ALLLIFE
COVER FOR THE LIVING

Advantage Life Policy

TERMS & CONDITIONS
DEFINITIONS

Accident	An unplanned and unexpected event which is caused solely and directly by violent, external, physical and visible means that is not traceable, even indirectly, to the insured's state of mental or physical health before the event.
AllLife	AllLife (Pty) Limited
Appendix/Appendices	The attachments to this Policy describing specific Policy Benefits, or specific Policy and/or Claim requirements, as applicable to the Benefits specified in the Policy Schedule.
Basic Premium	This Premium component forms part of the Total Premium, and must be paid monthly to maintain the Benefits under this Policy.
Beneficiary(ies)	The party (ies) nominated to receive any Benefits paid under this Policy.
Benefit	A payment(s) made by The Insurer under the terms and conditions of this Policy and its Schedules and Appendices on admission of a Claim.
Cede	The transfer of all or part of the Policy Benefits to another party by the Life Insured.
Cession	The act of transferring all or part of the Policy Benefits to another party by the Life Insured.
Cessionary	The party to whom Policy Benefits are Ceded by the Life Insured.
Commencement Date	The date when the Policy takes effect (as specified in the Policy Schedule).
Cover Termination Date	The date when the Policy ceases to be in effect (as specified in the Policy Schedule). Note that Cover will terminate immediately in the event of a Claim, or in the event that no Monthly Premium have been received during any continuous five month period during the life of this Policy, and after the expiry of the thirty (30) day grace period for payment of the Total Premium pertaining to the fifth month.
Death Benefit	A payment(s) made by The Insurer under the terms and conditions of this Policy and its Schedules and Appendices on admission of a Claim, in the event of the death of the Life Insured.
Exclusion(s)	Specific Situation(s) under which the Policy Benefit will not be paid out in the event of a Claim.
Health Monitoring Premium	The Health Monitoring Premium component forms part of the Total Premium, and must be paid monthly to maintain the Health Monitoring Benefit under this Policy.
Life Insured	The party specified in the Policy Schedule upon whose death Benefits may be claimed under this Policy, subject to the terms and conditions of this Policy and its Schedules and Appendices. The Life Insured is responsible for the appointment of beneficiaries, and any Policy related changes, and is considered the Policy Owner.
OMART	Old Mutual Alternative Risk Transfer Limited
Policy	An agreement between the Life Insured and The Insurer as set out in the Policy Schedule, General Conditions, and Appendices included here.
Policy Anniversary	The annually recurring date of the Policy inception.
Policy Owner	The Life Insured is the Policy Owner. The Policy Owner is authorised to make any change to the Policy, including the appointment of beneficiaries. Where an absolute Cession has been recorded, the Cessionary becomes the Policy Owner of the Policy. The Policy Owner may exercise all rights under this Policy without the consent of any Beneficiary.
Policy Payer	The party specified in the Policy Schedule who is responsible for the payment of the Total Premium. The Payer is only permitted to change payment related information.
Policy Schedule	The first section of this Policy Document, which sets out details of the Life Insured, Policy Benefits, Premiums payable, relevant disclosures provided in the application form, and the terms and conditions referring to them.
Reinstate	Restoration of Policy Benefits after they have been previously terminated.
Surrender	The voluntary cancellation of the Policy by the Life Insured.
Surrender value	A cash Benefit payable upon surrender, cancellation or termination of the Policy.
The Insurer	OMART, a registered South African life company which underwrites this Policy and against whom a claim may be registered in terms of this Policy.
Total Premium	The total monthly payment payable to maintain the Benefits under this Policy. The Total Premium includes both the Basic Premium and the Health Monitoring Premium.

Underwritten by Old Mutual Alternative Risk Transfer Limited (OMART), a registered Long-Term Insurer.
OLDMUTUAL

GENERAL CONDITIONS

1. BENEFITS

1.1. Policy Protection (South African patent application no. 2013/03141)

This Policy allows you to miss up to five consecutive Total Monthly Premiums. Where any Monthly Premium(s) has not been paid during the six month period immediately preceding a Claim (or whatever period has elapsed since the Commencement Date, where this is less than six months), the Benefit claimable will be in proportion to the number of Total Premium(s) received monthly during this period.

We will attempt to collect the Monthly Total Premium payable under this Policy by debit order on the agreed debit day each month. Where this debit order is returned unpaid, your Benefit will be temporarily reduced as set out above. If you want to maintain full Benefits under this Policy you may choose to make up this missed payment.

Should there be material changes made to the Benefits provided, the Life Insured, Policy Owner and the Policy Payer on this Policy will be notified. All details and reason for Benefit changes will be communicated only to the Life Insured, as the Policy Owner, due to confidentiality.

1.2. Death Benefits:

1.2.1. Advantage Life Term or Advantage Life Whole Life

If the Life Insured has selected either the Advantage Life Term or Advantage Life Whole Life product then, on the death of the Life Insured (prior to and not including the Cease Date where applicable), the Beneficiaries may claim the Death Benefit Assured Amount (subject to section 1.1). Such payment will be in South African Rand and made by electronic funds transfer to a South African bank account/s only.

1.2.2. Advantage Life Loan Protector

If the Life Insured has selected the Advantage Life Loan Protector product then, on the death of the Life Insured (prior to and not including the Cease Date), The Insurer will pay the Death Benefit Assured Amount stipulated in the Appendix which corresponds to the number of months that the Policy has been in force (subject to section 1.1). Such payment will be in South African Rand and made by electronic funds transfer to a South African bank account/s only.

1.3. Disability Benefits:

1.3.1. ADW Disability

If the Life Insured has selected a Life and ADW Disability Policy then, should the Life Insured become **permanently and totally disabled** in terms of Activities of Daily Work (ADW) Disability Definitions (prior to and not including the Cease Date or the day of the Life Insured's 65th birthday, whichever is the earlier, where applicable), The Insurer will pay the Permanent Total Disability Benefit Assured Amount, subject to a minimum waiting period of 6 months after the date of disability (subject to section 1.1). Such payment will be in South African Rand and made by electronic funds transfer to a South African bank account/s only.

Should the Life Insured become **temporarily and totally disabled** in terms of ADW Disability Definitions (prior to and not including the Cease Date or the day of the Life Insured's 65th birthday, whichever is the earlier, where applicable), The Insurer will waive the Monthly Premiums payable for a maximum period of 12 months, or until admission of a permanent total disability claim, or until the death of the Life Insured, whichever is the earlier, subject to a minimum waiting period of 2 months after the date of disability. Multiple temporary total disability claims may be admitted up to a maximum of 12 months waived Monthly Premiums over the life of the Policy.

1.3.2. Occupational Disability

If the Life Insured has selected a Life and Occupational Disability Policy then, should the Life Insured become **permanently and totally disabled** in terms of Occupational Disability Definitions (prior to and not including the Cease Date or the day of the Life Insured's 65th birthday, whichever is the earlier, where applicable), The Insurer will pay the Permanent Total Disability Benefit Assured Amount, subject to a minimum waiting period of 6 months after the date of disability (subject to section 1.1). Such payment will be in South African Rand and made by electronic funds transfer to a South African bank account/s only.

Should the Life Insured become **temporarily and totally disabled** in terms of Occupational Disability Definitions (prior to and not including the Cease Date or the day of the Life Insured's 65th birthday, whichever is the earlier, where applicable), The Insurer will waive the Monthly Premiums payable for a maximum period of 12 months, or until admission of a permanent total disability claim, or until the death of the Life Insured, whichever is the earlier, subject to a minimum waiting period of 2 months after the date of disability. Multiple temporary total disability claims may be admitted up to a maximum of 12 months waived Monthly Premiums over the life of the Policy.

