AFFINITY HEALTH

Product Guide 2017

Index

1. GENERAL
1.1. Affinity Health Products 1
1.2. Waiting Periods 1
1.3. Changing Options / Adding Dependants 2
1.4. Pre-Authorisation 2
1.5. Policy Premiums 3
1.6. Payment of Claims 3
1.7. Policy Cancellations 3
1.8. General Definitions and Abbreviations 4

2. DAY-TO-DAY BENEFITS
2.1. Unlimited GP Visits 6
2.2. Specialist Visit 7
2.3. Acute Medication 7
2.4. Chronic Essential 7
2.5. Chronic Booster 7
2.6. Radiology 8
2.7. Pathology 8
2.8. Out-of-Area Visits 8
2.9. Dentistry 8
2.10. Optometry 8
2.11. Emergency After Hours Casualty Benefit 9

3. HOSPITAL PLAN BENEFITS
3.1. Illness Hospitalisation 9
3.2. Specific Stated Conditions Benefit 9
3.3. Accident Hospitalisation 10
3.4. Accident Permanent Disability 10
3.5. Dread Disease 10
3.6. 24hr Medical Assistance 10

4. BENEFITS APPLICABLE TO BOTH OPTIONS
4.1. Post Hospital Private Home Nursing 11
4.2. Family Funeral Benefit 11

5. PROCEDURES
5.1. Claims Procedure 13
5.2. Policy Amendment Procedure 13
5.3. Payment Procedure 13

6. FREQUENTLY ASKED QUESTIONS 14

7. DO'S AND DONT'S 17

1. GENERAL

1.1 **Affinity Health Products** - Affinity Health offers a choice of two products:

1.1.1 Day-to-Day Benefits

Affinity Health offers unlimited managed doctor visits and medication for general day-to-day ailments such as colds and flu, allergies, stomach bugs and also routine health check-ups. Basic dentistry, optometry, blood tests and black and white x-rays are also provided when recommended by your network GP. As an added benefit for single members there is R700 per annum available for specialist consultation and for family members there is R1300 per annum available.

1.1.2 Hospital Plan Benefits

Affinity Health offers cover up to the stated amount for hospitalisation due to illness, dread disease and accidents. The Affinity Health Hospital Plan also includes cover in the event of the Principal Member or Spouse becoming permanently disabled .The plan also includes a family funeral benefit in the event of death of an Insured Person.

1.2 **Waiting Periods** - The following waiting periods are applicable when joining the Affinity Health family:

1.1.1 Day-to-Day Benefits

GP Visits, Acute Medication, Radiology, Pathology and the Casualty Room Benefit have a 1 Month waiting period from policy inception date. The Family Funeral Benefit, Specialist Visit Benefit and Dentistry Benefit has a 3 month waiting period from policy inception date. Chronic Medication has a 6 month waiting period and Optometry has a 12 month waiting period from policy inception date.

1.1.2 Hospital Plan Benefits

Illness Benefits have a 3 Month waiting period and Dread Disease has a 6 Month waiting period from inception date. Specific Stated conditions have a 12 month waiting period unless otherwise provided herein. Family Funeral Benefit has a 3 month waiting period and Accident Benefits are applicable immediately upon inception.

1.1.3 Pre-Existing Conditions for hospitalisation

A condition-specific exclusion from the inception date of your policy applies in respect of any pre-existing condition. Note that all claims arising from a known pre-existing condition are excluded for a minimum period of 24 months.

A diagnosis of an illness during the 90 day waiting period is considered pre-existing and shall fall within the 24 month waiting period for pre-existing conditions. Signs and symptoms prior to inception of the policy are also considered pre-existing.

1.3 Changing options / adding dependants

To add a new dependant or change your product option please contact -

- Affinity Health Client Care Centre at 086 111 0033 or
- Email: info@affinityhealth.co.za

1.4 Hospital Pre-Authorisation

Pre-Authorisation is the prior approval of any planned admission to a hospital. Note that this does not guarantee payment of a claim. Payment is at all times subject to available benefits and co-payments may apply.
Application for pre-authorisation should be made as soon as possible, preferably upon confirmation of admission by your Network Doctor.

It is recommended that application be made at least 48 hours ahead of a planned procedure, in case more information is required from your doctor. In the event of an emergency admission to hospital over a weekend or at night, the Affinity Pre-Authorisation line is available 24/7.

