Individual Life Policy Guide

V0.5.17

Underwritten by Guardrisk Life Limited, a licensed Life Insurer and FSP -76

Contents

1. Introduction

1.1 WELCOME TO ONESPARK

Welcome to OneSpark. We went on a mission to re-engineer, rebuild and redesign life insurance with the sole purpose to put customers first and enable them to better protect themselves and their families. We subsequently created a completely new type of life insurance, a revolutionary product that no longer requires You to lock into a static long term contract, but provides You with needs-matched cover that dynamically adjusts every year to ensure You are always optimally covered should You experience a Life Changing Event. It's simple. It's easy. But it dynamically evolves with You as Your needs change, ensuring You only pay for what You need, when You need it. That's why We call it Pay-As-You-Need Life Insurance. It just makes sense.

A OneSpark Policy enables You to protect Your most valuable assets, Your life, Your income and Your ability to obtain the most advanced treatments should You become severely ill. Our unique and (for many features) world-first products provide broad, comprehensive, efficient and dynamic long-term protection for You and Your family. You receive intelligent, tech-powered cover, unlimited risk cover for unrelated severe illnesses, complete transparency and peace-of-mind through our world-first ShareBack Benefit. Our Life Cover, Lump-Sum Disability Cover, Income Protection and Illness Cover Benefits are fully described in the rest of the Policy Guide.

This Policy Guide provides comprehensive information on all the Benefits offered by OneSpark. Details of the specific Benefits You have selected will appear on Your personal Policy Schedule accompanying this Policy Guide. It is important that You check Your Policy Schedule in conjunction with this Policy Guide carefully to ensure that the Benefits selected are correctly recorded on it.

This product is underwritten by Guardrisk Life Limited (FSP License Number 76) and administered by OneSpark (Pty) Ltd (FSP License Number 50594). Guardrisk Life Limited is a licensed life insurer in terms of the Insurance Act.

The headings and subheadings in this Policy are for the purpose of convenience and reference only and shall not be used in the interpretation of, nor to modify nor amplify, the terms of this Policy. Please also note that throughout the Policy where figures are referred to in numerals and in words, if there is any conflict between the two, the words shall prevail. If there is ever a discrepancy between this document, the Policy Guide, and the Schedule then the wording, terms and conditions in the Policy Guide will take precedence.

The Life Policy Guide has been written for Personal Assurance policies. All terms, conditions and Benefit workings in the Policy are exactly the same for Personal Assurance policies as well as Business Assurance policies, unless specified otherwise in the Policy.

1.2 DEFINITION OF TERMS

The definitions set forth below, unless inconsistent with the context in the Policy, shall bear the following meanings:

'Absolute Cession'	:is a cession where the Cessionary takes ownership of the Policy and becomes liable for the payment of Premiums on the Policy.
'Accident'	:means the sudden, unforeseen and uncertain event, which could not reasonably be expected to occur, which is caused by violent, external, physical and visible means at an identifiable time and place, resulting directly and independently of any other cause, in Bodily Injury. This does not include sickness or disease or any naturally occurring condition or degenerative process. Self-inflicted injury and suicide are excluded from this definition. "Accidental" has a corresponding meaning.
'Accidental Death'	:means Bodily Injury which (directly and independently of any other cause) results in the death of the Insured Life and shall exclude Natural Death.
'Accidental Disability'	:means Bodily Injury which (directly and independently of any other cause) results in the Insured Life meeting one of the specified Disability Objective Medical Criteria, and shall exclude Natural Disability.
'Activities of Daily Living'	:Activities of Daily Living (ADLs) is an internationally used scoring system that assesses the functional ability of a person including their physical, cognitive and interactive abilities. OneSpark uses the ADLs to assess functioning in both the Illness Cover, Disability Cover and Permanent Income Protection (disability) Benefits when objective criteria of impairment are needed – for example when neurological and connective tissue diseases are assessed. Changes to the ADLs must be permanent, must have occurred after the Commencement Date of the Policy, and must be due to the condition, illness or event that is being Claimed for.
'Administrator'	:means OneSpark (Pty) Ltd with Registration Number 2019/389648/07 and FSP Number 50594.
'Anniversary Start Date'	:refers to the first date on which a full month's Premium has been collected.
'Applicable Laws'	:shall mean the Insurance Act 18 of 2017, the Long-term Insurance Act 52 of 1998, the Policyholder Protection Rules (Long-term Insurance), 2017, the Protection of Personal Information Act 4 of 2013, and any other legislation relating to or regulating the protection or processing of data or Personal Information, direct marketing or unsolicited electronic communications

	and which may be applicable in the Republic of South Africa from time-to-time.
‘Benefit Amount’	:means the amount of cover that the Life Insured is covered for, as specified in the Policy Schedule, and for which the appropriate Premium has been paid monthly and for which payment is up to date at the Claim Event Date. “Insured Amount" and “Cover Amount” shall have a corresponding meaning.
‘Benefit Expiry Age’	:means the age of the Life Insured when the respective Benefit ceases. The Benefit expires at the end of the month in which the Life Insured turns the specified age.
‘Bodily Injury’	:means physical bodily injury to an Insured Life caused by an Accident. Bodily Injury shall be deemed to include death by starvation, thirst and/or exposure to the elements.
‘Business Day’	:means any Day excluding a Saturday, Sunday or recognised public holiday.
‘Cedent’	:is the person who transfers the Policy during a cession.
‘Cessionary’	:is the person or entity to whom the Policy is transferred during a cession.
‘Claim’	:means, unless the context indicates otherwise, a demand for Policy Benefits under this Policy by a Claimant, irrespective of whether or not the Claimant’s demand is valid, made by submitting a completed and signed claim form with supporting documentation to the Administrator.
‘Claim Anniversary’	:refers to the annual date which occurs after each 12 (twelve) (full calendar) month period of Benefit payments, starting from the date when the specified Benefit was first paid out. This anniversary date occurs annually until the end of the specified Benefit payment term. “Claim Anniversary Date” shall have a corresponding meaning.
‘Claim Event’	:means the risk insured (namely for death, disability, illness, disease and injury, as defined for each Benefit in different sections throughout this Policy) occurring during the currency of this Policy, and where the Premium has been paid up to date. “Life Changing Event” shall have a corresponding meaning.
‘Claim Event Date’	:means the date on which the Claim Event occurs giving rise to a Claim, and when all Claim and Policy criteria are met.

For Life Cover: It is the date of the Life Insured's death.

For the Illness Cover Benefit, it is:

- The date of diagnosis of the illness, medical condition, injury or trauma event; or
- The date on which the injury occurred;
  and when all Claim and Policy criteria are met.

For the Disability Cover Benefit, Temporary Income Protection Benefit and Permanent Income Protection Benefit: it is the Date of Disability.

'Claimant' :means a person who makes a Claim in relation to this Policy. This will be the Beneficiaries or Cessionary for death Claim Events (or any other person who is due the payment) and the Policyholder for all the other Claim Events.

'Collateral Cession' :is a cession where the right to Death, Illness and Disability Benefits on the Policy are transferred to a third party as security for an unpaid debt or obligation (usually a bank).

'Consumer Price Index' :Consumer Price Index (CPI) is the inflationary increase which is determined by Statistics South Africa. This rate will differ from year to year as CPI fluctuates. The Administrator will use the CPI figure as released by Statistics South Africa three months before each Policy Anniversary in its relevant calculations.

'Commencement Date' :means the date when this Policy, and its cover, starts and is effective, being the date on which the first Premium is paid, unless otherwise specified in the Schedule.

"Date of Commencement" shall have a corresponding meaning.

'Cooling-off Period' :means the 31 (thirty-one) Day period, starting from the earliest of the following:

1. The date on which the Policyholder receives this Policy document; or
2. From a reasonable date on which it can be deemed that the Policyholder received this Policy document.

During this 31 (thirty-one) Day period, as defined above, the Policyholder may inform the Administrator In Writing of their requested cancellation. If no Benefit Amount has been paid or claimed as yet or the Claim Events insured against have not yet occurred, then any Premium paid up to the date of receipt of the cancellation request by the Administrator will be refunded to the Policyholder in full. In this scenario, the cancellation will be made immediately on the date of receipt of the cancellation request. No

Benefit for the Life Insured on the Policy will be payable on or after the date of receipt of the cancellation request.

‘Date of Disability’ :For the Temporary Income Protection Benefit:
This is the first date where the client is partially or totally unable to perform the main duties of their Nominated Occupation due to experiencing an illness, injury, disease or condition which prevents them from working and earning an income, and where all Temporary Disability claims criteria are met. This date is to be confirmed by the Administrator/Insurer and must be based on objective, recognised and valid medical evidence received.

For the Disability Cover and Permanent Income Protection Benefits:
The Date of Disability is defined as follows:

- For Claims assessed under the Disability Objective Medial Criteria, this is the first date on which the Life Insured’s illness, injury, disease, impairment or condition satisfies the Disability Objective Medial Criteria, and where all Claims and Policy requirements have been met. The Date of Disability is to be confirmed by the Administrator/Insurer and must be based on objective, recognised and valid medical evidence received; or

- For Claims assessed under the Occupational Claims Criteria, this is the first date on which the Life Insured is totally unable to perform the material and substantial duties of their Nominated Occupation, due to illness, injury, disease or impairment, and prevents them from working and earning an income, and where all Claims and Policy requirements have been met. The Date of Disability is to be confirmed by the Administrator/Insurer and must be based on objective, recognised and valid medical evidence received.

“Disability Date” shall have a corresponding meaning.

‘Day’ :means a 24 (twenty-four) hour period and ‘Days’ has a corresponding meaning.

‘Debit Order’ :is when the Premium Payer gives the Administrator their banking details and the Administrator deducts the Premium directly from their bank account. In this case the Premium Payer is the person or entity from whom We collect the Premium.

This also refers to all deductions made from a debit card or credit card if this was selected by the Premium Payer as their preferred payment method.

‘Deduction Month’ :refers to the month before the No Cancel End Date.

'Disability Objective Medical Criteria'	:is an objective, transparent and fair Claim system used to assess the severity of the Life Insured's disability Claim Event. The Disability Objective Medical Criteria are assessed based on the severity of the Life Insured's medical Impairment. By focusing on the effect that the Life Insured's medical impairment has on the Life Insured and Their lifestyle, OneSpark has developed an evaluation system that is objective, transparent and fair. Please refer to the conditions covered as defined in Appendix 1 for a complete list of the conditions that the Life Insured is covered for. Please note that the Activities of Daily Living relating to these Objective Medical Criteria can be found in Appendix 3. "Objective Medical Criteria for disability" shall have a corresponding meaning.
'Discount Activation Premium'	:the amount payable in addition to the Premium as stated in the Policy Schedule or any endorsement issued in terms of this Policy to activate the No Cancel Discount. Please see section 16 for further details.
'Dynamic Benefit Adjustment'	:is the annual adjustment percentage suggested by the Dynamic Financial Needs Analysis, applied to each Benefit on the Policy at each Policy Anniversary. The Dynamic Benefit Adjustment (DBA) ensures that cover adjusts in line with the Life Insured's changing circumstances and is defined as $\frac{Proposed\ Sum\ Assured\ by\ DFNA}{Current\ Sum\ Assured} - 1$. Please see section 14 for further details.
'Dynamic Financial Needs Analysis'	:the Dynamic Financial Needs Analysis (DFNA) is the algorithm that calculates the Life Insured's required cover, based on Their individual and unique circumstances. The algorithm dynamically adjusts to match the Life Insured's changing needs as Their life and financial needs change. Please see section 14 for further details.
'Dynamic Premium Adjustment'	:is the annual Premium adjustment percentage applied to each Benefit Premium on the Policy, at each Policy Anniversary. The Dynamic Premium Adjustment (DPA) is made up of the Dynamic Benefit Adjustment for that specific Benefit, as well as a factor to take into account the Life Insured's increasing age. Please see section 14 for further details.
'Exclusion'	:means the losses or risk events not covered under this Policy.