2. CONTRIBUTIONS

Total Premium consists of 2 Premium components, the Basic Premium and the Health Monitoring Premium as shown in the Policy Schedule and is payable monthly, in advance starting on the Commencement Date agreed in the schedule. The Total Premium is regarded as paid once the Policy Payers' bank account has been successfully debited and provided the payment is not subsequently reversed.

The Total Premium are subject to the following conditions:

- The first Total Premium must be paid before the Policy can come into force.
- Tracking may be used in collecting your Total Premium. This means that we will endeavor to collect your Total Premium over a maximum tracking period of thirty two (32) days from your chosen debit day. If we fail to successfully collect on your chosen debit day, the debit will recheck your funds available over the tracking period and, in this way, you will avoid any RD charges if payment is made on a **later tracked day**.
- The Benefits claimable under this Policy will be reduced in proportion to the number of Total Premium(s) that were unpaid during the six (6) months' period prior to the Claim event (or whatever period has lapsed since the Commencement Date, where this is less than six (6) months).
- If you miss a payment (excluding the first Total Premium), you will not be required to pay the outstanding Total Premium(s) unless you would like to restore the full Benefits provided under the Policy.
- Benefits may be claimed under this Policy for a period of five months after the last Total Premium was received, plus a thirty (30) day grace period provided for payment of the Total Premium pertaining to the fifth month.
- If the Total Premium is not received during any continuous five month period during the life of this Policy, and after the expiry of the thirty (30) day grace period for payment of the Total Premium pertaining to the fifth month, the Policy will lapse. **No Benefits are payable under a lapsed Policy**.

Underwritten by Old Mutual Alternative Risk Transfer Limited (OMART), a registered Long-Term Insurer.

3. RIGHTS OF PARTIES

3.1. Beneficiaries

The Life Insured may at any time appoint a Beneficiary to receive the Death Benefit Assured Amount (subject to the rights of any Cessionary) or remove a Beneficiary. The Life Insured may nominate one or more Beneficiaries, providing that:

- The Life Insured reserves the right to change the list of Beneficiaries at any time.
- Nominations for Beneficiaries must be submitted in writing to AllLife, on behalf of The Insurer, in strict accordance with The Insurer's standard business practices.
- Beneficiary nomination will not be valid until the Life Insured has received written notice from AllLife on behalf of The Insurer that the nomination has been noted in its records.
- If the Life Insured is married in community of property, then any change in Beneficiaries requires consent from the Life Insured's spouse.

3.2. Cession

The Life Insured may Cede the Policy. No Cession will be binding on The Insurer or AllLife unless it is received in writing by AllLife (on behalf of The Insurer) and acknowledged as received by AllLife. Neither The Insurer nor AllLife is responsible for the validity of any Cession or nomination of Beneficiaries. Where an absolute Cession has been recorded, the Cessionary becomes the Policy Owner of the Policy.

Any Benefits due will be paid to the Policy Owner or his estate. However, if a Beneficiary has been appointed and no Cession has been recorded, the Death Benefit Assured Amount will be paid to the Beneficiary. Where a Cession has been recorded, any Benefits due will be paid to the Cessionary or, in the case of an absolute Cession, the Death Benefit Assured Amount will be paid to any Beneficiary nominated by the Cessionary in their capacity as Policy Owner.

Subject to any Cession, the Policy Owner may exercise all rights under this Policy without the consent of any Beneficiary. Where the Policy has more than one Policy Owner, the rights must be jointly exercised by all the Policy Owners.

Should the entire Policy, or a portion of the Policy, be Ceded to another person, the Cessionary will be paid out before any nominated Beneficiaries. Beneficiaries need not be aware of or give their consent to the ceding of a Policy.

4. CONTRIBUTORY ADJUSTMENTS

The Total Premium, contributed monthly consists of two Premium components, the **Basic Premium** and the **Health Monitoring Premium**. Both these Premiums are guaranteed for the first twelve (12) months, where after they become subject to Annual Increases and Premium Review as defined below:

4.1 Basic Premium

The Basic Premium is subject to an annual increase, on the Policy Anniversary, as indicated on the Policy Schedule. In addition the Basic Premium will be reviewed annually to determine whether the claims experience and expenses are higher than assumed. The Insurer will notify the Life Insured timeously and in writing of a pending review and the timing of the review if the review is expected to result in a Premium increase.

4.2 Health Monitoring Premium

The Health Monitoring Premium Health Monitoring Premium is subject to an annual increase, as indicated on the Policy Schedule, on the anniversary date of the Policy. In addition the Health Monitoring Premium will be reviewed annually based on underlying health monitoring and underwriting costs. The Insurer will notify the Life Insured timeously and in writing of a pending review and the timing of the review if the review is expected to result in a Premium increase.

Notice of changes to Premiums will be communicated to the Life Insured, thirty (30) days' prior to the change. The Insurer will require the revised Total Premium to be paid in order to maintain cover. Cover will only be maintained if the revised Premium is accepted and paid.

5. PREMIUM GUARANTEE REVIEW

The Total Premium is guaranteed for the first twelve (12) months, after which the two Premium components, the **Basic Premium** and the **Health Monitoring Premium** will be subjected to annual increases and Premium reviews as detailed in clause 4 above.

6. CHANGE OF RESIDENCE

The Benefits hereunder are payable while the Life Insured is resident in the Republic of South Africa. The Life Insured shall notify AllLife in writing if the Life Insured intends to reside outside the Republic of South Africa whereupon The Insurer shall have the right to increase the Basic Premium, modify or cancel this Benefit with immediate effect by sending written notice to the Policy Owner.

7. CLAIM NOTIFICATION

Benefits are claimable if and only if:

- Formal written notification of a claim including all claim documents and medical evidence are lodged with AllLife or The Insurer within three (3) months of the occurrence of the event giving rise to a claim hereunder. If a claim is notified to AllLife or The Insurer after three (3) months from the date of the Life Insured's death or the date of disability of the Life Insured, The Insurer may, at its sole and absolute discretion, reject the claim.
- At least one (1) Total Premium has been received during the six (6) calendar months preceding the claim event.

8. COOLING OFF PERIOD

If, after studying this Policy document the Life Insured is unhappy with the Policy he/she has purchased, the Life Insured may take advantage of a thirty-one (31) day "cooling off" period. This "cooling off" period enables the Life Insured to re-evaluate their purchase and cancel this Policy by sending a written cancellation notice to AllLife (within thirty-one (31) days) after this Policy document has been received or would reasonably be expected to have been received. The "cooling off" period only applies if no claims have been lodged against the Policy. Any Premiums paid will be refunded subject to the deduction of the cost of the risk cover actually enjoyed.

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9. EXCLUSIONS

A claim will not be admitted if the claim arises directly or indirectly from:

i. An injury which is self-inflicted or in any way deliberately caused by the Life Insured.
ii. Negligence, recklessness or any participation by the Life Insured in any criminal act.
iii. The Life Insured being under the influence of alcohol, inhalation of fumes, consumption of poisons, drugs, narcotics or medication, except as prescribed by a qualified medical practitioner and used as prescribed.
iv. Participation in any form of aviation, other than as a passenger travelling on a scheduled flight in an aircraft flown by a duly licensed pilot.
v. Participation in mountaineering, pace making or any speed contest and trials.
vi. The Life Insured failing to disclose required information prior to the commencement of the Benefit.
vii. Loss or expense of whatsoever nature caused by, resulting from, or in connection with any of the following, regardless of any other cause or event contributing concurrently or in any other sequence to the loss;

a. War, hostilities or warlike operations (whether war be declared or not),
b. Invasion,
c. Act of an enemy foreign to the nationality of the Life Insured or the country in, or over, which the act occurs,
d. Civil war,
e. Insurrection,
f. Revolution,
g. Overthrow of the legally constituted government,
h. Civil commotion assuming the proportion of, or amounting to, an uprising,
i. Military or usurped power.

viii. ABC Exclusion:
a. The use of nuclear, biological or chemical weapons, or any radioactive contamination; or
b. Attacks on or sabotage of facilities (including, but not limited to, nuclear power plants, processing plants, final repository sites and research reactors) and storage depots, which lead to the release of radioactivity or nuclear, biological or chemical warfare agents, irrespective of whether any of the aforesaid has been performed with the specific use of information technology.

