AFFINITY HEALTH JUNIOR

A Product of National Risk Managers (Pty) Ltd

Policy Document 2018

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1. BACKGROUND

1.1 The Policyholder named in the Policy Schedule has applied to the Insurer for the insurance as hereinafter set out. The Insurer hereby agrees to accept the risk in terms of this contract of insurance or any endorsement, alteration or variation to it, made in writing, subject to:

1.1.1 any proposal or other information supplied by, or on behalf of the Insured Person;

1.1.2 disclosure of all facts and circumstances known to the Insured Person that might be material to the assessment of the risks insured hereby, and which information forms part of the underwriting basis of this Policy; and

1.1.3 the condition of prior payment of the Premium by, or on behalf of, the Policyholder and the receipt thereof by, or on behalf of the Insurer notwithstanding anything to the contrary set out in this Policy or any section thereof.

2. DEFINITIONS

In this Policy, unless the context indicates a contrary intention, the following words and expressions bear the meanings assigned to them and cognate expressions bear corresponding meanings –

2.1 "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;

2.2 "Acute Medication" means medication used for diseases or conditions that have a rapid onset, severe symptoms and that require a short course of medicine treatment that lasts less than 90 days;

2.3 "Admission" means admission into a Hospital as an inpatient;

2.4 "Affinity Health Junior" means the junior product of National Risk Managers (Pty) Ltd, the Underwriting Managing Agency (UMA);

2.5 "Benefit" means the Benefit amount as set out in the Policy Schedule, provided by the Insurer in terms of this Policy;

2.6 "Benefit Start Date" means the date on which an Insured Person becomes entitled to benefits, upon completion of Waiting Periods;

2.7 "Bodily Injury" means Bodily Injury by violent, external and visible means caused by an Accident but shall include Bodily Injury caused by starvation, thirst and exposure to the elements as a result of a road accident;

2.8 "Casualty/Emergency Room" means the department of a Hospital providing immediate treatment for emergency cases;

2.9 "Chronic Medication" means medication that meets all the following requirements:

- Is within the Affinity Health formulary, as amended from time to time, and 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;
- Has been applied for in the manner and at the frequency prescribed and which application has been approved and accepted.

2.9.1 Maximum benefits per annum may be applied on certain conditions.

2.10 "Commencement Date" means the date on which the application for this insurance becomes effective, as specified in the Policy Schedule;

2.11 "Compensation" means the amount payable to the Insured Person in the event of a Benefit claim.

2.12 "Day" means 24 consecutive hours from time of Admission;

2.13 "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 etc;

2.14 "Defined Event" means the event which gives rise to the Insured Person having to seek medical treatment as set out in the schedule hereto, but excludes instances where, in the opinion of the Insurer, multiple treatments are sought and/or accepted where fewer treatments will suffice or other non-essential and premeditated acts of selection against the Insurer;

2.15 "Dread Disease" means any of the following:

2.15.1 Heart Attack as defined in clause 4 of Annexure 1;

2.15.2 Chronic Coronary Heart Disease, open-heart bypass surgery or surgical treatment of Coronary disease. This excludes angioplasty and/or any similar intra-arterial procedures;

2.15.3 Stroke as defined in clause 5 of Annexure 1;
2.15.4 Cancer as defined in clause 3 of Annexure 1;
2.15.5 Kidney Failure defined as end stage renal failure presenting a chronic irreversible failure of both kidneys to function, as a result of which regular renal dialysis is required on a long-term basis;
2.15.6 Major Organ Transplant defined as organ transplant from a human donor to the Insured Person of one, or more, of the following organs: Kidney, Heart, Lung, Liver, Pancreas or Bone Marrow. Transplantation of all other organs, parts of organs or any other tissue is excluded;

2.16 "EMS" means the emergency medical response unit available to the Insured Persons for urgent medical assistance;

2.17 "Formulary" means the exhaustive lists of procedures, prices and service providers, as approved and amended from time to time by Affinity Health, which together constitutes the maximum limit of Benefits which Affinity Health will be bound to pay in terms of this Policy;

2.18 "High Care" means the unit of a Hospital where patients can be cared for more extensively than a normal ward, but not to the point of intensive care;

2.19 "Hospital" means an establishment which meets all of the following requirements:
2.19.1 holds a licence as a Hospital or day clinic or nursing home (if licensing is required in the province or government jurisdiction);
2.19.2 operates primarily for the reception, care and treatment of sick, ailing or injured persons as inpatients;
2.19.3 provides organised facilities for diagnosis and surgical treatment;
2.19.4 is not primarily a rest or convalescent home or similar establishment and is not, other than incidentally, a place for rehabilitation of alcoholics or drug addicts;

2.20 "Illness" means the onset of any acute somatic, unforeseeable, unpredictable Illness (excluding mental Illness) which requires Admission to Hospital, and which was not a Pre-Existing Condition (unless otherwise provided for herein). A recurrence of any Illness will only be considered a separate Illness if 6 (six) months have lapsed from the date of onset of the preceding Illness;