For Pre-Authorisation call the Affinity Health Client Care Centre at 086 111 0033

Please ensure that you have the following when applying for pre-authorisation:

- Your membership card.
- Your policy number.
- Full name and identity number.
- Date of admission and the date of procedure.
- Surname and initials of attending doctor or service provider and practice number.
- Name of hospital and practice number to which the patient will be admitted.
- The reason for the admission to hospital.

Non-Disclosure of Pertinent Information:

Should you not disclose any previous accidents, illnesses or dread diseases on the application form, it may result in the cancellation of the policy and no premiums will be refunded.

All benefits that relate to the non-disclosed condition will be cancelled and any costs incurred will be for the members own account.

Junior Benefits:

Affinity Health's Junior Plan excludes the Family Funeral Benefit as well as the Accidental Permanent Disability Benefit.
(Maximum entry age 17 for Affinity Junior)

NOTICE:

If you do not contact hospital pre-authorisation we will not be able to assist and facilitate with any hospital admission.

If you do not apply for pre-authorisation in advance or within two working days (in the case of an emergency) after receiving treatment, no benefits will be payable.

1.5 **Policy Premiums**

Policy premiums are payable monthly in advance. If the policy premium is not received in time, payment of all benefits in terms of your policy are suspended. There is an extended grace period of 15 (fifteen) days to pay the premium in arrears.

If your contributions fall in arrears for more than 30 days, your policy will be terminated immediately without further notice.

1.6 Payment of Claims

Contact **086 111 0033** for pre-authorisation. Upon discharge you will need to complete the claim form from **www.affinityhealth.co.za** and submit to Affinity Health within 90 days following discharge from hospital.

The policyholder pays the hospital any balance owing or any excess of expenses.

For hospital claims: hospitalclaims@affinityhealth.co.za
For day-to-day claims: refunds@affinityhealth.co.za

1.7 **Policy Cancellations**

You may cancel your policy by giving written notice. In this case, you will still be covered for the remainder of the month for which the last premium was collected. No premiums will be refunded.

Affinity Health reserves the right to cancel your policy or that of any of your dependants if you or any of your dependants:

- Provide false information, or fail to disclose pre-existing conditions when applying for the policy.
- Provide false information upon submission of a claim.
- Allow any other person to use your membership card.
- Commit any other fraudulent act.
- Fail to pay premiums.
- Affinity and its insurer are obligated to either cap benefits or cancel a policy in the event that utilisation is of such significantly high nature, that it affects the risk pool. This practice is to ensure that the risk pool remains healthy and premiums remain affordable.

1.8 General definitions and abbreviations

"Accident" means an unfortunate, sudden, unusual, specific incident which occurs unexpectedly and unintentionally at an identifiable time and place resulting in injury during the period of the Policy.

"Acute medicine" means medicine used for diseases or conditions that have a rapid onset, severe symptoms, and that require a short course of medicine treatment, as well as medicines that qualify for benefits but have not been classified as chronic medicine.

"Adult" means a person who is 18 years or older, excluding full-time students who are younger than 26.

"Beneficiary" means the person nominated by the Principal Member to receive the Family Funeral Benefit payout in the event of death of the Principal Member.

"Benefit start date" means the date on which an Insured Person becomes entitled to benefits.

"Casualty/Emergency Room" means the department of a hospital providing immediate treatment for emergency cases.

"Chronic medicine" means medicine that meets all the following requirements:

- Is prescribed by a Network Medical Practitioner for an uninterrupted period of at least three months,
- Is for a condition appearing on the list of approved chronic conditions, as amended from time to time, and;
- Which has been applied for in the manner and at the frequency prescribed and which application has been approved and accepted.

"Day Procedure" means surgical procedures that can be performed in a single day, without the need to admit the patient for an overnight stay in hospital, for example colonoscopy, endoscopy, tonsillectomy, etc.

"Dependant" means the following persons for whom the principal applicant is liable for care and support who are duly registered as dependants:

- a child – including a natural child, an adopted child, stepchild or foster child, sisters and brothers;
- a full-time student.

"Family" means a policyholder his/her spouse and his/her dependants.

"Fertility Treatment" means any of the constellation of activities and procedures (e.g. in vitro fertilisation, embryo transfer, etc.) which are intended to result in a viable term pregnancy.

"Formulary" means the approved list of medications and procedures authorised by Affinity Health.

"Hospital" means registered unattached theatre and day clinic, but excludes an institution for rehabilitation of substance abuse.