'Family Member'	:means the Spouse, Child(ren), Parent(s) or Extended Family Member(s) of the Life Insured. Children are defined as natural children, legally adopted children and step-children. A Spouse is defined as the person married to the Life Insured by law, tribal custom, or Tenets of any Religion; and shall include a common law husband/wife of the Life Insured or such person residing with the Life Insured, who is normally regarded by the community as the Life Insured's husband/wife. A person of the same gender residing with the Life Insured who is regarded by themselves and the community as a common law couple shall also be regarded as a Spouse in terms of this Policy. A Parent is defined as the Principal Life Insured's parent(s) and/or the Spouse's parent(s) and this definition shall include natural parents, step parents and legally adoptive parents of the Principal Life Insured and/or their Spouse. An Extended Family Member is defined as a blood relative for whom the Life Insured or Life Insured's Spouse are financially responsible. "Family Members" shall have a corresponding meaning.
'Goodwill Payment'	:means a payment, whether in monetary form or in the form of a benefit or service, by or on behalf of the Insurer to a complainant as an expression of goodwill aimed at resolving a complaint, where the Insurer does not accept liability for any financial loss to the complainant as a result of the matter complained about.
'Illness Objective Medical Criteria'	:is an objective, transparent and fair Claim system used to assess the severity of the Life Insured's Illness Cover Claim. Our Illness Cover Benefit pays out an amount commensurate with the change in lifestyle following the Claim Event. The Illness Objective Medical Criteria are assessed based on the severity of the disease, illness, injury or Impairment. By focusing on the effect that the illness or impairment has on the Life Insured and Their lifestyle, OneSpark has developed an evaluation system that is objective, transparent and fair and pays out commensurate with the change in the Life Insured's lifestyle. Please refer to the conditions covered as defined in Appendix 2 for a complete list of the conditions the Life Insured is covered for. Please note that the Activities of Daily Living relating to these Objective Medical Criteria can be found in Appendix 3.

”Objective Medical Criteria for illness” shall have a corresponding meaning.

‘In Writing’ :means a letter handed over from the Policyholder to the Administrator (or Insurer) or vice versa. It also includes a registered letter, post or other modern form of written or electronic communication (that is, any communication by any appropriate electronic medium that is accurately and readily reducible to written or printed form).

“Written Notice”, “Written/Electronic Communication” and “Written Request” shall have a corresponding meaning.

‘In-Claim Escalation’ :means the annual increase factor applied to the in claim Benefit payment. It is applied each year at the Claim Anniversary.

“In-Claim Escalation Factor” shall have a corresponding meaning.

‘Income’ :is defined as follows:

In the case of the Life Insured being a salaried employee, it shall be Their monthly cost-to-company less any PAYE tax, as per Their payslip.

- This includes any 13th (thirteenth) cheques. This 13th cheque is limited to 1 (one) month’s additional net of tax salary, excluding any bonuses (this limit is the Life Insured’s monthly cost-to-company less any PAYE tax, as per Their payslip).
- The following are, however, excluded from this definition:
  - Annual bonuses (except 13th cheques);
  - Ad hoc bonuses;
  - Leave pay;
  - Merit awards;
  - Share incentives; and
  - Bonuses/incentives paid to retain services.

In the case of the Life Insured being a sole proprietor, partner, member of a close corporation or director of a private company, it shall be the Life Insured’s monthly share of fees for services rendered and gross profit from trading activities, less the Life Insured’s monthly share of the business overhead expenses and tax.

- Gross profit from trading activities is defined as monthly sales less cost of sales.
- The tax is calculated using tax tables and is based on the Life Insured’s income not reduced by tax.
- Where it is difficult to determine the Life Insured’s share of the income or expenses of the business, it shall be any income,

dividends, loan account repayments and other benefits that the Life Insured derives from the business in Their personal capacity, less tax (as per the tax tables).

Income for the purposes of this definition shall exclude passive income from assets such as property or shares in a business acquired purely for investment purposes and where the Life Insured is not engaged in the management of this business. This includes any passive income that is not related to the income being generated for the occupation being insured for example, but not limited to, dividends, interest and rental income generated from a property that the Life Insured owns.

Please note that only income received from the Life Insured's Nominated Occupation may be covered under the above definition.

Please note that the above Income definition will be reviewed from time to time and may be amended by the Insurer and/or Administrator, at either's sole discretion.

'Income Protection Benefit' :is used to refer to both the Temporary Income Protection Benefit and Permanent Income Protection Benefit, unless otherwise specified.

'Insured Life' :means the adult, who is at least 18 (eighteen) years of age but not yet 66 (sixty-six) years of age, who has applied for this Policy which has been accepted by the Insurer.

"Life Insured" shall have a corresponding meaning.

'Insurer' :shall mean a licensed life insurer in terms of the Insurance Act, namely Guardrisk Life Limited, with Registration Number 1999/013922/06 and FSP Number 76.

'Loss of Income Claims Criteria' :is the claims criteria, under the Temporary Income Protection Benefit. You can claim under the Loss of Income Claims Criteria by providing proof that the Life Insured is partially or totally unable to perform Their Nominated Occupation due to Their injury, disease, impairment or illness, and as a result are unable to maintain Their Income level.

You may only claim under the Loss of Income Claims Criteria if the Life Insured is unable to perform at least 25% of the material and substantial (main) duties of Their Nominated Occupation and is losing more than 25% of Their Pre-Claim Income. Please see section 8.1 for further details.

'Medical Practitioner'	:means a legally and duly qualified medical practitioner registered with the Health Professions Council of South Africa with a valid practice number.
'Mental and Behavioural Conditions'	:are mental or psychiatric disorders (including, but not limited to, adjustment disorders, cognitive impairments, communication disorders, dementia disorders, dissociative disorders, mood disorders, personality disorders, schizo-affective disorders and somatoform disorders, chronic fatigue syndrome and any other stress and anxiety related disorders). The Administrator defines mental or psychiatric disorders (Mental and Behavioural Conditions) in accordance with the latest version of the Diagnostic and Statistical Manual of Mental Disorders Criteria (DSM criteria). Please note that all depression and bipolar related claims, as well as psychosis and nervous breakdowns claims are included under the Mental and Behavioural Conditions definition.
'Misrepresentation'	:the conscious decision to provide inaccurate or incorrect information in relation to any personal details or medical history or to change the true facts to mislead an interested party. This shall also mean the failure to disclose material information at the date of application, that had the Insurer been aware of would have resulted in the Policy not being issued or issued on different terms. Misrepresentation also refers to situations where the Policyholder or Life Insured (or anyone acting on their behalf) fails to disclose any material information, or provides false information, or distorts information when applying for the Policy or at any point during the term of the Policy or at Claim stage. "Misrepresent" shall also have a corresponding meaning.
'Natural Death'	:shall refer to death that has not arisen from an Accident or Bodily Injury and is related to any illness, disease, infirmity or any other natural cause.
'Natural Disability'	:shall refer to a disability that has not arisen from an Accident or Bodily Injury and is related to any illness, disease, infirmity or any other natural cause.
'No Cancel Option'	:this Benefit gives You a Premium discount, depending on the Life Insured's age, if You agree not to cancel Your Policy during the following year (this period will be longer than one year if the option is selected between Anniversary Dates). You can select this option at the Commencement Date or at any point during Your Policy term. The discount applied upfront can be maintained for the entire duration of the Policy if the No Cancel Discount

	Option is selected each year, throughout the Policy term. Please see section 16 for further details. "No Cancel Benefit" shall have a corresponding meaning.
'No Cancel Discount'	:is the discount You receive upfront and throughout Your Policy term if You select the No Cancel Discount Option. Please see section 16 for further details.
'No Cancel End Date'	:refers to the next Policy Anniversary which is at least 1 (one) calendar year after the date on which the No Cancel Option was first selected (or applied, whichever is later) to Your Policy.
'Nominated Beneficiary'	:means the person or persons nominated by the Policyholder as the person or persons in respect of whom the Insurer should meet the Policy Benefit, other than the Policyholder, on the Death of the Policyholder. In order for an individual to be eligible to be a Nominated Beneficiary on the Policy, they must be at least 18 years of age as well as a South African Resident. A maximum of 5 (five) Nominated Beneficiaries may be allowed on the OneSpark Life Policy. "Nominated Beneficiaries", "Beneficiary" and "Beneficiaries" shall have a corresponding meaning.
'Nominated Occupation'	:means the occupation that the Life Insured is performing for all or the majority of Their working hours and is as selected by You at the Commencement Date (You cannot select two occupations). It is the occupation that the Life Insured is trained for, knowledgeable of and from which the Life Insured derives all or the majority of Their income and will be the occupation against which the Life Insured is assessed under the Occupational Claims Criteria, if applicable to Your Policy. Please see section 12.1 for further details.
'Occupational Claims Criteria'	:refers to the Claims criteria assessing permanent disability with respect to the Life Insured's occupation. The Occupational Claims Criteria relates to the Life Insured's inability to perform Their Nominated Occupation - namely that it is established, to the satisfaction of the Administrator/Insurer, that They are totally and permanently unable to perform the material and substantial duties of Their own Nominated Occupation (as indicated in Your Policy Schedule) due to sickness, injury, disease, impairment or illness.
'Occupational In-Claim	

Escalation Option'	:means the In-Claim Escalation (ICE) option selected on the Policy. There are three options: Core, Standard, and Executive. Each year at the Claims Anniversary, the Benefit Sum Assured is increased by a certain factor based on CPI, age of the Claimant at that point in time and the Occupational In-Claim Escalation Option selected. The increases applied have been designed to replicate the actual increases that the Life Insured would have received from Their Nominated Occupation each year if They did not become disabled and were not losing Income. Please see section 8.3.4 for more details.
'Off Period'	:is defined as follows: For Temporary and Permanent Income Protection Benefit Claims: If the Life Insured recovers or is rehabilitated and claims again for the same cause which resulted in the Life Insured's original inability to perform Their Nominated Occupation within three months of recovery, the Waiting Period will be waived for the subsequent Claim. This time period is called the Off Period.
'Partial Disability'	:means the Life Insured is unable to perform some, but not necessarily all, of the main duties of Their Nominated Occupation due to disablement and as a result, suffer a partial loss of income.
'Period of Insurance'	:the period for which Premiums remain paid and the Policy remains in force.
'Permanent Disability'	:is the disability, relating to the Life Insured, in which the Life Insured is assessed to be totally and permanently disabled. In this scenario, the Life Insured meets one of the Permanent Disability Claims Criteria. 'Permanently Disabled' shall have a corresponding meaning.
'Permanent Disability Claims Criteria'	:are Claim Events where the Life Insured is assessed to be Permanently Disabled, namely that it is established, in the opinion and to the satisfaction of the Administrator/Insurer, that the Life Insured either meets one of the Disability Objective Medical Criteria (found in Appendix 1) or the Life Insured qualifies for a Claim under the Occupational Claims Criteria. Please see sections 7 and 8.2 for more details. Please note that these are the Permanent Disability Claims Criteria, for both the Permanent Income Protection Benefit and the Disability Cover Benefit.
'Personal Information'	:means personal information as defined in the Protection of Personal Information Act 4 of 2013.

'Policyholder'	:means the policy owner. It also refers to the Premium Payer. This can be either a natural person or a juristic person.
'Policy'	:refers to the Policy Schedule, the terms and conditions contained in this document, and any endorsements thereto. This a legal document that binds the Policyholder and the Insurer. This also includes any declarations made or information provided by the Policyholder at application (and underwriting) stage.
'Policy Anniversary'	:refers to the annual anniversary which occurs on the same day and month as that of the Anniversary Start Date. "Policy Anniversary Date" shall have a corresponding meaning.
'Policy Benefits'	:means one or more sums of money, services or any other benefits on the Policy. This includes the ShareBack Benefit and No Cancel Discount. "Policy Benefit", "Benefit" and "Benefits" shall have a corresponding meaning.
'Progressive Claim'	:refers to conditions where a worsening of symptoms or stages of the disease can be expected, for example the progression of cancer, connective tissue disease or respiratory disease. A relapse of a previous cancer will be assessed as a progressive illness. Please see section 15.3 for further details. "Progressive Claims" shall have a corresponding meaning.
'Pre-Claim Income'	:means the Life Insured's average monthly Income from Their Nominated Occupation for the 12 (twelve) month period prior to the Their Claim Event. The following points relate to the Pre-Claim Income definition: • The Administrator/Insurer will not take into account a Sabbatical in the calculation of average Income. • If the Life Insured's Income is of a variable nature, the Administrator/Insurer, at either's sole discretion, may determine a period other than 12 (twelve) months to calculate average monthly Income. • Any Claim made within 12 (twelve) months of returning to work following a period of retrenchment will exclude the period of retrenchment for the purposes of calculating the Life Insured's Pre-Claim Income. • A certified copy of the official proof of the Life Insured's net Income for the past 12 (twelve) months (or other requested period, if required) before the date on which the Claim Event occurred is required.

- This may include salary advices, salary payslips, tax returns, bank statements and audited statements (if applicable).
- Please note that only Income received from the Life Insured's Nominated Occupation may be covered.
- Please note the income used here is that of the Income definition.