2.21 "Insured Persons" means the Minors, on whose behalf the Policyholder has taken this Policy, and excludes the Policyholder;

2.22 "Insurer" means Lion of Africa Life Assurance Company Limited (FSP 15283);

2.23 "Medicine" means a substance registered under the Medicines and Related Substances Control Act, 1965, as amended or replaced from time to time and within the Affinity Health formulary;

2.24 "Minor" means an Insured Person who is not yet 18 years old;

2.25 "National Risk Managers (Pty) Ltd" means the Underwriting Managing Agency (FSP 47132) and Binder Holder of the Affinity Health Junior Product;

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

2.27 "Policyholder" means the parent or person responsible for a Minor that has applied for this Policy on behalf of a Minor;

2.28 "Policy Schedule" means the long-term insurance policy schedule issued to the Policyholder in terms of section 48 of the Long-term Insurance Act;

2.29 "Pre-Existing Condition" means any Bodily Injury, Illness, Dread Disease, signs or symptoms whether existing or diagnosed that:

- The Insured Person sought or received medical advice, treatment, hospitalisation or monitoring for before the Benefit Start Date;
- The Insured Person could reasonably have been expected to have sought or received medical advice, treatment, and hospitalisation or monitoring for before the Benefit Start Date;
- The references in this definition to advice, treatment or monitoring include conventional or alternative advice, treatment or monitoring.

2.30 "Premium" means the premium payable to the Insurer on a monthly basis in terms of this Policy in order to secure the Benefits;

2.31 "Professional Sport" means a sporting activity in which an Insured Person engages and from which such Insured Person derives the majority of their monthly income;

2.32 "SCIDEP" means the ASISA Standardised Critical Illness Definitions Project;

2.33 "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;

2.34 "Superbug" means a pathogenic bacterium that has developed immunity to generally used antibiotics or resistance to drugs normally used to control or eradicate them;

2.35 "Territorial Limits" means the Republic of South Africa;

2.36 "The/This Policy" means this insurance agreement concluded between the Insurer and the Policyholder in respect of the Benefits underwritten by the Insurer;

2.37 "Underwriting" means the assessment of risk in terms of the Affinity Health Junior Policy;

2.38 "Waiting Period" means the number of months/days you have to wait from Commencement Date before you can access your Benefits;

2.39 "Writing" (or words of similar meaning) means legible Writing, in English, and includes any form of electronic communication contemplated in the Electronic Communications and Transactions Act, 25 of 2002;

2.40 "Year" means a calendar year.

2.41 Any reference to the singular includes the plural and vice versa; and

2.42 Any reference to a gender includes the other gender.

2.43 The clause headings in this Policy have been inserted for convenience only and shall not be taken into account in its interpretation.

2.44 If any provision in a definition is a substantive provision conferring rights or imposing obligations on any party, effect shall be given to it as if it were a substantive clause in the body of the Policy, notwithstanding that it is only contained in the interpretation clause.

2.45 This Policy shall be governed by, construed and interpreted in accordance with the law of the Republic of South Africa.

3. GENERAL PROVISIONS

3.1 This Policy together with the Policy Schedule and application form constitute the entire Policy and no other conditions, stipulations, warranties and representations whatsoever have been made by any party or that party's agent, other than as specifically included herein.

3.2 Unless otherwise provided for, Insured Persons must be below the age of 17 (seventeen) years at the time of application.
3.2.1 Benefits for Insured Persons will cease at the age of 18 (eighteen) years, unless otherwise agreed.

3.3 Once any Insured Person has been insured under this Policy for a period of 24 (twenty-four) consecutive months, any Pre-Existing Condition shall no longer apply, unless otherwise stated on the Policy Schedule.

3.4 There is a 31 (thirty-one) day cooling off period to cancel the Policy. If the Policyholder does not wish to continue with their Affinity Health Junior Policy, he/she must inform Affinity Health within 31 (thirty-one) days of receiving it. Any Premiums paid will be refunded and Affinity Health will confirm in writing that the Policy has been cancelled. Should cancellation fall outside this 31 (thirty-one) day period, Premiums will not be refunded.

3.5 Insurance cover shall commence on the Commencement Date subject to receipt of the first Premium by the Insurer.

3.6 This Policy and the Policy Schedule shall be read together as one contract and any word or expression to which a specific meaning has been attached in any part of this Policy or the Policy Schedule shall bear specific meaning wherever it may appear.

3.7 The Policyholder will be notified of any changes to the terms and conditions, including the Premium of the Policy by giving the Policyholder 31 (thirty-one) days notice in writing to the Policyholder's last known address or email address. Changes will only be made in order to reflect a change in the Insured Person's circumstances (i.e. premium age band changes), or in the event of a change in the law affecting this Policy, or changes to Affinity's underwriting or actuary recommendations (i.e. changes in benefits). If the changes are acceptable to the Policyholder, the policy will continue. If changes are not acceptable, the Policyholder may cancel this Policy in accordance with Sections 5 (Amendment/Upgrade/Cancellation Procedures). If the Policyholder cancels the Policy, no claim will be payable in respect of any claim after the next due date following the date that notice of cancellation was received.