"A high care unit" is an area in a hospital, usually located closely to the intensive care unit, where patients can be cared for more extensively than in a normal ward, but not to the point of intensive care. It is appropriate for patients who have had major surgery and for those with single-organ failure. Patients may be admitted to a High care unit because they are at risk of requiring intensive care admission, or as a step-down between intensive care and ward-based care.

"ICU or Intensive Care Unit (ICU)", also known as a critical care unit (CCU), is a special department of a hospital or health care facility that provides intensive care medicine. Intensive care units cater to patients with severe and life-threatening illnesses and injuries, which require constant, close monitoring and support from specialist equipment and medications in order to ensure normal bodily functions.

"Inception date" means the date on which the registration of the policy becomes effective. Successful inception date is dependent on a successful premium being collected.

"Medicine" means a substance registered under the Medicines and Related Substances Control Act, 1965, as amended or replaced from time to time.

"Multiple Births" means a birth at which two or more children are born at the same time.

"Option" means a product registered under the policy, which offers a specific structure of benefits.

"Policyholder" means a person who has been registered as the principal applicant.

"Minor" means a dependant who is not yet 18 years old, and a dependant who is over the age of 18, but not over the age of 26 years, who is studying full time at a recognised institution.

"Pandemic" means an epidemic of infectious disease that has spread through human populations across a large region, for instance multiple continents or even worldwide.

"Pre-authorisation reference number" is a number allocated by a managed healthcare agent, which is required before certain services qualify for benefits.

"Pre-Existing Condition" means any Dread Disease/Illness for which the Insured Person has already received medical advice and, treatment, or diagnosed within the 90 day waiting period from inception. This includes any signs or symptoms that the Insured may be aware of regardless of seeking medical advice. This also includes any operation prior to the Inception date.

"Service Provider" means a medical practitioner, dentist, pharmacist, medical auxiliary or hospital duly registered or licensed as such with a statutory council or relevant state department.

"Spouse" means a person to whom a client is married under a system recognised by South African law.

"Year" means one calender year from date of inception.

2. DAY-TO-DAY BENEFITS

2.1 Unlimited GP Visits

You may visit your Network-Registered GP as many times as you need to, subject to Affinity Health's Maximum Expenditure Formulary. Your doctor will provide healthcare services and dispense or prescribe medication according to the list of specified generic medications on our formulary.

Although the GP visits and medication is unlimited, the insurer reserves the right to cancel the policy or restrict benefits if utilisation is higher than actuarial calculations in that it affects the risk pool. This is common practice to protect the risk pool and ensures that premiums remain affordable.

The member is responsible for payments for all medication outside of our formulary.

1 Month waiting period applies.

2.2 **Specialist Visit**

1 Specialist Visit per member per year of up to R700 or R1300 per family per year as referred by the Network GP only. This is subject to pre-authorisation.

3 Month waiting period applies.

2.3 **Acute Medication**

All acute medication linked to the doctor consultation dispensed by the Network Provider or obtained on script from a pharmacy linked to our Medicine Formulary is covered. No over the counter benefit is available.

1 Month waiting period applies.

2.4 **Chronic Essential**

Chronic medication is subject to registration and approval and is limited to our chronic medication formulary. Any member who has three or more chronic conditions at time of application will go through an additional underwriting step. If you develop a chronic condition while the cover is in place please contact the Customer Care on 0861 11 00 33 or email chronic@affinityhealth.co.za to request an Chronic Application Form. An additional charge of R58 per member per condition will be added to your premium once this benefit is claimed.

6 Month waiting period applies.

2.5 **Chronic Booster**

We offer additional cover for Chronic Medication for four specific chronic illnesses not covered under the Chronic Essential Medication benefit on our Day-to-Day plan.

Additional cover for medication is available for an additional premium for the following diagnosed illnesses: Depression, Bipolar, Menopause and Diabetes (Type 1).

If you would like to have this booster added to your policy please contact the call centre on 0861 11 00 33

1 Month waiting period applies.

2.6 **Radiology**

Unlimited Basic Radiology (black and white x-rays) linked to the doctor visits as referred by the Network Provider from the Radiology Formulary.

1 Month waiting period applies.

2.7 **Pathology**

Unlimited Basic Pathology linked to the doctor visits as referred by the Network Provider from the Pathology Formulary (basic blood tests).