A claim will not be admitted if:

ix. The Claimant/Beneficiary is unable to produce full claims documentation and any additional information as may be required by The Insurer.

Where the Policy has not been underwritten, a claim will not be admitted if the claim arises directly or indirectly from a Pre-existing Condition, which is any condition that existed preceding the application for life cover, for which the Life Insured has:

a. consulted a medical practitioner or specialist, or
b. taken prescribed medicine, or,
c. received treatment, surgery or advice, or
d. been on a waiting list for medical treatment, or
e. manifested symptoms which would have caused a reasonable person to seek advice, or
f. received a terminal prognosis, or
g. an on-going medical condition of which the Life Insured is or ought to be aware.

This includes, but is not limited to, the conditions listed in the Pre-existing Conditions Appendix.

A claim against either the Permanent Total Disability Benefit, or the Temporary Total Disability Benefit will not be admitted should this claim arise directly or indirectly from any non-specific back pain. This means that other back conditions or disorders will be covered (subject to the Exclusions above), such as those due to paraplegia, quadriplegia, a malignant condition of the vertebra or spine, fractures of the spine or failed back syndrome after more than two previous back surgeries.

10. MISREPRESENTATION

The information given to The Insurer and AllLife in the application for this Policy, or to the call centre consultant, or any other documentation that the Life Insured or their medical representatives provided in support of the application for this Policy, forms the basis upon which this Policy is issued and maintained.

Should the Policy Owner, Life Insured or Beneficiaries fail to disclose any material information, fail to disclose any change in occupation or provide false information or distort information when applying for this Policy, or during the claims process, The Insurer will be entitled to void this Policy from the Commencement Date or to void any Benefit afforded under this Policy.

If any claim under this Policy is in any respect fraudulent or if any fraudulent means or devices are used by the Life Insured or anyone acting on their behalf or with their knowledge or consent to obtain any Benefit under this Policy or if any event is occasioned by the willful act or with the connivance of the Life Insured, the Benefit afforded under this Policy in respect of any claim shall be forfeited.

11. CONSENT

The Life Insured has consented to the exchange of information, including, but not limited to, medical information, between AllLife, The Insurer, any medical practitioner, any managed health care company, any medical aid and/or any pathology laboratory. The Life Insured gave The Insurer and AllLife permission to access/exchange this information in his/her application for this cover.

The Life Insured has indemnified AllLife, The Insurer OMART, and any other parties including, but not limited to, their shareholders, their directors, agents, and employees against any claims arising from any disclosure of this information. The Life Insured provided this indemnity in his/her application for this cover.

12. CHANGES TO POLICY DETAILS

The Life Insured has received a Policy Schedule from The Insurer upon the inception of this Policy. Should any of the Policy details change, please notify AllLife of these changes, once the Policy has been updated, the amended Policy Schedule that reflects these changes will be sent to the Life Insured and/or Policy Owner for safekeeping.

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13. CLAIMS NOTIFICATION AND CLAIMS PROCEDURE

13.1. Death Benefit Claim

In the event of a claim against the Death Benefit Sum Assured, the claimant will be required to fill in a claim form and provide AllLife (on behalf of The Insurer), with the following minimum details within three (3) months of the date of the death of the Life Insured:

i. A valid South African death certificate including cause of death issued by the South African Department of Home Affairs on a computer generated form
ii. A certified copy of the ID document of the Life Insured A fully completed Bl1663 Form
iii. A Policy number
iv. A certified copy/ies of ID Document/s of the Beneficiary/ies
v. The South African bank account details of the Beneficiary/ies (in their names)
vi. A signed doctor's report
vii. Any additional information that The Insurer and/or AllLife may stipulate

Please note that The Insurer and/or AllLife may, at their sole discretion, require additional information to process a claim.

A claim will not be paid if:

- The claimant/Beneficiary is unable to produce full claim's documentation and any additional information as may be required by The Insurer,
- AllLife or The Insurer is unable to obtain sufficient medical evidence from the Beneficiaries or treating medical practitioner to fulfill the Insurer's criteria for making a Benefit payment
- The claimant fails to produce a valid death certificate (as issued by SA Home Affairs or other relevant authority, at the discretion of AllLife)

13.2. Disability Benefit Claim

In the event of a claim against the Permanent Total Disability Benefit Sum Assured the Beneficiary is required to fill in a disability claim form and provide AllLife (on behalf of The Insurer) with the following documentation:

i. AllLife Disability Claim Form
ii. Certified Copy of ID document of the Life Insured
iii. Policy Number
iv. Bank account details of the Beneficiary/ies (in their names)
v. Relevant medical assessments and/or treating medical specialist records, paid for by the claimant, sufficient for The Insurer and/or AllLife to be able to determine whether or not the Life Insured is permanently and totally disabled in terms of the Disability Definitions applicable to this Policy.
vi. Any additional information that The Insurer and/or AllLife may stipulate.

Please note that The Insurer and/or AllLife may, at their sole discretion, require additional information to process a claim. A claim will not be paid if:

- The Life Insured/claimant is unable to produce full claims documentation and any additional information as required by The Insurer
- The Life Insured fails to undergo reasonable medical treatment by appropriate specialists, at the Life Insured's own cost, including the taking of appropriate medication.

13.3. Appeals against rejected claims

Should The Insurer reject the claim the claimant may, within a period no less than 90 days dispute the decision and make a representation against this decision, by addressing written communication directly to AllLife, or The Internal Complaints Department of Old Mutual Alternative Risk Transfer Limited (OMART). Old Mutual Alternative Risk Transfer Limited (OMART) will respond in writing within 45 days. The claimant are also at liberty to approach the Long Term Insurance Ombudsman should they have a complaint against Old Mutual Alternative Risk Transfer Limited (OMART), The Insurer, or the FAIS Ombudsman should you have a complaint against the Intermediary, AllLife.

The claimant is required to institute legal action within 180 days or 6 months after the expiration of the 90 day period referred to above. If legal proceedings is not instituted within that time the claimant will no longer be entitled to claim the Benefit under the Policy. If we persist in our rejection or dispute of the claim after representations have been made, the claimant may consult a lawyer who should institute the action for you within that time limit to avoid you losing your right to claim.

14. SURRENDER VALUE

This Policy has no surrender value.

15. BENEFIT WAITING, SUSPENSION PERIODS AND BENEFIT REDUCTION EVENTS

The death Benefit assured amount and death Benefit sum assured will be:

15.1 Subject to a 24 month waiting period

If the Life Insured does not complete the underwriting process within 90 days of the inception date of this Policy, the subjected 24 month waiting period will be applied, calculated from the date of inception. During the 24 month period, cover will be limited to Accidental Death Benefit only. After the 24 month period, the Death Benefit will apply, limited to 50% of the sum insured or R1 million, whichever is less. The Accidental Death Benefit cover will continue to apply. However, if the Life Insured completes the underwriting process at any stage during the 24 month period or afterwards, the cover limitation to the Death Benefit will no longer apply.