3.8 This Policy may be cancelled at any time by the Insurer giving 1 (one) month notice in writing or such other period as may be mutually agreed upon.

3.9 This Policy is not assignable. Compensation shall be payable only to the Insured Person or their estate, whose receipt shall for all intents and purposes discharge the Insurer.

3.10 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.

3.11 This Policy does not accumulate cash or surrender value and may not be converted into a paid up product.

3.12 The Insured Persons shall only be covered within the Republic of South Africa. Should such person have an accident or fall ill in one of the immediate neighbouring countries, being Swaziland, Lesotho, Botswana, Namibia, Mozambique or Zimbabwe, such Insured Person shall travel to the nearest South African border post and request assistance by calling the Affinity Health Telephone Number displayed on the membership card.

4. WAITING PERIODS

4.1 Day-to-Day Benefits

4.1.1 The following Benefit has no Waiting Period and is applicable from Commencement Date:
- Post-Hospital Private Home Nursing

4.1.2 The following Benefits are subject to a 1 (one) month Waiting Period from Commencement Date:
- Doctor Consultations
- Medical Society Clinic Consultations
- Casualty Room Treatment
- Acute Medication
- Radiology and Pathology
- Out-of-Network Visit

4.1.3 The following Benefits are subject to a 3 (three) month Waiting Period from Commencement Date:
- Dentistry
- Specialist Visit

4.1.4 The Optometry Benefit is subject to a 12 (twelve) month Waiting Period from the Commencement Date.

4.2 Hospital Benefits

4.2.1 The following Benefits have no Waiting Period and are applicable from Commencement Date:
- Accident Benefit
- 24-Hour Emergency
- Post-Hospital Private Home Nursing

4.2.2 The following Benefit is subject to a 1 (one) month Waiting Period from Commencement Date:
- Casualty Room Treatment

4.2.3 The following Benefit is subject to a 3 (three) month Waiting Period from Commencement Date:
- Daily Illness Hospitalisation

4.2.4 The following Benefit is subject to a 6 (six) month Waiting Period from Commencement Date:
- Dread Disease

4.2.5 The following Benefit is subject to a 12 (twelve) month Waiting Period from Commencement Date:
- Specific Stated Conditions

4.2.6 Pre-Existing Conditions have a 24 (twenty-four) month Waiting Period from Commencement Date:

4.3 Optional Benefits are subject to the below Waiting Periods from Commencement Date:
- Chronic Essential: 6 (six) month Waiting Period.
- Chronic Booster: 1 (one) month Waiting Period.
- Accident Booster: No Waiting Period
- ICU Add-on: 3 (three) month Waiting Period

5. AMENDMENT/UPGRADE/CANCELLATION PROCEDURE

5.1 Should you wish to change your personal details, amend any option or add Insured Persons onto your existing product please contact the Affinity Health offices directly on 0861 11 00 33, or e-mail info@affinityhealth.co.za along with your membership number.

5.2 You may cancel your membership by giving written notification. You will, however, still be covered for the remainder of the month for which the last Premium was collected. No Premiums will be refunded in instances where Benefits were not utilised by the Insured Persons.

5.3 Should you wish to reinstate your Policy after cancellation, you may do so within 2 (two) months from the cancellation becoming effective. However, the Commencement Date of the Policy will change to that of reinstatement, and the standard Waiting Periods mentioned herein will apply.

5.4 Affinity Health reserves the right to cancel or vary your membership or that of any of the Insured Persons by giving written notification, where possible, if you or any of the Insured Persons:

5.4.1 Provide false information or fail to disclose Pre-Existing Conditions when applying for any option;
5.4.2 Provide false information upon submission of a claim;
5.4.3 Allow any other person to use your membership card;
5.4.4 Commit any other fraudulent act;
5.4.5 Fail to pay Premiums;
5.4.6 Generally act in a manner indicative of a premeditated selection against the Insurer.

5.5 Affinity Health 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.

5.6 No amendment or cancellation of the Policy shall be of any force and effect unless such amendment or cancellation is in writing and signed by Affinity Health.

6. PREMIUM PAYMENTS

6.1 Premiums are payable monthly in advance via debit order from the chosen bank account of the Policyholder on the day of the month selected by him/her from the list of dates provided. If the Premium is not paid on the payment date, you have a 15 (fifteen) day grace period after which we will automatically deduct the Premium from the same account to ensure continuous cover for the period for which you did not pay. If your Premiums are paid monthly, the grace period will only apply from the second month of cover. If your contributions fall in arrears for more than 1 (one) month without alternative arrangements being made, your membership will lapse.

6.2 If your membership lapses due to non-payment you may, subject to the exercise of its discretion by Affinity Health, reinstate the product within the first 2 (two) months of such lapsing by making application for reinstatement in accordance with section 5 above.

