium.

Your premium will increase each year with the compulsory yearly increase you have chosen and we will waive this increased premium.

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

When does cover start?

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

When will Old Mutual start waiving the contract's premiums?

Once all our requirements have been met, we will start waiving the contract's premiums for a valid claim at the end of the waiting period. If we have received any premiums after the end of the waiting period, we will refund those premiums. We will not pay interest on this refund.

When will Old Mutual stop waiving the contract's premiums?

We will stop waiving the contract's premiums:

- on this benefit's cover end date shown on Personal, product and benefit details,
- if the insured person recovers from his/her occupational disability or functional impairment,
- if the insured person fails to meet our requirements for following reasonable medical advice or adequate medical treatment and regular evaluation of his/her occupational disability or functional impairment or to undergo re-skilling for an occupation for which he/she is reasonably suited,
- when we have waived the contract's premiums for 24 months in total while the insured person was unable to perform the main duties of his/her occupation as stated on Personal, product and benefit details from related events (as explained below),
- if the insured person dies,
- 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
- if this benefit is removed from the contract, or
- when his/her occupational disability cover stops (as explained under "When does occupational disability cover stop?") while we are waiving the contract's premiums because of occupational disability,

whichever happens first.

Start paying premiums again after we stop waiving premiums - Jane takes out an Old Mutual Protect contract where Johan, her husband is the insured person. The term of that benefit is for life. Jane also takes out a Premium Protection Disability benefit on her life. At the time of taking out this benefit, Jane is 45 years old. The term of the Premium Protection Disability benefit will be 20 years because the maximum cease age for this benefit is 65. If Jane were to become functionally impaired 2 years after taking out her contract, we will waive the contract's premiums for 18 years, until the Premium Protection Disability benefit ends. Thereafter, Jane will need to start paying the contract's premiums.

If we have stopped waiving the contract's premiums because we have waived the contract's premiums for 24 months in total because the insured person was unable to perform the main duties of his/her occupation from related events, we will re-evaluate the claim. If we determine that the insured person is unable to perform the main duties of another occupation for which he/she is reasonably suited or is functionally impaired, we will continue to waive the contract's premiums until we stop waiving the contract's premiums for one of the other reasons listed above. If not, we will stop waiving the contract's premiums but the benefit will continue until the cover end date and you can claim in future for occupational disability or functional impairment.

If we have stopped waiving the contract's premiums 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 continue to waive the contract's premiums until we stop waiving the contract's premiums for one of the other reasons listed above. If not, we will stop waiving the contract's premiums but the benefit will continue until the cover end date and you can claim in future for functional impairment.

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

When we stop waiving the contract's premiums and the contract continues, you must start paying your premiums again.

When does cover stop?

The cover stops:

- if the insured person dies,
- on this benefit's cover end date shown on Personal, product and benefit details,
- 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 we do not receive your premiums and the grace period has passed,
- if your contract is cancelled, or
- if this benefit is removed from the contract,

whichever happens earlier.

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.

When will Old Mutual not waive the contract's premiums?

We will not waive the contract's premiums:

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

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

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

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 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, or
- that does not meet all the requirements that the functional impairment must meet to qualify.

Excluded events, activities or conditions

We will not waive the contract's premiums if the insured person's occupational disability or functional impairment 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 waive the contract's premiums 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, or to undergo re-skilling for an occupation for which he/she is reasonably suited,
- the insured person's occupational disability or functional impairment 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 THE PREMIUM PROTECTION FUNCTIONAL IMPAIRMENT BENEFIT

What is it?

This benefit waives the contract's premiums if the insured person (whose name appears on Personal, product and benefit details) becomes functionally impaired after the cover started and if the waiting period is met. Its premium is included in the starting premium for the product on Personal, product and benefit details. The premium for this benefit is reviewed every year.

Waives the contract's premiums means that the cover continues while no premiums are payable.

Functionally impaired means that the insured person has suffered and met the requirements of a qualifying functional impairment. See the list of functional impairments that qualify 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 functional impairment must have continued before we will start waiving the contract's premiums. It starts on the date of the functional impairment as confirmed by our medical officer. The waiting period is 6 months. You must continue to pay your premiums during the waiting period and while we decide if your claim is valid. If your contract is cancelled before the waiting period ends, we will not start waiving the contract's premiums.

We may not apply the waiting period if the insured person was functionally impaired, recovers and then becomes functionally impaired from a related event within six months after his/her recovery.

If we do not apply the waiting period, we will start waiving the contract's premiums from the date of the functional impairment.

Waiting period end – Frank is diagnosed with chronic gastrointestinal disease on 1 January 2016. The waiting period starts on 1 January and ends at midnight on 30 June 2016. We will start waiving the contract's premiums from 1 July 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 functionally impaired for the 6-month waiting period so we will start waiving the contract's premiums from month seven. She recovers twelve months after her diagnosis and we stop waiving the contract's premiums. Two months later she is diagnosed with chronic liver disease and is again functionally impaired. Because we consider chronic liver and gastrointestinal diseases to be related functional impairments and because her second functional impairment happened within six months of her recovery from the first functional impairment, Sally chooses to not apply another 6-month waiting period and we will start waiving the contract's premiums immediately.

Unrelated event and the waiting period is applied again - Sally is diagnosed with chronic gastrointestinal disease and is functionally impaired She is functionally impaired for the 6-month waiting period so we will start waiving the contract's premiums from month seven. She recovers twelve months after her diagnosis and we stop waiving the contract's premiums. Two months later she is diagnosed with hypertension and is again functionally impaired. Because chronic gastrointestinal disease is unrelated to hypertension and despite the short time between her recovery from the first functional impairment and her diagnosis with the second, we will apply another 6-month waiting period and will start waiving the contract's premiums only from month seven.

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.

How does the cover amount or premium on the contract change while Old Mutual is waiving its premiums?

If you have chosen currency-linked scheduled yearly cover increases, the cover amount and premium will still increase yearly, but:

- the percentage cover increase is limited to the inflation rate as set by us, and
- we will waive the increased premium.

Your premium will increase each year with the compulsory yearly increase you have chosen and we will waive this increased premium.

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

When does cover start?

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

When will Old Mutual start waiving the contract's premiums?

Once all our requirements have been met, we will start waiving the contract's premiums for a valid claim at the end of the waiting period. If we have received any premiums after the end of the waiting period, we will refund those premiums. We will not pay interest on this refund.

When will Old Mutual stop waiving the contract's premiums?

We will stop waiving the contract's premiums:

- on this benefit's cover end date shown on Personal, product and benefit details,
- if the insured person recovers from his/her functional impairment,
- if the insured person fails to meet our requirements for following reasonable medical advice or adequate medical treatment and regular evaluation of his/her functional impairment,
- if the insured person dies,
- 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
- if this benefit is removed from the contract,

whichever happens first.

We will determine the number of the contract's premiums to waive, in line with the period of time the life covered is functionally impaired 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 waiving further contract premiums if the treating doctor can provide us with sufficient medical motivation in the form of specialist reports and/or test results. Any supporting medical proof that we need will be at your own cost.

When we stop waiving the contract's premiums and the contract continues, you must start paying your premiums again.

Start paying premiums again after we stop waiving premiums - Jane takes out an Old Mutual Protect contract where Johan, her husband is the insured person. The term of that benefit is for life. Jane also takes out a Premium Protection Functional Impairment benefit on her life. At the time of taking out this benefit, Jane is 45 years old. The term of the Premium Protection Functional Impairment benefit will be 20 years because the maximum cease age for this benefit is 65. If Jane were to become functionally impaired 2 years after taking out her contract, we will waive the contract's premiums for 18 years, until the Premium Protection Functional Impairment benefit ends. Thereafter, Jane will need to start paying the contract's premiums.

When does cover stop?

The cover stops:

- if the insured person dies,
- on this benefit's cover end date shown on Personal, product and benefit details,
- 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 we do not receive your premiums and the grace period has passed,
- if your contract is cancelled, or
- if this benefit is removed from the contract,

whichever happens earlier.

When will Old Mutual not waive the contract's premiums?