The above definition, the period over which it is determined and the method of calculation will be reviewed from time to time and may be amended by the Insurer and/or Administrator from time to time, at either's sole discretion.

'Pre-Existing Condition' :shall mean an illness or injury sustained or contracted by the Life Insured which he or she has been aware of, or should reasonably have been aware of, or received medical treatment or advice by a Medical Practitioner prior to the initial Commencement Date or reinstatement date of the Policy (whichever occurred last). This includes, but is not limited to, any physical or mental defect, symptoms, disease, infirmity or condition which existed prior to the initial Commencement Date or reinstatement date of the Policy (whichever occurred last).

"Pre-Existing Medical Condition'" shall have a corresponding meaning.

'Premium' :the monthly amount payable as stated in the Policy Schedule or any endorsement issued in terms of this Policy.

"Premiums" shall have a corresponding meaning.

'Premium Payer' :means the person or entity from whose bank account We deduct the Premiums if the Premium payment method is by Debit Order. This also means the person or entity from whose debit or credit card We deduct the Premiums if the Premium payment method selected is by debit or credit card. The owner of this Policy must be the Premium Payer.

'Repudiate' :means, in relation to a Claim, any action by which the Insurer rejects or refuses to pay a Claim or any part of a Claim, for any reason, and includes instances where a Claimant lodges a Claim-

(i) in respect of a loss event or risk not covered under this Policy;
(ii) in respect of a loss event or risk covered under this Policy but the Premium or Premium(s) payable in respect of this Policy has/have not been paid up to date; and
(iii) in respect of Policy terms and conditions not being met.

and 'Repudiation' shall have a corresponding meaning.

'Regulatory Authority/Body'	:refers to the Information Regulator, the Financial Sector Conduct Authority (FSCA) and the Prudential Authority (PA).
'Related Claim'	:is a Claim Event where there is a link to a previous Claim, for example, complications or consequences of a disease or injury previously claimed for. This would be where the later Claim Event would not have arisen if it was not for the initial condition or illness. It also includes side effects or complications of treatment of the previously claimed for condition. Progressive Claims are not included in this definition. Please see section 15.3 for further details. "Related Claims" shall have a corresponding meaning.
'Sabbatical'	:is a period of leave from employment which does not fall within the employee's employment contract. The Administrator/Insurer will allow the Life Insured a maximum Sabbatical term of 6 (six) months every three years on the Policy.
'Schedule'	:the document specifying the scope of cover with information relating to the significant Exclusions, name and characteristics of the Life Insured, Benefit features, Cover Amounts, Premiums and any other material Policy terms and conditions, as attached to this Policy. "Policy Schedule" and "Key Information Document" shall have a corresponding meaning.
'ShareBack Benefit'	:is the Benefit which makes a payment at the ShareBack Payout Date to all in force clients, based on factors such as premium size, claims experience and various other factors during the ShareBack Calculation Period. Please see section 13 for more details. "ShareBack" and "ShareBacks" shall have a corresponding meaning.
'ShareBack Calculation Period'	:means the annual 12 (twelve) month period, starting from 1 December in a given year and ending on 1 December in the following year.
'ShareBack Payout Date'	:refers to the date on which the ShareBack Benefit payout will be made. This payment will only be paid to the Policyholder if their Policy is still in force at the ShareBack Payout Date. This date will be confirmed 60 (sixty) Days before such payout falls due, which is dependent on a number of factors being reached. Please see section 12 for more details.

'Specialist'	:is a Medical Practitioner registered as such with the Health Professionals Council of South Africa, with a valid practice number, who has completed advanced education and clinical training in a specific area of medicine (their specialty area) (that is, this person must be registered with the Health Professions Council of South Africa in a relevant specialty).
'Sum Assured'	:means the equivalent of the Benefit Amount as stated in the Schedule.
'Survival Period'	:means the period which the Life Insured must survive (not die), without the assistance of any life support, in order to be eligible to receive Policy Benefits/in order for a valid Claim to be made. During this period, the Policyholder is not entitled to Policy Benefits, that is, during this period no Benefit Amount will be paid out.
'Temporary Disability'	:is the disability, relating to the Life Insured, in which the Life Insured is assessed to be either partially or totally disabled. In this scenario, the Life Insured does not meet the Permanent Disability Claims Criteria but is still unable to perform some or all of the main duties of their Nominated Occupation (after workplace modifications or assistance) due to sickness, injury, disease, impairment or illness (disablement). Here, the Life Insured must also satisfy the Loss of Income Claims Criteria.
'Their, Them, They, Themself'	:refers to the Life Insured.
'Total Disability'	:means the Life Insured's is unable to perform all of the main duties of Their Nominated Occupation, due to illness, disease, impairment or injury or any other disablement.
'Unclaimed Benefit'	:means a benefit in terms of an approved Claim where the Benefit can't be paid to the Nominated Beneficiary within 3 (three) months of the Claim having been approved because the Nominated Beneficiary is not contactable. In other words, the Nominated Beneficiary cannot be located, his/her emails are undelivered, his/her post is returned to the Administrator and/or his/her contact number is no longer in use. "Unclaimed Benefits" shall have a corresponding meaning.
'Unrelated Claim'	:is a Claim Event which is not related or due to the original Claim. It is also a Claim where the Claim Event did not progress from a previous Claim Event and/or previous condition which gave rise to the Claim Event. Please see section 15.3 for further details. "Unrelated Claims" shall have a corresponding meaning.

'Variation'	:means any act that results in a change to: (i) the Premium; (ii) any terms; (iii) any condition; (iv) any Policy Benefit(s); (v) any ShareBack Benefit workings; (vi) any Exclusion; or (vii) the duration/term of this Policy/Benefits, and "Vary" and "Variations" shall have a corresponding meaning.
'Waiting Period'	:means a period during which a Policyholder is not entitled to Policy Benefits, that is, a period in which no Claim amount will be paid out.
'We, Us, Our'	:means the Insurer.
'You, Your'	:the person named as the Policyholder in the Policy Schedule.

2. Eligibility

The Life Insured qualifies for this Policy if:

- At the Commencement Date of Your Policy, the Life Insured is at least 18 (eighteen) years old but not older than 65 (sixty-five) years of age.
- You have a South African bank account.

Cover may only be taken out for the Life Insured. Separate policies, can, however, be taken out for the Life Insured's spouse or children, if they qualify. You will be the policy owner as well as the Premium Payer.

2.1 MINIMUM AND MAXIMUM ENTRY AGES

Please refer to Your Schedule for the minimum and maximum entry ages on the Policy.

3. Business Assurance Policy

Business owners may take out cover on a Business Assurance Policy to cover Business Assurance needs.

We understand that business owners have worked hard to build a sustainable business. The risks they have undertaken to guide their business in the direction of their vision is the reason they need to protect it.

We offer comprehensive, personalised, whole-of-life protection for Your business assurance needs to help maintain the business if the Life Insured experiences a Life Changing Event such as death, severe illness or disability.

Our Benefits are designed to address business assurance needs such as contingent liability insurance and key person cover.

- Contingent liability insurance protects a business owner's family from the creditors of the business. Very often a business owner is required to stand surety in their personal capacity for the obligations of the business. If the creditors of the business for any reason call the business owner to perform under the surety (pay the debt on behalf of the business), their family may suffer. It is for this reason that the business will take out a life insurance policy on the life of the business owner to pay the proceeds to the creditors if the business owner suffers a Life Changing Event and the creditors decide to call up the surety. The proceeds of this Policy will be paid to the business unless this Policy has been ceded to creditors of the business. Through this insurance, the business owner's family is protected.

- Key person cover is a life insurance policy taken out by the business on the life of the business owner or a person who is very important to the business (a key person). This is to ensure that on the key person suffering a Life Changing Event, the cash flow is available immediately to minimise the effects of the loss of the key person and replace the deceased/disabled key person.

Only the following benefits will be allowed on a Business Assurance policy:

- Life Cover
- Illness Cover Benefit
- Disability Cover

The main differences between the Personal Assurance policy and a Business Assurance policy are:

- On the Business Assurance policy, the Cover Amounts increase each year at Policy Anniversary with CPI.
- The Dynamic Financial Needs Analysis doesn't apply to Business Assurance policies.
- More than 1 Business Assurance policy can be taken out on a single Life Insured.
- ShareBacks do not apply to the Business Assurance policies.
- The conversion of Life Cover and Disability cover to Illness Cover does not apply to Business Assurance policies.
- The Disability Cover Benefit and Illness Cover Benefit are accelerated, meaning that a Claim on either the Disability Cover Benefit or Illness Cover Benefit will result in a reduction of the Life Cover Benefit amount.

4. Operative Clause for the OneSpark Life Policy Guide

In return for the timeous and prior payment of the required monthly Premium by You, the Policyholder, and receipt thereof by the Insurer and subject to the terms of cover, a Benefit Amount will be paid, for a valid Claim, on receipt of the necessary Claim documentation based on the following:

- The Claim Event occurs within the Period of Insurance;
- The event giving rise to a Claim is covered in terms of the Exclusions and/or the terms and conditions of this Policy;
- The truth and accuracy of the information given at the time of application;
- The Claim Event arises outside any applicable Waiting Period(s), where applicable;
- The Claimant provides Us with all the relevant documents that We may require; and
- The Claim Event is reported within the prescribed periods.

This means that Benefit Amounts under this Policy will only be considered or made if both the Insured Life and Policyholder on this Policy have complied with all the terms and conditions of this Policy, and if the Insured Life/Policyholder or the Life Insured's/Policyholder's representative(s) has complied with all the requirements of the Claims process.

5. Life Cover

5.1 WHAT IS THE PURPOSE OF THE BENEFIT?

The Life Cover Benefit provides a Benefit payment to the Beneficiaries should the Life Insured die. It can be used to cover all the expected future expenses incurred by the Life Insured's family. These can be used to pay for such costs as education, healthcare, food, housing, transport and for any other expenses incurred by the Life Insured's family. A portion can also be used to pay off the Life Insured's outstanding debts, as well as transfer wealth to the Life Insured's family members.

5.2 OVERVIEW

This Benefit will pay out 100% of the Life Cover Sum Assured on a valid Claim. Please note that an amount equal to, but not exceeding, the Life Cover Benefit Amount (as specified in Your Policy Schedule) will be paid if the Life Insured passes away, provided all the required Claims criteria specified throughout this Policy are met.

5.3 HOW DOES THE BENEFIT CHANGE?

For Personal Assurance policies, the Benefit Sum Assured will change each year, at Policy Anniversary, by the Dynamic Benefit Adjustment, specified by the Dynamic Financial Needs Analysis. The Dynamic Financial Needs Analysis is the smart algorithm that calculates required cover on an ongoing basis, based on the Life Insured's individual and unique circumstances. The algorithm automatically and dynamically adjusts cover to match the Life Insured's changing needs as the Life Insured's life and financial needs change. You may also elect for the cover to increase at CPI at Your Policy Anniversary.

For Business Assurance policies, the Benefit Sum Assured will change each year with CPI.

5.4 CLAIMS

The full Life Cover Sum Assured will be paid out for a valid Claim.

All death Claim Events will be covered, except death Claims for any specific Exclusions as specified in section 12.2 or any other Exclusions specified throughout this Policy.

There is a Waiting Period of 60 (sixty) full calendar months for suicide Claims. The Waiting Period applies to cover taken out at the Commencement Date, additional cover taken out through a voluntary servicing

change (e.g. voluntary increase in salary, voluntary change in occupation, voluntary increase of cover etc.) during the term of Your Policy and from the reinstatement date of the Policy. The Waiting Period will apply from the date that the cover is successfully added onto the Policy (from the date on which the Insurer accepts the liability). Payouts will only be made for a suicide Claim Event which occurs after the Waiting Period.

Each time You make a voluntary servicing change and increase Your Life Cover Benefit, a new 60 (sixty) month Waiting Period will apply to the additional portion of cover added. The portion of Life Cover Sum Assured that You had before You increased Your cover will be paid out if the Claim is past the original 60 (sixty) month Waiting Period.

Example

Example details:

- You take out a Policy with R5 000 000 Life Cover on 1 July 2020.
- You are both the Policyholder and Life Insured on the Policy.
- For simplicity, assume the Sum Assured remains level and does not grow in this example.
- Six years later, on 1 July 2026, You add an additional R2 000 000 Life Cover, meaning Your total Life Cover is now R7 000 000.
- Unfortunately, one year later, on 1 July 2027, You pass away and the Claim Event was due to suicide.