1 Month waiting period applies.

2.8 **Out-of-Network Visits**

You receive unlimited Out-of-Network Visits, according to Affinity Health's Maximum Expenditure Formulary. The member will pay the GP and claim back the benefit offered from Affinity Health. The member will be entitled to a reimbursement of up to R220 for the consultation. Please remember to ask your GP to prescribe according to our Medication Formulary.

1 Month waiting period applies.

2.9 **Dentistry**

Basic Dentistry includes; full mouth assessment or scale and polish, infecction control, 2 intra oral radiographs, extractions (Maximum of 3 per member per annum), 3 amalgam fillings. Treatment as per Affinity Health Formulary.

3 Month waiting period applies.

2.10 **Optometry**

One eye test per beneficiary per 24 months and one set of standard frames and lenses. Only available at Spec Savers nationwide. No contact lenses will be covered.

12 Month waiting period applies.

2.11 **Emergency After Hours Casualty Benefit**

After Hours Emergency Casualty Benefit amount of up to R2 500 per 12 (twelve) month period if you take either the Day-to-Day or the Hospital product and up to R4 000 per 12 (twelve) month period if you take the Combined product. Pre-Authorisation must be obtained by calling the 24 hour pre-authorisation number 0861 11 00 33 as displayed on your Affinity Health Membership Card. This benefit is only available after hours from 16h30 to 08h30 during weekdays and on Saturdays, Sundays and Public Holidays.

3. HOSPITAL BENEFITS

3.1 Daily Illness Hospital Benefit

The following stated benefits are payable for illness hospitalisation:

1st Day	2nd Day	3rd Day	4th Day	5th Day
R8500	R5500	R5000	R4000	R4000

thereafter R1 500 per day up to max of 21 days per member, per illness event.

Maximum benefit payable is R51 000.00. There is a 3 month waiting period for illness.

3.1.1 ICU Booster Benefit

If you have taken the ICU Booster Benefit, your daily amount allocated will be increased to a maximum of R12 500 per day up to a maximum of 5 days spent in ICU. Same waiting periods pertaining to Illness Hospitalisation and Pre-Existing Conditions will apply.

3.2 Specific Stated Conditions Benefit

The following stated benefits are payable regardless of the days admitted for these conditions:

Stated Benefit	Amount Payable	Waiting Period
Appendix Removal	R30 000	12 months
Kidney Stones - Theatre	R30 000	12 months
Ectopic Pregnancy	R20 000	12 months
Hernia	R15 000	12 months

Stated Benefit	Amount Payable	Waiting Period
Gall Bladder Removal	R40 000	12 months
Miscarriage	R10 000	12 months
Maternity (Natural)	R20 000	12 months
Maternity C-Section	R30 000	12 months
Hysterectomy	R40 000	24 months

The above procedures require authorisation and will only be covered under Specific Stated Conditions if 12 month's consecutive premiums have been received. If the policy is less than 12 months old, then the Stated Daily Benefits are not applicable. Pre-existing waiting periods of 24 Months will still apply.

3.3 Accidental Hospitalisation

Medical expenses as a result of an accident are payable up to R175 000 per incident, per single person and up to R275 000 per incident, per family.

3.3.1 Accident Benefit Booster

If you have taken the Accident Benefit Booster Product benefits will be increased up to R1 050 000 for the single Accident Benefit Booster and up to R1 000 000 for the Family Accident Benefit Booster depending on the option chosen by you.

If you would like to have the benefit booster added to your policy please contact the call centre on 0861 11 00 33.

3.4 Accidental Permanent Disability

R250 000 is payable in respect of the permanent disability of the principal member or the nominated spouse. This is a once-off benefit.

3.5 Dread Disease

R200 000 payable in instalments of R9 000 for every 24 hours admitted to hospital or upon diagnosis covering: Heart Attack, Coronary Heart Disease, Cancer, Stroke, Kidney Failure, Major Organ Transplant, Paraplegia and Blindness.

Pre-existing and 6 month waiting periods are applicable.

3.6 24hr Medical Assistance

24 hour emergency response by use of paramedics in rapid road response vehicles and, where necessary, air ambulance. 24 hour emergency medical advice line for CPR, choking, bleeding control or any other medical emergency to be administered while paramedics respond. Treatment and stablisation at the scene of the emergency. Medical transportation to the closest most appropriate hospital.