6.3 The Insurer can increase the Premium annually at its discretion and based on the actuarial considerations, provided that the Policyholder is notified of any such increase in writing, 31 (thirty-one) days in advance.

7. BENEFITS

7.1 **Day-to-Day Benefits**

If selected, the following Policy Benefits are payable, subject to the Affinity Health formulary:

7.1.1 Doctor Consultations
Unlimited, managed General Practitioner (GP) Consultations subject to a maximum rand value as per Affinity Health's Maximum Expenditure Formulary – defined as R 286.00 per consultation for a non-dispensing doctor and R315.00 for a dispensing doctor.

7.1.2 Medical Society Clinic Consultations
Unlimited, managed visits to a Medical Practitioner at a Medical Society Centre. Includes Acute Medication prescribed and dispensed by the Medical Practitioner.

7.1.3 Specialist Visit
1 (one) specialist visit per single member policy per year up to R700 or up to R1 300 per family policy per year as referred by a network GP only. Pre-authorisation is required.

7.1.4 Casualty Room Treatment

After hours emergency casualty room treatment up to R2 500 per policy per 12 (twelve) month period. Pre-authorisation is required. This Benefit is only available from 16h30 to 08h30 during weekdays and on Saturdays, Sundays and public holidays.

7.1.5 Acute Medication

Acute Medication linked to a doctor consultation and either prescribed or dispensed by the doctor will be covered, subject to the Affinity Health Medicine Formulary.

Insured Persons are responsible for payment of medication outside of the Medicine Formulary.

7.1.6 Radiology

Unlimited basic radiology as referred by a network GP, subject to Affinity Health's Maximum Expenditure Formulary. Black and white x-rays only.

7.1.7 Pathology

Unlimited basic pathology as referred by a network GP, subject to Affinity Health's Maximum Expenditure Formulary.

7.1.8 Out-of-Network Visits

Unlimited out-of-network visits subject to Affinity Health's Maximum Expenditure Formulary. The Insured Person will pay the GP and claim back from Affinity Health.

The Member will be entitled to a reimbursement amount of up to R220 for the consultation. Please remember to ask the GP to prescribe medication according to Affinity Health's Medicine Formulary.

7.1.9 Dentistry

Basic dentistry cover including 1 (one) full mouth assessment or 1 (one) scale and polish, infection control, 2 (two) intraoral radiographs, 3 (three) extractions and 3 (three) amalgam fillings per member per year. Treatments as per Affinity Health's Maximum Expenditure Formulary.

7.1.10 Optometry

1 (one) eye test and 1 (one) set of standard frames and lenses per member per 24 (twenty-four) months, subject to Affinity Health's Maximum Expenditure Formulary. Only available from Spec-Savers. No cover for contact lenses.

7.1.11 Post-Hospital Private Home Nursing

Up to R10 000 per policy per annum is provided where the member is totally unable to perform 3 (three) or more activities of daily living, listed below, 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 a 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.

7.2 Hospital Benefits

If selected, the following Policy Benefits are payable, subject to the Affinity Health formulary:

7.2.1 Accident Cover

Cover in the event of an Accident as defined in Section 2 above. Up to R175 000 per single member per event or R275 000 per family per event.

7.2.2 Casualty Room Treatment

After hours emergency casualty room treatment up to R2 500 per policy per 12 (twelve) month period. Pre-authorisation is required. This Benefit is only available from 16h30 to 08h30 during weekdays and on Saturdays, Sundays and public holidays.

7.2.3 24-Hour Emergency

24-Hour response by use of paramedics in rapid response vehicles and, where necessary, air ambulance. Includes treatment and stabilisation at the scene of the emergency and transportation to the closest, most appropriate Hospital. Access to a 24-Hour medical advice line for assistance with CPR, choking, bleeding control or any other medical emergency.

7.2.4 Daily Illness Hospitalisation

When hospitalised due to Illness, the following amounts will be payable:

1st Day	2nd Day	3rd Day	4th Day	5th Day
R8 500	R5 500	R5 000	R4 000	R4 000

thereafter R1 500 per day up to a maximum of 21 days per member, per illness event.
Maximum benefit payable is R51 000.00.

7.2.4.1 If an Insured Person is admitted into Hospital within a 6 month period for the same or similar illness, the Benefit amount payable will recommence from the last day of the previous admission.

7.2.5 Specific Stated Conditions Benefit

The following stated Benefits are payable regardless of the days spent in Hospital as an inpatient:

Tonsillectomy & Adenoidectomy	R10 000
Myringotomy (With or without grommets)	R7 500
Circumcision	R9 500
Hernia	R25 000
Sinus Procedures	R15 000
Orchiopexy	R15 000
Appendix Removal	R30 000

7.2.5.1 Cover will only be provided for umbilical and inguinal hernias.
7.2.5.2 This Benefit will only be payable if 12 (twelve) months' consecutive Premiums have been received.
7.2.5.3 Only one claim per Specific Stated Condition per 12 (twelve) month period will be payable.