We will not waive the contract's premiums:

- if the insured person's functional impairment is before the cover start date,
- if we do not recognise the insured person's functional impairment (as explained below),
- if the insured person's functional impairment 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 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, or
- that does not meet all the requirements that the functional impairment must meet to qualify.

Excluded events, activities or conditions

We will not waive the contract's premiums if the insured person's functional impairment 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 waive the contract's premiums 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 functional impairment 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.

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

ABOUT THE PREMIUM PROTECTION RETRENCHMENT BENEFIT

What is it?

This benefit waives the contract's premiums if the insured person (whose name appears on Personal, product and benefit details) is retrenched after the cover started and if the waiting period is met. Its premium is included in the starting premium for the product on Personal, product and benefit details. The premium for this benefit is reviewed every year.

What is a waiting period?

A waiting period is the number of consecutive days or months during which the insured person does not become employed before we will start waiving the contract's premiums. It starts on the date of retrenchment as confirmed by us and ends one month later. You must continue to pay your premiums during the waiting period and while we decide if your claim is valid. If your contract is cancelled before the waiting period ends, we will not start waiving the contract's premiums.

How does the cover amount or premium on the contract change while Old Mutual is waiving its premiums?

If you have chosen currency-linked scheduled yearly cover increases, the cover amount and premium will still increase yearly, but:

- the percentage cover increase is limited to the inflation rate as set by us, and
- we will waive the increased premium.

Your premium will increase each year with the compulsory yearly increase you have chosen and we will waive this increased premium.

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

Waives the contract's premiums means that the cover continues while no premiums are payable.

Retrenched means that the insured person stops practising his/her occupation as stated on Personal, product and benefit details because his/her employment is terminated by his/her employer because or in anticipation of, business conditions or decisions that result in staff reduction.

The insured person is not retrenched if:

- he/she retires,
- he/she resigns or takes voluntary retrenchment,
- he/she is dismissed,
- his/her fixed term employment contract comes to an end or
- he/she is medically boarded because of a nervous breakdown, stress, burnout, disability or sickness.

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

Date of retrenchment is the day after the insured person's last day of employment.

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

When does cover start?

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

When will Old Mutual start waiving the contract's premiums?

Once all our requirements have been met, we will start waiving the contract's premiums for a valid claim at the end of the waiting period. If we have received any premiums after the end of the waiting period, we will refund those premiums. We will not pay interest on this refund.

When will Old Mutual stop waiving the contract's premiums?

We will stop waiving the contract's premiums:

- on this benefit's cover end date shown on Personal, product and benefit details,
- if the insured person dies,
- if the insured person becomes employed,
- when we have waived the contract's last premium that the insured person qualifies for (as explained under "For how long will Old Mutual waive the contract's premiums?"),
- 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
- if this benefit is removed from the contract,

whichever happens first.

When we stop waiving the contract's premiums and the contract continues, you must start paying your premiums again.

How long will Old Mutual waive the contract's premiums for?

We will waive the contract's premiums for up to 12 months for each claim. A maximum of three claims can qualify provided that the insured person was continuously employed and qualified for this benefit for at least 12 months before he/she was retrenched again.

When does cover stop?

The cover stops:

- on this benefit's cover end date shown on Personal, product and benefit details,
- if the insured person dies,
- 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"),
- after three valid claims,
- if we do not receive your premiums and the grace period has passed,
- if your contract is cancelled, or
- if this benefit is removed from the contract,

whichever happens earlier.

Start paying premiums again after we stop waiving premiums - Johan takes out an Old Mutual Protect contract where he is the insured person. He also takes out a Premium Protection Retrenchment benefit. Johan is retrenched for two years – we will waive his contract's premiums for 12 months because we will only waive the contract's premiums for up to 12 months. After this, Johan will need to start paying the contract's premiums again.

When will Old Mutual not waive the contract's premiums?

We will not waive the contract's premiums:

- if the insured person receives notice of retrenchment at any time before the cover start date,
- if the insured person is retrenched or receives notice of retrenchment within 12 months from the cover start date,
- after three valid claims,
- if insured person:
  - was not continuously employed for, or
  - did not qualify for this benefit at any time during, the 12 months before he/she was retrenched again,
- if the insured person's retrenchment is because of an excluded event (as explained below), or
- if the waiting period is not met.

Excluded events, activities or conditions

We will not waive the contract's premiums if the insured person's retrenchment 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") or
- the insured person is retrenched as a result of government action.

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

HOW DO I...?

How do I contact Old Mutual?

Use any of these contact details to contact us

By phone	076 0535 TBC Monday – Friday between 7:30am and 5pm 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 Mutualpark 7451
Compliance officer	(021) 509 1193	RMMcompliance@oldmutual.com	PO Box 73 Cape Town 8000
Old Mutual Internal Arbitrator	(021) 504 7700	arbitrator@oldmutual.com	PO Box 80 Mutualpark 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 Claremont 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 (012) 348 3447	info@faisombud.co.za	PO Box 74571 Lynwood Ridge 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 Functional Impairment 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.

You must pay the costs related to satisfying our requirements for your Premium Protection Death 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; and
- if the person entitled to the benefits is not in South Africa, the cost to travel to South Africa if we need him/her to meet with us.

You must pay the costs related to satisfying our requirements for your Premium Protection Disability 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;
- the cost of reasonable medical advice or adequate medical treatment as determined by our medical officer; and
- the cost of learning a new occupation for which the insured person is reasonably suited given his/her experience, skills if required.

You must pay the costs related to satisfying our requirements for your Premium Protection Functional Impairment 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.

You must pay the costs related to satisfying our requirements for your Premium Protection Retrenchment 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; and
- if the person entitled to the benefits is not in South Africa, the cost to travel to South Africa if we need him/her to meet with us.

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 FUNCTIONAL IMPAIRMENT 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 and their effect on the contract, depend on whether you told us about the change or whether we found out about it.

What changes about the insured person	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)	We may: • change the premium, • offer different terms**, • remove the benefit*** or • 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: • reject your claim***

* 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 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.

*** 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.

CHANGES TO THE CIRCUMSTANCES OF THE INSURED PERSON ON THE PREMIUM PROTECTION DISABILITY 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 waiving the contract's premiums at the time of the change. Some changes in circumstances will only affect waiving of the contract's premiums or the contract itself, while other changes may affect both. Any change to the insured person's circumstances while we are not waiving the contract's premiums will affect only the contract itself.

What changes about the insured person	**Actions we can take while we are waiving the contract's premiums**		**Actions we can take when we are not waiving the contract's premiums**	
	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 waiving of the contract's premiums None Impacts on the contract itself We may: • change the premium or • offer different terms**	Same as under "You tell us about the change" on the left	We may: • change the premium, • offer different terms**, • remove the benefit*** or • recover premiums we had already waived 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: • 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 a miner changes from working above the ground to working underground with or without explosives)	Impacts on the waiving of the contract's premiums We may: • stop waiving the contract's premiums or • recover premiums we had already waived but that the insured person did not qualify for, from you Impacts on the contract itself We may: • change the premium, • offer different terms** or • remove any benefits that you no longer qualify for***	Same as under "You tell us about the change" on the left	We may: • change the premium, • offer different terms**, • remove any benefits you no longer qualify for*** or • recover premiums we had already waived 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: • 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 waiving of the contract's premiums We may: • stop waiving the contract's premiums or • recover premiums we had already waived but that the insured person did not qualify for, from you Impacts on the contract itself We may: • change the premium, • offer different terms** or • remove any benefits that you no longer qualify for***	Same as under "You tell us about the change" on the left	We may: • change the premium, • offer different terms**, • remove any benefits you no longer qualify for*** or • recover premiums we had already waived 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: • reject your claim***