Pre-Existing:

- Pre-existing conditions are subject to a waiting period of 24 months or may be excluded in their entirety if agreed to by the Insurer in writing.
- Illnesses diagnosed within the initial 3 month waiting period are considered pre-existing and the 24 month waiting period for pre-existing conditions shall apply.

- Dread Diseases diagnosed within the initial 6 month waiting period are considered pre-existing and may be excluded.

Notice:

- The Affinity Health Hospital Plan is not a medical aid scheme, but an insured stated benefit hospital plan, in that the daily cash benefits are payable to the member and not to the medical services provider, alternatively your benefits may be ceded to the hospital.
- Maximum entry age is 54.
- Persons not eligible for the Hospital Plan are employees of SAPS & SADF and pre-existing HIV applicants among others. For a full list of exclusions please refer to your Policy Wording.

4. BENEFITS APPLICABLE TO BOTH DAY-TO-DAY & HOSPITAL PLAN OPTIONS

4.1 Post Hospital Private Home Nursing

Post Hospital Private Home Nursing of up to R10 000 per family per annum is provided where the member is totally unable to perform 3 or more activities of daily living because of illness or accidental injury without the help of another person, but with the use of appropriate assistive or corrective aids and appliances. This must be confirmed in a report from the member's Network GP, and an examination by a medical professional appointed by Affinity Health:

- Washing: The ability to wash in a bath or shower (including getting into and out of a bath or shower)
- Dressing: The ability to put on, take off, secure and unfasten all garments
- Feeding: The ability to cut meat, butter bread and to get food and drink into the mouth using fingers or utensils
- Toileting: The ability to use the lavatory and to recognise the need to void the bladder or bowel
- Mobility: The ability to move indoors from room to room on level surfaces
- Transferring: The ability to move from a bed to a chair or wheelchair and vice versa
- Communicating: The ability to answer the telephone and take a message

Full time care is defined as direct supervision and assistance for at least 25 hours per week. Affinity Health is a health insurance policy not a medical aid scheme.

4.2 Family Funeral Benefits

Package	Day-to-Day	Hospital Plan	Combined
Principal Member	R12 500	R25 000	R30 000
Spouse & Children over 14	R12 500	R10 000	R15 000
Children age 6 to 14	R6 000	R5 000	R10 000

3 Month Waiting Period

Package	Day-to-Day	Hospital Plan	Combined
Birth to age 6	R3 000	R2 500	R5 000
Stillborn from 28 weeks	R1 500	R1 250	R2 500

4.2 Family Funeral Benefits continued

Repatriation of mortal remains benefit

- Repatriation of mortal remains within South Africa
- When a member's death occurs more than 100km from their normal place of residence / place of burial, the deceased will be transported to the place of burial irrespective of where the death occurred, or where the burial will take place, provided that the repatriation is within the defined territory
- 24 hour client and claims assistance service

General Terms & Conditions

Affinity Health must be notified of death claims within 6 months of a member's death. Even if all the required information is not yet available, Affinity must still be notified of the potential claim.

The following information is required to process a claim (standard claims package)

- Fully completed, signed and stamped claim form
- Copy of the deceased's identity document
- Copy of the death certificate
- Copy of the beneficiary nomination form
- Copy of the premium schedule
- Beneficiaries' banking details – If we are paying an institution, we will need confirmation of banking details on the institution's letterhead.
- If the cause of death is unnatural – a copy of the police statement is required.

Spouse's Funeral Benefit – all of the above, including:

- Copy of the main member's identity document
- Copy of the marriage certificate, if not available, a copy of the Lobola letter is required.

Children's Funeral Benefit – all the above, including:

- If no identity document or birth certificate – a copy of the clinic card or a hospital file is required
- If the child is over the age of 20 – we require a certified copy of a letter from the educational facility confirming that the child is registered and the course / grade that they are registered for.

5. PROCEDURES

5.1 Claims Procedure

5.1.1 Day-to-Day Benefits

Claims for GP visits, prescribed medication and other Day-to-Day Benefits are all covered when your premium is paid. Should your GP or Medical Services Provider charge a rate above the benefit payable on your policy, **then such difference is payable by the member.**

When making use of a Service Provider that is not on our Network it is important to inform your GP that medicines prescribed outside of our formulary are not covered and the pharmacy will require the member to pay for such medicines. **Prescribed medication that is not within our formulary is payable by the member.**

The same applies to Pathology and Radiology and members are cautioned to inform their GP of our formularies.
Day-to-day claims can be emailed to **refunds@affinityhealth.co.za.**

5.1.2 Hospital Plan Benefits

Once you have been discharged from hospital you can either download a claim form from our website www.affinityhealth.co.za or you can call us on 0861 11 00 33 to get the form e-mailed or faxed to you.

