Advantage Life

Life Cover for people living with HIV

1. ABOUT THIS POLICYS

1.1 Nature of the Contract

This policy is a life insurance contract entered into between the policy owner and Old Mutual Alternative Risk Transfer Limited, the licensed life insurer and product provider of this policy (the insurer). In return for the monthly payment of the premium related to the core benefits and the disability benefit (where applicable), the insurer agrees to provide the policy benefits described in this policy, subject to its terms, conditions, limitations, waiting periods and exclusions.

1.2 Administrator

This policy is administered by AllLife Proprietary Limited ("AllLife").

1.3 Order of Precedence

If there is any inconsistency between the documents forming part of this policy, the following order of precedence applies:

- The policy application (All information received, whether electronically, in paper format or voice recorded in support of the application)
- The policy schedule;
- These policy terms and conditions; and
- All annexures that form part of the policy terms and conditions.

Any marketing material, illustrations or frequently asked questions are provided for information purposes only and do not form part of this policy.

1.4 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 indemnifies AllLife, the insurer 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.

1.5 Changes to Policy details

The policy schedule sets out the specific details applicable to the policy as it has been shared with AllLife. Should any of the policy details change the policy owner must notify AllLife. AllLife will update the information and send the amended policy schedule and applicable terms and conditions of the policy owner for safekeeping.

2. DEFINITIONS AND INTERPRETATION

2.1 Defined Words

Certain words and expressions have specific meanings in this policy. These words are defined in section 2.2 below.

Unless the context indicates otherwise, words importing the singular include the plural and vice versa, and words importing any gender include all genders.

2.2 Important Definitions

Accelerated benefit	A percentage of the death benefit payable at the time of a terminal illness diagnosis or on death to cover immediate expenses, which reduces the death benefit by the amount paid. It does not constitute an additional or separate benefit.
Accident	An unplanned, sudden and unforeseen event caused solely and directly by violent, external, physical and visible means and not caused by a pre-existing medical condition or illness.
Annexure	Any document attached to and forming part of this policy, setting out additional benefit definitions, conditions or requirements applicable to specific benefits.
Benefit	Any amount payable or premium waived in accordance with this policy following the acceptance of a valid claim.
Exclusion	Any circumstance, condition or event specified in this policy for which no benefit will be payable.
Life insured	The person named in the policy schedule on whose life this policy is issued. The life insured is also the policy owner unless there is a cessionary on the policy.
Non-accidental	Death or disability resulting from causes other than an accident.

3. COMMENCEMENT, DURATION AND TERMINATION OF COVER

3.1 Commencement of Cover

Cover under this policy commences on the commencement date, provided that the first total monthly contribution has been successfully received by AllLife.

3.2 Duration of Cover

This policy remains active until the earliest of:

- Payment of the death benefit
- Termination in accordance with this policy
- The cover termination date shown in the policy schedule for the disability benefit (if applicable)

3.3 Cooling-Off Period

A 31-day cooling-off period applies to all new policies. The cooling-off period is calculated from the commencement date of the policy and applies only if no claims have been lodged. Written cancellation must be received within this period, and any total monthly contribution paid will be refunded less the cost of risk cover enjoyed.

4. TOTAL MONTHLY CONTRIBUTIONS AND PAYMENT

4.1 Payment of Total Monthly Contributions

Definitions	
Total monthly contribution	The total monthly contribution is the total amount payable each month. It consists of the total monthly premium and the non-insurance service fee.
Total monthly premium	The total monthly premium is the portion of the total monthly contribution required to maintain the core benefits and, if applicable, includes the disability benefit. It is made up of the basic premium and the disability premium if applicable.
Disability premium	This portion of the total monthly premium relates to the optional disability benefit.
Non-insurance service fee	The non-insurance service fee is the portion of the total monthly contribution that is attributed to the non-insurance services.
Policy anniversary	Each anniversary of the commencement date, as reflected in the policy schedule.
Grace Period	The period of 15 days from the agreed debit day during which the policy will remain in force despite a failed or unpaid debit order and during with the life insured may make good on the outstanding total monthly contribution. If the outstanding total monthly contribution is not received within the grace period, the policy may lapse or certain benefits under the policy may be reduced in accordance with these terms and conditions.

Total monthly contribution = Total monthly premium + non-insurance service fee

Total monthly premium = Basic premium + disability premium (if applicable)

The total monthly contributions are payable monthly in advance on the agreed debit day with AllLife. Tracking may be used in collecting the total monthly contributions. This means that AllLife will endeavor to collect the total monthly contribution over a maximum tracking period of 10 days from the agreed debit day. If AllLife fails to successfully collect on the agreed debit day, the debit will recheck the funds available in the bank account over the tracking period and, in this way, RD charges can be avoided, if the total monthly contribution is successfully collected before the end of the maximum tracking period.

4.2 Consequences of Non-Payment

If the total monthly contribution is not received during any consecutive 5-month period during the life of this policy and after expiry of the grace period applicable to the 5th month, the policy will be cancelled and the core benefits, disability benefit (if applicable) and the non-insurance services will stop.

Any claim with a claim event date before the effective date of the cancellation of the policy will be considered subject to waiting periods and limitations as at the date of the event.
Contribution payment status and any applicable benefit reduction rules are set out in section 5 and Annexure 1.

4.3 Reinstatement

A lapsed policy may be reinstated at AllLife's discretion, subject to:

- Payment of all outstanding total monthly contributions; and
- Any underwriting requirements.

Any claim with an event date between the effective date of the lapse and the reinstatement date will not be considered.

5. CORE BENEFITS PROVIDED BY THIS POLICY

Definitions	
Core benefits	The insurance benefits automatically included under this policy and funded by the total monthly premium comprising the death benefit and any accelerated benefits expressly stated to form part of the death benefit, including the terminal illness benefit and the immediate needs benefit.
Beneficary	A beneficiary is any person nominated by the policy owner to receive the death benefit and the immediate needs benefit. The policy owner is the beneficiary for the disability benefit (where applicable) and terminal illness benefit.

The benefits hereunder are payable while the life insured is resident in the Republic of South Africa. The life insured must notify AllLife in writing if the life insured intends to immigrate or plans to leave the Republic of South Africa for more than 90 days. AllLife shall have the right to increase the total monthly premium or modify or cancel the policy with immediate effect by sending written notice to the policy owner.

5.1 Death Benefit

Definitions	
Death benefit	The death benefit amount payable on the death of the life insured subject to applicable waiting periods, benefit limitations, underwriting-related limitations, the policy protection benefit and the exclusions contained in this policy.

If the life insured dies and it is a valid claim, AllLife will pay the death benefit to the nominated beneficiary.

The death benefit is subject to the:

- Total monthly contributions being paid up to date (Section 5)
- Policy protection benefit (Section 5)
- Waiting periods and benefit limitations set out in (Section 8)
- Exclusions (Section 9).

5.2 Terminal Illness Benefit

Definitions	
Terminal illness benefit	This accelerated benefit is payable upon diagnosis of a terminal illness as set out in this section. It pays the lower of R500,000 and 50% of the death benefit applicable at the time of diagnosis subject to the applicable waiting periods and exclusions set out in section 8 and 9. A terminal illness is any medical condition that a medical specialist confirms will lead to the life insured having a life expectancy of 12 months or less.

The terminal illness benefit shall only become payable once the applicable underwriting-related limitation period has expired.