15.2 Suspended for a 12 month period

If the Life Insured does not comply with the Adherence and Adherence Health Monitoring Policy as defined in Appendix 1, the subjected 12 month waiting period will be applied, calculated from the date of non-compliance. During the 12 month period, cover will be limited to Accidental Death only. After the 12 month period, the Death Benefit will apply, limited to 50% of the sum insured or R2 million, whichever is less. Accidental Death cover will continue to apply. However, if the Life Insured complies with the Adherence Policy and Adherence Health Monitoring Policy, as defined in Appendix 1, at any stage during the 12 month period or afterwards, the cover limitation to the Death Benefit will no longer apply.

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16. COMMUNICATIONS

AllLife will gladly attempt to resolve any questions or problems you may have regarding this policy.

0861 255 543	**Customer Care**	customercare@alllife.co.za
0866 171 888	**Claims Department**	claims@alllife.co.za
PO Box 787159, Sandton, 2416	**Compliance Department**	compliance@alllife.co.za

Please always include your ID Number and your policy details when communicating with AllLife.

The Insurer undertakes to settle all valid claims as quickly as possible following receipt of all required documentation. Should the Policy Owner or Beneficiary have any query or complaint regarding the settlement of any claims or is in any way unhappy about the service that they have received, they may contact the Compliance Department.

If the inquiry is not satisfactorily resolved, the Policy Owner or Beneficiaries may contact:

Old Mutual Alternative Risk Transfer Limited (OMART)

(021) 509 2191

PO Box 66, Cape Town, 8000

OMARTComplaints@oldmutual.com

If still not satisfactorily resolved, the Policy Owner or Beneficiaries may contact:

Long Term Insurance Ombud

0860 662 837 / (021) 657 5000	(021) 674 0951
Private Bag X45, Cape Town, 7735	info@ombud.co.za

FAIS Ombud

0860 324 766	(012) 348 3447 / (012) 470 9080
P.O. Box 74571, Lynnwood Ridge, 0040	info@faisombud.co.za

APPENDIX
ADHERENCE AND ADHERENCE HEALTH MONITORING POLICY – PART I

This Adherence and Adherence Health Monitoring Policy can change on 30 days' notice at AllLife's sole discretion, based on reasonable medical practice.

A: ADHERENCE POLICY

The following adherence protocol must be met to avoid the suspension of the Death Benefit Assured Amount as set out in clause 15 *(Benefit Waiting and Suspension Periods and Benefit Reduction Events*).

Note that, while the AllLife adherence Policy requires that the Life Insured goes for tests every 12 months, the HIV Clinicians Society recommends testing every 3 months. The Life Insured should discuss more regular testing with their treating doctor and/or managed health care company.

The Life Insured is required to go for regular blood tests as specified below, and to ensure that AllLife is provided with copies of these test results. Make sure to include "AllLife" as a "copy doctor" when you fill in the form at the testing Laboratory for the testing Laboratory to forward a copy of your results to AllLife:

a. Prior to initiating ART, the Life Insured is required to be tested for, and to provide to AllLife, their CD4+ count every 12 months.
b. The Life Insured must enroll on ART within sixty (60) days after a CD4+ count of below 200 cells/mm3 has been recorded (the HIV Clinicians Society recommends starting ART at a CD4+ count of 350 cells/mm3 or below), or the Life Insured has contracted an AIDS defining illness. Details of the original ART regimen must be provided to AllLife within 30 days of initiation of ART (all ART regimens must include 3 or more antiretroviral agents, capable of suppressing HIV virus replication and must be as prescribed by a clinician).
c. After starting ART, the Life Insured is required to be tested for, and to provide to AllLife, their RNA viral load and CD4+ count every 12 months.
d. The Life Insured's blood test results after initiating ART must be as specified in the Adherence Health Monitoring Policy in order to remain adherent.
e. Although AllLife will endeavor to access all blood test results directly from the testing laboratory or the Life Insured's managed health care company (if any), it will be the responsibility of the Life Insured to provide the data to AllLife on a 12 monthly basis. If AllLife does not receive the blood test results, the Life Insured will be defined as non-adherent. Once defined as non-adherent, the Life Insured is required to submit test every 6 months for monitoring, until adherent status is achieved.
f. The Life Insured must provide AllLife with proof that they have started ART by providing a receipt for purchase of anti-retroviral within 90 days of receiving test results indicating a CD4+ count of below 200 cells/mm3. Such proof must:
    i. be computer generated
    ii. include the Life Insured name
    iii. include the name of the selling or providing entity
    iv. include the date of the sale or provision of the anti-retroviral
    v. include the details of the antiretroviral drugs purchased
g. The process described in (f) above must be repeated at each change of ART regimen.

B: ADHERENCE HEALTH MONITORING POLICY

Adherence, as defined, is the taking of all appropriate ART medication (defined as medication which prevents viral replication and is approved by the HIV Clinicians Society) in the appropriate dosage at the appropriate time every day. AllLife utilises the following protocol to check adherence after the Life Insured has started ART: Either of the RNA viral load condition or the CD4+ count condition shall be sufficient to indicate non-adherence. Once defined as non-adherent, the Life Insured is required to submit test results every 6 months for monitoring, until adherent status is achieved.

The Life Insured will be deemed to be non-adherent, unless they are on their third ART regimen, if either:

a. the RNA viral load test results do not show a reduction in RNA viral load of at least 1 log (measured against their RNA viral load prior to starting ART), and a RNA viral load of below 5000 copies/mL, by the second scheduled test post ART initiation, unless the Life Insured has changed their regimen before the second scheduled test (scheduled tests occur once every 6 months, although the Life Insured may undergo more frequent testing if required by their treating doctor). In the case where the Life Insured has changed their ART regimen, the Life Insured must show a reduction in RNA viral load of at least 1 log (measured against their RNA viral load prior to initiating ART), and an RNA viral Load of below 5000 copies/mL, by their third scheduled test post ART initiation. Proof will need to be submitted regarding change of regimen; or
b. from 12 (twelve) months after initiating ART, the RNA viral Load is over 1000 copies/mL for any two consecutive scheduled tests.

OR IF:

c. CD4+ count drops by more than 50 cells/mm3 or 20% of baseline* whichever is smaller over a 12 month (or shorter) period; and
d. Two consecutive blood tests have shown a downward trend in the Life Insured's CD4+ count.

Then the Life Insured will be deemed to be non-adherent unless the Life Insured is on their third ART regimen.

- Each customer has a baseline CD4+ count determined as the higher of (i-iii) as follows:
    i. CD4+ count at initiation of ART (must initiate at CD4+ count less than 200 cells/mm3); or
    ii. Highest post ART initiation test score; or
    iii. If already on ART at inception of cover, CD4+ count at initiation of cover or highest test score post initiation of cover, whichever is higher?

APPENDIX
ADHERENCE AND ADHERENCE HEALTH MONITORING POLICY – PART II

ADHERENCE HEALTH MONITORING POLICY (CONTINUED)

In addition, if no blood test is conducted within thirty days of the stipulated date (every 12 months), then the Life Insured is deemed to be non-adherent until they provide AllLife with their test results (irrespective of having started ART). If these test results show that CD4+ count has dropped by less than 50 cells/mm3 or 20% of baseline* whichever is smaller, then the Life Insured will be deemed to be adherent and their cover will be restored appropriately. The testing interval will remain that of the original and will not be based off of the new test date. Once defined as non-adherent, the Life Insured is required to submit test every 6 months for monitoring, until adherent status is achieved.

In cases where laboratory results are unusual or discrepant in the opinion of AllLife, these will be evaluated on a case-by-case basis by AllLife and, if necessary, repeat tests may be required.

All CD4+ count and RNA viral Load tests must be done at SANAS or ASISA approved laboratories.