In this scenario, Your Beneficiaries will be paid R5 000 000, since the Claim Event is past the 60 (sixty) months (or five year) Waiting Period for the original Life Cover Sum Assured. However, the R2 000 000 Life Cover added on 1 July 2026 will not be paid out as this portion of Your Life Cover is still in its 60 (sixty) month Waiting Period for suicide Claims.

Please note that increases to the Life Cover amount suggested by the Dynamic Financial Needs Analysis will only attract a new 60 (sixty) month Waiting Period for suicide Claim Events if the increase in cover is above the maximum allowed servicing limits, at the time of change in cover. Please note that these maximums will be reviewed from time to time and may be amended by the Insurer and/or Administrator, at either's sole discretion.

Payouts will be made only when the Administrator/Insurer are satisfied that all the Policy and Claims requirements are met. There is no specified timeframe for this.

Please note that the Death Claim Events covered under this Benefit, as described in this section, must have occurred after the commencement of this Benefit in order for the Claimant to be eligible for a Claim pay-out.

Should the Administrator/Insurer exclude or decline cover for any previous or Pre-Existing Medical Condition, We will not pay out for any Claims that arise under any body system that is directly related to or is a consequence of the conditions or body system that was declined or excluded.

5.4.1 Advances on Life Cover Claims

To support your nominated beneficiaries with costs that may be incurred with your death, the Life Cover benefit automatically includes an Immediate Expense Benefit. With this Benefit, a nominal amount of the minimum of R50 000, or 5% of the Life Cover Benefit Amount (whichever is the lessor) at the time of the Life Insured's death will be paid within 48 hours of submitting a valid death certificate, claims form and associated documentation, in the case of a valid death Claim. In order to qualify for this Benefit, Your Policy must have been in force for at least two years and the cause of death of the Life Insured must be known. After paying out the Immediate Expense Benefit Claim, the remainder of the Life Cover Benefit Amount will be paid out when a normal Life Cover Claim would have been paid out, as specified in section 5.4.

The Immediate Expense Benefit will be paid at Our discretion where there are claim requirements or documentation outstanding, uncertainty surrounding the Claim Events or when there is a criminal investigation in connection with the death of the Life Insured, or any of the Beneficiaries is a suspect in connection with the death of the Life Insured.

If, after the Immediate Expense Benefit is made by Us, We repudiate the Claim, or if any of the Beneficiaries are found guilty of a criminal charge in connection with the death of the Life Insured, We will claim back any Immediate Expense Benefit payout made.

Example

Example details:

- You take out a Policy with R500 000 Life Cover on 1 July 2020.
- You are both the Policyholder and Life Insured on the Policy.
- For simplicity, assume the Sum Assured remains level and does not grow in this example.
- Ten years later, on 1 July 2030, You unfortunately pass away from a heart attack.

In this scenario, within 48 hours after submitting a valid death certificate, Your Beneficiaries will be paid R25 000 (calculated as the minimum of R50 000 or R500 000 x 5% = R25 000). After processing the Immediate Expense Benefit Claim, Your Beneficiaries will be paid the remaining amount of the Life Cover Sum Assured, which will be R 475 000 (R500 000 – R25 000).

5.5 WHEN DOES THE BENEFIT END?

There is no Benefit Expiry Age for the Life Cover Benefit, meaning that the Life Cover Benefit will be provided for the Life Insured's whole life, as long as the Life Insured still needs Life Cover. The Dynamic Financial Needs Analysis will re-assess the amount of Life Cover required every year to ensure the Life Insured is always optimally protected.

The Benefit will also cease on a death Claim, as well as any instances where the Policy has been terminated by the Policyholder or by the Insurer, for whatever reason.

5.6 THINGS TO NOTE

Please note that:

- Life Cover Claims will be subject to an overall maximum Claim amount. Please refer to Your Policy Schedule for this maximum amount. The maximum amount will be reviewed annually and may be amended by the Insurer and/or Administrator, at either's sole discretion.
- All rules, terms, conditions, calculations and Benefit formulas and workings and rules stated throughout section 5 above will be reviewed from time to time by the Administrator/Insurer and may be changed or amended, from time to time, at the Administrator/Insurer's sole discretion.
- HIV positive clients may be offered Life Cover on this Policy. If the Life Insured is HIV positive and receives cover, please refer to Appendix 4 which outlines the ongoing monitoring programme for HIV positive clients.
- Occupations affect the Premiums charged – if the Life Insured's occupation changes, the Administrator/Insurer requests that You inform Us. We reserve the right to amend Your Premiums and/or Benefits should You alter the Life Insured's occupation to one considered to be of a higher risk than Their previous occupation. The classification of whether the new occupation is deemed to be a higher risk occupation will be made at the sole discretion of the Administrator/Insurer.

6. Illness Cover Benefit

6.1 WHAT IS THE PURPOSE OF THE BENEFIT?

The Illness Cover Benefit provides a payment if the Life Insured suffers a severe illness, injury or disease. The payout is in the form of a single cash lump sum and it can be used to cover all unforeseen medical costs, lifestyle changes, assistive medical devices, rehabilitation programmes as well as assisting in accessing new breakthrough global treatments.

The Benefit was designed to ensure that the payout matches the severity of the Claim Event, ensuring the Life Insured has adequate cover for the impact that the illness or injury is expected to have on Their lifestyle.

6.2 OVERVIEW

Our Illness Cover Benefit pays out an amount commensurate with the change in lifestyle following the Claim Event. This means that the Illness Cover Benefit offers a tiered payout with four severity levels, as follows:

- Severity A: 120% - 200%
- Severity B: 100%
- Severity C: 75%
- Severity D: 50%

Example

Example Details:

- You have an Illness Cover Benefit Sum Assured of R1 000 000.
- You are both the Policyholder and the Life Insured on the Policy.
- You Claim for a Stage IV cancer which qualifies for a Severity B claim (100% payout).

In this scenario, You will receive R1 000 000 = R 1 000 000 x 100%.

Please note that an amount equal to, but not exceeding, the Illness Cover Benefit Amount (as specified in Your Policy Schedule) will be paid if the Life Insured suffers a valid Claim, under the Illness Objective Medical Criteria in Appendix 2, provided the Life Insured meets all the required Policy and Claims criteria specified throughout this Policy. In certain circumstances where the Severity percentage is above 100%, We will pay more than the Illness Cover Sum Assured at the time of Claim. The definitions found in Appendix 2 may also refer to the Activities of Daily Living definitions and metrics, which can be found in Appendix 3.

The Illness Cover Benefit is a standalone Benefit. This means that Claim payouts from this Benefit will not reduce the Life Cover Sum Assured or any other Benefits on Policy, and that the Benefit can be taken out as a standalone Benefit without the need to have Life Cover on the Policy.

6.3 HOW DOES THE BENEFIT CHANGE?

For Personal Assurance policies, the Benefit Sum Assured will change each year, at Your Policy Anniversary, by the Dynamic Benefit Adjustment, specified by the Dynamic Financial Needs Analysis. The Dynamic Financial Needs Analysis is the smart algorithm that calculates required cover on an ongoing basis, based on the Life Insured's individual and unique circumstances. The algorithm automatically and dynamically adjusts cover to match the Life Insured's changing needs as the Life Insured's life and financial needs change. You may also elect for Your cover to increase at CPI at Your Policy Anniversary.

For Business Assurance policies, the Benefit Sum Assured will change each year with CPI.

6.4 CLAIMS

The payout for the Illness Cover Benefit will be equal to the Sum Assured at the Claim Event Date multiplied by the severity percentage.

The Illness Cover Benefit will have a 1 (one) month Survival Period from the Claim Event. This will be 1 (one) full calendar month from the Claim Event Date.

Additionally, there will be a 1 (one) month Waiting Period from the Claim Event Date before the payment may be made to You. This is to give the Administrator/Insurer time to assess the validity and permanence of the Claim Event. This means that Claims will only be paid out at a minimum 1 (one) full calendar month after the Claim Event Date. If further time is required to assess the permanence of a Claim, then the Claim will only be paid out once the medical team of the Administrator/Insurer are satisfied that the condition meets the Illness Objective Medical Criteria. The maximum period for permanence to be established will be 12 (twelve) months from the Claim Event Date. Please refer to the definitions in the Illness Objective Medical Criteria (in Appendix 2) to see which conditions specifically require Waiting Periods longer than 1 month to assess the permanence of the illness, injury, disease or condition.

Please note that Premiums must continue to be paid during both the Waiting and Survival Periods, and whilst the Claim is being assessed (up until permanence of the illness, condition or injury is established, that is, up until the date on which the Claim is deemed valid).

Please note that if the Life Insured survives the 1 (one) month Survival Period, then the cover will reinstate to the full amount before the Claim Event. Future Unrelated Claims will be paid from this fully reinstated amount, whilst Related and Progressive Claims will only be paid for higher severities using the difference in severity percentages between the latest (current) Claim and the highest of all previous Claims, multiplied by the full Sum Assured. Please see section 15 for more details on multiple claim rules.

Example

Example Details:

- You take out R1 000 000 Illness Cover.
- You are both the Policyholder and Life Insured on the Policy.
- Unfortunately, 2 years later, You Claim for a stage III cancer.
- You qualify for a 100% pay out.

This means We will pay out R1 000 000 x 100% = R1 000 000.

If You survive the one-month Survival Period, then the Sum Assured will increase back to the full R1 000 000. This is because You will still have full coverage for all future Unrelated Claims – that is, You will receive a payout based on the full Sum Assured and the relevant severity for all for all future Unrelated Claims.

As mentioned above, if the Life Insured survives the 1 (one) month Survival Period, then cover will reinstate to the full amount before the Claim Event Date. Illness Cover Premiums will also continue to be paid in full thereafter – that is, the Premium payable will be for 100% of the full reinstated Illness Cover Sum Assured.

If an Illness Cover Claim is Repudiated (for whatever reason), then the Illness Cover Premium will continue to be paid thereafter. This is done so that the Life Insured continues to be protected, should They experience a Claim Event in the future.

Should the Administrator/Insurer exclude or decline cover for any previous or Pre-Existing Medical Condition, We will not pay out for any Claim Events that arise under any body system that is directly related to or is a consequence of the conditions or body system that was declined or excluded. Please refer to Your Schedule to see if any Exclusions apply to Your Policy.

Exclusions for the Illness Cover Benefit can be found in section 12.2. Certain condition specific/category specific Exclusions can also be found in Appendix 2.

6.5 WHEN DOES THE BENEFIT END?

The Illness Cover Benefit provides whole-of-life coverage and changes every year with the Life Insured's changing circumstances, ensuring that cover remains relevant to the Life Insured's evolving needs. This means that there is no explicit expiry age for the Illness Cover Benefit.

The Benefit will cease when:

- The Life Insured dies; or

- The Policy has been terminated by any party, for whatever reason.

6.6 THINGS TO NOTE

Please note that:

- Illness Cover Claims will be subject to an overall maximum Claim amount. Please refer to Your Policy Schedule for this maximum amount. The maximum amount will be reviewed annually and may be amended by the Insurer and/or Administrator, at either's sole discretion.
- Occupations affect the Premiums charged – if the Life Insured's occupation changes, the Administrator/Insurer requests that You inform Us. We reserve the right to amend Your Premiums and/or Benefits should You alter the Life Insured's occupation to one considered to be of a higher risk than Their previous occupation. The classification of whether the new occupation is deemed to be a higher risk occupation will be made at the sole discretion of the Administrator/Insurer.
- The OneSpark Policy is a living, dynamic Policy which changes as the Life Insured and the world around the Life Insured changes. This means it evolves and updates with the changing medical landscape. Therefore, the Administrator and/or Insurer reserves the right, at their sole discretion, to review and amend the specified list of Illness Objective Medical Criteria conditions as well as Activities of Daily Living (found in Appendix 2 and Appendix 3) from time to time, after consultation with medical experts. Amendments may be due to, but are not limited to, changes in the relevance, prognosis, occurrence, recovery rates, survival rates, mortality rates (following the onset of the condition) and lifestyle impacts of each condition. This means that the Administrator and/or Insurer may add or remove conditions from the Illness Objective Medical Criteria Claim Events, from time to time at their sole discretion. The Administrator and/or Insurer reserves the right to review and adjust the Illness Cover Benefit Premium, at their sole discretion, in light of any amendments to the Illness Objective Medical Criteria categories covered and the definitions contained therein.

