

## 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.
Cancer	Cancer is a disease manifested by the presence of a malignant neoplasm or tumour characterised by the uncontrolled growth and metastasis of malignant cells and the invasion and destruction of normal tissue diagnosed through appropriate histology.
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.
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 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.

## GENERAL CONDITIONS

### 1. BENEFITS

#### 1.1. Policy Protection (South African patent application no. 2014/02800)

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

If the Life Insured selected the Prestige Life Cover product then, on the death of the Life Insured, 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.

#### 1.3. Disability Benefits:

##### 1.3.1. Occupational Disability

If the Life Insured selected the Prestige Occupational Disability Cover product then, should the Life Insured become **permanently and totally disabled** in terms of the 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 six (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.

##### 1.3.2. ADW Disability

If the Life Insured has selected the Prestige ADW Disability cover product then, should the Life Insured become **permanently and totally disabled** in terms of the 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 six (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 the 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 Total Monthly Premium payable for a maximum period of twelve (12) months, or until admission of a permanent total disability claim, or until the death of the Life Insured, whichever is earlier, subject to a minimum of two (2) months after the date of disability. Multiple temporary total disability claims may be admitted up to a maximum of twelve (12) months waived Total Monthly Premium over the life of the Policy.

### 2. CONTRIBUTIONS

Total Premium consists of a Basic Premium as shown in the 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 monthly 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.**

### 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 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 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 Owner.

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

#### 4.1. Total Premium

The Total Premium is subject to an annual increase, on the Policy Anniversary, as indicated on the Policy Schedule. In addition the Total 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.

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 it 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 Policy Owner 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 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 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) full Monthly 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 Policy Owner is unhappy with the Policy he/she has purchased, the Policy Owner may take advantage of a thirty-one (31) day "cooling off" period. This "cooling off" period enables the Policy Owner 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 on the Policy. Any Premiums paid will be refunded subject to the deduction of the cost of the risk cover actually enjoyed.

## 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. Suicide clause:
  - a. A claim will not be admitted in the event of the Life Insured loss of life is the result of a suicide within two years from the policies inception.

A claim with 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.

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.

AllLife has been allowed to move this Policy to any other underwriter at the discretion of AllLife.

## 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.

## 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 BI1663 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. Certified Copy of ID document of the Life Insured
- ii. Policy Number
- iii. Bank account details of the Beneficiary/ies (in their names)
- iv. 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.
- v. 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 Life Insured must successfully complete and pass the underwriting process to maintain the full Benefits of this Policy. Note that the Premium payable for the Benefits provided under this Policy, may be reduced or increased if the risk profile of the Life Insured is shown to be materially different from the representation made by the Life Insured in the application process.

### 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 apply, 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 R 500,000, 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.