AllLife must be informed of any changes in ART regimen and such change may only be with the written approval or instruction of the Life Insured's healthcare provider.

The Life Insured will be defined as adherent should their RNA viral Load be below 500 copies/mL and their CD4+ count be above 500 cells/mm3, irrespective of variations in their CD4+ count as described above.

Please note: Rulings in regard to the above protocol will be subject to appeal. All appeals must be lodged in writing with AllLife within sixty (60) days of any non-adherence ruling being communicated to the Life Insured.

- Each customer has a baseline CD4+ count determined as the higher of (i-iii) as follows:
  iv. CD4+ count at initiation of ART (must initiate at CD4+ count less than 200 cells/mm3); or
  v. Highest post ART initiation test score; or
  vi. If already on ART at inception of cover, CD4+ count at initiation of cover or highest test score post initiation of cover, whichever is higher?

APPENDIX
ADVANTAGE LIFE DIABETIC CONTROL AND CONTROL HEALTH MONITORING POLICY

This Diabetic Control and Control Health Monitoring Policy applies in addition to the Adherence and Adherence Health Monitoring Policy, only where the Policy is an Advantage Life for Diabetics Policy (as specified in the Policy Schedule). This Policy can change on 30 days' notice at AllLife's sole discretion based on reasonable medical practice.

A: ADVANTAGE LIFE DIABETIC CONTROL POLICY

The following diabetic control protocol must be met to maintain Benefit levels under the Advantage Life product range.

The Life Insured is required to go for regular blood tests as specified below, and to ensure that AllLife is provided with copies of these test results. Make sure to include "AllLife" as a "copy doctor" when you fill in the form at the testing Laboratory for the testing Laboratory to forward a copy of your results to AllLife:

a. The Life Insured is required to be tested for, and to provide to AllLife, their glycosylated hemoglobin (HbA1c) test result every 12 months, starting from the last blood test prior to cover being initiated.
b. The Life Insured must follow a recognised and accepted diabetes mellitus treatment regime, prescribed by a qualified medical doctor, and designed to achieve control of blood glucose levels.
c. The Life Insured's blood test results must be as specified in the Advantage Life Diabetic Control Health Monitoring Policy in order to remain controlled.
d. Although AllLife will endeavor to access all the above test results directly from the testing laboratory or the Life Insured's managed health care company (if any), it will be the responsibility of the Life Insured to provide the data to AllLife on a 12 monthly basis (allowing for a 30 day grace period for receipt of data, accompanied by appropriate warnings).

B: ADVANTAGE LIFE DIABETIC CONTROL HEALTH MONITORING POLICY

Diabetic control, as defined, is the conformance to a prescribed diabetes mellitus treatment regime designed to maintain blood glucose and HbA1c at safe and healthy levels. AllLife utilises the following protocol to check diabetic control of the Life Insured:

The Life Insured will be deemed to be uncontrolled if their glycosylated hemoglobin (HbA1c) test result is greater than or equal to 8.0% for any two consecutive scheduled tests (scheduled tests occur every 12 months, although the Life Insured may undergo more frequent testing if required by their treating doctor). Once defined as uncontrolled, the Life Insured is required to submit test results every 6 months for monitoring, until controlled status is achieved.

In addition, if no blood test is conducted within thirty days of the scheduled test date (every 12 months), then the Life Insured is deemed to be uncontrolled until they provide AllLife with their test results. Where this deemed uncontrolled period exceeds 6 months, the Life Insured is deemed to be uncontrolled permanently. In cases where laboratory results are unusual or discrepant in the opinion of AllLife, these will be evaluated on a case by case basis by AllLife and, if necessary, repeat tests may be required.

All HbA1c tests must be done at SANAS or ASISA approved laboratories.

Please note: Rulings in regard to the above protocol will be subject to appeal. All appeals must be lodged in writing with AllLife within 60 days of any diabetic control ruling being communicated to the Life Insured.

Diabetic Control & Control Monitoring

IMPORTANT DISCLOSURE AND OTHER LEGAL REQUIREMENTS: PLEASE READ CAREFULLY
As a long-term insurance Policyholder, or prospective Policyholder, you have the right to the following information:

STATUTORY DISCLOSURE NOTICE IN TERMS OF THE POLICY PROTECTION RULES
(LONG-TERM INSURANCE ACT) & THE FINANCIAL ADVISORY AND INTERMEDIARY SERVICES ACT ("FAIS")

ALLLIFE
COVER FOR THE LIVING

THE INTERMEDIARY (INSURANCE BROKER OR REPRESENTATIVE) DEALING WITH YOU MUST AT THE EARLIEST REASONABLE OPPORTUNITY DISCLOSE

A: Name, physical and postal address, and telephone number
B: Legal capacity: independent or representative for brokerage
C: Concise details of relevant experience
D: Insurance products that may be sold
E: Insurers whose products may be marketed
F: Indemnity cover held – Yes/No
G: Shareholdings in Insurers if 10% or more
H: Name of Insurers from which the intermediary received 30% or more of total commission and Remuneration during past calendar year

The intermediary must be able to produce proof of contractual relationship with and accreditation by The Insurers concerned

YOUR RIGHT TO KNOW THE IMPACT OF THE DECISION YOU ELECT TO MAKE

The intermediary or Insurer dealing with you must inform you of:

A: (1) The Premium you may be paying and
(2) The nature and extent of Benefits you may receive
B: If the Benefits are linked to the performance of certain assets:
(1) How much of the Premium will go towards the Benefit
(2) To what portfolio your Benefits will be linked
C: The possible impact of this purchase on your finances
D: The possible impact of this purchase on your other Policies (affordability)
E: The possible impact of this purchase on your Investment portfolio (affordability)
F: The flexibility of changes you may make to the proposed contract
G: The contract terms of the product you intend to purchase

It is very important that you are sure that the product or transaction meets your needs and that you feel you have all the information You need to make a decision

YOUR RIGHT WHEN BEING ADVISED TO REPLACE AN EXISTING POLICY

You may not be advised to cancel a Policy to enable you to purchase a new Policy or amend an existing Policy unless:

A: The intermediary identified the Policy as a replacement Policy
B: The implications of cancellation of the Policy are disclosed to you such as:
(1) The influence on your Benefits under the old Policy
(2) The additional costs incurred with the replacement
C: The Insurer that issued the original Policy will contact you. You are advised to discuss the matter with its representative

ALLLIFE DOES NOT AND HAS NOT ADVISED YOU TO REPLACE ANY EXISTING POLICY

YOUR RIGHT TO BE INFORMED BY THE INSURER

The Insurer will forward you documentation confirming Policy details as discussed in paragraph 2 of this Notice, which will also include:

A: The name of The Insurer
B: The product being purchased
C: The cost in Rand of the transaction and specifically:
- The loadings, if any
- The initial expense, and
- The amount of commission and other remuneration being paid to the intermediary
D: In the case of policies with an investment element, the ongoing expense or any other fees or charges payable
E: The summary in terms of section 48 of the long-term insurance Act, 1998
F: The contact number and address of the complaints and Compliance officers of The Insurer

YOUR RIGHT TO CANCEL THE TRANSACTION

In most cases, you have a right to cancel a Policy in writing within thirty-one (31) days after receipt of the summary contemplated in Section 48 of the Long-term Insurance Act from The Insurer.