5.3 Immediate Needs Benefit

Definitions	
Immediate needs benefit	This accelerated benefit is payable upon the death of the life insured to assist with immediate expenses arising from the death. It pays the lower of R50,000 and 10% of the death benefit applicable at the time of the life insured's death, subject to applicable waiting periods and exclusions set out in section 8.

5.4 Policy Protection Benefit

This benefit allows the policy owner to miss up to 5 consecutive total monthly contributions, and the policy will not be cancelled.

For purposes of determining the death benefit payable, AllLife will assess the payment history for the six (6) months preceding the date of the claim event. The death benefit will be reduced by one-sixth (1/6) for each total monthly contribution that remained unpaid after expiry of its applicable grace period during this six-month period.

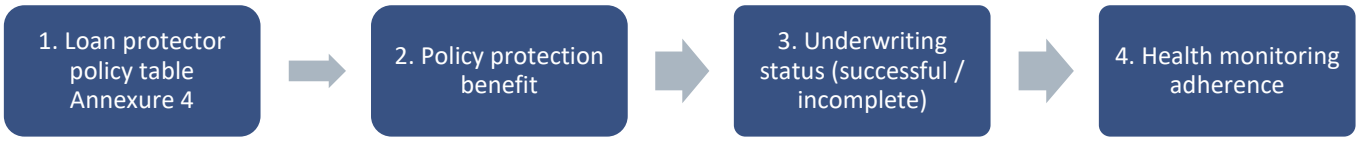
Where a missed total monthly contribution is paid within its applicable grace period, no reduction will apply in respect of that contribution. Contributions not paid within the applicable grace period may not be made up thereafter.

No total monthly contributions will be accepted after the date of death has been confirmed and the applicable grace period for the last unpaid contribution has expired.

An illustration of how this benefit operates is set out in Annexure 1.

5.5 Advantage Life Loan Protector policy

Where the life insured has selected the Advantage life loan protector policy and where there is a valid claim, the death benefit applicable will be calculated by first using the Loan protector policy table as defined in annexure 4 and thereafter will be subject to the policy protection benefit conditions and underwriting limitations as defined in these terms.



6. OPTIONAL DISABILITY BENEFITS

Definitions	
Disability benefit	This benefit pays the disability benefit if the life insured suffers a qualifying disability, subject to the applicable terms, conditions, waiting periods, exclusions and benefit limits. If selected by the policy owner, the benefit and its details are reflected in the policy schedule. Qualifying disabilities are set out in annexure 2 and 3.

The disability benefit will cease on the life insured's 65th birthday.

6.1 Scope of Disability Benefits

If selected, disability benefits include:

- Benefit payable on permanent disability; and
- Waiver of total monthly contributions during temporary disability.

6.2 Conditions and Limitations

Disability benefits are subject to:

- Waiting periods and limitations set out in section 8
- Medical and occupational assessments
- Definitions and scoring as set out in annexures 2 and 3.

7. TOTAL MONTHLY PREMIUM ADJUSTMENTS

The total monthly premium will increase yearly on the policy anniversary. A fixed annual percentage increase as reflected in the policy schedule applies.

Additionally, total monthly premiums are based on expectations of future conditions and expected to be sufficient for the duration of this policy. However, future conditions are uncertain and may be different to these expectations. For this reason, the premiums will be reviewed each year on the policy anniversary. If, at a review, there is a total monthly premium change, notification will be sent to the policy owner of the total monthly premium change at least 31 days before the total monthly premium change is implemented.

The total monthly premium may change at any time, even before the next policy anniversary, if the cost of providing cover changes significantly because of changes in tax or other laws.

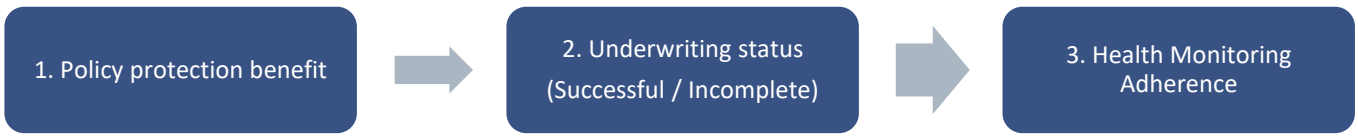
Notice of changes to the total monthly contribution which includes the total monthly premium will be communicated to the policy owner at least 31 days prior to the change becoming effective.

8. WAITING PERIODS AND LIMITATIONS APPLICABLE TO CORE AND DISABILITY BENEFITS

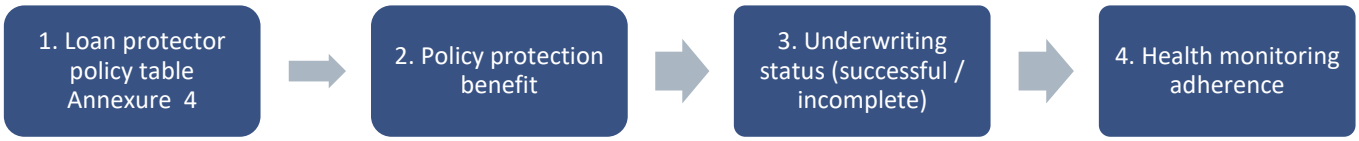
Definitions	
Successfully completed underwriting	The point at which all underwriting requirements have been fulfilled to the satisfaction of AllLife and confirmed in writing.
Health monitoring adherence	Health Monitoring adherence means the life insured takes all prescribed ART medication exactly as directed and maintains required clinical outcomes and testing in line with AllLife's protocols set out in the health monitoring service annexure.
Non-adherence date	Non-adherence date means the date determined from the policy commencement date - being 12 months where the life insured has successfully completed underwriting or underwriting is not required, or 24 months where successfully completed underwriting has not been completed —on which adherence is assessed and annually thereafter on the policy anniversary, for purposes of determining whether the life insured is non-adherent and whether any benefit limitations apply.

8.1 More than one limitation applies

Where more than one limitation applies, all relevant restrictions will be taken into consideration and applied, unless otherwise expressly stated.



Further limitations apply to the Advantage life loan protector policy (ONLY)



8.3 Underwriting-Related Limitation

Where underwriting is required and for as long as successfully completed underwriting has not occurred, an underwriting-related limitation will apply. During the first 24 months from the commencement date, the underwriting-related limitations are:

- Accidental death
  Where the life insured's death results from an accident, the full death benefit will be payable. The immediate needs benefit does not apply during this period.

- Non-accidental death
  Where death results from non-accidental causes, the death benefit payable will be limited to the total monthly contributions successfully received up to the date of the claim event. The immediate needs benefit does not apply during this period.

- Immediate needs benefit
  The immediate needs benefit does not apply during this period.

- Terminal illness benefit
  The terminal illness benefit does not apply during this period.

- Accidental disability
  Where the life insured's disability results from an accident, the full disability benefit will be payable.

- Non-accidental disability
  Where disability results from non-accidental causes, the disability benefit payable will be limited to the total monthly contributions successfully received up to the date of the claim event.

If successfully completed underwriting has not occurred by the end of 24-months from the commencement date, the underwriting-related limitation is:

- Accidental death
  If the life insured dies as a result of an accident, 10% of the death benefit will be paid as an immediate needs benefit subject to a maximum amount payable of R50,000 for this benefit and the rest of the death benefit applicable at the time of death will be paid if the claim is assessed as valid.

- Non-accidental death
  If the life insured dies as a result of non-accidental causes, the death benefit is 50% of the total death benefit that applies at the time of death. The immediate needs benefit payable will be limited to 10% of this death benefit applicable at the time of death or R25,000, whichever is lower.