## 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

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

**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:

THE INTERMEDIARY (INSURANCE BROKER OR REPRESENTATIVE) DEALING WITH YOU MUST AT THE EARLIEST REASONABLE OPPORTUNITY DISCLOSE	YOUR RIGHT TO KNOW THE IMPACT OF THE DECISION YOU ELECT TO MAKE	YOUR RIGHT WHEN BEING ADVISED TO REPLACE AN EXISTING POLICY																																																																
<p>A: Name, physical and postal address, and telephone number</p> <p>B: Legal capacity: independent or representative for brokerage</p> <p>C: Concise details of relevant experience</p> <p>D: Insurance products that may be sold</p> <p>E: Insurers whose products may be marketed</p> <p>F: Indemnity cover held – Yes/No</p> <p>G: Shareholdings in Insurers if 10% or more</p> <p>H: Name of Insurers from which the intermediary received 30% or more of total commission and Remuneration during past calendar year</p> <p>The intermediary must be able to produce proof of contractual relationship with and accreditation by The Insurers concerned</p>	<p>The intermediary or Insurer dealing with you must inform you of:</p> <p>A: (1) The Premium you may be paying and (2) The nature and extent of Benefits you may receive</p> <p>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</p> <p>C: The possible impact of this purchase on your finances</p> <p>D: The possible impact of this purchase on your other Policies (affordability)</p> <p>E: The possible impact of this purchase on your Investment portfolio (affordability)</p> <p>F: The flexibility of changes you may make to the proposed contract</p> <p>G: The contract terms of the product you intend to purchase</p> <p>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</p>	<p>You may not be advised to cancel a Policy to enable you to purchase a new Policy or amend an existing Policy unless:</p> <p>A: The intermediary identified the Policy as a replacement Policy</p> <p>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</p> <p>C: The Insurer that issued the original Policy will contact you. You are advised to discuss the matter with its representative</p> <div style="border: 1px solid black; padding: 5px; text-align: center; margin-top: 10px;"> <p><b>ALLLIFE DOES NOT AND HAS NOT ADVISED YOU TO REPLACE ANY EXISTING POLICY</b></p> </div>																																																																
YOUR RIGHT TO BE INFORMED BY THE INSURER	YOUR RIGHT TO CANCEL THE TRANSACTION	IMPORTANT WARNING																																																																
<p>The Insurer will forward you documentation confirming Policy details as discussed in paragraph 2 of this Notice, which will also include:</p> <p>A: The name of The Insurer</p> <p>B: The product being purchased</p> <p>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</p> <p>D: In the case of policies with an investment element, the ongoing expense or any other fees or charges payable</p> <p>E: The summary in terms of section 48 of the long-term insurance Act, 1998</p> <p>F: The contact number and address of the complaints and Compliance officers of The Insurer</p>	<p>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.</p> <p>The same applies to certain changes you may make to a Policy</p> <p>The Insurer is obliged to confirm to you whether you have this right and to explain how to exercise it</p> <p>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</p>	<p>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</p> <p>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</p> <p>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</p> <p>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</p>																																																																
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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.



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

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 R1 000 000 and is linearly scalable for other initial cover amounts.

NUMBER OF MONTHLY PREMIUMS NOT PAID IN LAST SIX MONTHS	COVER AMOUNT
0	1 000 000
1	833 333
2	666 666
3	500 000
4	333 333
5	166 666
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.



## 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.

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

### OWN OR REASONABLE OCCUPATION

The insured will be regarded as permanently and totally disabled if, in the opinion of AllLife, the Life Insured is unable to perform the important duties of any reasonable gainful occupation due directly to injury or sickness.

A reasonable occupation is an occupation which the insured:

- is reasonably qualified or could reasonably be expected to become qualified, based on his/her education, training, or experience; and
- could reasonably expect to earn an annual income equal to or greater than 75% of the annual income of the insured at the time of the claim event

## APPENDIX

### DEFINITION OF ADW DISABILITY

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
<b>CATEGORY 1</b>		
1	The claimant scores 25 or less out of 30 on the Mini Mental State Examination.	6
<b>CATEGORY 2</b>		
2	The claimant requires full time nursing care or a caregiver as a result of his/her medical condition.	6
<b>CATEGORY 3</b>		
<i>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.</i>		
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
<b>CATEGORY 4</b>		
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
<b>CATEGORY 5</b>		
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
<b>CATEGORY 6</b>		
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
<b>CATEGORY 7</b>		
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

## FREQUENTLY ASKED QUESTIONS

### WHAT FACTORS IMPACT ON THE COST OF MY LIFE COVER?

Life Insured's age, gender, smoking status, 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 as per the terms and conditions of this Policy.

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 as long as any such payments are made prior to any claim event.

### 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 collect your Monthly Premium via a debit order lodged on your bank account. No cash payments will be accepted. Should you miss a payment, you can directly deposit or EFT the amount into AllLife's bank account with your Policy number as reference, Please call our call centre on 0861 255 543 should you require any assistance.

### WHO PAYS FOR MY MEDICAL EXAMINATION AND BLOOD TEST?

AllLife will be responsible for the costs of any medical test and/or examinations required for the initial underwriting for the Policy however, the Life Insured or the Policy Owner is responsible for the costs of all regular blood tests.

### 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.