The insured person changes how much time of his/her day is spent doing administrative or manual tasks and travelling*	<u>Impacts on the waiving of the contract's premiums</u> We may: • stop waiving the contract's premiums or • recover premiums we had already waived but that the insured person did not qualify for, from you <u>Impacts on the contract itself</u> We may: • change the premium, • offer different terms** or • remove any benefits that you no longer qualify for***	Same as under "You tell us about the change" on the left	We may: • change the premium, • offer different terms**, • remove any benefits you no longer qualify for*** or • recover premiums we had already waived 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: • 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)	<u>Impacts on the waiving of the contract's premiums</u> We may: • stop waiving the contract's premiums or • recover premiums we had already waived but that the insured person did not qualify for, from you <u>Impacts on the contract itself</u> We may: • change the premium, • offer different terms**, • remove any benefits that you no longer qualify for***	Same as under "You tell us about the change" on the left	We may: • change the premium, • offer different terms**, • remove any benefits you no longer qualify for*** or • recover premiums we had already waived 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: • reject your claim***
The insured person starts/ stops a second occupation* or changes the number of hours per week that he/she works	<u>Impacts on the waiving of the contract's premiums</u> We may: • stop waiving the contract's premiums or • recover premiums we had already waived but that the insured person did not qualify for, from you <u>Impacts on the contract itself</u> We may: • change the premium, • offer different terms** or • remove any benefits that you no longer qualify for***	Same as under "You tell us about the change" on the left	We may: • change the premium, • offer different terms**, • remove any benefits you no longer qualify for*** or • recover premiums we had already waived 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: • reject your claim***

The insured person's health/medical status changes (he/she recovers or his/her condition improves) while we are waiving the contract's premiums	Impacts on the waiving of the contract's premiums We may: • stop waiving the contract's premiums or • recover premiums we had already waived but that the insured person did not qualify for, from you Impacts on the contract itself None	In addition to what is listed under "You tell us about the change" on the left, we may: • remove the benefit***	None	Same as under "You tell us about the change" on the left
The insured person dies	Impacts on the waiving of the contract's premiums We may: • stop waiving the contract's premiums or • recover premiums we had already waived but that the insured person did not qualify for, from you Impacts on the contract itself 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 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.

*** 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.

CHANGES TO THE CIRCUMSTANCES OF THE INSURED PERSON ON THE PREMIUM PROTECTION FUNCTIONAL IMPAIRMENT 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 waiving the contract's premiums at the time of the change. Some changes in circumstances will only affect waiving of the contract's premiums or the contract itself, while other changes may affect both. Any change to the insured person's circumstances while we are not waiving the contract's premiums will affect only the contract itself.

What changes about the insured person	**Actions we can take while we are waiving the contract's premiums**		**Actions we can take when we are not waiving the contract's premiums**	
	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 waiving of the contract's premiums None Impacts on the contract itself We may: • change the premium or • offer different terms**	Same as under "You tell us about the change" on the left	We may: • change the premium, • offer different terms**, • remove the benefit*** or • recover premiums we had already waived 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: • reject your claim***
The insured person's health/medical status changes (he/she recovers or his/her condition improves) while we are waiving the contract's premiums	Impacts on the waiving of the contract's premiums We may: • stop waiving the contract's premiums or • recover premiums we had already waived but that the insured person did not qualify for, from you Impacts on the contract itself None	In addition to what is listed under "You tell us about the change" on the left, we may: • remove the benefit***	None	Same as under "You tell us about the change" on the left
The insured person dies	Impacts on the waiving of the contract's premiums We may: • stop waiving the contract's premiums or • recover premiums we had already waived but that the insured person did not qualify for, from you Impacts on the contract itself 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 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.

*** 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.

CHANGES TO THE CIRCUMSTANCES OF THE INSURED PERSON ON THE PREMIUM PROTECTION RETRENCHMENT 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 waiving the contract's premiums at the time of the change. Some changes in circumstances will only affect waiving of the contract's premiums or the contract itself, while other changes may affect both. Any change to the insured person's circumstances while we are not waiving the contract's premiums will affect only the contract itself.

What changes about the insured person	**Actions we can take while we are waiving the contract's premiums**		**Actions we can take when we are not waiving the contract's premiums**	
	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 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 a miner changes from working above the ground to working underground with or without explosives)	Impacts on the waiving of the contract's premiums We may: • stop waiving the contract's premiums or • recover premiums we had already waived but that the insured person did not qualify for, from you Impacts on the contract itself We may: • change the premium, • offer different terms** or • remove any benefits that you no longer qualify for***	Same as under "You tell us about the change" on the left	We may: • change the premium, • offer different terms**, • remove any benefits you no longer qualify for*** or • recover premiums we had already waived 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: • 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 waiving of the contract's premiums We may: • stop waiving the contract's premiums or • recover premiums we had already waived but that the insured person did not qualify for, from you Impacts on the contract itself We may: • change the premium, • offer different terms** or • remove any benefits that you no longer qualify for***	Same as under "You tell us about the change" on the left	We may: • change the premium, • offer different terms**, • remove any benefits you no longer qualify for*** or • recover premiums we had already waived 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: • 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 waiving of the contract's premiums We may: • stop waiving the contract's premiums or • recover premiums we had already waived but that the insured person did not qualify for, from you Impacts on the contract itself We may: • change the premium, • offer different terms**, • remove any benefits that you no longer qualify for***	Same as under "You tell us about the change" on the left	We may: • change the premium, • offer different terms**, • remove any benefits you no longer qualify for*** or • recover premiums we had already waived 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: • 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 waiving of the contract's premiums We may: • stop waiving the contract's premiums or • recover premiums we had already waived but that the insured person did not qualify for, from you Impacts on the contract itself We may: • change the premium, • offer different terms** or • remove any benefits that you no longer qualify for***	Same as under "You tell us about the change" on the left	We may: • change the premium, • offer different terms**, • remove any benefits you no longer qualify for*** or • recover premiums we had already waived 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: • reject your claim***
The insured person becomes: • a company director, • a business partner, or • an employee of a company that has its head office based outside South Africa or Namibia • employed in a family business where he/she is a member of the family	Impacts on the waiving of the contract's premiums We may: • stop waiving the contract's premiums or • recover premiums we had already waived but that the insured person did not qualify for, from you Impacts on the contract itself We may: • change the premium, • offer different terms**, • remove any benefits that you no longer qualify for***	Same as under "You tell us about the change" on the left	We may: • change the premium, • offer different terms**, • remove any benefits you no longer qualify for*** or • recover premiums we had already waived 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: • reject your claim***

The insured person dies	Impacts on the waiving of the contract's premiums We may: • stop waiving the contract's premiums or • recover premiums we had already waived but that the insured person did not qualify for, from you Impacts on the contract itself 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 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.

*** 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 FUNCTIONAL IMPAIRMENT 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. With evidence of the following requirements which need to be permanent and irreversible, despite adequate medical treatment: • Shortness of breath so severe that symptoms are present at rest (NYHA, Class IV), and • Symptoms of palpitations and syncope or dizziness correlating with ECG evidence of serious arrhythmia are present daily.	100%
	Congestive Cardiac Failure	The diagnosis of Congestive cardiac failure by a specialist cardiologist or physician as a result of coronary artery disease or valvular heart disease or diseases of the aorta or pericardial disease. With evidence of the following requirements which need to be permanent and irreversible: • Ejection fraction (EF) consistently less than 40% after adequate medical treatment, and shortness of breath so severe that symptoms are present during less than ordinary activity or at rest (NYHA Class lll - IV), or • Awaiting cardiac transplantation.	100%
	Hypertension	The diagnosis of uncontrolled hypertension confirmed by a medical specialist. With evidence of diastolic pressure permanently greater than or equal to 110mmHg on adequate treatment and complicated by 2 or more of the following requirements which need to be permanent and irreversible: • Stage 4 Kidney dysfunction • Cerebrovascular incident (excluding transient ischaemic attacks) confirmed by neuroimaging • Echocardiogram evidence of LVH (septal wall thickness to posterior LV wall thickness 1.3:1) • Grade IV retinopathy • Congestive Cardiac Failure with evidence of an ejection fraction (EF) consistently less than 45% after adequate medical treatment, and marked limitation in activity due to symptoms, even during ordinary or less than ordinary activity e.g. walking short distances (NYHA Class ll - lll).	100%
	Peripheral Arterial Disease	The diagnosis of peripheral arterial disease of the lower limbs by a vascular surgeon. With evidence of a permanently absent pulse on Doppler readings, and 1 of the following requirements which need to be permanent and irreversible: • Severe Vascular Ulceration, or • Gangrene secondary to peripheral arterial disease.	100%