Hospital claims can be emailed to: **hospitalclaims@affinityhealth.co.za**. Pre-Authorisation must be obtained before any hospital admission.

5.2 Policy Amendment Procedure

Should you wish to change your personal details, amend your policy or add dependants onto your existing policy please contact either the office or e-mail info@affinityhealth.co.za along with your membership number.

5.3 Payment Procedure

Premiums are pre-paid by debit order on the given date that you request on the application form.

6. FREQUENTLY ASKED QUESTIONS

6.1 Day-to-Day Benefits

Can I go to any Doctor and are the visits unlimited?

Answer: The Network Doctor you choose will become your regular GP. The GP visits are unlimited subject to Affinity Health's Maximum Expenditure Formulary. Alternatively, you may visit any doctor of your choice and claim back the benefit payable. Please note that should your GP charge a higher rate than the benefit payable on your plan, you shall be responsible for payment of the difference. Please also request your GP to prescribe medication within our formulary if appropriate. The member is responsible for payments for all medication outside of our formulary.

What happens if I am ill and out of town?

Answer: The Affinity Health Day-to-Day plan caters for unlimited out-of-area visits, provided that they are within South Africa. Call in and request a GP for your current area. Alternatively you can go to a GP of your choice, provided that you pay for the consultation and afterwards reclaim the benefit payable from Affinity Health.

Please note that should your GP charge a higher rate than the benefit payable on your plan, you shall be responsible for payment of the difference. Please also request your GP to prescribe medication within our formulary. The member is responsible for payments for all medication that is not within our formulary. This also applies to Pathology and Radiology.

Send Affinity Health a copy of your receipt and you will be reimbursed the agreed stated insured benefit for the consultation.

What happens if there isn't a Network Doctor in my area? Can I nominate my own GP?

Answer: Call Affinity Health on 086 111 0033 or email us at admin@affinityhealth.co.za to nominate your own doctor.

We will first establish if there is an existing GP in the area and if not, we will contact your GP to establish if he would like to join the network, but the choice to join will be up to the GP.

Are Specialist visits covered?

Answer: One Specialist visit per family member per annum as referred by the Network doctor for up to R700 for a single member and R1300 for the family.

Can I buy my medication over the counter?

Answer: No, your Network GP has to prescribe medication in accordance to the Medication Formulary. If your Network Doctor is a non-dispensing practitioner, your GP will provide you with a script to be submitted to a Clicks, Dischem or Mediscor pharmacy. The member is responsible for payments for all medication that is not within our formulary.

Do I have to select a Dentist from the Network list?

Answer: Yes, you have to select a Dentist from the Network and remember; only basic dentistry is covered i.e. preventative treatment (cleaning), fillings and normal extractions performed in the Dentist's chair only.

Can I see a GP if I am outside SA?

Answer: You are only covered within South Africa.

Is Physiotherapy covered?

Answer: No, Physiotherapy is not covered. It will only be covered under the Affinity Hospital Plan Benefits, following a hospital admission due to an accident and limited to the insured sum.

Can I go to any optometrist for my glasses?

Answer: No, but you can go to any Specsavers branch countrywide.

6.2 Hospital Plan Benefits

Can I go to any hospital?

Answer: With an Affinity Health Hospital Plan you can go to any hospital i.e. Private or State, but remember the Stated Benefits as described in the Policy Wording, will be paid to you and you will be responsible for settling with the hospital.

What happens if I am admitted to hospital following an accident and I only end up being in hospital for a few hours, will I still be covered?

Answer: For accident events, there is no time restriction.

What happens if I am ill and I am admitted to hospital for less than 24 hours?

Answer: A member has to be admitted to hospital for a full 24 hours before the benefits are payable.

What happens if I fall ill or have an accident outside SA?

Answer: You are only covered within South Africa, but if you have an accident or fall ill in one of the immediate neighbouring countries, being Swaziland, Lesotho, Botswana, Namibia, Mozambique or Zimbabwe, you will have to travel to the nearest South African border post and request assistance by calling 086 111 0033.

How do I get admitted to hospital?