The same applies to certain changes you may make to a Policy

The Insurer is obliged to confirm to you whether you have this right and to explain how to exercise it

Please bear in mind that you may not exercise it if you have already claimed under the Policy or in the event, which the Policy insures you against, has already happened. If the Policy has an investment component, you will carry any investment loss

IMPORTANT WARNING

A: It is important that you are sure that the product or transaction meets your needs and that you feel you have all the information you need before making a decision
B: It is recommended that you discuss with the intermediary or Insurer the possible impact of the proposed transaction on your finances, your other policies or your broader investment portfolio. You should also ask for information about the flexibility of any proposed Policy
C: Where paper forms are required, only sign these once they are fully completed. Feel free to make notes regarding verbal information, and to ask for written confirmation or copies of documents
D: Remember that you may contact either the Long-term Insurance Ombudsman or the registrar of Long-term Insurance, whose details are set out below, if you have any concerns regarding a product sold to you or advice given to you

PARTICULARS OF LONG-TERM INSURANCE AND FAIS OMBUDSMEN & FINANCIAL SECTOR AUTHORITY

Long-term Insurance Ombud
Private Bag X45, Claremont
Cape Town, 7735
Tel: 0860 662 837
(021) 657 5000
Fax: (021) 674 0951
Email: info@ombud.co.za
Web: www.ombud.co.za

FAIS Ombud
P O Box 74571, Lynnwood Ridge 0040
Tel: 0860 324 766
(012) 470 9030
Fax: (012) 348 3447
Email: info@faisombud.co.za

Financial Sector Conduct Authority
P.O. Box 35655,
Menlo Park, 0102
Tel: (012) 428 8000
Fax: (012) 347 0221

FSCA registration details
AllLife (Pty) Ltd: ..... FSP 4946

PARTICULARS OF THE FINANCIAL SERVICES PROVIDER AND BINDER HOLDER

Name:	AllLife (Pty) Ltd.
Trading name:	AllLife
Registration number:	2004 / 008283 / 07
FSCA Registration number:	4946
Postal address:	P.O. Box 787159, Sandton, 2146
Physical address:	14th Floor, Libridge Building, 25 Ameshoff Street, 2001
Telephone number:	0861 255 543
Facsimile number:	0866 126 595
Internet address:	www.alllife.co.za
Email address:	customercare@alllife.co.za
Compliance Officer:	Germa Beukes
Telephone number:	0861 255 543/0128091180

INFORMATION ON THE PRODUCT SUPPLIER

Name:	Old Mutual Alternative Risk Transfer Limited (OMART)
Trading name:	OMART
Registration number:	1977 / 008994 / 06
Postal address:	P.O. Box 66, Cape Town, 8000
Compliance Officer:	The internal compliance officer
Telephone number:	021 504 2191
Email address:	OMARTComplaints@oldmutual.com
Telephone number of Complaints Department	
Telephone number:	021 504 2191
Email address:	OMARTComplaints@oldmutual.com

In terms of the Financial Advisory and Intermediary Services Act, the following information must be disclosed to you as our client.

AllLife (Pty) Ltd is a company registered in terms of the Companies Act and is an authorised Financial Services Provider. AllLife has appointed representatives to act on its behalf in rendering financial services to its clients. Should an AllLife representative physically call on you, please ask the representative to show you his / her letter of authorisation. AllLife accepts responsibility for the activities of duly authorised representatives that are performed under the supervision of an AllLife key individual, within the scope of and in the course of their employment as a representative of AllLife.

AllLife has been authorised to provide financial advisory and intermediary services in respect of Long-term Insurance: Categories A and B. The license conditions or restrictions as well as any exemptions which are applicable to AllLife are listed below. AllLife holds professional indemnity insurance to the value of R 3 million. AllLife is not required to and nor does it hold guarantees or fidelity insurance cover. AllLife designs, distributes and administers its unique set of life insurance through a cell arrangement with OMART, which provides the regulatory framework necessary for AllLife to provide insurance. AllLife has been mandated to act as an intermediary and binder holder of OMART. (AllLife earns more than 30% of its total remuneration from OMART). In terms of conflict of interest provisions of the FAIS Act 37 of 2002, no actual or potential conflicts of interest were identified. This is reviewed at least annually and reported on to the Financial Sector Conduct Authority. A conflict of interest management Policy is available to clients upon request. AllLife's complaint's process and Policy are also available to clients from AllLife's offices upon request.

Statutory Disclosure Notice

APPENDIX
POLICY PROTECTION BENEFIT
(SOUTH AFRICAN PATENT APPLICATION NO. 2014/02800)

Underwritten by Old Mutual Alternative Risk Transfer Limited (OMART), a registered Long-Term Insurer.

OLDMUTUAL

The table below shows the Benefit value claimable for a Policy where one or more Monthly Premiums have not been paid during the six (6) month period preceding a claim. The table is based on an initial cover amount of R100 000 and is linearly scalable for other initial cover amounts.

NUMBER OF MONTHLY PREMIUMS NOT PAID IN LAST SIX MONTHS	COVER AMOUNT
0	100 000
1	83 333
2	66 666
3	50 000
4	33 333
5	16 666
6	0

Where a claim occurs during the first six (6) months of the Policy term, and where one or more Monthly Premiums have not been paid, the Benefit value claimable is reduced in proportion to the number of unpaid Monthly Premiums.

Where the Monthly Premium is not paid for a period of five (5) months, and after the expiry of the thirty-day grace period, the Policy will lapse.

Policy Protector Benefit

APPENDIX
APPLICABLE ONLY IF YOU HAVE AN ADVANTAGE LIFE LOAN PROTECTOR POLICY

The table below shows the cover amount for both a ten year and twenty year loan protector product from month of Policy inception (Month 1) until the product cease date (Month 120 or Month 240). The table is based on an initial cover amount of R100, 000 and is linearly scalable for other initial cover amounts.