7. Disability Cover Benefit

7.1 WHAT IS THE PURPOSE OF THE BENEFIT?

The Disability Cover Benefit provides a payment if the Life Insured becomes Permanently Disabled. The payout is made as a single cash lump sum and it can be used to cover the Life Insured's expected future lost income and/or all the expected future expenses incurred by the Life Insured and Their family. These can be used to pay for such costs as education, healthcare, food, housing, transport and for any other expenses incurred by the Life Insured and Their family. This payment is made as a single lump sum payment to You. The lump sum, or a portion thereof, can also be used to pay off any outstanding debts, if so required.

7.2 OVERVIEW

This Benefit will pay out 100% of the Disability Cover Benefit Sum Assured on a valid Claim. An amount equal to, but not exceeding, the Disability Cover Benefit Sum Assured (as specified in Your Policy Schedule) will be paid if the Life Insured suffers a valid Claim, under the Disability Objective Medical Criteria or the Occupational Claims Criteria and provided that the Life Insured meets all other Policy requirements.

This Benefit is a standalone Benefit. This means that any Claim amount from this Benefit will not reduce the Life Cover Sum Assured or any other Benefits on the Policy.

In circumstances when the Life Insured discloses that they are HIV positive or have diabetes, the Benefit will reduce the Life Cover Sum Assured on a valid Claim.

7.3 HOW DOES THE BENEFIT CHANGE?

For Personal Assurance policies, the Benefit Sum Assured will change each year, at Your Policy Anniversary, by the Dynamic Benefit Adjustment, specified by the Dynamic Financial Needs Analysis. The Dynamic Financial Needs Analysis is the smart algorithm that calculates the required cover on an ongoing basis, based on the Life Insured's individual and unique circumstances. The algorithm automatically and dynamically adjusts cover to match the Life Insured's changing needs as Their life and financial needs change. You may also elect for Your cover to increase at CPI at Your Policy Anniversary.

For Business Assurance policies, the Benefit Sum Assured will change each year with CPI.

7.4 CLAIMS

The full Disability Cover Benefit Sum Assured will be paid out for a valid Claim. This means that 100% of the Benefit Sum Assured will be paid out on a valid Claim.

This Benefit will pay out on 2 (two) different claims criterion, namely the Permanent Disability Claim Events:

- The Disability Objective Medical Criteria
- The Occupational Claims Criteria

Disability Objective Medical Criteria

The Disability Objective Medical Criteria is an objective, transparent and fair Claim system used to assess the severity of the Life Insured's disability. The disability is assessed based on the severity of the Life Insured's medical impairment.

Occupational Claims Criteria

The Benefit will pay out if the Life Insured's disability meets the Occupational Claims Criteria definition.

Please note that the Occupational Claims Criteria is not available for certain occupations. Please refer to Your Policy Schedule to see if the Life Insured's occupation qualifies for the Occupational Claim Criteria.

Please note that chronic fatigue syndrome (and any manifestations thereof), fibromyalgia (or conditions similar thereto), chronic pain disorders, any Mental and Behavioural Conditions and any lower back conditions are excluded under the Occupational Claims Criteria. The lower back Exclusion is defined as follows: *No amount or Sum Assured under this Benefit shall be payable for a disability which is caused wholly or partly, directly or indirectly, by an injury to, or a disorder of Lumbar Sacral spine or any complications thereof*.

Please note that the Life Insured will still be able to claim for Mental and Behavioural or lower back conditions if They meet one of the Disability Objective Medical Criteria definitions.

Please note that the maximum specified timeframe for the Claims assessment under the Disability Objective Medical Criteria or Occupational Claims Criteria is 12 (twelve) months from the Claim Event Date (longer periods will be allowed if specifically specified in any of the individual Disability Objective Medical Criteria definitions). A Claim decision, and payment, will only be made when the Administrator/Insurer are comfortable that the Claim meets the Permanent Disability claims criteria.

Please note that there is a 1 (one) month Waiting and Survival Period from the Claim Event:

- The 1 (one) month Survival Period means that the Life Insured will need to survive 1 (one) full calendar month from the Claim Event Date in order for a Claim to be made.

- In order to give the Insurer time to assess the validity and permanence of the Claim Event, there will be a 1 (one) month Waiting Period from the Claim Event. This means that Claims will only be paid out at a minimum of 1 (one) month after the Claim Event Date. Further time may be required to assess the permanence of a Claim Event and the Claim will only be paid out once the Administrator/Insurer are satisfied that the Claim condition meets the Permanent Disability Claims definition. Please also refer to the definitions in Appendix 1 to see which conditions specifically require Waiting Periods longer than 1 (one) month to assess the permanence of the illness, injury, disease or condition. No other Policy changes will be allowed in the time period from the Date of Disability until the end of the Waiting Period or until permanence is established, whichever comes later.

Premiums must continue to be paid during the Survival and Waiting Periods, as well as during the time when the Claim is being assessed. They must continue to be paid up to the date at which permanence is established.

If the Claim is repudiated, then the Disability Cover Benefit and Premiums will both continue to ensure the Life Insured remains protected if They were to experience a Claim Event going forward.

Please note that no Claim payout will be made if the Claim Event condition is due to an Exclusion, as defined in section 12.2. Certain condition specific/category specific Exclusions can also be found in Appendix 1.

Please also note that no multiple Claims will be allowed under the Disability Cover Benefit. This means that once 100% of the Benefit Sum Assured is paid out, then no further Claim payments will be made from the Disability Cover Benefit.

Please note that the Claim Events covered under this Benefit, as described in this section, must have occurred after the commencement of this Benefit in order for the Claimant to be eligible for a Claim pay-out.

Should the Insurer exclude or decline cover for any previous or Pre-Existing Medical Condition, We will not pay out for any Claims that arise under any body system that is directly related to or is a consequence of the conditions or body system that was declined or excluded.

7.5 WHEN DOES THE BENEFIT END?

The Benefit will cease when

- The Life Insured dies; or
- The Policy has been terminated by any party, for whatever reason; or
- A valid Disability Cover Benefit Claim has occurred; or
- The Life Insured turns age 65 (sixty-five).

If the Life Insured still has outstanding debt at age 65 (sixty-five), then the Benefit will not expire when the Life Insured turns 65 (sixty-five) and may be extended until the end of the month in which the Life Insured turns 70 (seventy). The following paragraphs detail how this works.

If the Life Insured still has outstanding debt when the Life Insured is 65 (sixty-five) and You want to keep the Disability Cover to cover this debt, then You will need to send Us proof of the outstanding debt before the first Policy Anniversary before the Life Insured turns 65 (sixty-five). In this scenario, the Disability Cover Benefit Sum Assured will be equal to the Life Insured's outstanding debt amount, provided the Cover Amount is equal to or less than the Disability Cover before the Life Insured turns 65 (sixty-five).

If no proof of outstanding debt is received by the Administrator/Insurer from You by the Policy Anniversary when the Life Insured turns 65 (sixty-five), the Disability Cover Benefit will automatically fall away when the Life Insured turns 65 (sixty-five) and You will not be able to reinstate the Disability Cover Benefit thereafter. Proof of outstanding debt will need to be provided to the Administrator/Insurer on an annual basis before each Policy Anniversary to keep the cover in force. The cover that You take out cannot exceed the outstanding debt amount provided at that point in time. It also cannot exceed the Disability Cover Sum Assured at Your previous Policy Anniversary, as well as the Disability Cover Sum Assured at the point in time when the Life Insured turned 65 (sixty-five). The Disability Cover Benefit will fall away at the end of the month in which the Life Insured turns age 70 (seventy).

No further Disability Cover will be offered for a Life Insured on a Business Life Plan after age 65 (sixty-five).

The Disability Cover Benefit will provide protection for Claim Events under the Disability Objective Medical Criteria only and not for the Occupational Claims Criteria after age 65 (sixty-five).

All rules, terms, conditions, exclusions, loadings and Benefit workings specified throughout this section (section 7.5 as well as section 7) will be applied to this Cover post age 65 (sixty-five), unless otherwise specified.

7.6 THINGS TO NOTE

Please note that:

- Disability Cover Claims will be subject to an overall maximum Claim amount. Please refer to Your Policy Schedule for this maximum amount. The maximum amount will be reviewed annually and may be amended by the Insurer and/or Administrator, at either's sole discretion.
- HIV positive clients may be offered Disability Cover on this Policy. If the Life Insured is HIV positive and receives cover, please refer to Appendix 4 which outlines the ongoing monitoring programme for HIV positive clients.
- Occupations affect the Premiums charged – if the Life Insured's occupation changes, the Administrator/Insurer requests that You inform Us. We reserve the right to amend Your Premiums and/or Benefits should You alter the Life Insured's occupation to one considered to be of a higher risk than Their previous occupation. The classification of whether the new occupation is deemed to be a higher risk occupation will be made at the sole discretion of the Administrator/Insurer.

- The OneSpark Policy is a living, dynamic Policy which changes as the Life Insured and the world around Them changes. This means it evolves and updates with the changing medical landscape. Therefore, the Administrator and/or Insurer reserves the right, at their sole discretion, to review and amend the specified list of Disability Objective Medical Criteria conditions as well as Activities of Daily Living (found in Appendix 1 and Appendix 3) as well as the Occupational Claims Criteria from time to time, after consultation with medical experts. Amendments may be due to, but not limited to, changes in the relevance, prognosis, occurrence, recovery rates, survival rates, mortality rates (following the onset of the condition) and lifestyle impacts of each condition. This means that the Administrator and/or Insurer may add or remove conditions from the Disability Objective Medical Criteria and/or Occupational Claims Criteria, from time to time at their sole discretion. The Administrator and/or Insurer reserves the right to review and adjust the Disability Cover Premium, at their sole discretion, in light of any amendments.

8. Income Protection Benefit

The Income Protection Benefit is a Benefit which pays out a regular Income should the Life Insured experience an illness, disease, impairment or injury preventing the Life Insured from working and earning an Income. It consists of 2 (two) income protection components. These are the:

- Temporary Income Protection Benefit – This Benefit will provide protection in situations where the Life Insured is unable to perform Their Nominated Occupation and are losing income, but are not deemed Permanently Disabled, and the
- Permanent Income Protection Benefit – This Benefit will provide protection on Permanent Disability Claims.

8.1 TEMPORARY INCOME PROTECTION BENEFIT

8.1.1 What is the purpose of the Benefit?

The Temporary Income Protection Benefit pays out a regular income should the Life Insured experience an illness, disease, impairment or injury preventing the Life Insured from working and earning an Income upon becoming Temporarily Disabled and where the Life Insured is unable to perform Their own Nominated Occupation. This Benefit is used to replace lost Income when the Life Insured cannot work and cannot earn an Income as a result of a Temporary Disability.

The Benefit is designed to complement the Permanent Income Protection Benefit, which only pays on Permanent Disability. Please see section 8.2 for further details.

8.1.2 Overview

An amount equal to, but not exceeding, the Temporary Income Protection Benefit Sum Assured (as specified in Your Policy Schedule) will be paid if the Life Insured suffers a valid Claim Event under the Temporary Income Protection Benefit.

Please note that valid Benefit payouts will not reduce the Life Cover Sum Assured or any other Benefits on the Policy on Claim.

8.1.3 How does the Benefit change?

The Benefit Sum Assured will change each year, at Your Policy Anniversary, by the Dynamic Benefit Adjustment, specified by the Dynamic Financial Needs Analysis. The algorithm automatically and dynamically adjusts cover to match the Life Insured's changing needs as the Life Insured's life and financial needs change. The Temporary Income Protection Benefit Sum

Assured will grow in line with the Life Insured's projected net of tax salary, as projected by the Dynamic Financial Needs Analysis. You may also elect for the cover to increase at CPI at Policy Anniversary.

Please note that the above adjustments are made when the Life Insured is not claiming under the Temporary Income Protection Benefit. The In-Claim Escalations (increases) can be found in section 8.3.4.

8.1.4 Claims

A payout for a valid Claim under the Temporary Income Protection Benefit will be defined as the lesser of the Temporary Income Protection Benefit Sum Assured and the Life Insured's Pre-Claim Income at the Claim Event Date. Payments will only be made for full Days that the Life Insured qualifies for payouts under the Temporary Income Protection Benefit.

The first payment to You will be made at the end of the month in which the Waiting Period expires. Thereafter, Benefit payments will always be made at the end of the month.

Under the Temporary Income Protection Benefit, You can claim under the Loss of Income Claims Criteria by providing proof that the Life Insured is unable to perform at least 25% of the main duties of Their Nominated Occupation due to injury or illness, and as a result are unable to maintain Their income level.