Respiratory	Chronic Respiratory Failure	The diagnosis of a chronic respiratory failure by a pulmonologist. With evidence of at least 1 of the following requirements which need to be permanent and irreversible: • Impaired airflow with FEV1 less than or equal to 40%, or • FVC less than or equal to 50%, or • DLCO of less than or equal to 40%.	100%
	Pulmonary Arterial Hypertension	The diagnosis of pulmonary hypertension by a medical specialist. With evidence of a permanent Systolic Pulmonary Artery Pressure greater than 70mmHg and complicated by at least 1 of the following requirements which need to be permanent and irreversible: • Right sided heart failure, or • Shortness of breath so severe that symptoms are present at rest (NYHA Class IV).	100%
Gastrointestinal	Ano-rectal impairment	Faecal incontinence • With evidence of complete faecal incontinence despite adequate medical and/or surgical treatment by a gastroenterologist or equivalent specialist.	100%
	Chronic Gastrointestinal Disease	The diagnosis of a chronic gastrointestinal disease by a gastroenterologist or equivalent specialist, as a result of a medical condition. With evidence of the following requirements which need to be permanent and irreversible: • Medical findings confirming organic disease, and • Significant unintentional weight loss resulting in a BMI of less than 15 or 25% weight loss below the lower limit of the normal range for the individual, and • Symptoms uncontrolled by medical or surgical treatment. Psychiatric conditions are excluded.	100%
	Chronic Liver Failure	The diagnosis of permanent and irreversible chronic end-stage liver failure, with a Child Pugh Classification of class C, by a gastroenterologist or equivalent specialist.	100%
Urogenital	Bladder Impairment	The diagnosis of a bladder impairment despite adequate surgical and medical treatment by a nephrologist or urologist. With evidence of 1 of the following requirements which need to be permanent and irreversible: • No detectable reflex or voluntary urine control as a result of organic pathology, resulting in urinary incontinence, or • Total bladder resection, or • Chronic disorders of the bladder and its structures that require a permanent indwelling catheter.	100%
	Chronic Kidney Failure	The diagnosis of chronic renal failure despite adequate medical treatment by a nephrologist or urologist. With evidence of 1 of the following requirements which need to be permanent and irreversible: • End-stage renal disease with an estimated GFR less than 24ml/min, or • Creatinine clearance of less than 28 ml per minute, or • Renal function deterioration that requires life-long peritoneal dialysis or lifelong haemodialysis.	100%

Central Nervous System	Impaired consciousness	The diagnosis of a coma of a specified severity by a neurologist or neurosurgeon. Medically induced comas are excluded. With evidence of the following for 14 days or more: • A decreased level of consciousness, with a Glasgow Coma Scale of less than 9, and • Requiring total medical support including intubation and assisted ventilation.	100%
	Aphasia	The diagnosis of aphasia by a neurologist or neurosurgeon. With evidence of the following requirements which need to be permanent and irreversible: • A total inability to express oneself or communicate (through speech, writing, or signs), or to comprehend spoken or written language, due to injury or disease of the brain, and • Deficits in the formal aspects of language such as naming, word choice, comprehension, spelling and syntax, and • Objective medical findings supporting the diagnosis of aphasia. Psychiatric conditions are excluded.	100%
	Cranial Nerve VII	The diagnosis of facial nerve paralysis confirmed by a neurologist or neurosurgeon. With evidence of the following requirements which need to be permanent and irreversible: • Slight or no movement of the face, and • An inability to actively close the eyelids, and • Slight or no movement of the mouth.	100%
	Cranial Nerve VIII	The diagnosis of Vestibulocochlear nerve paralysis confirmed by a neurologist or neurosurgeon. With evidence of the following requirements which need to be permanent and irreversible: • Nerve damage with severe imbalance resulting in limitation of activities of daily living such that the insured person is permanently unable to perform 3 of the Basic Activities of Daily Living or 4 of the Advanced Activities of Daily Living.	100%
	Cranial Nerves IX, X, XII	The diagnosis of Cranial Nerve IX, X, XII paralysis confirmed by a neurologist or neurosurgeon. With evidence of the following requirements which need to be permanent and irreversible: • An inability to swallow or process oral secretions without choking, and • Need for external suctioning device, and • Medical findings confirming organic disease.	100%
	Epilepsy	The diagnosis of epilepsy by a neurologist or neurosurgeon supported by objective medical findings and resistant to optimal therapy as confirmed by drug serum-level testing. With evidence of the following requirements which need to be permanent and irreversible: • 3 or more generalised seizures per week, and • An inability to perform 3 of the Basic Activities of Daily Living or 4 of the Advanced Activities of Daily Living.	100%
	Hemiplegia	The total and permanent loss of the functioning of one side of the body due to an injury or disease of the brain as confirmed by a neurologist or neurosurgeon and correlating with objective medical findings.	100%

Central Nervous System (continued)	Dementia (incl. Alzheimer's Disease)	The diagnosis of dementia by a neurologist, physician or neurosurgeon With evidence of the following requirements which need to be permanent and irreversible: • A diminished intellectual ability (may include personality changes and episodes of confusion), and • A score of 2 under the 5 point Clinical Dementia Rating scale, and • Needs constant supervision.	100%
	Paraplegia / Diplegia	The total and permanent loss of the functioning of both legs or both arms due to an injury or disease of the brain or spinal cord. This must be confirmed by a neurologist or neurosurgeon and correlate with objective medical findings.	100%
	Quadriplegia	The total and permanent loss of the functioning of both legs and both arms due to an injury or disease of the brain or spinal cord. This must be confirmed by a neurologist or neurosurgeon and correlate with objective medical findings.	100%
Cancer	Cancer	The diagnosis of an advanced stage of cancer as confirmed by an oncologist with supporting documentation. With evidence of the following requirements which need to be permanent and irreversible: • Diagnosis of at least a stage III cancer, and the insured person is unable to perform 2 of the Basic Activities of Daily Living or 3 of the Advanced Activities of Daily Living, or • stage IV cancer or • Cancer which has resulted in organ failure will be assessed under the affected organ. Organ failure will only be assessed under the following definitions: Congestive Cardiac Failure or Chronic respiratory failure or Chronic liver failure or Chronic kidney failure or Organic Brain Disorders/ Dementia	100%

Senses	Loss of sight	Confirmed diagnosis of total and permanent bilateral loss of sight by an ophthalmologist. The loss of sight cannot be improved through refractive correction or medication. With evidence of 1 of the following: • A reading of 6/60 or worse (or equivalent measure on a non-metric scale) in each eye after best correction, or • Severe proliferative diabetic retinopathy, or • Grade IV hypertensive retinopathy, or • Permanent Hemianopia in both eyes, or • A visual field loss to a 10˚ radius in the better eye. Loss of sight due to cataracts is excluded, unless there is evidence of failed cataract surgery or contraindications to cataract surgery.	100%
	Loss of hearing	Total and permanent loss of hearing in both ears as confirmed by an ear, nose and throat surgeon. With evidence of the following: • Audiometry measurements, done with the use of hearing aids, with an average loss of greater than 87dB.	100%
	Loss of speech	The total and permanent loss of the ability to produce intelligible and audible speech due to injury or disease, as confirmed by an ear, nose and throat surgeon, neurologist or neurosurgeon. • Objective medical evidence of an ear, nose and throat disorder causing the impairment must be provided. Loss of speech due to psychiatric causes are excluded.	100%
Endocrine	Endocrine Disorders	The diagnosis of an endocrine disorder, which despite adequate medical and surgical treatment, has resulted in permanent organ failure, as confirmed by a medical specialist. • Organ failure will only be assessed under the following definitions: Congestive Cardiac Failure or Chronic respiratory failure or Chronic liver failure or Chronic kidney failure or Organic Brain Disorders/ Dementia	100%
Psychiatric	Psychiatric Disorder	The diagnosis of a psychiatric disorder, as confirmed by a specialist psychiatrist. Resulting in permanent institutionalisation and with evidence of the following: • permanent GAF score of 40 or less certified under the DSM IV classification, or • permanent WHODAS average domain score of 4 certified under the DSM 5 classification	100%
Trauma	Facial Disorders or Disfigurement	Total facial disfigurement as confirmed by a maxillofacial specialist or related specialist. There should be destruction or loss of skin, bone, or muscles that requires reconstructive surgery.	100%
	Major Burns	The diagnosis of third degree burns (full thickness burns) by a plastic surgeon or trauma specialist. With evidence of at least: • 30% of total body surface affected as measured on the Lund and Browder Chart or equivalent scale, or • more than 50% of the combined surface area of the bilateral upper limbs affected including involvement of at least 60% of combined surface area of the palms of both hands; and restriction of joint mobility of at least two of the following: 3 fingers, wrist or elbow.	100%