- Terminal illness benefit
  If the life insured is diagnosed with a terminal illness, the benefit payable will be the lower of 50% of the death benefit applicable at the time of death or R250,000, subject to claims requirements set out in section 11 being met

- Accidental disability
  Disability arising from an accident will remain payable at 100% of the applicable benefit.

- Non-accidental disability
  Disability arising from non-accidental causes will be limited to 50% of the disability benefit or R250,000 whichever value is lower.

The underwriting-related limitation will stop applying as soon as successfully completed underwriting has occurred.

8.4 Health monitoring adherence related limitation

Whether the life insured has successfully completed underwriting, or where underwriting was not required or where successfully completed underwriting has not occurred, AllLife requires that the life insured adheres to the health monitoring adherence policy as outlined in the health monitoring services annexure. Failure to do so will mean that the life insured is not adherent and the following limitations will be imposed:

8.4.1 Where the life insured has successfully completed underwriting or where underwriting was not required and the life insured is not adherent with the requirements of the health monitoring services annexure then for the first 12 months after the non-adherence date, the life insured will only be covered for death and disability due to accidental causes. The immediate needs and terminal illness benefits will not be payable during this period.

8.4.2 Where the life insured has successfully completed underwriting, or where underwriting was not required and the life insured is not adherent, and a period of 12 months has elapsed from the non-adherence date, the life insured's benefits shall be subject to the following limitations.

- Accidental death
  If the life insured dies as a result of an accident, 10% of the death benefit will be paid as an immediate needs benefit subject to a maximum amount payable of R50,000 for this benefit and the rest of the death benefit applicable at the time of death will be paid if the claim is assessed as valid.

- Non-accidental death
  If the life insured dies as a result of non-accidental causes, the death benefit is 50% of the total death benefit that applies at the time of death. The immediate needs benefit payable will be limited to 10% of this death benefit applicable at the time of death or R25,000, whichever is lower.

- Terminal illness benefit
  If the life insured is diagnosed with a terminal illness, the benefit payable will be the lower of 50% of the death benefit applicable at the time of death or R250,000, subject to claims requirements set out in section 11 being met

- Accidental disability
  Disability arising from an accident will remain payable at 100% of the applicable benefit.

- Non-accidental disability
  Disability arising from non-accidental causes will be limited to 50% of the disability benefit or R250,000 whichever value is lower.

8.4.3 Where the life insured has not successfully completed underwriting and is deemed to be non-adherent in accordance with the requirements of the health monitoring services section of this policy, an additional period of 12 months shall apply from the non-adherence date, during which the life insured will only be covered for death and disability due to accidental causes. The Immediate Needs Benefit and Terminal Illness Benefit shall not be payable during this period.

8.5 If the life insured meets the requirements of the health monitoring service and is subsequently confirmed as adherent by AllLife in writing (which may occur at any time after the non-adherence date), then the full policy benefits will be restored, subject to the terms, conditions and any applicable underwriting requirements still outstanding.

Examples of these limitations are set out below.

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Underwriting-related limitation
(During the first 24 months, calculated from the commencement date of the policy)

Thembi's cover under her Advantage Life policy commenced on 1 January 2026. She has R 1,000,000 death cover for a total monthly contribution of R1,000. **Thembi completed underwriting successfully.**

1. If Thembi dies in an accident on the 18th of June 2026 having paid all her total monthly contributions due, her beneficiaries would be paid the immediate needs benefit of R50,000 followed by the remaining death benefit of R950,000
2. If however, at time of death Thembi had only paid 4 of the 6 total monthly contributions due (being January 2026 to June 2026) then her beneficiaries would be paid the immediate needs benefit of R50,000 followed by the remaining death benefit of R616,667.

Underwriting completed successfully

	Policy protector benefit	Total death benefit available	Terminal illness benefit payable	Immediate needs benefit payable	Death benefit payable
Cause of death non-accidental	Monthly contributions up to date	R1000,000	Not applicable (cause of death was accidental)	R50,000	R950,000
	1 Missed premium	R833,333		R50,000	R783,333
	2 Missed premiums	R666,667		R50,000	R616,667
	3 Missed premiums	R500,000		R50,000	R450,000
	4 Missed premiums	R333,333		R33,333	R300,000
	5 Missed premiums	R166,667		R16,667	R150,000

Underwriting-related limitation
(During the first 24 months, calculated from the commencement date of the policy)

Thembi's cover under her Advantage Life policy commenced on 1 September 2025. She has R 1,000,000 death cover for a total monthly contribution of R1,000. **Thembi completed underwriting successfully.**

1. If Thembi is diagnosed on the 15th of May 2026 with a terminal illness she will be paid her terminal illness benefit of R500,000
2. If Thembi subsequently passes away on the 18th June 2026 of either an accident or non-accident her beneficiaries will be paid out the immediate needs benefit of R50,000 followed by the remaining death benefit of R450,000
3. If however, at time of death Thembi had only paid 4 of the last 6 total monthly contributions due (being January 2026 to June 2026) then her beneficiaries would be paid the immediate needs benefit of R50,000 followed by the remaining death benefit of R116,667.
4. If at time of death Thembi had paid 3 or less of the last 6 total monthly contributions due (being January 2026 to June 2026) and had already been paid out the terminal illness benefit then no additional benefits would be payable.

Underwriting completed successfully

	Policy protector benefit	Total death benefit available	Terminal illness benefit payable	Immediate needs benefit payable	Death benefit payable
Cause of death non-accidental	Monthly contributions up to date	R1000,000	R500,000	R50,000	R450,000

Cause of death non-accidental	1 Missed premium	R833,333	R500,000	R50,000	R283,333
	2 Missed premiums	R666,667	R500,000	R50,000	R116,667
	3 Missed premiums	R500,000	R500,000	R0	R0
	4 Missed premiums	R333,333	R500,000	R0	R0
	5 Missed premiums	R166,667	R500,000	R0	R0

Health monitoring adherence related limitation (Claim event greater than 12 months from non-adherence date)

Thembi's cover under her Advantage Life policy commenced on 1 January 2024. She has R 1,000,000 death cover for a total monthly contribution of R1,000. Thembi completed underwriting successfully but **has not met the requirements of the health monitoring service due by 1 January 2025** and is deemed **non-adherent.**

1. If Thembi passes away on the 18th June 2026 of a non-accident but did not claim the terminal illness benefit, her beneficiaries will be paid out the immediate needs benefit of R25,000 followed by the remaining death benefit of R475,000.
2. If however, at time of death Thembi had only paid 4 of the last 6 total monthly contributions due (being January 2026 to June 2026) then her beneficiaries would be paid the immediate needs benefit of R25,000 followed by the remaining death benefit of R308,333.

Underwriting completed successfully

	Policy protector benefit	Total death benefit available	Terminal illness benefit payable	Immediate needs benefit payable	Death benefit payable
Cause of death non-accidental	Monthly contributions up to date	R500,000	Not applicable (Nature of death was natural but no terminal illness benefit was claimed by life insured)	R25,000	R475,000
	1 Missed premium	R416,667		R25,000	R391,667
	2 Missed premiums	R333,333		R25,000	R308,333
	3 Missed premiums	R250,000		R25,000	R225,000
	4 Missed premiums	R166,667		R16,667	R150,000
	5 Missed premiums	R83,333		R8,333	R75,000

Underwriting-related limitation
(During the first 24 months, calculated from the commencement date of the policy)

Thembi's cover under her Advantage Life policy commenced on 1 January 2026. She has R 1,000,000 death cover for a total monthly contribution of R1,000. **Thembi did not complete underwriting successfully.**

1. If Thembi dies in an accident on the 18th of June 2026 having paid all her total monthly contributions due, her beneficiaries would be paid the death benefit of R1000,000.
2. If however, at time of death Thembi had only paid 4 of the 6 total monthly contributions due (being January 2026 to June 2026) then her beneficiaries would be paid the death benefit of R666,667.