7.2.6 Dread Disease

R9 000 payable per day upon diagnosis of a Dread Disease as described in clause 2.15 above , up to a maximum of R200 000.

7.2.6.1 Upon payment of 100% of the Benefit amount, this Benefit will be terminated and cannot be reinstated.

7.2.7 Post-Hospital Private Home Nursing

Up to R10 000 per policy per annum is provided where the member is totally unable to perform 3 (three) or more activities of daily living, listed below, 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 a 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.

7.3 If selected, optional benefits are payable as follows:

7.3.1 Chronic Essential

Chronic Medication covered under the Chronic Essential Benefit and linked to the Affinity Health Medicine Formulary will be dispensed by a Network GP or obtained on script from a pharmacy linked to Affinity Health. Medication is endorsed upon application for this Benefit.

An additional surcharge of R65 per member per condition will be payable by the Policyholder when this Benefit is claimed.

7.3.2 Chronic Booster

Chronic Medication covered under the Chronic Booster Benefit will be dispensed by a Network GP or obtained on script from a pharmacy linked to Affinity Health. Medication is endorsed upon application for this Benefit.

An additional surcharge will be payable by the Policyholder when this Benefit is claimed.

Any Member with 3 (three) or more chronic conditions will be subject to an additional underwriting process.

7.3.3 Accident Booster

The Accident booster accompanies the Accident Cover Benefit. The amount payable for this Benefit will increase according to the level of Booster selected by the Insured Person:

Single		Family	
OPTION	COVER	OPTION	COVER
Level 1	R250 000	Level 1	R400 000
Level 2	R350 000		
Level 3	R450 000	Level 2	R550 000
Level 4	R550 000		
Level 5	R650 000	Level 3	R700 000
Level 6	R750 000		
Level 7	R850 000	Level 4	R850 000
Level 8	R950 000		
Level 9	R1 050 000	Level 5	R1 000 000

7.3.4 ICU Add-On

The ICU Add-On Benefit accompanies the Daily Illness Hospitalisation Benefit and provides Insured Persons with R12 500 cover per day spent in ICU, up to a maximum of 5 (five) days. If claimed, this Benefit amount will replace any amount payable by the Daily Illness Hospitalisation Benefit.

7.4 If a Combined Plan has been selected by the Policyholder, the following Benefits will be payable:

7.4.1 Casualty Room Treatment:

After hours emergency casualty room treatment up to R4 000 per policy per 12 (twelve) month period. Pre-authorisation is required. This Benefit is only available from 16h30 to 08h30 during weekdays and on Saturdays, Sundays and public holidays.

7.5 The Insured Persons must make application for pre-authorisation of certain Benefits as contained in this document. Moreover, the Insured Person must determine the maximum Benefit payable for each and every Defined Event as the level of Benefit is determined by the actual procedure followed by the service provider. To do this, the Insured Person must contact Affinity Health by telephone on 0861 11 00 33 or by e-mail info@affinityhealth.co.za.

8. CLAIMS

8.1 All claims under this Policy are covered when your Premium is paid. If your GP or other Medical Services Provider charge a rate above the Benefit payable under this policy, then such difference is payable by the Member.

8.2 Qualified medical advice shall be sought by the Insured Person at the Policyholder's own expense, and followed promptly on the occurrence of any Bodily Injury, Dread Disease or Illness and the Insurer shall not be liable for any part of any claim which in the opinion of the medical advisor arises from the unreasonable or wilful neglect or failure of an Insured Person to seek and remain under the care of a qualified member of the medical profession.

8.3 Day-to-Day claims can be emailed to refunds@affinityhealth.co.za.

8.4 Hospital claims can be emailed to hospitalclaims@affinityhealth.co.za.

8.5 Written notice on the prescribed form must be given to National Risk Managers in writing as soon as practicable of any occurrence which may give rise to a claim under this Insurance, but in any event within 3 (three) months of such occurrence, failing which the claim will not be entertained.

8.6 Costs associated with the claim need to be submitted to National Risk Managers within 120 (one hundred twenty) days of service. In the event of the costs being submitted after 120 (one hundred twenty) days, they will be deemed stale and the Insurer will not be liable to cover the costs.

8.6.1 Any claims for the Accident Cover Benefit need to be submitted within 30 (thirty) days of the event giving rise to such claim. Any claim received thereafter will be deemed stale and the Insurer will not be liable to cover the costs.

8.6.2 Any claims relating to a previous accident claim submitted within the same 6 (six) month period will not be payable.

8.7 In the event that the Insurer repudiates liability for any claim under the Policy, the claimant shall have 90 (ninety) days from the date of notice of the repudiation within which to make representations to the Insurer disputing the repudiation of the claim. If the claimant concerned does not, in respect of the subject matter of such claim, within 12 (twelve) months, after the 90 (ninety) day period to make representations, commence legal proceedings in a competent court and prosecute such proceedings to final judgment, any liability of the Insurer shall be extinguished and no benefits shall be payable in respect of such claim and/or the insured event concerned.