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

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

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

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

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

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

FUNCTIONAL IMPAIRMENTS THAT QUALIFY UNDER THE PARTIAL FUNCTIONAL IMPAIRMENT 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. With evidence of the following requirements which need to be permanent and irreversible, despite adequate medical treatment: • Marked limitation in activity due to symptoms, even during less-than-ordinary activity, e.g. walking short distances (NYHA Class III), and • Symptoms of palpitations and syncope or dizziness correlating with ECG evidence of serious arrhythmia are present frequently with at least 3 episodes per week.	50%
	Congestive Cardiac Failure	The diagnosis of Congestive cardiac failure by a specialist cardiologist or physician as a result of coronary artery disease or valvular heart disease or diseases of the aorta or pericardial disease. With evidence of the following requirements which need to be permanent and irreversible: • Ejection fraction (EF) consistently less than 45% after adequate medical treatment, and marked limitation in activity due to symptoms, even during ordinary or less than ordinary activity e.g. walking short distances (NYHA Class II - III).	50%
	Hypertension	The diagnosis of uncontrolled hypertension confirmed by a medical specialist. With evidence of diastolic pressure permanently greater than 105mmHg on adequate treatment and complicated by 1 of the following requirements which need to be permanent and irreversible: • Stage 3 Kidney dysfunction, or • Cerebrovascular incident (excluding transient ischaemic attacks) confirmed by neuroimaging, or • Grade III retinopathy.	50%
	Peripheral Arterial Disease	The diagnosis of peripheral arterial disease of the lower limbs by a vascular surgeon. With evidence of the following requirements which need to be permanent and irreversible: • Abnormal diminished pulse on Doppler readings, and • Ankle-brachial index (ABI) < 0.9 and • Pain on exercise as a result of peripheral arterial disease with claudication on walking less than 500m	50%
	Peripheral Venous Disease	The diagnosis of veno-occlusive disease of the lower limbs by a vascular surgeon. With evidence of the following requirements which need to be permanent and irreversible: • Severe deep and widespread vascular ulceration, and • Oedema of the lower limbs	50%

Respiratory	Chronic Respiratory Failure	The diagnosis of a chronic respiratory failure by a pulmonologist. With evidence of at least 1 of the following requirements which need to be permanent and irreversible: • Impaired airflow with FEV1 less than or equal to 50%, or • FVC less than or equal to 60%, or • DLCO of less than or equal to 50%.	50%
	Pulmonary Arterial Hypertension	The diagnosis of pulmonary hypertension by a medical specialist. With evidence of a permanent Systolic Pulmonary Artery Pressure of 40-70 mmHg and complicated by at least 1 of the following requirements which need to be permanent and irreversible: • Right sided heart failure, or • Marked limitation in activity due to symptoms, even during less-than-ordinary activity, e.g. walking short distances (NYHA Class III).	50%
Gastrointestinal	Ano-rectal impairment	A permanent and irreversible stoma created by a gastroenterologist or equivalent specialist due to a gastrointestinal disorder.	50%
	Biliary Tract Disease	The diagnosis of a biliary tract disease by a liver specialist, gastroenterologist or equivalent medical specialist. With evidence of the following requirements which need to be permanent and irreversible: • Persistent biliary tract obstruction with recurrent cholangitis, and • Persistent jaundice	75%
	Chronic Gastrointestinal Disease	The diagnosis of a chronic gastrointestinal disease by a gastroenterologist or equivalent specialist, as a result of a medical condition. With evidence of the following requirements which need to be permanent and irreversible: • Medical findings confirming organic disease, and • Significant unintentional weight loss resulting in a BMI between 15 and 16.1 or 20% weight loss below the lower limit of the normal range for the individual, and • Symptoms uncontrolled by medical or surgical treatment. Psychiatric conditions are excluded.	75%
		The diagnosis of a chronic gastrointestinal disease by a gastroenterologist or equivalent specialist, as a result of a medical condition. With evidence of the following requirements which need to be permanent and irreversible: • Medical findings confirming organic disease, and • Significant unintentional weight loss resulting in a BMI between 16.2 and 17 or 15% weight loss below the lower limit of the normal range for the individual, and • Symptoms uncontrolled by medical or surgical treatment. Psychiatric conditions are excluded.	50%
	Chronic Liver Failure	The diagnosis of permanent and irreversible chronic liver disease, with a Child Pugh Classification of class B, by a gastroenterologist or equivalent specialist.	50%
	Irreducible Hernia	The diagnosis of an irreducible hernia, following unsuccessful surgical repair of the hernia, by a gastroenterologist or equivalent specialist. With evidence of the following requirements which need to be permanent and irreversible: • Bowel dysfunction which impacts on activities of daily living, such that the insured person is permanently unable to perform 2 of the Basic Activities of Daily Living and 2 of the Advanced Activities of Daily Living.	50%

Urogenital	Chronic Kidney Failure	The diagnosis of chronic renal failure despite adequate medical treatment by a nephrologist or urologist. With evidence of 1 of the following requirements which need to be permanent and irreversible: • Chronic renal disease with an estimated GFR between 24-40ml/min, or • Creatinine clearance of 28 to 42 ml per minute.	50%
Central Nervous System	Impaired consciousness	The diagnosis of a coma of a specified severity by a neurologist or neurosurgeon. Medically induced comas are excluded. With evidence of the following: • Decreased level of consciousness, with a Glasgow Coma Scale of less than 9, which is constant and present for greater than 96hrs.	50%
	Cranial Nerve V (Trigeminal Neuralgia)	The diagnosis of severe unilateral or bilateral facial neuralgic pain by a neurologist due to an affliction of the Trigeminal Nerve. With evidence of the following requirements which need to be permanent and irreversible: • Resistance to pharmacological treatment, and • Has resulted in decompression surgery.	50%
	Cranial Nerve VII	The diagnosis of facial nerve paralysis confirmed by a neurologist or neurosurgeon. With evidence of the following requirements which need to be permanent and irreversible: • Slight or no movement of one half of the face with asymmetry at rest, and • An inability to actively close the eyelid on the affected side, and • Slight or no movement of the mouth.	50%
	Cranial Nerve VIII	The diagnosis of Vestibulocochlear nerve paralysis confirmed by a neurologist or neurosurgeon. With evidence of the following requirements which need to be permanent and irreversible: • Nerve damage with moderately-severe imbalance resulting in limitation of activities of daily living such that the insured person is permanently unable to perform 2 of the Basic Activities of Daily Living and 2 of the Advanced Activities of Daily Living.	50%
	Cranial Nerves IX, X, XII	The diagnosis of Cranial Nerve IX, X, XII paralysis confirmed by a neurologist or neurosurgeon. • With evidence of the following requirements which need to be permanent and irreversible:Severe dysarthria or dysphagia, and • Nasal regurgitation, and • Aspiration of liquids or semi-solid foods, and • Medical findings confirming organic disease.	50%
	Epilepsy	The diagnosis of epilepsy by a neurologist or neurosurgeon supported by objective medical findings and resistant to optimal therapy as confirmed by drug serum-level testing. With evidence of the following requirements which need to be permanent and irreversible: • 6 or more generalised seizures per month, and • An inability to perform 2 of the Basic Activities of Daily Living and 2 of the Advanced Activities of Daily Living.	50%