Underwriting not completed successfully – Claim event less than 24 months from commencement date

	Policy protector benefit	Total death benefit available	Terminal illness benefit payable	Immediate needs benefit payable	Death benefit payable
Cause of death non-accidental	Monthly contributions up to date	R1000,000	Not applicable (underwriting not completed successfully and claim event occurring within first 24 months from commencement date)	Not applicable (underwriting not completed successfully and claim event occurring within first 24 months from commencement date)	R1000,000
	1 Missed premium	R833,333			R833,333
	2 Missed premiums	R666,667			R666,667
	3 Missed premiums	R500,000			R500,000
	4 Missed premiums	R333,333			R333,333
	5 Missed premiums	R166,667			R166,667

Underwriting-related limitation
(During the first 24 months, calculated from the commencement date of the policy)

Thembi's cover under her Advantage Life policy commenced on 1 January 2026. She has R 1,000,000 death cover for a total monthly contribution of R1,000. **Thembi did not complete underwriting successfully.**

1. If Thembi is diagnosed on the 15th of March 2026 with a terminal illness she will be not be paid her terminal illness benefit because her underwriting has not been completed successfully.
2. If Thembi subsequently passes away on the 18th June 2026 of either an accident or non-accident and her total monthly contributions are paid up then her beneficiaries will be paid her death benefit equivalent to the sum of total monthly contributions received (6 x R1000).
3. If however, at time of death Thembi had only paid 4 of the last 6 total monthly contributions due (being January 2026 to June 2026) then her beneficiaries would be paid the death benefit of R4000.

Underwriting not completed successfully – Claim event less than 24 months from commencement date

	Policy protector benefit	Total death benefit available	Terminal illness benefit payable	Immediate needs benefit payable	Death benefit payable
Cause of death non-accidental	Monthly contributions up to date	R6000	Not applicable (underwriting not completed successfully and claim event occurring within the first 24 months from commencement date)	Not applicable (underwriting not completed successfully and clam event occurring within first 24 months from commencement date)	R6000
	1 missed premium	R5000			R5000

Cause of death non-accidental	2 Missed premiums	R4000	Not applicable (underwriting not completed successfully and claim event occurring within the first 24 months from commencement date)	Not applicable (underwriting not completed successfully and clam event occurring within first 24 months from commencement date)	R4000
	3 Missed premiums	R3000			R3000
	4 Missed premiums	R2000			R2000
	5 Missed premiums	R1000			R1000

Underwriting-related limitation
(Greater than 24 months, calculated from the commencement date of the policy)

Thembi's cover under her Advantage Life policy commenced on 1 January 2024. She has R 1,000,000 death cover for a total monthly contribution of R1,000. **Thembi did not complete underwriting successfully.**

1. If Thembi dies in an accident on the 18th of June 2026 having paid all her total monthly contributions due, her beneficiaries would be paid the immediate needs benefit of R50,000 followed by the death benefit of R950,000.
2. If however, at time of death Thembi had only paid 4 of the 6 total monthly contributions due (being January 2026 to June 2026) then her beneficiaries would be paid the immediate needs benefit of R50,000 followed by the death benefit of R616,667.

Underwriting not completed successfully –claim event greater than 24 months from commencement date

	Policy protector benefit	Total death benefit available	Terminal illness benefit payable	Immediate needs benefit payable	Death benefit payable
Cause of death non-accidental	Monthly contributions up to date	R1000,000	Not applicable (cause of death was accidental)	R50,000	R950,000
	1 Missed Premium	R833,333		R50,000	R783,333
	2 Missed Premiums	R666,667		R50,000	R616,667
	3 Missed Premiums	R500,000		R50,000	R450,000
	4 Missed Premiums	R333,333		R33,333	R300,000
	5 Missed Premiums	R166,667		R16,667	R150,000

Underwriting-related limitation
(Greater than 24 months, calculated from the commencement date of the policy)

Thembi's cover under her Advantage Life policy commenced on 1 January 2024. She has R 1,000,000 death cover for a total monthly contribution of R1,000. **Thembi did not complete underwriting successfully.**

1. If Thembi is diagnosed on the 15th of March 2026 with a terminal illness she will be paid her terminal illness benefit of R250,000.
2. If Thembi subsequently passes away on the 18th June 2026 of either an accident or non-accident her beneficiaries will be paid out the immediate needs benefit of R25,000 followed by the remaining death benefit of R225,000.
3. If however, at time of death Thembi had only paid 4 of the last 6 total monthly contributions due (being January 2026 to June 2026) then her beneficiaries would be paid the immediate needs benefit of R25,000 followed by the remaining death benefit of R58,333.

4. If at time of death Thembi had paid 3 or less of the last 6 total monthly contributions due (being January 2026 to June 2026) and had already been paid out the terminal illness benefit then no additional benefits would be payable.

Underwriting not completed successfully – claim event greater than 24 months from commencement date

	Policy protector benefit	Total death benefit available	Terminal illness benefit payable	Immediate needs benefit payable	Death benefit payable
Cause of death non-accidental	Monthly contributions up to date	R500,000	R250,000	R25,000	R225,000
	1 Missed premium	R416,667	R250,000	R25,000	R141,667
	2 Missed premiums	R333,333	R250,000	R25,000	R58,333
	3 Missed premiums	R250,000	R250,000	R0	R0
	4 Missed premiums	R166,667	R250,000	R0	R0
	5 Missed Premiums	R83,333	R250,000	R0	R0

Underwriting and Health monitoring adherence related limitation (Claim event greater than 12 months from non-adherence date and within 36 months from commencement date)

Thembi's cover under her Advantage Life policy commenced on 1 January 2024. She has R 1,000,000 death cover for a total monthly contribution of R1,000. Thembi did not complete underwriting successfully and **has not met the requirements of the health monitoring service due by 1 January 2025** and is deemed **non-adherent.**

1. If Thembi passes away on the 18th June 2026 of a non-accident but did not claim the terminal illness benefit, her beneficiaries will be paid out the death benefit equivalent to the sum of the total monthly contributions received (29 total monthly contributions x R1000 = R29,000).
2. If however, at time of death Thembi had only paid 4 of the last 6 total monthly contributions due (being January 2026 to June 2026) then her beneficiaries would be paid the immediate needs benefit of R25,000 followed by the remaining death benefit of R308,333.

Underwriting completed successfully

	Policy protector benefit	Total death benefit available	Terminal illness benefit payable	Immediate needs benefit payable	Death benefit payable
Cause of death non-accidental	Monthly contributions up to date	R29,000	Not applicable (underwriting not completed successfully and life insured non-adherent with health monitoring requirements. Claim event occurring within the first 36 months from commencement date)	Not applicable (underwriting not completed successfully and life insured non-adherent with health monitoring requirements. Claim event occurring within the first 36 months from commencement date)	R29,000
	1 Missed premium	R24,167			R24,167
	2 Missed premiums	R19,333			R19,333
	3 Missed premiums	R14,500			R14,500

Cause of death non-accidental	4 Missed premiums	R9,667	Not applicable (underwriting not completed successfully and life insured non-adherent with health monitoring requirements. Claim event occurring within the first 36 months from commencement date)	Not applicable (underwriting not completed successfully and life insured non-adherent with health monitoring requirements. Claim event occurring within the first 36 months from commencement date)	R9,667
	5 Missed premiums	R4,833			R4,833

9. EXCLUSIONS

Definitions	
Pre-existing condition	Any condition, illness, injury or medical state which existed before or on the commencement date and that the life insured was or ought to have been aware of and for which the life insured: • consulted a medical practitioner or specialist, • was prescribed any medication, • received treatment, surgery or advice, • manifested symptoms which would have caused a reasonable person to seek advice or • received a diagnosis.
Exclusion	Any circumstance, condition or event under which no benefit will be payable.