The Claim payment that the Life Insured receives will depend on the Income that They are losing whilst They are in claim. If the Life Insured suffers a partial loss of income, You will be paid a proportionate claim payment which will equal the Temporary Income Protection Sum Assured multiplied by the proportion of Income lost.

Whilst the Life Insured is in claim, the Temporary Income Protection Benefit Premiums will be waived, that is, You will not pay any Temporary Income Protection Benefit Premiums during claim. Even if the Life Insured is only claiming for a portion of Their income, the Temporary Income Protection Premiums will be waived, that is, You do not need to be claiming for 100% of the Temporary Income Protection Benefit Sum Assured to have the Temporary Income Protection Benefit Premiums waived.

However, during claim, You will continue to pay Premiums for other Benefits (i.e. for Life Cover, Disability Cover, Illness Cover and Permanent Income Protection). If You do not pay the Premiums for these Benefits, they will fall away.

There is a 1 (one) or 3 (three) month Waiting Period for the Temporary Income Protection Benefit. Please refer to Your Schedule to see which Waiting Period applies to Your Policy. This means that this Benefit will only pay out after the Waiting Period has expired and only once the

Administrator/Insurer are satisfied that the Life Insured has satisfied the Temporary Income Protection Benefit claims criteria.

The Temporary Income Protection Benefit pays out, as long as the Benefit remains in force, until the earlier of:

- The Life Insured has recovered sufficiently to return to work;
- The end of the month in which the Life Insured turns age 65 (sixty-five);
- The Life Insured's death;
- The date on which the Life Insured qualifies for a Permanent Disability Claim, irrespective if You have the Permanent Income Protection Benefit or the Disability Cover Benefit on Your Policy.

In order to receive a Claim payout, You will have to send in a certified bank statement at month end as well as any other documents as required by the Administrator/Insurer, showing that the Life Insured has lost Income. The actual payment will be made at the month end of the relevant month for valid Claims.

Please note that:

- You may only Claim under this Benefit if the Life Insured is losing more than 25% of Their Pre-Claim Income.
- You may only Claim if the Life Insured is unable to perform at least 25% of the main (material and substantial) duties of Their Nominated Occupation.
- Benefits will be aggregated against income earned in claim as well as against other disability product payouts received in claim. Please see section 8.3.7 for further details.
- All Mental and Behavioural and lower back conditions will be excluded from the Temporary Income Protection Benefit, and no claims will be made under the Temporary Income Protection Benefit for these conditions.
- The wording for the lower back Exclusion is defined as follows: *No amount or Sum Assured under this Benefit shall be payable for a disability which is caused wholly or partly, directly or indirectly, by an injury to, or a disorder of Lumbar Sacral spine or any complications thereof.*
- No Claim payout will be made if the Claim Event condition is due to an Exclusion, as defined in sections 8.3.6 and 12.2.
- Claim Events covered under this Benefit, as described in this section, must have occurred after the commencement of this Benefit in order for the Claimant to be eligible for a Claim pay-out.

The Claimant may at any time apply for a review of the existing Claim, provided that new medical information is submitted. The Administrator/Insurer may also at any stage review whether the Claim qualifies for the Loss of Income Claims Criteria, under the Temporary Income Protection Benefit claims criteria.

Should the Administrator/Insurer exclude or decline cover for any previous or Pre-Existing Medical Condition, We will not pay out for any Claims that arise under any body system that

is directly related to or is a consequence of the conditions or body system that was declined or excluded.

8.1.5 When does the Benefit end?

The Benefit will cease when:

- The Life Insured turns 65 (sixty-five);
- The Life Insured dies; or
- The Policy has been terminated by any party, for whatever reason.
- The Life Insured qualifies under the Permanent Disability claims criteria, whether or not the Life Insured has the Disability Cover or Permanent Income Protection benefit on the Policy.

8.1.6 Things to note

Please note that:

- Temporary Income Protection Benefit Claims will be subject to an overall maximum Claim amount. Please refer to Your Policy Schedule for this maximum amount. The maximum amount will be reviewed annually and may be amended by the Insurer and/or Administrator, at either's sole discretion.
- Occupations affect the Premiums charged – if the Life Insured's occupation changes, the Administrator/Insurer requests that You inform Us. We reserve the right to amend Your Premiums and/or Benefits should You alter the Life Insured's occupation to one considered to be of a higher risk than Their previous occupation. The classification of whether the new occupation is deemed to be a higher risk occupation will be made at the sole discretion of the Administrator/Insurer.
- In order to qualify for a Benefit payment for a Claim arising from fibromyalgia, a rheumatologist's confirmation of the diagnosis and inability to work is required. In order to qualify for a Benefit payment for a Claim arising from chronic fatigue syndrome, a specialist physician's confirmation of the diagnosis and inability to work is required.
- The OneSpark Policy is a living, dynamic Policy which changes as the Life Insured and the world around changes. This means it evolves and updates with the changing medical landscape. Therefore, the Administrator and/or Insurer reserves the right, from time to time and at either of their sole discretion, to review and amend the claims criteria under the Temporary Income Protection Benefit, after consultation with medical experts. Amendments may be due to, but are not limited to, changes in the relevance, prognosis, occurrence, survival rates, recovery rates, mortality rates (following the onset of the condition) and lifestyle impacts of different illnesses, diseases or injuries as well as of different claim underpins. This means that the Administrator and/or Insurer may add or remove claims criteria under the Temporary Income Protection Benefit, from time to time at their sole discretion. The Administrator and/or Insurer reserves the right to review and adjust the Temporary Income Protection Benefit Premium, at their sole discretion, in light of any

amendments to the claim criteria (and/or individual conditions) under the Temporary Income Protection Benefit.

8.2 PERMANENT INCOME PROTECTION BENEFIT

8.2.1 What is the purpose of the Benefit?

The Permanent Income Protection Benefit pays out a regular income should the Life Insured experience a disease, illness, impairment or injury preventing the Life Insured from working and earning an Income upon becoming Permanently Disabled. This Benefit is used to replace lost Income when the Life Insured cannot work and cannot earn an Income as a result of suffering a Permanent Disability Claim Event.

The Permanent Income Protection Benefit is designed to complement the Temporary Income Protection Benefit, which pays on Temporary Disability, where the Permanent Income Protection Benefit will begin to pay out once permanence is established.

8.2.2 Overview

Please note that an amount equal to, but not exceeding, the Permanent Income Protection Benefit Sum Assured (as specified in Your Policy Schedule) will be paid if the Life Insured suffers a valid Claim Event under the Permanent Income Protection Benefit.

Please note that valid Benefit payouts will not reduce the Life Cover Sum Assured or any other Benefits on Claim.

8.2.3 How does the Benefit change?

The Benefit Sum Assured will change each year, at Policy Anniversary, by the Dynamic Benefit Adjustment, specified by the Dynamic Financial Needs Analysis. The algorithm automatically and dynamically adjusts cover to match the Life Insured's changing needs as the Life Insured's life and financial needs change. The Permanent Income Protection Benefit Sum Assured will grow in line with the Life Insured's projected net of tax Salary, as projected by the Dynamic Financial Needs Analysis. You may also elect for the cover to increase at CPI at Policy Anniversary.

Please note that the above adjustments are made when the Life Insured is not claiming under the Permanent Income Protection Benefit. The In-Claim Escalations can be found in section 8.3.4.

8.2.4 Claims

A payout for a valid Claim under the Permanent Income Protection Benefit will be defined as the lesser of Your Permanent Income Protection Benefit Sum Assured and the Life Insured's Pre-Claim Income at the Claim Event Date. Payouts will only be made for full Days that the Life Insured qualifies for payouts under the Permanent Income Protection Benefit

The first payment will be made at the end of the month in which the Waiting Period expires. Thereafter, Benefit payments will always be made at the end of the month.

This Benefit will pay out on 2 (two) different claims criterion, namely the Permanent Disability Claim Events:

- The Disability Objective Medical Criteria
- The Occupational Claims Criteria

Objective Medical Criteria

The Disability Objective Medical Criteria is an objective, transparent and fair Claim system used to assess the severity of the Life Insured's disability. The disability is assessed based on the severity of the Life Insured's medical impairment.

Occupational Claims Criteria

The Benefit will pay out if the Life Insured's disability meets the Occupational Claims Criteria definition.

Please note that the Occupational Claims Criteria is not available for certain occupations. Please refer to Your Policy Schedule to see if the Life Insured's occupation qualifies for the Occupational Claim Criteria.

Please note that chronic fatigue syndrome (and any manifestations thereof), fibromyalgia (or conditions similar thereto), chronic pain disorders, any Mental and Behavioural Conditions and any lower back conditions are excluded under the Occupational Claims Criteria. The lower back Exclusion is defined as follows: *No amount or Sum Assured under this Benefit shall be payable for a disability which is caused wholly or partly, directly or indirectly, by an injury to, or a disorder of Lumbar Sacral spine or any complications thereof.*

Please note that You will still be able to claim for Mental and Behavioural or lower back conditions if the Life Insured meets one of the Disability Objective Medical Criteria definitions.

Please note that the maximum specified timeframe for the claims assessment under the Disability Objective Medical Criteria or Occupational Claims Criteria is 12 (twelve) months from the Claim Event Date (longer periods will be allowed if specified in any of the individual Disability Objective Medical Criteria definitions). A Claim decision, and payment, will only be made when the Administrator/Insurer are satisfied that the Claim meets the Permanent Disability claims criteria.

Please note that whilst there is a Permanent Income Protection Claim being paid out, the Permanent Income Protection Benefit Premiums will be waived - that is, You will not pay any Permanent Income Protection Benefit Premiums during claim. Please note that even if the Life Insured is only claiming a portion of Their income, the Permanent Income Protection Premiums will be waived.

However, You will need to continue paying for Your other Premiums on Your Policy (Life Cover, Disability Cover and Illness Cover) whilst in claim. If You do not pay the Premiums for these individual Benefits, they will fall away.

There is a 1 (one) or 3 (three) month Waiting Period for Claims on the Permanent Income Protection Benefit. Please refer to Your Schedule to see which applies to Your Policy. This Benefit will only begin to pay out on the later of the Waiting Period having expired and permanence being established (permanence being established is when the Claimant meets the Permanent Disability Claim Criteria). Payment will only commence once the Administrator/Insurer are satisfied that the Life Insured has met the Permanent Distality Claims Criteria, after the Waiting Period has elapsed.

Example

Example Details:

- You take out a OneSpark Policy with both Temporary and Permanent Income Protection Benefits.
- You are both the Policyholder and Life Insured on the Policy.
- You become really ill and are unable to work.
- Your Income Protection Benefit starts to pay out under the Temporary Income Protection Benefit, once the Waiting Period has expired. In this example, the Waiting Period is 3 (three) months. You remain Temporarily Disabled for 6 months in total. The Insurer pays out for 3 months.
- After 6 months from the start of the condition, You are deemed to be Permanently Disabled.

Here the Income Protection Benefit begins to pay out under the Permanent Income Protection Benefit and the Temporary Income Protection Benefit stops paying out.

Please note that the Permanent Income Protection Benefit Premiums are required to be paid whilst (and until) the date where permanence is established by the Administrator/Insurer at either's sole discretion.

The Permanent Income Protection Benefit pays out, as long as the Benefit remains in force, until the earlier of:

- The Life Insured has recovered sufficiently to return to work;
- The end of the month in which the Life Insured turns age 65 (sixty-five); or
- The Life Insured's death.

Once You have claimed under the Permanent Income Protection Benefit, Your Temporary Income Protection Benefit (if selected on Your Policy) will fall away.

Please note that:

- Benefits will be aggregated against income earned in claim as well as against other income protection benefits received from other companies in claim, for Claims under all of the Permanent Disability Claims Criteria. Please see section 8.3.7 for further details.
- No Claim payout will be made if the Claim condition is due to an Exclusion, as defined in section 9.2.

If the Claim has not been assessed as permanent as yet (even after the Wating Period has expired), then no payout will be made from the Permanent Income Protection Benefit until permanence is established. Once Permanent Disability is established in accordance with the claim's assessment procedure for the Permanent Income Protection Benefit, then the Permanent Income Protection Benefit will start paying out and the Temporary Income Protection Benefit will stop paying out (if selected on the Policy).

Please note that no Claim payout will be made if the Claim condition is due to an Exclusion, as defined in sections 8.3.6 and 12.2. Certain condition specific Exclusions can also be found in Appendix 1.