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. With evidence of the following requirements which need to be permanent and irreversible: • Needs assistive devices or mechanical support for daily functions, or • An inability to perform 2 of the Basic Activities of Daily Living and 2 of the Advanced Activities of Daily Living, or • Documented previous falls and inability to stand, walk, stoop, squat, kneel, climb stairs, or • Inability to grasp and pincer grip and a complete loss of fine or gross motor coordination or grip strength.	50%
		The diagnosis of a cerebellar disorder by a neurologist or neurosurgeon correlating with objective medical findings. With evidence of the following requirements which need to be permanent and irreversible: • Difficulty with standing or maintaining a standing position, without assistive devices, and needs assistance with walking, or • Difficulty with fine or gross motor coordination or grip strength.	25%
	Dementia (including Alzheimer's Disease)	The diagnosis of dementia by a neurologist, physician or neurosurgeon With evidence of the following requirements which need to be permanent and irreversible: • A diminished intellectual ability (may include a personality change and episodes of confusion), and • A score of 1 under the 5 point Clinical Dementia Rating scale, and • Needs some supervision with everyday duties.	50%
Senses	Loss of sight	Confirmed diagnosis of total and permanent bilateral loss of sight by an ophthalmologist. The loss of sight cannot be improved through refractive correction or medication. With evidence of 1 of the following: • A reading of 6/36 or worse (or equivalent measure on a non-metric scale) in each eye after best correction, or • Severe non-proliferative diabetic retinopathy, or • Grade III hypertensive retinopathy, or • A visual field loss to a 20˚ radius in the better eye. Loss of sight due to cataracts is excluded, unless there is evidence of failed cataract surgery or contraindications to cataract surgery.	50%
		Confirmed diagnosis of total and permanent loss of sight in one eye by an ophthalmologist. The loss of sight cannot be improved through refractive correction or medication. With evidence of the following: • A reading of 6/60 or worse (or equivalent measure on a non-metric scale) in one eye after best correction, or • The diagnosis of a hemianopia in one eye, or • A visual field loss to a 10˚ radius. Loss of sight due to cataracts is excluded, unless there is evidence of failed cataract surgery or contraindications to cataract surgery.	25%

Senses (continued)	Loss of hearing	Total and permanent loss of hearing in both ears as confirmed by an ear, nose and throat surgeon. With evidence of the following: • Audiometry measurements, done with the use of hearing aids, averaging between 70-87dB.	50%
		Total and permanent loss of hearing in one ear as confirmed by an ear, nose and throat surgeon. With evidence of the following: • Audiometry measurements, done with the use of hearing aids, with an average loss of greater than 70dB.	25%
	Loss of speech	The permanent loss of 50% of speech, as confirmed by an ear, nose and throat surgeon, neurologist or neurosurgeon. Objective medical evidence of an ear, nose and throat disorder causing the impairment must be provided, with clinical evidence of 2 of the following requirements which need to be permanent and irreversible: • Audibility: while whisper may be present, there is no audible voice. • Intelligibility: while single words may be recognisable, most words are unintelligible. • Function: speech is impractically slow and laboured. Loss of speech due to psychiatric causes are excluded.	50%
Psychiatric	Psychiatric Disorder	The diagnosis of a psychiatric disorder, as confirmed by a specialist psychiatrist. Requires constant supervision on a permanent basis and with evidence of the following: • permanent GAF score of 40 or less certified under the DSM IV classification, or • permanent WHODAS average domain score of 4 certified under the DSM 5 classification	75%
Trauma	Major Burns	The diagnosis of third degree burns (full thickness burns) by a plastic surgeon or trauma specialist. With evidence of: • at least 20% of total body surface affected as measured on the Lund and Browder Chart or equivalent scale, or • more than 50% of the combined surface area of the bilateral lower limbs including involvement of at least 60% of the combined surface area of the soles of both feet; or • more than 50% of the combined surface area of an upper and lower limb including involvement of at least 60% of the combined surface area of the sole of one foot and the palm of one hand	50%
	Inhalational Burn	Inhalational burns resulting in a permanent tracheostomy.	50%
Haematology	Red Blood Cell Disorders	The diagnosis of severe chronic anaemia by a physician or haematologist. With evidence of the following requirements which need to be permanent and irreversible: • Hb less than 8g/dL, and • Requiring 2-3U of blood every 4-6 weeks.	50%
	White Blood Cell Disorders	The diagnosis of a severe white blood cell disorder by a physician or haematologist. With evidence of 1 of the following requirements which need to be permanent and irreversible: • An absolute neutrophil count of between 250 and 500 , resulting in at least 2 hospitalisations per year for acute bacterial infections, or • Lymphoma or Leukaemia requiring at least 1 chemotherapy regimen per year.	50%

Musculoskeletal	Chronic Spinal Column Conditions	• A history of chronic pain syndrome due to a chronic spinal condition for a duration of at least two years. It must be treated by a multidisciplinary pain management team with at least two of the four requirements listed below, which must be permanent and irreversible as confirmed by an orthopaedic or neurosurgeon . All these criteria must be present in the same region, as defined below, for a valid claim to be paid. Spinal Regions: The neck and lower back are part of the spine. The spinal regions are: • Cervical region (C1-C7). • Thoracic region (T1-T12) and • Lumbosacral region (L1-S1). The C7 to T1 joint will be classified in the cervical region, and the T12 to L1 joint in the thoracolumbar region. List of four requirements: 1. 50% or more compression of a vertebral body or multiple level compression fractures giving rise to kyphotic deformity. 2. Clinically significant radiculopathy (motor and sensory deficit or muscle atrophy and clinical signs of nerve tension and radiological evidence at the same site as clinically found. NB – We will not accept radiological signs of nerve compression without clinical evidence of neurological involvement as proof of functional impairment. 3. Alteration of motion segment integrity confirming instability with neurological deficit. 4. Multiple back or cervical operations (i.e. two or more on separate occasions within a period of 5 years) comprising laminectomy, discectomy or fusion, or a combination thereof.	50%

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

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

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

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

CHILD IMPAIRMENTS AND CONGENITAL BIRTH DEFECTS THAT QUALIFY UNDER THE CHILD IMPAIRMENT BENEFIT

Body system	Child impairment or congenital birth defect	Requirements that the child impairment or congenital birth defect must meet to qualify	Percentage of the cover amount payable
Congenital Birth Defects	Achondroplasia	The undergoing of surgery to treat complications of achondroplasia. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
	Anal atresia	The undergoing of surgery to correct anal atresia. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
	Biliary Atresia	Confirmed diagnosis of biliary atresia by the treating specialist. **Requirements for a claim to be considered:** • Supportive imaging and blood tests	50%
	Brain and skull disorders	Confirmed diagnosis of one of the following disorders by the treating specialist: • Microcephaly • Hydrocephaly • Craniostenosis • Craniosynostosis **Requirements for a claim to be considered:** • Supportive imaging and blood tests • The disorder results in severe neurological deficit.	100%
	Cerebral Palsy	Confirmed diagnosis of cerebral palsy by the treating specialist. **Requirements for a claim to be considered:** One of the following must be present for at least 6 months: • Spastic diplegia • Spastic hemiplegia • Spastic quadriplegia	100%
	Choanal atresia	The undergoing of surgery to correct choanal atresia. **Requirements for a claim to be considered:** • The complications have resulted in at least two surgical interventions, on two separate occasions, other than for diagnostic purposes • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
	Cleft lip and complete cleft palate	Confirmed diagnosis of cleft lip and complete cleft palate (hard and soft palate) by the treating specialist.	50%
	Clubbed feet (Talipes)	The undergoing of surgery to correct bilateral clubbed feet. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
		The undergoing of surgery to correct a clubbed foot. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	25%