A claim will not be accepted if the claim arises directly or indirectly from, contributed to, or accelerated by:

- an injury which is self-inflicted or in any way deliberately caused by the life insured.
- negligence, recklessness or any participation by the life insured in any criminal act.
- 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.
- 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.
- participation in extreme sports such as mountaineering, skydiving or any speed contest and trials.
- the life insured failing to disclose required information prior to the commencement date of the policy.
- war and war-like activities including:
    - war, hostilities, or war-like operations (whether war be declared or not),
    - invasion,
    - act of an enemy foreign to the nationality of the life insured or the country in, or over, which the act occurs,
    - civil war,
    - insurrection,
    - revolution,
    - overthrow of the legally constituted government,
    - civil commotion assuming the proportion of, or amounting to, an uprising,
    - military or usurped power.
- the use of nuclear, biological or chemical weapons or any radioactive contamination.
- 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.

Additional exclusions that apply until successfully completed underwriting have occurred:

A claim will not be accepted if the claim arises directly or indirectly from, contributed to, or accelerated by a pre-existing condition and Covid-19. Deaths related to Covid-19 will not be covered until underwriting has been completed.

A claim for the permanent 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 2 previous back surgeries.

10. MISREPRESENTATION

The information and documentation given to AllLife by the policy owner or life insured during the application process (including through the call centre operator) or by the life insured's medical representatives 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 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, AllLife is 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. CLAIMS

11.1 Death Benefit Claim

In the event the life insured's death, the claimant must fill in a claim form and provide AllLife with the following minimum details within 3 months of the date of the death of the life insured:

- A valid South African death certificate including cause of death issued by the South African Department of Home Affairs on a computer-generated form
- A certified copy of the ID document of the life insured
- A fully completed BI1663 document
- A certified copy/ies of ID Document/s of the beneficiary/ies
- A bank account confirmation letter no older than 3 months from a South African bank, in the name/s of the beneficiary/ies

Please note that 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 all the required claim documentation and/or AllLife is unable to obtain sufficient medical evidence to assess or verify the claim.

11.2 Immediate Needs Benefit Claim

In the event of a claim against the immediate needs benefit, the claimant will be required to fill in a claim form and provide AllLife, with the following minimum details at their earliest convenience following the death of the life insured:

- A fully completed BI-1663 document
- Death certificate
- Police/accident report for unnatural cause death
- Certified copy/ies of ID Document/s of the beneficiary/ies
- A bank account confirmation letter no older than 3 months from a South African bank, in the name/s of the beneficiary/ies

Please note that AllLife may, at their sole discretion, require additional information to process a claim. Payment of the immediate needs benefit does not constitute an approved claim. Should the claim be found invalid or not approved, no further death benefit payment will be made.

A claim will not be paid if:

- The life insured's death occurred in the first 12 months from commencement date, or within the first 24 months from the commencement date if the life insured had not successfully completed underwriting (subject to further restrictions set out in section 8).
- The claimant/beneficiary is unable to produce full claim documentation and any additional information as may be required by AllLife.
- AllLife is unable to obtain sufficient medical evidence from the beneficiaries or treating medical practitioner to fulfil AllLife'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).

11.3 Terminal Illness Benefit Claim

In the event of a claim against the terminal illness benefit; the claimant will be required to fill in a claim form and provide AllLife with the following minimum details within 3 months of the date on which the life insured suffered a terminal illness:

- A certified copy of the ID document of the life insured
- Written confirmation of a terminal illness diagnosis from 2 registered medical practitioners, at least 1 of whom must be a medical specialist, registered with the Health Professions Council of South Africa (HPCSA)
- A signed doctor's report confirming the nature of the illness or injury and that the life insured has a life expectancy of less than 12 months
- Full details of the treating medical practitioners
- Any additional medical records or information relating to the condition and
- Any additional information that AllLife may stipulate.

A claim will not be paid if:

- The life insured suffers a terminal illness in the first 12 months from commencement date, or within the first 24 months from the commencement date if the life insured has not successfully completed underwriting (Subject to further restrictions as defined in section 8).
- The claimant is unable to produce full claim documentation and any additional information as may be required by AllLife;
- AllLife is unable to obtain sufficient medical evidence from the life insured or treating medical practitioners to fulfil AllLife's criteria for making a benefit payment;
- The medical evidence provided does not meet the definition of terminal illness as set out in this policy; or
- The diagnosis of terminal illness is not confirmed while the policy is active.

AllLife reserves the right to require the life insured to undergo an independent medical examination, at AllLife's cost.

If the Life Insured passes away while a Terminal Illness Benefit claim is under assessment, such claim shall be deemed withdrawn and will no longer be considered. In such circumstances, the claim will instead be assessed as a death claim. Any benefits payable will be determined in accordance with the policy's Immediate Needs and Death Benefit claim requirements, subject to the terms and conditions of the policy

11.4 Disability Benefit Claim

In the event of a claim against the permanent total disability benefit, the beneficiary is required to fill in a disability claim form and provide AllLife with the following documentation:

- Certified copy of ID document of the life insured
- Bank account confirmation letter from a South African bank, in the name of the life insured
- Relevant medical assessments and/or treating medical specialist records, paid for by the claimant, sufficient for the 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.
- Any additional information that AllLife may stipulate.

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 AllLife.

11.5 Appeals against rejected claims

Within 90 days from a rejected claim, the life insured / claimant may make representations about this decision by writing to:

AllLife Proprietary Limited

0861 255 543

0866 171 888

PO Box 787159, Sandton, 2416

Customer Care
customercare@alllife.co.za

Claims Department
claims@alllife.co.za

Compliance Department
compliance@alllife.co.za

If your complaint has not been satisfactorily addressed, you may submit a complaint to OMART complaints:

Old Mutual Alternative Risk Transfer Limited (OMART)

PO Box 66, Cape Town, 8000

OMARTComplaints@oldmutual.com

If your complaint is still not satisfactorily addressed, you may contact the Old Mutual Regulatory Complaints team at:

PO Box 80, Mutualpark, 7451

arbitrator@oldmutual.com

Finally, you have the right to complain to the relevant industry ombud:

For product/administrator related complaints - National Financial Ombud Scheme (NFO): nfosa@co.za
For sales complaints - FAIS ombud: faisombud.co.za

If you wish to institute legal action, you need to do so within 6 months from the expiry of the 90-day period referred to under "Dispute procedure". If you fail to do so within this period, you forfeit the right to institute legal action. When a complaint is lodged with the NFO, the above period is suspended and will start running again when the complaint is withdrawn or has been determined by the NFO's office or an appeal in terms of its rules has been dealt with.