Answer: You call the Affinity Health 24hr pre-authorisation number 086 111 0033 as displayed on your Affinity Health membership Card. Quote your membership number and the reason for your admission (more than likely you will have a doctor's note which you can relay to the authorisation clerk). Always remember to carry your Affinity Health membership card with you and the emergency stickers provided should be displayed on your windscreen/cell phone.

How do I claim my hospital plan benefits?

Answer: Following your discharge from hospital, you can either download a claim form from the Affinity Health website www.affinityhealth.co.za or you can call Affinity Health on 086 111 0033 and request that a claim form be faxed to you. Once the claim form is completed, return it to claims@affinityhealth.co.za or fax: 086 607 9419 or post it to Affinity Health, Postnet Suite 124, Private Bag X101, Farrarmere, Benoni, 1518.

Any claim form received after 120 days following discharge from hospital, will be declined.

NB. Remember to attach all the necessary hospital and doctor invoices to your claim form. Not doing so will result in a delay in the settlement of your claim.

Do`s and Dont`s

Always...		Or you may...
Make use of a network GP. The list is available on www.affinityhealth.co.za or contact customer care department on 0861 11 00 33.	**GP Consultations** 1 Month Waiting Period	Have to pay upfront for your consultation and claim back a partial amount. You may also have to pay for prescribed medication that is not according to the formulary.
Ensure you get a referral from a network GP for your specialist visit.	**Specialist Visits** 3 Month Waiting Period	You may be liable for the payment as there are some exclusions and limits.
Ask your GP to prescribe medication that is on the Affinity Health formulary.	**Acute Medication** 1 Month Waiting Period	Be required to contribute towards your medication costs.
Register as a chronic member before trying to claim your chronic medication (remember there is a 6 month waiting period).	**Chronic Medication** 6 Month Waiting Period	Not have your medication dispensed and you may have to revisit the doctor to obtain a script and complete the Chronic Application form.
Get a referral letter from your Network Doctor should you require x-rays or blood tests. Check with the doctor or Customer Care Department if the codes requested are on the formulary.	**Radiology & Pathology** 1 Month Waiting Period	Be liable for payments on the tests done as they are not according to the formulary.
Ask your Network Dentist to obtain pre-auth to check if you are fully covered for procedures that are required.	**Dentistry** 3 Month Waiting Period	Be required to pay for procedures that you are not covered for.

Always...		Or you may...
Visit Spec-Savers when getting prescription spectacles. Choose frames from the Spec-Savers grey sticker range. (remember there is a 12 month waiting period)	**Optometry** 12 Month Waiting Period	Be required to pay for the visit and any spectacles prescribed if you make use of another provider.
Obtain pre-auth for the after hour casualty benefit in the event of severe illness or injury. Pre-auth may be obtained on 0861 11 00 33.	**Casualty Benefit** 1 Month Waiting Period	Be liable for the payment of these accounts.
Call the pre-auth line to obtain pre-authorisation 0861 11 00 33	**Illness Benefit** 3 Month Waiting Period	Be declined at the hospital admissions counter or be liable for the accounts.
Ensure that your premiums are paid up to date.	**Premiums**	Have a claim that is declined as your benefits will be suspended.
Contact our Customer care department if there are any changes that you need to make to your policy.	**Amendments**	Not receive important correspondence sent by Affinity Health or have a claim repudiated as a result of non-disclosure.
Ensure that claims are submitted within the appropriate time frames.	**Claims**	Have a claim that is deemed invalid and thus declined.

Thank you for choosing Affinity Health as your medical insurance provider. Your health is our priority where your whole family can now enjoy private health care at affordable rates. We look forward to a long and healthy relationship with you.

Notes

Notes

Notes

www.facebook.com/affinityhealthcoza

PHYSICAL ADDRESS

1 Dingler Street
Rynfield
Benoni
South Africa

POSTAL ADDRESS

Postnet Suite 124
Private Bag X101
Farrarmere
Benoni
1518

CONTACT US

To discuss your healthcare needs call:

0861 11 00 33

To fax your documentation:

086 607 9419

Affinity Health, a product of National Risk Managers (Pty) Ltd (FSP 47132), the Underwriting Manager; Lion of Africa Life Assurance Company Ltd (FSP 15283), the Insurer and its Service Providers reserve the right to decline any application for cover. This policy shall be voidable in the event of misrepresentation, misdescription or non-disclosure of any particular material fact to this insurance by or on behalf of an insured person. Terms and conditions as contained in the policy document apply.