Congenital Birth Defects (continued)	Congenital blindness	Confirmed diagnosis of total visual loss in both eyes at birth, by the treating specialist. **Requirements for a claim to be considered:** • Supportive clinical evidence	100%
		Confirmed diagnosis of total visual loss in one eye at birth, by the treating specialist. **Requirements for a claim to be considered:** • Supportive clinical evidence	50%
	Congenital deafness	Confirmed diagnosis of total hearing loss in both ears at birth by the treating specialist. **Requirements for a claim to be considered:** • Supportive clinical evidence using the Automated Otoacoustic Emission test or the Automated Auditory Brainstem Response test (or equivalent measure).	100%
		Confirmed diagnosis of total hearing loss in one ear at birth by the treating specialist. **Requirements for a claim to be considered:** • Supportive clinical evidence using the Automated Otoacoustic Emission test or the Automated Auditory Brainstem Response test (or equivalent measure).	50%
	Congenital heart disease	The correction of any congenital structural abnormality of the heart, through surgically opening the chest cavity (thoracotomy or sternotomy). **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions:** • Any investigative procedure	100%
		The correction of any congenital structural abnormality of the heart, through any minimally invasive surgery. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions:** • Any investigative procedure • Patent ductus arteriosus	50%
	Congenital hip dislocation	The undergoing of surgery to correct congenital bilateral hip dislocation. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
		The undergoing of surgery to correct congenital unilateral hip dislocation. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	25%

Congenital Birth Defects (continued)	Cystic fibrosis	Confirmed diagnosis of cystic fibrosis by the treating specialist. **Requirements for a claim to be considered:** • A diagnostic sweat test • Pulmonary complications (e.g. recurrent pneumonia, suppurative lung disease, lung abscesses) confirmed by radiological investigations	100%
	Down Syndrome	Confirmed diagnosis of Down syndrome by the treating specialist. **Requirements for a claim to be considered:** • Supportive genetic tests	100%
	Duchenne Syndrome or Congenital Myotonic Dystrophy	Confirmed diagnosis of one of the following by the treating specialist: • Duchenne muscular dystrophy • Congenital myotonic muscular dystrophy (MMD 1) **Requirements for a claim to be considered:** For Duchenne muscular dystrophy: • Evidence of clinical symptoms • Raised creatine kinase • Muscle biopsy with abnormal levels of dystrophin protein For Congenital myotonic muscular dystrophy: • Supportive genetic tests	100%
	Haemophilia	Confirmed diagnosis of haemophilia by the treating haematologist. **Requirements for a claim to be considered:** • Despite adequate treatment for at least 6 consecutive months, both of the following are present: • 1% of the normal clotting factor in the blood • At least four units of blood or blood products has been transfused per month for at least 3 consecutive months	50%
	Hirschsprung's disease	Confirmed diagnosis of Hirschprung's disease by the treating specialist. **Requirements for a claim to be considered:** • Full-thickness rectal biopsy	50%

Congenital Birth Defects (continued)	Hydrocephalus	The surgical insertion of a shunt to treat congenital hydrocephalus. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
	Hypospadias	The undergoing of surgery to treat hypospadias in a male child. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
	Inborn metabolic disorders	Confirmed diagnosis of one of the following inborn errors of metabolism by the treating specialist: • Gaucher's disease • Glycogen storage disease • Tay Sachs Disease • Mucopolysaccharidosis **Requirements for a claim to be considered:** • Supportive laboratory tests	100%
	Autosomal recessive polycystic kidney disease	Confirmed diagnosis of autosomal recessive polycystic kidney disease by the treating specialist. **Requirements for a claim to be considered:** • Supportive genetic tests	100%
	Klinefelter's syndrome	Confirmed diagnosis of Klinefelter's syndrome by the treating specialist. **Requirements for a claim to be considered:** • Supportive genetic tests	25%
	Necrotising enterocolitis	The undergoing of surgery to treat necrotising enterocolitis. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
	Neurodevelopmental disorders	Confirmed diagnosis of one of the following developmental disorders of the by the treating specialist: • Symptomatic Rett syndrome with a MECP2 mutation • Symptomatic fragile X syndrome with a FMR1 mutation • Symptomatic tuberous sclerosis with a TSC2 mutation • Symptomatic neurofibromatosis **Requirements for a claim to be considered:** • Supportive genetic tests • Supportive clinical evidence	100%
	Myelomeningocele	Confirmed diagnosis of myelomeningocele by the treating specialist. **Requirements for a claim to be considered:** • Supportive imaging and blood tests	100%
	Tracheooesophageal Fistula or Oesophageal Atresia	Confirmed diagnosis of a tracheo-oesophageal fistula or oesophageal atresia by the treating specialist. **Requirements for a claim to be considered:** • Supportive imaging and blood tests • Pulmonary complications (e.g. recurrent pneumonia, suppurative lung disease, lung abcesses) confirmed by radiological investigations	50%
Central Nervous System	Paraplegia, hemiplegia or quadriplegia	Total and permanent paralysis of 2 or more limbs from any cause.	100%

Senses	Loss of Hearing	The total and permanent loss of hearing of greater than 70dB in both ears as diagnosed by an Ear, Nose and Throat Specialist. The measurements are done with the use of hearing aids for the assessment of hearing impairment.	100%
	Loss of Sight	Confirmed diagnosis of total and permanent bilateral loss of sight by an ophthalmologist. The loss of sight cannot be improved through refractive correction or medication. With evidence of 1 of the following: • A reading of 6/60 or worse (or equivalent measure on a non-metric scale) in each eye after best correction, or • A visual field loss to a 10° radius in the better eye. Loss of sight due to cataracts is excluded.	100%
	Loss of Speech	The total and permanent loss of the ability to produce intelligible and audible speech due to injury or disease, as confirmed by an ear, nose and throat surgeon, neurologist or neurosurgeon. • Objective medical evidence of an ear, nose and throat disorder causing the impairment must be provided. Loss of speech due to psychiatric causes are excluded.	100%
Trauma	Major Burns	The diagnosis of third degree burns (full thickness burns) by a plastic surgeon or trauma specialist. With evidence of: • at least 20% of total body surface affected as measured on the Lund and Browder Chart or equivalent scale, or • more than 50% of the combined surface area of the bilateral lower limbs including involvement of at least 60% of the combined surface area of the soles of both feet; or • more than 50% of the combined surface area of an upper and lower limb including involvement of at least 60% of the combined surface area of the sole of one foot and the palm of one hand.	100%
	Accidental brain damage	Permanent impairment of intellectual capacity as a result of brain damage sustained in an accident, as defined. Confirmation of intellectual impairment by neuropsychological testing. Note: An accident is an unexpected and visible event of external origin that causes traumatic bodily injury and is not traceable, even indirectly, to the child's state of mental or physical health before the event.	100%
	Trauma	An accident resulting in severe physical injury. With evidence of the following: • Requires mechanical ventilation in an intensive care unit for at least 48 hours , and • Results in permanent neurological deficit. Note: An accident is an unexpected and visible event of external origin that causes traumatic bodily injury and is not traceable, even indirectly, to the child's state of mental or physical health before the event.	100%
		An accident resulting in severe physical injury, requiring mechanical ventilation in an intensive care unit for at least 96 hours. Note: An accident is an unexpected and visible event of external origin that causes traumatic bodily injury and is not traceable, even indirectly, to the child's state of mental or physical health before the event.	50%
Cancer	Cancer	• The diagnosis of an advanced stage of cancer as confirmed by an oncologist with supporting documentation. • With evidence of the following: • Diagnosis of at least a stage III cancer, and the child is permanently confined to a bed or a wheelchair, or • Stage IV cancer	100%

Terminal Illness	Terminal Illness	The diagnosis of a medical condition which, according to Old Mutual's Medical Officer, will result in death within 12 months. The claim must be received within this 12 month period.	100%
Activities of Daily Living	Permanent confinement to a bed or a wheelchair.	Permanent confinement to a bed or a wheelchair, as confirmed by the treating specialist due to an organic disease or injury.	100%

FUNCTIONAL IMPAIRMENTS THAT QUALIFY UNDER THE PREMIUM PROTECTION DISABILITY BENEFIT

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

Gastrointestinal	Ano-rectal impairment	Faecal incontinence • With evidence of complete faecal incontinence despite adequate medical and/or surgical treatment by a gastroenterologist or equivalent specialist.
	Chronic Gastrointestinal Disease	The diagnosis of a chronic gastrointestinal disease by a gastroenterologist or equivalent specialist, as a result of a medical condition. With evidence of the following: • Medical findings confirming organic disease, and • Significant unintentional weight loss resulting in a BMI of less than 15 or 25% weight loss below the lower limit of the normal range for the individual, and • Symptoms uncontrolled by medical or surgical treatment. Psychiatric conditions are excluded.
	Chronic Liver Failure	The diagnosis of chronic end-stage liver failure, with a Child Pugh Classification of class C, by a gastroenterologist or equivalent specialist.
Urogenital	Bladder Impairment	The diagnosis of a bladder impairment despite adequate surgical and medical treatment by a nephrologist or urologist. With evidence of 1 of the following: • No detectable reflex or voluntary urine control as a result of organic pathology, resulting in urinary incontinence, or • Total bladder resection, or • Chronic disorders of the bladder and its structures that require a permanent indwelling catheter.
	Chronic Kidney Failure	The diagnosis of chronic renal failure despite adequate medical treatment by a nephrologist or urologist. With evidence of 1 of the following: • End-stage renal disease with an estimated GFR less than 24ml/min, or • Creatinine clearance of less than 28 ml per minute, or • Renal function deterioration that requires life-long peritoneal dialysis or lifelong haemodialysis.