12. BENEFICIARIES, OWNERSHIP AND CESSION

Definitions	
Beneficary	A beneficiary is any person nominated by the policy owner to receive the death benefit and the immediate needs benefit. The policy owner is the beneficiary for the disability benefit (where applicable) and terminal illness benefit.
Policy owner	The policy owner shall be the life insured, unless a cession has been recorded. The policy owner is entitled to exercise all rights under the policy, including the nomination of beneficiaries and the request of policy changes. Where a cession has been recorded, the policy owner shall retain such rights; provided that any policy changes which may affect the underlying value of the cession shall require the prior written consent of the cessionary. The policy owner shall remain liable for payment of the total monthly contributions, unless otherwise agreed in writing. The policy owner may appoint another person to make such payments on their behalf, in which case the payer's details shall be recorded in the policy schedule
Cession	The transfer of the rights under, and ownership of, this policy by the policy owner to another person.
Cessionary	The person or entity in whose favor a cession has been affected.

12.1 Beneficiaries

The policy owner may nominate or change 1 or more beneficiaries at any time, provided that:

- Nominations for beneficiaries must be submitted in writing to AllLife and must be received by AllLife before the death of the life insured.
- Beneficiary nominations will not be valid until the policy owner has received written notice from AllLife that the nomination has been noted in its records.

Where a cession is recorded on the policy, the policy owner may still nominate and change beneficiaries but any such beneficiary nominations are suspended while a cession is recorded on the policy.

12.2 Cession

The policy owner may cede this policy. Upon cession, the rights under this policy vest in the cessionary to the extent of the cession.

Where the policy has been ceded, the cession shall apply to the death benefit as defined in this policy. Upon cession of the policy, the life insured irrevocably waives any entitlement to the terminal illness benefit and the immediate needs benefit provided for under the policy.

Accordingly, no claim for the terminal illness benefit or the immediate needs benefit shall be payable while the policy remains ceded. These benefits shall only become available again if the cession is cancelled.

13. GENERAL LEGAL PROVISIONS

- This policy is governed by the laws of the Republic of South Africa.
- Any amendments to this policy will only be valid when communicated in writing to the policy owner.
- No policy owner-initiated amendments to this policy will be valid until a replacement policy or policy schedule has been issued to the policy owner.
- If any provision of this policy is found to be invalid or unenforceable, the remaining provisions will continue in full force and effect.

Annexures

Specific & Legal Annexures

ANNEXURE 1 – POLICY PROTECTION BENEFIT

Below is an illustration of how the death benefit will reduce as a result of unpaid total monthly contributions. The illustration is based on a death benefit amount of R1 000 000 and scales proportionally for other benefit amounts.

Number of unpaid total monthly contributions	Benefit amount
0	1 000 000
1	833 333
2	666 666
3	500 000
4	333 333
5	166 666
6	0 (policy terminated)

Key points:

- If a claim occurs and 1 or more total monthly contributions have not been paid over the last 6 months the benefit amount is reduced proportionally based on the number of total monthly contributions unpaid
- If total monthly contributions remain unpaid for 5 consecutive months and the 15-day grace period has expired, the policy will lapse.

Example:

If the life insured fails to pay a premium in policy year 2 and again in policy year 4, and a claim arises in policy year 6, the following provisions will apply:

A missed premium in policy year 2 will result in a reduction of the policy cover by one-sixth (1/6). This reduced level of cover will remain in force until the next five (5) consecutive premiums have been received in full and on their due dates, at which point the full cover will be reinstated.

The same provisions will apply in respect of the missed premium in policy year 4.

Provided that all subsequent premiums have been paid in full and on time, the policy cover will have been fully reinstated by policy year 6, and any valid claim arising at that time will be payable in full in accordance with the terms and conditions of the policy.

ANNEXURE 2 – OCCUPATIONAL DISABILITY

Definition of Disability

A life insured is considered permanently disabled if, in the opinion of AllLife, the life insured becomes permanently unable to perform the essential duties of the life insured's own occupation or a reasonable alternative occupation due to injury or sickness and the condition is permanent and continuous despite appropriate medical treatment at the life insured's own cost, having reached maximum medical improvement.

Disability claims will be assessed based on the information held on record regarding the Life Insured's occupation at the time of assessment. It is therefore the responsibility of the Life Insured to promptly notify AllLife of any changes to their occupation. Failure to disclose such changes may impact the assessment and outcome of any disability claim.

A life insured is considered temporarily disabled if they meet the above criteria, but a permanent disability claim has been submitted and is still under review.

A life insured's own occupation is the occupation that the life insured has notified AllLife that the life insured is performing.

A reasonable alternative occupation is an occupation for which the life insured is qualified or could reasonably become qualified, based on education, training or experience and which could provide at least 75% of the life insured's annual income immediately before the disability.

ANNEXURE 3– ADW DISABILITY (Activities of Daily Work)

Definition of ADW Disability

A life insured is permanently and totally disabled if they score 6 or more points on the ADW scale and the disability is permanent and continuous despite reasonable medical treatment at the life insured's own cost.

Temporary disability applies if a permanent claim is submitted but not yet approved.

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 is 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 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 1 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

Assessment is performed by AllLife or a qualified agent.

HIV SPECIFIC DISABILITY

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

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YOU DESERVE THE RIGHT TO BE INSURED

ANNEXURE 4

APPLICABLE ONLY IF YOU HAVE AN ADVANTAGE LIFE LOAN PROTECTOR POLICY

The table below shows the applicable death benefit amount for a ten-year and twenty-year loan protector policy from the month of the commencement date 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		

ANNEXURE 5- 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.

WHAT HAPPENS IF I MISS A TOTAL MONTHLY CONTRIBUTION?

Paying total monthly contributions is the responsibility of the policy owner. AllLife will inform the policy owner (via email or SMS) of the non-payment of a total monthly contribution.

This policy allows you to miss up to 5 consecutive total monthly contributions.
Where any total monthly contribution has not been paid within the last 6 months, the benefit claimable will be reduced by 1/6th. This will happen 5 times. When the 6th premium is also unpaid, after the expiry of the 15-day grace period, the policy will be cancelled and cover will stop.

We will attempt to collect the total monthly contribution 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 and within the 15-day grace period for that applicable total monthly contribution.

CAN I INCREASE MY COVER?

The policy owner may apply for additional cover, up to R 10 million, subject to approval. If approved, a new policy will be issued.

HOW DO I PAY MY TOTAL MONTHLY CONTRIBUTIONS?

AllLife will collect the total monthly contribution via a debit order lodged on the payer's bank account. No cash payments will be accepted. Should a total monthly contribution be missed, it may be directly deposited or paid by EFT into AllLife's bank account with the policy number as reference. Please call our call centre on 0861 255 543 should any assistance be required.

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. However, the policy owner is responsible for the costs of all regular blood tests.

HOW ARE CLAIMS PAID?

In the event of a valid claim, AllLife will pay the benefit amount into the bank account of the beneficiary and/or cessionary, as the case may be.

HOW DO I CLAIM?

In the event of a claim, please contact us for assistance. Documentation required and applicable contact information is outlined in section 11 of these terms for easy reference.

ANNEXURE 6 – PROTECTION OF PERSONAL INFORMATION AND STATUTORY DISCLOSURES

PROTECTION OF PERSONAL INFORMATION

OMART DISCLOSURES	ALLLIFE DISCLOSURES
OMART may use your information or obtain information about you for the following purposes:	**AllLife** may use your information or obtain information about you for the following purposes:

- Underwriting
- Assessment and processing of claims
- Credit searches and/or verification of personal information
- Claims checks
- Tracing beneficiaries
- Fraud prevention and detection
- Market research and statistical analysis
- Audit & record keeping purposes
- Compliance with legal & regulatory requirements
- Verifying identity
- Sharing information with service providers including appointed administrators (AllLife as at time of policy issue) we engage to process such information on our behalf or who render services to us. These service providers may be abroad, but we will not share personal information with them unless we are satisfied that they have adequate security measures in place to protect the personal information.