The Claimant may at any time apply for a review of the existing Claim, provided that new medical information is submitted. The Administrator/Insurer may also at any stage review whether the Benefit qualifies for the Occupational Claims Criteria, under the Permanent Income Protection Benefit claims criteria.

Please note that the Claim Events covered under this Benefit, as described in this section, must have occurred after the commencement of this Benefit in order for the Claimant to be eligible for a Claim pay-out.

Should the Administrator/Insurer exclude or decline cover for any previous or Pre-Existing Medical Condition, We will not pay-out for any Claim Events that arise under any body system that is directly related to or is a consequence of the conditions or body system that was declined or excluded

8.2.5 When does the Benefit end?

The Benefit will cease when:

- The Life Insured turns 65 (sixty-five);

- The Life Insured dies; or
- The Policy has been terminated by any party, for whatever reason.

8.2.6 Things to note

Please note that:

- Permanent Income Protection Benefit Claims will be subject to an overall maximum Claim amount. Please refer to Your Policy Schedule for this maximum amount. The maximum amount will be reviewed annually and may be amended by the Insurer and/or Administrator, at either's sole discretion.
- Occupations affect the Premiums charged – if the Life Insured's occupation changes, the Administrator/Insurer requests that You inform Us. We reserve the right to amend Your Premiums and/or Benefits should You alter the Life Insured's occupation to one considered to be of a higher risk than Their previous occupation. The classification of whether the new occupation is deemed to be a higher risk occupation will be made at the sole discretion of the Administrator/Insurer.
- The OneSpark Policy is a living, dynamic Policy which changes as the Life Insured and the world around changes. This means it evolves and updates with the changing medical landscape. Therefore, the Administrator and/or Insurer reserves the right, at their sole discretion, to review and amend the specified list of Disability Objective Medical Criteria conditions as well as Activities of Daily Living (found in Appendix 1 and Appendix 3) as well as the Occupational Claims Criteria from time to time, after consultation with medical experts. Amendments may be due to, but not limited to, changes in the relevance, prognosis, occurrence, recovery rates, survival rates, mortality rates (following the onset of the condition) and lifestyle impacts of each condition. This means that the Administrator and/or Insurer may add or remove conditions from the Disability Objective Medical Criteria and/or Occupational Claims Criteria, from time to time at their sole discretion. The Administrator and/or Insurer reserves the right to review and adjust the Permanent Income Protection Premium, at their sole discretion, in light of any amendments.

8.3 INCOME PROTECTION BENEFIT GENERAL TERMS AND CONDITIONS

Please note that all sections in 8.3 are related to both the Temporary and Permanent Income Protection Benefits, falling under the Income Protection Benefit. The wording 'Income Protection Benefit' is used to refer to both the Temporary and Permanent Income Protection Benefits, throughout section 8.3.

8.3.1 Take-A-Break Benefit

The Administrator/Insurer will allow clients a maximum Sabbatical term of 6 (six) months every 3 (three) years. An Income Protection Benefit Claim submitted during a Sabbatical will be assessed on whether the Life Insured is medically certified to be able to perform Their Nominated Occupation.

Please note that You still need to pay Your Temporary Income Protection Benefit and Permanent Income Protection Benefit Premiums during the Sabbatical, in order to receive coverage under the Temporary Income Protection and Permanent Income Protection Benefits.

The Sabbatical will exclude certain countries where the risks, in the opinion of the Administrator/Insurer and at their sole discretion, are greater than those to which They would have been exposed in South Africa. This list will be reviewed and changed, from time to time, at the Administrator's/Insurer's sole discretion.

8.3.2 Proof of Income on Claim

You have 90 (ninety) Days from the date of the Claim Event to prove the Life Insured's Income (Pre-Claim Income) over the last 12 (twelve) months before disability.

- Should You not correctly disclose the Life Insured's Income to Us at application stage or when You have affected changes to Your Policy, the Administrator reserves the right to recoup any Benefit overpayments as well as terminate the Benefit with no further Benefit payouts.
- If the Life Insured has no Income at the time of the condition giving rise to the Claim and the Life Insured is not on a Sabbatical, You will not be able to Claim as there is no loss of Income due to the condition (for example if the Life Insured has been retrenched or if the Life Insured has resigned from Their Nominated Occupation or if They are in prison).
- Any Claim made within 12 (twelve) months of returning to work following a period of retrenchment will exclude the period of retrenchment for the purposes of calculating the Life Insured's Pre-Claim Income.
- Please note that Claim payouts will be made during this 90 (ninety) Day period (where applicable).
    - If the Benefit Amount is reduced after receiving such proof, the Administrator/Insurer reserves the right to recoup any previous overpayments.

It is in Your and the Life Insured's (if different) interest to redo the Dynamic Financial Needs Analysis each year, one month before Policy Anniversary to make sure the Life Insured remains fully insured.

- This will assist in preventing the Life Insured from becoming over or under-insured.
- Note that only Income received from the Life Insured's Nominated Occupation will be covered by this Benefit. Please see section 8.1 and 8.2 for more details.
- The Administrator/Insurer assume no liability if You do not update Your or the Life Insured's details and cover is not in line with the Life Insured's current needs.

Please note that all the above the terms, conditions, rules, calculations and formulas in section 8.3.2 (for example, but not limited to, the definition of Pre-Claim Income, the period over which it is determined, the period to prove Income and the methods of calculation) will be reviewed from time to time and may be amended by the Insurer and/or Administrator from time to time, at either's sole discretion.

8.3.3 Waiting Period

The Waiting Period is the period for which the Life Insured will need to be continuously disabled (and for scenarios where the Claim is assessed against Their occupation, unable to perform Their Nominated Occupation) due to injury or illness in the opinion of the Administrator/Insurer after the Date of Disability before You can start claiming for a Temporary or Permanent Disability Claim.

Both the Temporary Income Protection Benefit and Permanent Income Protection Benefit will have the same Waiting Period from the Date of Disability.

Each month, the payout for the time that the Life Insured satisfies the relevant Claims criteria in that month will be made at the end of that relevant month, after proof of loss of Income is received from You, where relevant.

No Benefit payout will be made for Temporary or Permanent Income Protection Benefit Claims during the Waiting Period and only once the Waiting Period has ended will the Benefit payments commence. Please note that no retrospective payments will be made in relation to the Waiting Period. In other words, the Claim payouts only commence after the expiration of the Waiting Period and will only be paid in respect of the period after the Waiting Period expires.

Please note that the usual Dynamic Benefit Adjustment will be applied to the Temporary and Permanent Income Protection Benefit Sum Assureds if Your Policy Anniversary either comes before the end of the Waiting Period or coincides with it (but also which is after the Date of Disability). No other Policy changes will be allowed in the time period from the Date of Disability until the end of the Waiting Period or until permanence is established, whichever comes later.

Note that only full Days which the Life Insured satisfies the Claims criteria contribute towards the Waiting Period.

If the Life Insured recovers or is rehabilitated and Claims again for the same cause which resulted in Their original inability to perform Their Nominated Occupation within 3 (three) months of recovery, the Waiting Period will be waived for the subsequent Claim. This is known as the 'off-period'. Please note that no Temporary or Permanent Income Protection Benefit payouts will be made in the period between the date of recovery and the new Benefit Claim Event Date.

Example

Example Details:

- You take out a OneSpark policy with the Income Protection Benefit.
- You are both the Policyholder and Life Insured on the Policy.
- Unfortunately, You become disabled and start losing more than 25% of Your Income from Your Nominated Occupation.
- After the 3-month Waiting Period, You begin to receive monthly Benefit payouts from the Temporary Income Protection Benefit.
- Six months later You recover, Your monthly Benefit payouts have stopped, and You go back to work.
- Two months after Your recovery, You become disabled again (due to the same illness or injury) for a second time and again begin to lose more than 25% of Your Income.

In this scenario, You will not have to go through a further 3 (three) month Waiting Period again and will start to receive monthly Benefit payouts immediately from the date of the new valid Claim Event.

Please note that Premiums are payable during the Waiting Period. If a client does not pay the Temporary and Permanent Income Protection Benefit Premiums during the Waiting Period, then the Temporary and Permanent Income Protection Benefits will fall away.

Please note that if the Insured Life dies within the relevant Waiting Period, no Income Protection Benefit will be paid. If The Life Insured dies during the Temporary Income Protection Benefit Waiting Period, then no Temporary Income Protection Benefit will be made. If the Life Insured dies during the Permanent Income Protection Benefit Waiting Period, then no Permanent Income Protection Benefit will be made.

8.3.4 In-Claim Escalation

The In-Claim Escalation Factor is the percentage that the Temporary and Permanent Income Protection Benefits will increase by each year, at Your Claim Anniversary.

Please note there are 2 (two) claim escalation options, namely the:

- CPI option
- Occupational In-Claim Escalation Option, which has 3 (three) categories:
  - Core Option
  - Standard Option
  - Executive Option

  These all apply an increase of CPI plus a certain factor to take into account the Claimants age as well as expected future occupational increases relating to their specific occupation. The category within the Occupational In-Claim Escalation

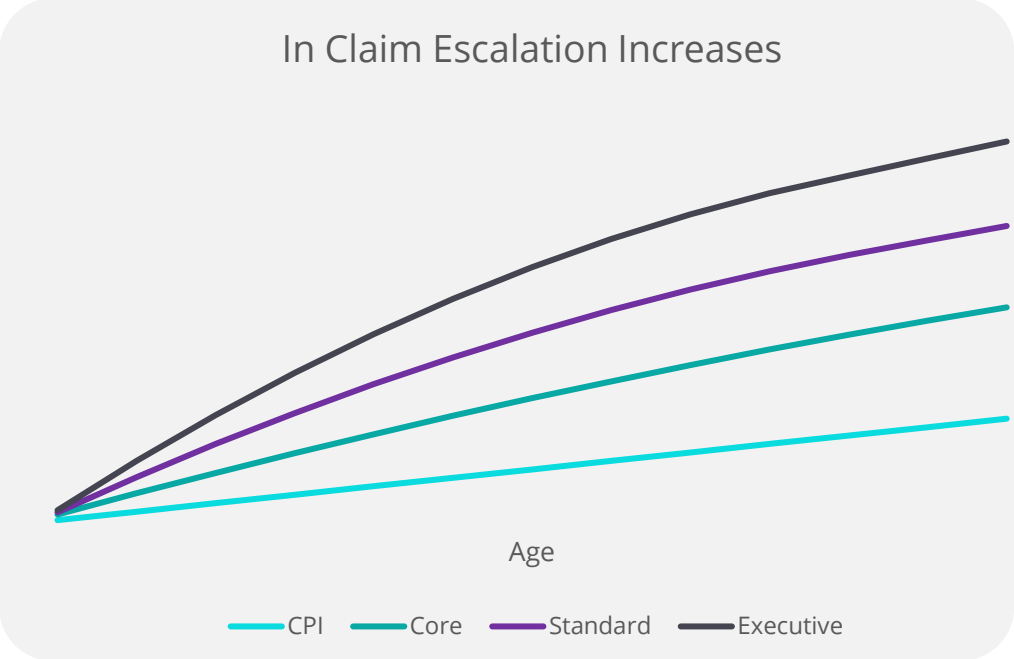
Option will be automatically applied to Your Policy based on the Life Insured's Nominated Occupation.

Please refer to Your Policy Schedule to see which option has been selected on Your Policy.

Depending on the option selected, each year on the Claim Anniversary Date, the Temporary and Permanent Income Protection Benefit Sum Assureds will increase by a specified factor. The specified factor will be based on the following factors:

- CPI
- The Life Insured's Nominated Occupation
- The Life Insured's age each year in claim

The In-Claim Escalation increase option look as follows:



CPI used in the above calculation will be subject to an overall maximum percentage of 10%. Please note that these maximums will be reviewed annually by Administrator and may be amended by the Administrator, at its sole discretion.

These In-Claim Escalation increases will be applied each Claim Anniversary after each 12 (twelve) full calendar month period of Benefit payments. The Administrator will use the CPI figure as released by Statistics South Africa three months before the Claim Anniversary.

Example 1

Example Details

- You take out a OneSpark Policy on 1 August 2020.
- You are the Policyholder and Life Insured on the Policy.

- You take out cover of R50 000 on the Income Protection Benefit (meaning You have R50 000 coverage under the Temporary Income Protection Benefit and R50 000 coverage under the Permanent Income Protection Benefit)
- You have the Core Occupational In-Claim Escalation Option on Your Policy.
- Unfortunately, later in that year, You become Permanently Disabled.
- CPI is assumed to be 5% for each year.