Month	10-Year Term	20-Year Term	Month	10-Year Term	20-Year Term	Month	10-Year Term	20-Year Term	Month	20-Year Term	Month	20-Year Term
1	100 000	100 000	51	74 053	94 857	101	27 603	85651	151	69170	201	39 665
2	99615	99 924	52	73 365	94721	102	26370	85407	152	68 733	202	38 882
3	99 226	99 847	53	72 668	94 583	103	25 123	85 160	153	68 290	203	38 090
4	98 832	99 769	54	71 963	94 443	104	23861	84910	154	67 842	204	37 288
5	98 434	99 690	55	71 250	94302	105	22 584	84 657	155	67 389	205	36 477
6	98031	99610	56	70 528	94 159	106	21 292	84401	156	66931	206	35 657
7	97 623	99 529	57	69 799	94014	107	19 986	84 142	157	66 467	207	34 827
8	97211	99 447	58	69 060	93 868	108	18 664	83 880	158	65 998	208	33 987
9	96 794	99 365	59	68313	93 720	109	17 326	83615	159	65 524	209	33 137
10	96371	99281	60	67 557	93570	110	15 973	83 346	160	65 044	210	32 278
11	95 944	99 196	61	66 792	93418	111	14 604	83075	161	64 558	211	31 408
12	95512	99111	62	66019	93 265	112	13219	82801	162	64 067	212	30 529
13	95075	99024	63	65 236	93110	113	11818	82 523	163	63 569	213	29 638
14	94 632	98 936	64	64 444	92 953	114	10 400	82 242	164	63 066	214	28 738
15	94 185	98 847	65	63 643	92 794	115	8966	81 958	165	62 557	215	27 827
16	93 732	98 758	66	62 832	92 634	116	7515	81670	166	62 043	216	26 905
17	93 274	98 667	67	62012	92471	117	6046	81 379	167	61 522	217	25 973
18	92811	98 575	68	61 183	92307	118	4561	81 085	168	60 995	218	25029
19	92 342	98 482	69	60 343	92 140	119	3058	80 787	169	60461	219	24075
20	91 867	98 388	70	59 494	91 972	120	1538	80 485	170	59 922	220	23109
21	91 387	98 293	71	58 635	91802	121		80181	171	59 376	221	22 132
22	90902	98 197	72	57 765	91 629	122		79 872	172	58 824	222	21 143
23	90411	98 099	73	56 886	91 455	123		79 560	173	58 266	223	20 143
24	89914	98001	74	55 996	91 279	124		79 244	174	57700	224	19 132
25	89411	97901	75	55 096	91100	125		78 925	175	57 129	225	18108
26	88902	97 800	76	54 185	90 920	126		78602	176	56 550	226	17072
27	88 387	97 698	77	53 264	90 737	127		78 275	177	55 965	227	16025
28	87 867	97 595	78	52 332	90 552	128		77 944	178	55 373	228	14 965
29	87 340	97491	79	51 389	90 366	129		77610	179	54 774	229	13 892
30	86807	97 385	80	50 435	90 176	130		77271	180	54 168	230	12807
31	86 268	97 278	81	49 469	89 985	131		76 929	181	53 555	231	11710
32	85 722	97170	82	48 493	89 792	132		76 582	182	52 934	232	10 599
33	85170	97061	83	47 505	89 596	133		76 232	183	52307	233	9476
34	84612	96 950	84	46 505	89 398	134		75 877	184	51 672	234	8339
35	84 047	96 838	85	45 494	89 197	135		75518	185	51029	235	7189
36	83 475	96 725	86	44471	88 994	136		75 155	186	50 379	236	6025
37	82 897	96610	87	43 435	88 789	137		74 788	187	49 722	237	4848
38	82312	96 494	88	42 388	88 582	138		74416	188	49 057	238	3657
39	81 720	96 377	89	41 328	88 372	139		74 040	189	48 383	239	2452
40	81 122	96 258	90	40 256	88 159	140		73 660	190	47703	240	1233
41	80516	96 138	91	39 172	87 944	141		73 275	191	47014		
42	79 903	96017	92	38075	87 727	142		72 886	192	46317		
43	79 283	95 894	93	36 965	87507	143		72 492	193	45612		
44	78 655	95770	94	35841	87 284	144		72 093	194	44 898		
45	78021	95 644	95	34705	87 059	145		71 690	195	44 176		
46	77 379	95517	96	33 556	86831	146		71 282	196	43 446		
47	76 729	95 388	97	32 393	86601	147		70870	197	42707		
48	76072	95 258	98	31216	86 367	148		70 452	198	41 960		
49	75407	95 126	99	30025	86131	149		70 030	199	41 204		
50	74 734	94 992	100	28821	85 893	150		69602	200	40 439		

Loan Protector Benefit Schedule

APPENDIX

DEFINITION OF ADW DISABILITY (PART I)

The Life Insured is considered to be permanently and totally disabled if, in the opinion of AllLife, the Life Insured is disabled in terms of the defined *Activities of Daily Work (ADW)* assessment scale (scoring 6 or more points on this scale), and if this disability is regarded as permanent and continuous despite reasonable medical treatment by appropriate specialists (at the Life Insured's own cost), and if the claimant has reached maximal medical improvement.

The Life Insured is considered to be temporarily and totally disabled if they are disabled in terms of the above definition and if a permanent disability claim has been submitted, but not been admitted or declined.

No Benefit will be paid in respect of a Life Insured who fails to undergo reasonable medical treatment by appropriate specialists and/or fails to provide AllLife with proof of such treatment, at the Life Insured's own cost, including the taking of appropriate medication. Due allowance will be given for the risk and prognosis of such treatment.

ACTIVITIES OF DAILY WORK (ADW)

These definitions are based on the basic activities needed to perform work. A claim will be admitted if the claimant scores 6 or more on the following scale as a result of his/her medical condition arising from injury or illness that is regarded as permanent and continuous, and the claimant has reached maximal medical improvement. This assessment will be performed by AllLife or a suitably qualified agent of their choosing.

ADW CATEGORIES		POINTS
CATEGORY 1		
1	The claimant scores 25 or less out of 30 on the Mini Mental State Examination.	6
CATEGORY 2		
2	The claimant requires full time nursing care or a caregiver as a result of his/her medical condition.	6
CATEGORY 3		
This section to be completed by a Psychiatrist according to the DSM-IV TR criteria (or subsequent updated version). The GAF score needs to be assessed over a period of twenty-four (24) months where the individual has shown no improvement over the period despite optimal medical treatment.		
3.1	A score of 51 – 60 on the Global Assessment of Function (GAF) scale. The claimant has moderate symptoms or moderate difficulty in social or occupational functioning.	2
3.2	A score of 41 - 50 on the Global Assessment of Function (GAF) scale. The claimant has serious symptoms or serious difficulty in social or occupational functioning.	4
3.3	A score of 31 - 40 on the Global Assessment of Function (GAF) scale. There is some impairment in reality testing or communication and there is a major impairment in several areas of functioning including work, family relationships, judgement, thinking or mood.	6
CATEGORY 4		
4.1	The claimant is unable to function independently in the workplace even with the use of assistive devices as a result of total loss of vision in both eyes.	6
4.2	The claimant is unable to hear an instrument given to him in a quiet room even with the use of a hearing aid.	3
4.3	The claimant is regarded as having total loss of functional hearing in both ears even with the use of a hearing aid.	4
4.4	The claimant is unable to communicate verbally in the workplace in order to make him understand even with the use of an assistive device or another person.	4
CATEGORY 5		
5.1	The claimant is unable to walk without the use of an assistive device or use of a wheelchair to move about in the workplace.	2
5.2	The claimant is unable to move about in the workplace independently without the assistance of another person and appropriate assistive devices despite the workplace meeting the legislative requirements for accessibility.	4
CATEGORY 6		
6.1	The claimant is unable to perform activities requiring minimal exertion without experiencing severe shortness of breath (for example, dressing).	3
6.2	The claimant is unable to perform activities requiring moderate exertion without experiencing severe shortness of breath (for example, climbing one flight of stairs).	1
6.3	The claimant experiences severe shortness of breath at rest.	6
CATEGORY 7		
7.1	The claimant is able to perform work tasks requiring gross motor movement but requires the assistance of another person and appropriate adaptations and assistive devices to perform fine motor movements.	2
7.2	The claimant is unable to perform work tasks requiring gross and fine motor movements despite the use of assistive devices and assistance of another person after appropriate adaptations have been made.	4

APPENDIX

DEFINITION ON OF ADW DISABILITY (PART II)

HIV SPECIFIC DISABILITY

This definition is specifically for individuals claiming as a result of HIV/AIDS.

The claim will only be admitted if the claimant has been diagnosed with one of the WHO Stage 4 defined conditions listed below, and is no longer responding despite optimal treatment. All existing treatment options at the time of claim must have been exhausted.

- HIV wasting syndrome
- Pneumocystis pneumonia
- Recurrent bacterial pneumonia
- Chronic herpes simplex infection (orofacial, genital or anorectal of more than one month's duration or visceral at any site)
- Esophageal candidiasis (or candidiasis of trachea, bronchi or lungs)
- Extra pulmonary tuberculosis
- Kaposi sarcoma
- Cytomegalovirus infection (retinitis or infection of other organs)
- Central nervous system toxoplasmosis
- HIV encephalopathy
- Extra pulmonary Cryptococcus's including meningitis
- Disseminated non-tuberculous mycobacteria infection
- Progressive multifocal leukoencephalopathy
- Chronic cryptosporidiosis
- Chronic isosporiasis
- Disseminated mycosis (coccidiomycosis or histoplasmosis)
- Recurrent septicemia (including non-typhoid Salmonella)
- Lymphoma (cerebral or B cell non-Hodgkin)
- Invasive cervical carcinoma
- Atypical disseminated leishmaniosis
- Symptomatic HIV-associated nephropathy or HIV-associated cardiomyopathy

APPENDIX

DEFINITION OF OCCUPATIONAL DISABILITY

The Life Insured is considered to be disabled if, in the opinion of AllLife, the Life Insured is unable to perform their *Own or another Reasonable Occupation*, and if their disability is regarded as permanent and continuous despite reasonable medical treatment by appropriate specialists (at the Life Insured's own cost), and if the claimant has reached maximal medical improvement.