The personal information we hold about any data subject (including the life insured, policy owner, beneficiary, cessionary and payer) may be accessed by the data subject who may also request us to correct any errors or to delete this information. In certain cases, the data subject has the right to object to the processing of his/her personal information.

INFORMATION REGULATOR

Complaints may be logged with the Information Regulator, whose contact details are:

010 023 5200

https://inforegulator.org.za/

enquiries@inforegulator.org.za

MARKETING

OMART DISCLOSURES	ALLLIFE DISCLOSURES
The Old Mutual Group [of which OMART is a subsidiary] would like to offer you ongoing financial services and may use your personal information to provide you with information about products or services that may be suitable to meet your financial needs.	**AllLife** would like to offer you ongoing financial services and may use your personal information to provide you with information about products or services that may be suitable to meet your financial needs.

OPT-OUT

If you prefer to no longer receive such information and/or financial services from:

The Old Mutual Group: Please sms your ID number to 30994 To view the Old Mutual Group full privacy notice and to exercise your preferences, please visit our website on https://www.oldmutual.co.za/privacy-notice/	**AllLife:** Please visit our website on www.alllife.co.za to view the AllLife full privacy notice and to exercise your preferences.

ALLLIFE
YOU DESERVE THE RIGHT TO BE INSURED

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

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. 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 intermediary services in respect of Long-term Insurance: Categories A and B1. The license conditions or restrictions as well as any exemptions which are applicable to AllLife are listed below. 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 a representative 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 Complaints Process and Policy are also available to clients upon request.

IMPORTANT DISCLOSURE AND OTHER LEGAL REQUIREMENTS: PLEASE READ CAREFULLY
YOUR RIGHT TO CANCEL THE TRANSACTION

You have a right to cancel a policy in writing within 31 days after receipt of the information as stipulated in the Policyholder Protection Rules under the Long-Term Insurance Act. The same applies to certain changes you may make to a policy. The cool-off right doesn't apply under these circumstances.

AllLife does not and has not advised you to replace any existing Policy.

PARTICULARS OF INSURANCE AND FAIS OMBUDSMEN & FINANCIAL SECTOR AUTHORITY

National Financial Ombud Scheme South Africa NPC

Private Bag X45, Claremont
Cape Town, 7735
Tel: 0860 800 900

Email: info@nfosa.co.za
Web: www.nfosa.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

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
Internet address:	www.alllife.co.za
Email address:	customercare@alllife.co.za
Compliance Officer:	Germa Beukes
Email address:	compliance@alllife.co.za

INFORMATION ON THE PRODUCT SUPPLIER AND INSURER

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
Email address:	OMARTCompliance@oldmutual.com

Complaints Department

Email address: OMARTComplaints@oldmutual.com

Non-Insurance Services

Health Monitorng, Emergency Medical, Trauma Advice & Ambulance Assistance

NON-INSURANCE SERVICES

Definitions	
Non-insurance services	Services offered with this policy that are not insurance services and no underwriting is required. These services do not give rise to any insured claim or cash payment but may impact total monthly contribution increases and are provided subject to Service Provider availability, operational limitations as set out in this section.
Health monitoring service	Provides access to health monitoring services designed to support the management and monitoring of the life insured's medical condition, as described in this section. This service is intended to promote improved health outcomes and may influence cover amounts applicable if adherence is not maintained annually.
Emergency medical and ambulance assistance service	A non-insurance service providing the life insured and his/her immediate family access to 24-hour emergency medical advice, trauma support and emergency ambulance evacuation services, including road or air ambulance services where medically necessary, as administered by the appointed service provider and subject to the limitations set out in this section.

Non-insurance services:

- Are not underwritten by the insurer;
- Do not give rise to any claim payment by the insurer;
- Are not regulated as insurance benefits; and
- Are provided as ancillary services to support the well-being of the life insured.

Non-insurance services are provided subject to:

- Availability of the relevant service provider;
- Operational, medical and geographic constraints; and
- The specific terms, conditions, exclusions, and limitations set out in the policy and this section.

Non-insurance services fees

The non- insurance services fees are subject to annual increases, as indicated in the policy schedule, on the policy anniversary. In addition, the non- insurance services fees will be reviewed annually based on underlying health monitoring, underwriting and servicing costs.

The insurer accepts no liability for any loss, damage, injury, cost or expense arising directly or indirectly from the provision, delay, failure or unavailability of any non-insurance service. Non-insurance services may be amended, substituted or withdrawn on reasonable notice without affecting the validity or continuation of the insurance services under this policy.

HEALTH MONITORING AND ADHERENCE SERVICE

This Health Monitoring and Adherence Service may be amended by AllLife on 30 days' written notice, at its sole discretion, based on reasonable medical practice.

1. Requirements and Obligations

To avoid the application of benefit limitations as set out in Section 8, the life insured must comply with the following requirements within 30 days of the due date being 12 months from commencement date

a. Testing and Submission of Results

- The life insured must undergo blood testing at least every 12 months, calculated from the commencement date, and ensure that all results are provided to AllLife.
- The life insured must nominate AllLife as a "copy doctor" when completing laboratory forms.
- Notwithstanding any direct sharing of results, the life insured remains responsible for ensuring submission.

b. Pre-ART Requirements

- Prior to initiating ART, the life insured must undergo CD4+ count testing every 12 months and submit results to AllLife.

c. Initiation of ART

- The life insured must commence ART within 60 days of:
  - a CD4+ count below 200 cells/mm^3; or
  - diagnosis of an AIDS-defining illness.
- The ART regimen must:
  - consist of at least three antiretroviral agents; and
  - be prescribed by a qualified medical practitioner.
- Details of the ART regimen must be provided to AllLife within 30 days of initiation.

d. Post-ART Monitoring

- Following ART initiation, the life insured must undergo RNA viral load and CD4+ count testing every 12 months and submit results to AllLife.

e. Proof of ART and Changes in Regimen

- Proof of ART initiation must be provided within 90 days of a qualifying CD4+ result and must meet prescribed documentation requirements.
- These requirements apply to each change in ART regimen.
- The life insured must notify AllLife of any regimen changes, which must be made under the direction of a treating medical practitioner.

f. Failure to Test or Submit Results

- Failure to provide required test results within 30 days of the scheduled testing date will result in the life insured being deemed non-adherent.
- Once deemed non-adherent, test results must be submitted every 6 months from the Non-Adherence Date until adherent status is restored.

2. Assessment of Adherence

a. Definition of Adherence

Adherence means the consistent use of prescribed ART medication, in the correct dosage and at the prescribed times, and full compliance with the testing and submission requirements set out in section 1. of the health monitoring and adherence service appendix

b. Assessment Criteria

AllLife will assess adherence based on RNA viral load and CD4+ count results. Either measure may be used to determine non-adherence.

c. Non-Adherence Criteria

The life insured will be deemed non-adherent (unless on a third ART regimen) if:

i. RNA Viral Load Criteria:

- No reduction of at least 1 log from pre-ART levels and viral load remains above 5,000 copies/mL by the second scheduled test; or
- Where the ART regimen is changed, failure to meet these criteria by the third scheduled test (with proof of change); or
- From 12 months post-ART initiation, viral load exceeds 1,000 copies/mL for two consecutive tests.