8.8 All certificates, information and evidence required by the Insurer shall be furnished in the form prescribed and without expense to the Insurer. The Insured Person shall attend a medical examination on behalf of, and at the expense of, the Insurer as often as shall be required in connection with any claim.

8.9 The Insured Person must notify Affinity Health Pre-Authorisation at least 48 (forty-eight) hours prior to being hospitalised by contacting them on 0861 11 00 33 and providing full particulars of the hospitalisation. Failure to do so may result in non-payment of claims. Where it is not possible to notify Affinity Health Pre-Authorisation prior to hospitalisation due to an emergency, this condition will not apply, subject to Affinity Health Pre-Authorisation being notified within 48 (forty-eight) hours after admission provided that the Insured Person is physically able to do so.

8.10 If any claim under this Insurance be in any respect fraudulent or intentionally exaggerated or if any fraudulent means or devices are used by the Insured Person or anyone acting on his behalf to obtain any Benefits under this Insurance, all Benefits herein shall be forfeited and no Premiums shall be refunded.

8.11 It is a condition precedent to the Insurer's liability to pay Benefits on behalf of an Insured Person that all medical records, notes and correspondence referring to the subject of a claim or a related Pre-existing Condition shall be made available to any medical or other advisor appointed by the Insurer and such advisor or advisors shall, for the purpose of reviewing the claim, be allowed so often as may be deemed necessary, to make examination of the Insured Person or any other record pertaining to the claim.

9. EXCLUSIONS

9.1 The Insurer shall not be liable to pay Compensation in respect of any Insured Person:

9.1.1 if resulting from suicide of such person or attempt thereat, whether due to mental disorders or not, or any other self-injury or intentional exposure to obvious risk of Injury (unless in an attempt to save a human life);

9.1.2 if caused by a Pre-Existing Condition (unless otherwise provided for herein);

9.1.3 if caused by, or as a result of, the influence of alcohol, drugs or narcotics upon such Insured Person, unless administered by or prescribed by and taken in accordance with the instructions of a member of the medical profession (other than himself);

9.1.4 if caused by, or arising from, exposure to or contamination by atomic energy and/or nuclear fission or reaction;

9.1.5 whilst travelling by air other than as a passenger and not as a member of the aeroplane crew or technical staff for the purpose of any technical operation thereon or therein;

9.1.6 whilst participating in any riot, civil commotion or public disorder, including authorised and sanctioned union activity or active involvement in war, acts of terrorism, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection or political risk of any kind;

9.1.7 whilst participating in a Professional Sport;

9.1.8 for any mental and/or nervous disorders, other than those caused by an Accident as defined in this Insurance, and covered under this Policy;

9.1.9 for any claims for mountaineering or rock climbing necessitating the use of ropes or guides, potholing, hang gliding, sky diving, riding or driving in a race or rally, underwater activities involving the use of artificial breathing apparatus unless the Insured Person has an open water diving certificate and is diving within the depth limitations of such certification, but to a depth no greater than 30 (thirty) meters, and/or similar activities, unless agreed by the Insurer;

9.1.10 for any claim arising whilst the Insured Person is perpetrating an intentional unlawful act in terms of South African Law;

9.1.11 if caused by any gradually operating cause of which the Insured Person is aware;

9.1.12 for any congenital abnormalities;

9.1.13 for claims in respect of expenses arising out of regular medical treatments on an ongoing (chronic) basis;

9.1.14 for elective, elective cosmetic, corrective optical and laser surgery or treatment and costs resulting therefrom;

9.1.15 for treatment, directly or indirectly arising from, or connected with, male and female birth control, infertility and any form of assisted reproduction;

9.1.16 for any newborn children where the Illness or Dread Disease was known by the Insured Person prior to the birth of that Dependent Child;

9.1.17 if the person is at the time of the Accident engaged in a race or speed test;

9.1.18 if injuries are sustained whilst any person driving the vehicle is under the age prescribed by law, or who is not authorised or qualified to drive the vehicle;

9.1.19 for the cost incurred for the treatment of obesity;

9.1.20 for the treatment of any sexually transmitted diseases, unless as a result of rape or a crime that has been reported to the South African Police Services;

9.1.21 for services rendered by a person not registered with the SA Medical and Dental Council and/ or the South African Health Professions Council;

9.1.22 for any treatment or control of any Superbugs as defined in point 2.34 above;

9.1.23 where the Insured Person is covered in terms of a statutory body (such as the Compensation for Occupational Injuries and Diseases Act No 130 of 1993 or the Road Accident Fund Act 56 of 1996) or their successors, or any other statutory cover, in relation to an Accident, this Policy shall be obliged to pay only the amounts for which the Insured Person is liable (i.e. shortfall between actual expense and amount paid to the Insured Person) up to the maximum benefit amount;

9.1.24 for admissions requested for Diagnostic Procedures. All costs associated with Diagnostic Procedures will be for the member's own costs;

9.1.25 for Day Procedures as described in clause 2.13 above. The Insurer may, at it's discretion, provide cover for Day Procedures up to the maximum Benefit amount provided for the 1st (first) day of the Daily Illness Hospitalisation Benefit;

9.1.26 for costs incurred as a result of failure to carry out the instructions or advice of a medical doctor, including deferring treatment in order to have costs covered once Waiting Periods and endorsements are no longer applicable;

9.1.27 for a Pandemic as described in clause 2.26 above.