The Life Insured is considered to be temporarily disabled if they are disabled in terms of the above definition and if a permanent disability claim has been submitted, but not been admitted or declined.

No Benefit will be paid in respect of a Life Insured who fails to undergo reasonable medical treatment by appropriate specialists, and/or fails to provide AllLife with proof of such treatment, at the Life Insured's own cost, including the taking of appropriate medication. Due allowance will be given for the risk and prognosis of such treatment.

OWN OR REASONABLE OCCUPATION

The insured will be regarded as permanently and totally disabled, if, in the opinion of AllLife, injury or illness has rendered the Life Insured totally and irreversibly unable to perform his/her own occupation or any occupation for which he/she is or could reasonably be expected to become qualified for or suited to, taking into account his/her degree of disability and his/her knowledge, training, education, ability, experience and age, and provided that the insured is not engaged in any employment for remuneration.

The disease/injury that has resulted in the disability must be properly treated, and the claimant must be left with a resultant irreversible functional impairment.

Where the occupation of the insured has been misrepresented at application stage, the claim will be assessed in terms of this stated occupation.

HIV SPECIFIC DISABILITY

This definition is specifically for individuals claiming as a result of HIV/AIDS.

The claim will only be admitted if the claimant has been diagnosed with one of the WHO Stage 4 defined conditions listed below, and is no longer responding despite optimal treatment. All existing treatment options at the time of claim must have been exhausted.

- HIV wasting syndrome
- Pneumocystis pneumonia
- Recurrent bacterial pneumonia
- Chronic herpes simplex infection (orofacial, genital or anorectal of more than one month's duration or visceral at any site)
- Esophageal candidiasis (or candidiasis of trachea, bronchi or lungs)
- Extra pulmonary tuberculosis
- Kaposi sarcoma
- Cytomegalovirus infection (retinitis or infection of other organs)
- Central nervous system toxoplasmosis
- HIV encephalopathy
- Extra pulmonary Cryptococcus's including meningitis
- Disseminated non-tuberculous mycobacteria infection
- Progressive multifocal leukoencephalopathy
- Chronic cryptosporidiosis
- Chronic isosporiasis
- Disseminated mycosis (coccidiomycosis or histoplasmosis)
- Recurrent septicemia (including non-typhoid Salmonella)
- Lymphoma (cerebral or B cell non-Hodgkin)
- Invasive cervical carcinoma
- Atypical disseminated leishmaniosis
- Symptomatic HIV-associated nephropathy or HIV-associated cardiomyopathy

PRE-EXISTING CONDITIONS

Pre-existing conditions, as defined, include, but are not limited to, the following list of conditions:

• Unexplained1* severe weight loss (over 10% of presumed or measured body weight)	• Kaposi sarcoma
• Unexplained chronic diarrhoea for longer than one month	• Cytomegalovirus infection (retinitis or infection of other organs)
• Unexplained persistent fever (intermittent or constant for longer than one month)	• Central nervous system toxoplasmosis
• Persistent oral candidiasis	• HIV encephalopathy
• Oral hairy leukoplakia	• Extra pulmonary Cryptococcus's including meningitis
• Pulmonary tuberculosis (current)	• Disseminated non-tuberculous mycobacteria infection
• Severe bacterial infections (e.g. pneumonia, empyema, pyomyositis, bone or joint infection, meningitis, bacteremia, severe pelvic inflammatory disease)	• Progressive multifocal leukoencephalopathy
• Acute necrotizing ulcerative stomatitis, gingivitis or periodontitis	• Chronic cryptosporidiosis
• Unexplained anemia, neutropenia and / or chronic thrombocytopenia	• Chronic isosporiasis
• HIV wasting syndrome	• Disseminated mycosis (coccidiomycosis or histoplasmosis)
• Pneumocystis pneumonia	• Recurrent septicaemia (including non-typhoid Salmonella)
• Recurrent bacterial pneumonia	• Lymphoma (cerebral or B cell non-Hodgkin)
• Chronic herpes simplex infection (orolabial, genital or anorectal of more than one month's duration or visceral at any site)	• Invasive cervical carcinoma
• Oesophageal candidiasis (or candidiasis of trachea, bronchi or lungs)	• Atypical disseminated leishmaniasis
• Extrapulmonary tuberculosis	• Symptomatic HIV-associated nephropathy or HIV-associated cardiomyopathy

1* Unexplained refers to where the condition is not explained by other conditions

FREQUENTLY ASKED QUESTIONS

What factors impact on the cost of my life cover?

The most significant factor in determining the cost of cover is the health of the Life Insured and their commitment to starting (or continuing) an approved ART regimen. Failure to adhere to the adherence protocol outlined both in this document and during the application process will have a very significant impact on the level of cover you enjoy.

In addition, a number of other factors such as the duration (term) of the Policy, the Life Insured's age, gender, overall health and occupation impact on the cost of your cover.

What happens if I miss a payment?

Making a payment is the responsibility of the Policy Owner, however AllLife's normal practice is to inform you (via email, fax, letter or SMS) of the non-payment of a Monthly Premium.

This Policy allows you to miss up to five consecutive Monthly Premiums. Where any Monthly Premium(s) has not been paid during the six month period immediately preceding a Claim (or whatever period has elapsed since the Commencement Date, where this is less than six months), the Benefit claimable will be in proportion to the number of Monthly Premium(s) received during this period.

We will attempt to collect the Monthly Premium payable under this Policy by debit order on the agreed debit day each month. Where this debit order is returned unpaid, your Benefit will be temporarily reduced as set out above. If you want to maintain full Benefits under this Policy you may choose to make up this missed payment.

Can I re-instate a Policy that has been cancelled?

If your Policy is cancelled as a result of non-payment as outlined above, you may apply to AllLife to have your Policy re-instated. Such applications will only be considered provided you are able to prove that your (ART) adherence status has not changed during this lapse period. If you are still adherent, then upon receipt of the full amount outstanding, your Policy may be re-instated at the sole discretion of AllLife.

Can I increase my cover?

Yes. You are welcome to apply for additional cover. A new Policy will be issued, subject to the application being approved by AllLife and The Insurer.

How do I pay my Premiums?

AllLife will only collect your Monthly Premiums via a debit order lodged on your bank account. No cash payments will be accepted. Should you miss a payment, you may directly deposit or EFT the amount into AllLife's bank account with appropriate reference information. Please call our call centre on 0861 255 543 to ensure that the appropriate procedure is followed.

Who pays for my medical examination and blood test?

The Life Insured or the Policy Owner is responsible for the costs of all regular blood tests. AllLife's requirements are in accordance with accepted best practice regarding HIV monitoring, and as such should form part of an HIV positive individual's normal HIV monitoring protocol. AllLife is not responsible for any of the medical costs associated with adherence.

How are claims paid?

The Beneficiary/ies and/or Cessionary/ies, or any other nominated person, such as the executor of the estate, needs to notify AllLife or The Insurer of the claim and submit full documentation. On admission of the claim, The Insurer will make payment to the nominated Beneficiary/ies and/or Cessionary/ies.

Underwritten by Old Mutual Alternative Risk Transfer Limited (OMART), a registered Long-Term Insurer.