OR

ii. CD4+ Count Criteria:

- CD4+ count decreases by more than 50 cells/mm³ or 20% of baseline (whichever is lower) over 12 months or less; and
- Two consecutive results show a downward trend.

d. Adherent Status

The life insured will be regarded as adherent if:

- RNA viral load is below 500 copies/mL; and
- CD4+ count exceeds 500 cells/mm³.

e. Delayed or Inconsistent Results

- If test results are delayed, the original testing cycle will continue to apply.
- Where results are inconsistent or inconclusive, AllLife may assess on a case-by-case basis and require repeat testing.

f. Approved Laboratories

All tests must be conducted at laboratories approved by the South African National Accreditation System or the Association for Savings and Investment South Africa.

g. Appeals

All adherence determinations are subject to appeal. Appeals must be submitted in writing within 60 days of notification.

ADVANTAGE LIFE DIABETIC CONTROL AND HEALTH MONITORING SERVICE

This service applies in addition to the Health Monitoring and Adherence Service. This service may be amended by AllLife on 30 days' written notice, at its sole discretion, based on reasonable medical practice.

1. Requirements and Obligations

To maintain benefit levels under the Advantage Life product range, the life insured must comply with the following requirements:

a. Testing and Submission of Results

- The life insured must undergo glycosylated haemoglobin (HbA1c) testing at least every 12 months, calculated from the commencement date, and ensure that all results are provided to AllLife.
- The life insured must nominate AllLife as a "copy doctor" when completing laboratory documentation.
- Notwithstanding any direct sharing of results, the life insured remains responsible for ensuring submission.
- A 30-day grace period applies for submission of results.

b. Treatment Plan Compliance

- The life insured must follow a recognised diabetes treatment plan prescribed by a qualified medical practitioner.

c. Failure to Test or Submit Results

- If required test results are not provided within 30 days of the scheduled testing date, the life insured will be deemed uncontrolled until such results are received.
- Where the life insured is deemed uncontrolled, test results must be submitted every 6 months from the Non-Adherence Date until controlled status is achieved.
- If no test results are provided for a period exceeding 6 months, the life insured will be deemed permanently uncontrolled.

2. Assessment of Diabetic Control

a. Definition of Diabetic Control

Diabetic control means adherence to a prescribed treatment plan and compliance with the testing and submission requirements set out in Section 1, aimed at maintaining HbA1c levels within acceptable clinical ranges.

b. Assessment Criteria

AllLife will assess diabetic control based on HbA1c test results.

c. Uncontrolled Status

The life insured will be deemed uncontrolled if HbA1c is equal to or greater than 8.0% for two consecutive scheduled tests.

d. Controlled Status

The life insured will be regarded as controlled where HbA1c levels are maintained below 8.0%, subject to compliance with the requirements in Section 1.

e. Testing Intervals

Scheduled testing occurs every 12 months from the commencement date, unless more frequent testing is required by a medical practitioner.

f. Delayed or Inconsistent Results

- Where test results are delayed, the original testing cycle will continue to apply.

- Where results are inconsistent or inconclusive, AllLife may assess such results on a case-by-case basis and may require repeat testing.

g. Approved Laboratories

All HbA1c tests must be conducted at laboratories approved by the South African National Accreditation System or the Association for Savings and Investment South Africa.

h. Appeals

All diabetic control determinations are subject to appeal. Appeals must be submitted in writing within 60 days of notification.

EMERGENCY MEDICAL AND AMBULANCE ASSISTANCE SERVICE

Nature and overview of this service

This emergency medical, trauma advice and ambulance assistance service provides the life insured and their immediate family access to emergency medical and trauma assistance.

A non-underwritten service is a service that is:

- Not an insurance benefit;
- Is not subject to underwriting;
- Does not give rise to any insurance claim or cash payment; and
- Is provided subject to availability, operational capability, and the terms and limitations set out in this section.

The life insured is defined as the person referenced in the policy schedule and their immediate Family includes:

- The life insured's spouse, the person to whom the life insured is legally married or the life insured's permanent life partner (where applicable); and
- The life insured's dependent children, being biological, legally adopted or stepchildren younger than 22 years of age and financially dependent on the life insured at the time assistance is requested.

Scope of Services

Subject to the terms of this policy and this annexure, the assistance service provides access to:

24-Hour Emergency Medical Assistance Contact Centre

Access to a 24-hour contact centre staffed by medically trained personnel registered with the Health Professions Council of South Africa (HPCSA), who provide telephonic emergency medical advice and trauma support.

Emergency Medical Response

The dispatch of emergency medical services, including road or air ambulances, where medically necessary and operationally available, to provide stabilisation and life-saving intervention.

One-Way Emergency Transfer

One-way transfer to an appropriate medical facility following the initial emergency response, where such transfer is medically necessary.

Repatriation Within South Africa

Where the emergency incident occurs more than 200 kilometers from the life insured's usual place of residence within the Republic of South Africa, and where medically appropriate, transfer to a medical facility closer to home may be arranged.

All services are subject to:

- medical necessity as determined by the Service Provider's clinical protocols;
- operational availability;
- geographic accessibility; and
- compliance with the service provider's reasonable instructions.

Territorial Limits and Eligibility

This assistance service is available only while the policy remains active and total monthly contributions are up to date.

- Is available to the life insured and their immediate family while resident in the Republic of South Africa.
- Does not cover incidents occurring outside South Africa, except where repatriation within South Africa is medically necessary following stabilisation.

Service Provider and Responsibility

The assistance service is delivered by an independent third-party service provider, being the entity contracted by AllLife to render the non-insured services in accordance with agreed service levels.

AllLife facilitates access to the assistance service; collects the applicable non-insurance service fee; and oversees service standards in line with applicable regulatory requirements.

AllLife does not:

- directly provide emergency medical services;
- guarantee response times;
- guarantee availability in all geographic areas; or
- assume liability for clinical decisions, acts, omissions or negligence of the service provider or emergency medical personnel.

The service provider remains responsible for the operational delivery of the emergency ambulance service.

Fees and Payment

This service fee forms part of the total monthly contribution payable.

AllLife reserves the right to amend, replace or withdraw the assistance service on reasonable notice, subject to regulatory requirements and provided that such amendment does not unfairly prejudice the policy owner.

Complaints

Any complaints regarding the conduct of the Service Provider; or the administration of the assistance service may be lodged with AllLife in accordance with the policy's complaints resolution process. If unresolved, the claimant may escalate the matter as outlined below:

Complaints Relating to Clinical Conduct or Medical Personnel

If the complaint relates specifically to:

- the professional conduct of paramedics, doctors or medical personnel;
- clinical decision-making;
- ethical breaches; or
- professional misconduct

The complaint may be referred to the Health Professions Council of South Africa (HPCSA). The HPCSA regulates healthcare professionals registered in South Africa and investigates allegations of unprofessional conduct.

Complaints can be lodged by:

- Completing the HPCSA complaint form;
- Submitting a sworn affidavit with supporting documents; or
- Sending the complaint via email or post to the HPCSA.

Consumer Protection Complaints – (Complaints other than medical)

If the complaint relates to:

- misleading marketing;
- failure to provide services paid for;
- unfair pricing practices; or
- non-compliance with consumer rights, the complaint may be referred to the National Consumer Commission, who enforces the Consumer Protection Act.

Complaints may be lodged:

- Online through the Commission's complaint portal;
- By submitting a completed Form CC1 with supporting documentation; or
- Through a provincial consumer affairs office, the Commission may investigate or refer the matter to the National Consumer Tribunal.