9.2 Compensation under one Benefit pertaining to this Policy shall not be in addition to another. The Insured Person could thus not claim under the Specific Stated Conditions Benefit in addition to the Daily Illness Hospitalisation Benefit or the Dread Disease Benefit.

9.3 The Insurer reserves the right to permanently exclude the Benefits based on Pre-Existing Conditions. Endorsements will be noted on applicable Policy Schedules.

9.4 The Insured Persons shall take all reasonable precautions to prevent Accidents and to comply with all statutory requirements and regulations;

9.4.1 if the consequences of an Accident shall be aggravated by any condition or physical disability of the Insured Person which existed before the Accident occurred, the amount of any compensation payable under this Insurance in respect of the Consequences of the accident shall be the amount which it is reasonably considered by the insurer would have been payable if such consequences had not been so aggravated.

9.5 In the case where the Insured Person is also covered by a Medical Aid as defined in the Medical Schemes Act, 131 of 1998, a 3 (three) day franchise will be applied and thereafter the admission is covered up to a maximum of 18 (eighteen) days per illness event paying the daily limit provided under the Daily Illness Hospitalisation Benefit per day whilst in hospital. This means that no claim will be paid for the first three days. The Insurer reserves the right to apply the average length of stay to the relevant admission based on the clinical guidelines as provided by the Department of Health.

10. DISPUTE RESOLUTION

10.1 This agreement shall be governed, interpreted and construed in accordance with the laws of the Republic of South Africa. Any legal action or proceedings arising out of or in connection with this Policy which is to be instituted in a court of law shall be brought in the High Court of South Africa and irrevocably submitted to the exclusive jurisdiction of such court.

11. NEW LAWS

11.1 If, at any time after the Commencement Date, any legislation, rulings or regulations (including any taxation laws) applying to this Policy, comes into operation, the Insurer shall be entitled to a 3 (three) months prior written notice to the Policyholder, to change, amend or alter any terms or conditions of this Policy in order to comply with such legislation, rulings or regulations (including any tax laws) or otherwise to be placed in the same position it would have been was it not for the legislation, rulings or regulations becoming applicable.

12. DOMICILIUM

12.1 The *domicilium citandi et executandi* of the Policyholder shall be the address set out in the application form or such later address as notified in writing.

12.2 For purposes of this insurance policy, the Insurer's address shall be 1st Floor, Block D, The Boulevard Office Park, Searle Street, Woodstock 7925.

12.3 Any notice given in terms of this Product shall be in writing and shall –

12.3.1 if delivered by hand be deemed to have been duly received by the addressee on the date of delivery;

12.3.2 if posted by prepaid registered post be deemed to have been received by the addressee on the 8th (eighth) day following the date of such posting;

12.3.3 if transmitted by facsimile be deemed to have been received by the addressee on the day following the date of dispatch, unless the contrary is proved;

12.3.4 if transmitted via email, be deemed to have been received by the addressee on the day of the transmission, unless the contrary is proved.

12.4 Notwithstanding anything to the contrary contained or implied in the Policy, a written notice or communication actually received by the Insurer or a member from the other as the case may be, including by way of facsimile transmission or electronic mail shall be adequate written notice or communication to such party.

13. SHARING OF INSURANCE INFORMATION

13.1 The Policyholder, by making this application for insurance, acknowledges that the sharing of insurance information for Underwriting and claims purposes (including credit information) between Insurers is in the public interest as it enables Insurers to underwrite policies and assess the risks fairly and to reduce the incidence of fraudulent claims with a view of limiting Premiums.

13.2 The Policyholder, on his/her own behalf or any person who is represented, hereby waives any rights to confidentiality with regards to Underwriting or claims information (including credit information) that has been provided by any person in respect of any insurance Policy or claim made or lodged by the Policyholder.

13.3 The Policyholder acknowledges that the insurance information so provided may be stored in the shared database and used as set out above as well as for any decision pertaining to the continuance of the Policyholder's Policy or the meeting of any claim that the Policyholder may submit.

13.4 The Policyholder hereby consents to such information being disclosed to any other insurance company or its agent and acknowledges that the information may be verified against legally recognised sources or databases.

1. BACKGROUND

1.1 The Policy together with this Annexure 1 constitutes an indivisible agreement between the parties.

1.2 All words and expressions defined in the Policy shall have a similar meaning in this Annexure 1, unless expressly stipulated otherwise or inconsistent with, or otherwise indicated by the context.

2. SCIDEP DEFINITIONS

2.1 For purposes of this Policy, the Dread Diseases shall bear the meanings as assigned to them in this Annexure 1, which definitions are prescribed in terms of the SCIDEP definitions.