Central Nervous System	Impaired consciousness	The diagnosis of a coma of a specified severity by a neurologist or neurosurgeon. Medically induced comas are excluded. With evidence of the following for 14 days or more: • A decreased level of consciousness, with a Glasgow Coma Scale of less than 9, and • Requiring total medical support including intubation and assisted ventilation.
	Aphasia	The diagnosis of aphasia by a neurologist or neurosurgeon. With evidence of the following: • A total inability to express oneself or communicate (through speech, writing, or signs), or to comprehend spoken or written language, due to injury or disease of the brain, and • Deficits in the formal aspects of language such as naming, word choice, comprehension, spelling and syntax, and • Objective medical findings supporting the diagnosis of aphasia. Psychiatric conditions are excluded.
	Cranial Nerve VII	The diagnosis of facial nerve paralysis confirmed by a neurologist or neurosurgeon. With persistent evidence of the following: • Slight or no movement of the face, and • An inability to actively close the eyelids, and • Slight or no movement of the mouth.
	Cranial Nerve VIII	The diagnosis of Vestibulocochlear nerve paralysis confirmed by a neurologist or neurosurgeon. With evidence of the following: • Nerve damage with severe imbalance resulting in limitation of activities of daily living such that the insured person is unable to perform 3 of the Basic Activities of Daily Living or 4 of the Advanced Activities of Daily Living.
	Cranial Nerves IX, X, XII	The diagnosis of Cranial Nerve IX, X, XII paralysis confirmed by a neurologist or neurosurgeon. With evidence of the following: • An inability to swallow or process oral secretions without choking, and • Need for external suctioning device, and • Medical findings confirming organic disease.
	Epilepsy	The diagnosis of epilepsy by a neurologist or neurosurgeon supported by objective medical findings and resistant to optimal therapy as confirmed by drug serum-level testing. With evidence of the following: • 3 or more generalised seizures per week for at least 3 consecutive months, and • An inability to perform 3 of the Basic Activities of Daily Living or 4 of the Advanced Activities of Daily Living.
	Hemiplegia	The total loss of the functioning of one side of the body due to an injury or disease of the brain as confirmed by a neurologist or neurosurgeon and correlating with objective medical findings.
	Dementia (incl. Alzheimer's Disease)	The diagnosis of dementia by a neurologist, physician or neurosurgeon With evidence of the following: • A diminished intellectual ability (may include personality changes and episodes of confusion), and • A score of 2 under the 5 point Clinical Dementia Rating scale, and • Needs constant supervision.
	Paraplegia / Diplegia	The total loss of the functioning of both legs or both arms due to an injury or disease of the brain or spinal cord. This must be confirmed by a neurologist or neurosurgeon and correlate with objective medical findings.

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

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

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

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

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

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

FUNCTIONAL IMPAIRMENTS THAT QUALIFY UNDER THE PREMIUM PROTECTION FUNCTIONAL IMPAIRMENT BENEFIT

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

Gastrointestinal	Ano-rectal impairment	Faecal incontinence • With evidence of complete faecal incontinence despite adequate medical and/or surgical treatment by a gastroenterologist or equivalent specialist.
	Chronic Gastrointestinal Disease	The diagnosis of a chronic gastrointestinal disease by a gastroenterologist or equivalent specialist, as a result of a medical condition. With evidence of the following: • Medical findings confirming organic disease, and • Significant unintentional weight loss resulting in a BMI of less than 15 or 25% weight loss below the lower limit of the normal range for the individual, and • Symptoms uncontrolled by medical or surgical treatment. Psychiatric conditions are excluded.
	Chronic Liver Failure	The diagnosis of chronic end-stage liver failure, with a Child Pugh Classification of class C, by a gastroenterologist or equivalent specialist.
Urogenital	Bladder Impairment	The diagnosis of a bladder impairment despite adequate surgical and medical treatment by a nephrologist or urologist. With evidence of 1 of the following: • No detectable reflex or voluntary urine control as a result of organic pathology, resulting in urinary incontinence, or • Total bladder resection, or • Chronic disorders of the bladder and its structures that require a permanent indwelling catheter.
	Chronic Kidney Failure	The diagnosis of chronic renal failure despite adequate medical treatment by a nephrologist or urologist. With evidence of 1 of the following: • End-stage renal disease with an estimated GFR less than 24ml/min, or • Creatinine clearance of less than 28 ml per minute, or • Renal function deterioration that requires life-long peritoneal dialysis or lifelong haemodialysis.

Central Nervous System	Impaired consciousness	The diagnosis of a coma of a specified severity by a neurologist or neurosurgeon. Medically induced comas are excluded. With evidence of the following for 14 days or more: • A decreased level of consciousness, with a Glasgow Coma Scale of less than 9, and • Requiring total medical support including intubation and assisted ventilation.
	Aphasia	The diagnosis of aphasia by a neurologist or neurosurgeon. With evidence of the following: • A total inability to express oneself or communicate (through speech, writing, or signs), or to comprehend spoken or written language, due to injury or disease of the brain, and • Deficits in the formal aspects of language such as naming, word choice, comprehension, spelling and syntax, and • Objective medical findings supporting the diagnosis of aphasia. Psychiatric conditions are excluded.
	Cranial Nerve VII	The diagnosis of facial nerve paralysis confirmed by a neurologist or neurosurgeon. With persistent evidence of the following: • Slight or no movement of the face, and • An inability to actively close the eyelids, and • Slight or no movement of the mouth.
	Cranial Nerve VIII	The diagnosis of Vestibulocochlear nerve paralysis confirmed by a neurologist or neurosurgeon. With evidence of the following: • Nerve damage with severe imbalance resulting in limitation of activities of daily living such that the insured person is unable to perform 3 of the Basic Activities of Daily Living or 4 of the Advanced Activities of Daily Living.
	Cranial Nerves IX, X, XII	The diagnosis of Cranial Nerve IX, X, XII paralysis confirmed by a neurologist or neurosurgeon. With evidence of the following: • An inability to swallow or process oral secretions without choking, and • Need for external suctioning device, and • Medical findings confirming organic disease.
	Epilepsy	The diagnosis of epilepsy by a neurologist or neurosurgeon supported by objective medical findings and resistant to optimal therapy as confirmed by drug serum-level testing. With evidence of the following: • 3 or more generalised seizures per week for at least 3 consecutive months, and • An inability to perform 3 of the Basic Activities of Daily Living or 4 of the Advanced Activities of Daily Living.
	Hemiplegia	The total loss of the functioning of one side of the body due to an injury or disease of the brain as confirmed by a neurologist or neurosurgeon and correlating with objective medical findings.
	Dementia (incl. Alzheimer's Disease)	The diagnosis of dementia by a neurologist, physician or neurosurgeon With evidence of the following: • A diminished intellectual ability (may include personality changes and episodes of confusion), and • A score of 2 under the 5 point Clinical Dementia Rating scale, and • Needs constant supervision.
	Paraplegia / Diplegia	The total loss of the functioning of both legs or both arms due to an injury or disease of the brain or spinal cord. This must be confirmed by a neurologist or neurosurgeon and correlate with objective medical findings.

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

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

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

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

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

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