2.2 For the sake of convenience, a layman's definition is included herein due to the complexity of the medical definitions of Dread Diseases.

2.3 Affinity Health will cover Dread Diseases according to Tiered Benefits as per SCIDEP Definitions and will be applicable to all Dread Disease Benefits (where severity D is the mildest and severity A the most severe).

SEVERITY	Affinity Health Tiered Benefits as per SCIDEP Definitions (Applicable to all Dread Disease Benefits)
Severity A	100%
Severity B	75%
Severity C	50%
Severity D	25%

3. CANCER

3.1 Cancer is an uncontrolled growth that spreads into the normal tissue surrounding the organ where the cancer originates. The diagnosis must be supported by evidence received from a radiologist, pathologist and/or histology laboratory. Some cancers have been specifically excluded because the long-term outcome is good and the effect on quality of life is minimal, and treatment is neither expensive nor extensive.

3.2 There are specific exclusions to this definition and as such also excluded from any Benefits. These include:

3.2.1 Cancerous cells that have not invaded the surrounding or underlying tissue;

3.2.2 Early cancer of the prostate gland and breast; and

3.2.3 All cancers of the skin except cancerous moles that have invaded underlying tissue.

3.3 Staging of cancer:

3.3.1 As a general rule there are four stages of cancer.
Stage 1 cancer is defined by an invasive cancer confined to the tissue or organ of origin.
Stage 2 cancer is defined by the involvement of adjacent structures or organs.
Stage 3 cancer involves spreading to regional lymph nodes.
Stage 4 cancer is characterised by distant metastasis.

3.3.2 However, each type of cancer is staged specifically by the American Joint Committee for Cancer (AJCC). This staging is based on the outcome of the specific cancer and does not always follow the general rule as stated above.

4. HEART ATTACK

Four levels of severity of heart attacks are defined:

4.1 Severity D is the mildest and Severity A is the most severe.

4.2 In Severity A and B, more permanent damage has resulted, which means the heart function is less than 100% after recovery.

4.3 The effect of the heart attack on heart function should be measured 6 weeks after the heart attack.

4.4 Severity A: Heart attack severe impairment in function.

4.4.1 These are heart attacks where a significant proportion of the heart muscle was damaged. The same tests are used to measure the damage as under Severity B but the results would show a more serious level of impaired function.

4.4.2 The patient will have difficulty coping with normal activities of daily living, and will most likely not be able to work.

4.5 Severity B: Heart attack with mild permanent impairment in function.

4.5.1 This is usually a heart attack in which the heart does not recover 100% of normal function. The degree of permanent damage can be measured by a heart sonar, an exercise tolerance test or a measurement of physical abilities.

4.6 Severity C: Moderate heart attack of specified severity.

4.6.1 In this case, damage to the heart muscle is more than in Severity D. In some cases a cardiologist will intervene early and reverse the potential damage. This intervention may include administration of drugs to dissolve the blood clot in the coronary artery(ies) or balloon stretching of the coronary artery, with or without a stent.

4.6.2 Due to clinical methods of diagnosing the severity of this heart attack being unambiguous, only 2 (two) of the 3 (three) below criteria are required to be met:

4.6.2.1 Typical chest pain or other symptoms typically associated with a heart attack;

4.6.2.2 Certain defined ECG changes. At this level the changes are more marked and more specific to a heart attack;

4.6.2.3 Elevated blood test results greater than required for Severity D.

4.7 Severity D: Mild heart attack with full recovery.

4.7.1 This is a heart attack where the ECG changes and blood test results are mildly abnormal. Therefore, all 3 (three) of the below criteria are required to be met:

4.7.1.1 Typical chest pain or other symptoms typically associated with a heart attack;

4.7.1.2 Certain defined ECG changes;

4.7.1.3 Elevated blood test results. e.g. Typical chest pain or other symptoms associated with a heart attack; and certain defined ECG changes and an elevation in certain blood test results.

5. STROKE

5.1 A stroke occurs when the blood supply to a portion of the brain is obstructed and this part of the brain tissue dies. It can also happen when there is bleeding into the brain tissue due to a weakening or abnormality of the blood vessel wall. A common cause of the rupture of a brain blood vessel is longstanding, uncontrolled high blood pressure.

5.2 The result of a stroke is usually paralysis of an arm and leg, sometimes with one half of the face affected as well. In some cases people also lose their ability to speak. The paralysis can recover to varying degrees. Some recover fully, whereas others may retain permanent weakness of a limb(s).

5.3 A Transient Ischaemic Attack (TIA) occurs when the blood supply is momentarily interrupted, but restored before any permanent damage can occur. It usually results in 1 (one) or more of the following symptoms

5.3.1 A loss of sensation;
5.3.2 Dizziness;
5.3.3 Lameness of a limb;
5.3.4 Loss of speech, which only occurs for a few minutes to hours.

Recovery is quick and spontaneous and is therefore excluded from any Benefits.

Notes:

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