Assume the CPI and Occupational In-Claim Escalation Percentages are as follows:

Age	CPI	Core increases (in addition to CPI)	Total Increase
25	5%	5.25%	10.25%
26	5%	5.00%	10.00%
27	5%	4.75%	9.75%
28	5%	4.50%	9.50%
29	5%	4.25%	9.25%
30	5%	3.80%	8.80%

The Claim payout made to You will be under the Permanent Income Protection Benefit and will be as follows:

Age	Year since Disability Claim Event Date	Total Increase	Monthly Permanent Income Protection Benefit	Calculation
25	0	10.25%	R50 000.00	
26	1	10.00%	R55 000.00	R50 000 x (1 + 10.00%)
27	2	9.75%	R60 362.50	R55 000 x (1 + 9.75%)
28	3	9.50%	R66 096.94	R60 362.50 x (1 + 9.50%)
29	4	9.25%	R72 210.90	R66 096.94 x (1 + 9.25%)
30	5	8.80%	R78 565.46	R72 210.90 x (1 + 8.80%)

Example 2

Example Details

- You take out a OneSpark Policy on 1 August 2020.
- You are both the Policyholder and Life Insured on the Policy.
- You take out cover of R50 000 on the Income Protection Benefit (meaning You have R50 000 coverage under the Temporary Income Protection Benefit and R50 000 coverage under the Permanent Income Protection Benefit)
- You select the CPI In-Claim Escalation Option.

- Unfortunately, later in that year, You become Permanently Disabled.
- CPI is assumed to be 5% for each year.

The Claim payout made to You will be under the Permanent Income Protection Benefit and will be as follows:

Age	Year since Disability Claim Event Date	CPI	Monthly Permanent Income Protection Benefit	Calculation
25	0	5%	R50 000.00	
26	1	5%	R52 500.00	R50 000 x (1 + 5.00%)
27	2	5%	R55 125.00	R52 500.00 x (1 + 5.00%)
28	3	5%	R57 881.25	R55 125.00 x (1 + 5.00%)
29	4	5%	R60 775.31	R57 881.25 x (1 + 5.00%)
30	5	5%	R63 814.08	R60 775.31 x (1 + 5.00%)

Please note that If the Life Insured recovers and the payments cease, the Temporary and Permanent Income Protection Benefit Sum Assureds will change back to the amounts that would have applied if no Claim had been submitted. In other words, Your Benefit Amounts will revert to the Benefit Amount that applied at the start of the Claim payments, increased by any applicable Dynamic Benefit Adjustments for the duration that You were receiving payments.

Please note that the In-Claim Escalation factors described in this section will also be used to increase the Life Insured's Pre-Claim Income amount (Section 8.3.2).

Please note that all rules, terms, conditions , formulas, calculations and workings described in section 8.3.4 will be revised, from time to time, and may be amended at the Administrator's/Insurer's sole discretion.

8.3.5 Taxation

The Benefit payments under the Income Protection Benefit (both the Temporary and Permanent Income Protection Benefits) will not be subject to tax. Additionally, the Premiums for the Temporary and Permanent Income Protection Benefits are not tax-deductible.

The Administrator/Insurer reserves the right, at its sole discretion, to adjust the Benefits and/or Premiums applicable to Your Temporary and Permanent Income Protection Benefits in the event of a change to the tax laws applicable to these Benefits.

8.3.6 Claim terminations and Exclusions

Payment of any Temporary Income Protection Benefits and Permanent Income Protection Benefits will be terminated in the following circumstances:

- If the Life Insured unreasonably refuses to undergo or is not complying with recommended medical treatment or rehabilitation to reduce the extent of Their disability, impairment or illness.
    - Recommended medical treatment will be as defined by the Life Insured's treating Specialist to the satisfaction of the Administrator/Insurer.
    - This includes the Life Insured failing or refusing to manage Their lifestyle or chronic (medical) condition with appropriate and reasonable recommendations and treatment protocols from Their treating medical Specialist.
    - Please note that Benefit payments will cease on the occurrence of the Claimant being deemed rehabilitated by the Administrator/Insurer.
- If You fail to provide the Administrator/Insurer with satisfactory proof of the Life Insured's disability within 30 (thirty) Days of being requested to do so, and if You fail to submit to a physical examination and tests required at the Administrator/Insurer's request and expense.
    - If You cannot provide this proof, the payment of Benefits will terminate.
- If the Life Insured is not performing Their Nominated Occupation for 3 (three) consecutive months before the Claim Event Date.
    - Note that this requirement does not apply if the Life Insured is on Sabbatical.
- If You fail to inform the Administrator/Insurer of a change in the Life Insured's occupation, We reserve the right to terminate Your Temporary and Permanent Income Protection Benefits if the Life Insured's new occupation would not normally be covered by Your Policy.
- Both the Temporary and Permanent Income Protection Benefit payments will end immediately when the Life Insured begins earning an income that is equal to or more than the Life Insured's Pre-Claim Income level, notwithstanding Their injury or illness, except for specified scenarios as defined in section 8.3.7.
- If there has been a material change in the Life Insured's health or income that affects the continuation or validity of the Claim, We reserve the right to terminate Your Temporary and Permanent Income Protection Benefits payments immediately.
- If You fail to provide satisfactory evidence of the Life Insured's continued incapacity and/or loss of Income when requested to do so by the Administrator/Insurer from time to time.
- On termination of Your Policy, by the Administrator or by You, for any reason whatsoever.
- Benefit payments will cease on the date, as decided by the Administrator/Insurer, on which the Life Insured no longer suffers a reduction in Income that is solely attributable to the injury, illness, disease or surgical operation that gave rise to the Claim.
- If You refuse to submit to any physical examinations or tests required by the Administrator/Insurer to assess the continuation of an admitted Claim.

- Please note that Claims resulting in loss of access to gainful employment for reasons unrelated to the Life Insured's medical condition or disability will not be taken into consideration for any Claim payouts whatsoever, for example, retrenchment or redundancy. These will not be covered under the Temporary or Permanent Income Protection Benefits.
- If the Life Insured is claiming under the Income Protection Benefit and the Life Insured recovers sufficiently to return to work (in the opinion of the Administrator/Insurer). If the Life Insured returns in a reduced capacity, We will aggregate Benefit payouts against the percentage of the material and substantial duties that the Life Insured can perform of Their Nominated Occupation (in the opinion of the Administrator /Insurer).
- For Temporary Income Protection Benefit Claims only: If the Life Insured is claiming under the Loss of Income Claims Criteria and the Life Insured recovers sufficiently to return to work (in the opinion of the Administrator/Insurer). If the Life Insured returns in a reduced capacity, We will aggregate the payout against the income the Life Insured earns (Please see section 8.3.7 for further details).
- For Permanent Income Protection Benefit Claims only: If the Life Insured is claiming under the Permanent Disability Claims Criteria and the Life Insured recovers sufficiently to return to work (in the opinion of the Administrator/Insurer). If the Life Insured returns in a reduced capacity, We will aggregate the payout against the income the Life Insured earns (Please see section 8.3.7 for further details).

The Administrator/Insurer also reserves the right, at its sole discretion, to refuse Claims for the Temporary and Permanent Income Protection Benefits (from the outset of a submitted Claim) when the Claim is a result of any of the following:

- Treatment/rehabilitation for alcohol or narcotic abuse;
- All cosmetic procedures (however reconstructive surgical procedures where a medical condition is present will be covered);
- Organ donation;
- Routine pregnancy, including maternity leave (complications of pregnancy will be covered provided they are confirmed by the Life Insured's treating gynecologist).
    - The first 30 (thirty) Days after the birth of a baby will be regarded as maternity leave regardless of the Waiting Period on the Policy.

Please note that the above lists (all rules, terms and conditions as contained in section 8.3.6) will be reviewed from time to time and may be amended by the Insurer and/or Administrator from time to time, at either's sole discretion.

The above Exclusions apply in addition to the terms and conditions stated in Section 12.2.

8.3.7 Aggregation

Below are some scenarios when both the Temporary Income Protection and Permanent Income Protection Benefits Claim payouts may be different, owing to scenarios where aggregation takes place against income earned and other income protection policies. These are as follows:

8.3.7.1 Claim Amount when aggregating against income earned

You may not receive more than 100% of the Life Insured's Pre-Claim Income (or Your Sum Assured, whichever is less) when taking into account the Benefit Amount that the Administrator pays out to You plus income earned, whilst in claim.

In order to assist the Life Insured in returning to work and getting the treatment They require, for the first 6 (six) months post Claim Event, the Administrator encourages clients to go back to work and allows them to earn in excess of 100% of their Pre-Claim Income or Claim Amount (whichever is lower at Claims stage).

These months are the total period since the Claim Event Date. This means the period for the actual payout is the number of months specified below minus the Waiting Period duration. So, 6 (six) months in the table below with a 1 (one) month Waiting Period means 5 (five) months of payments.

The Administrator will only ever pay out a maximum of 100% of the Life Insured's Pre-Claim Income or Claim Amount (whichever is lower at Claims stage) in all cases, that is, the Administrator will never pay more than 100% of the amount defined in sections 8.1.4 and 8.2.4 above.

The Administrator will aggregate the Claim amount against income earned for all Claims assessed under both the Temporary and Permanent Disability Claims criteria. Income will be aggregated in all scenarios, irrespective of whether the Life Insured is working in Their Nominated Occupation or any other occupation (or job) during Claim.

The payment calculation by the Administrator is as follows:

Adjusted Claim Amount for Income Earned = Min {(Claim Amount / (income earned whilst in claim + Claim Amount)) x Maximum Percentage Amount x Claim Amount, Claim Amount}

Claim Amount is the Temporary or Permanent Income Protection Benefit claim amount defined in sections 8.1.4 and 8.2.4 above.

The Maximum Percentage Amount is as follows (from the Claim Event Date):

Benefit being Claimed on	First 3 months (1-3 months)	3 - 6 months	More than 6 months
Temporary	100%	100%	100%
Permanent (Disability Objective Medical Criteria)	100%	100%	100%
Permanent	130%	130%	100%

(Occupational Claims Criteria)			

Please note that the above Maximum Percentage Amount will be reviewed from time to time by the Administrator/ and or Insurer and may be amended, at either's sole discretion.

The Administrator will not reduce the Benefit payments as a result of the following earnings (these are passive earnings):

- Interest;
- Rent;
- Dividends;
    - However, dividends payable by a private company/close corporation of which the Life Insured is the owner and in terms of which They actively participate (after the Life Insured's disability) in the management of the company will be included.
- Earnings generated before disability but only received after disability.

You must notify the Administrator/Insurer if the Life Insured starts earning an income while a Claim is in payment. Should the Administrator/Insurer determine that We were not notified of this while a Claim was in payment, the Administrator/Insurer may recover any amount that was paid in excess of the amount that would have been paid if You had notified Us that the Life Insured was earning an income.

8.3.7.2 Claim Amount when receiving other income protection benefits

If You or Life Insured receives disability income or sickness benefits from other policies (either from the Administrator or any other insurers) and these benefits together with Your Claim amount (as defined in sections 8.1.4 and 8.2.4) exceed 100% of the Life Insured's Pre-Claim Income, the payment made to You will be adjusted proportionately. The formula to calculate the adjusted payment is as follows:

> Adjusted Claim Amount for other Benefits = Min {[(Claim Amount) / (Claim Amount + benefit amounts from other disability income or sickness Benefits)] x 100% of the Pre-Claim Income, Claim Amount}
>
> Claim Amount is the Temporary or Permanent Income Protection Benefit Claim amount defined in sections 8.1.4 and 8.2.4.

This adjustment will apply up to the end of the Temporary and Permanent Income Protection payment periods (as described in section 8).

8.3.8 Re-assessment of Claims

Under the Temporary Income Protection Benefit, reassessments of the Life Insured's ability (or inability) to perform Their Nominated Occupation are allowed at any time, at the Administrator or Insurer's sole discretion. This will be performed on a case-by-case basis.

Under the Permanent Income Protection Benefit, reassessments of the Life Insured's ability (or inability) to perform Their Nominated Occupation are allowed at any time, at the Administrator or Insurer's sole discretion. This will be performed on a case-by-case basis.

8.3.9 Scenarios when the Life Insured travels, moves or lives outside of South Africa whilst in claim

If the Life Insured travels or moves outside South Africa while a Claim is in payment, and We require proof that the Life Insured is still disabled and still have a loss of Income (where relevant), We will require the medical and financial proof issued in a foreign country to be in English.

- You will be primarily responsible for the cost of medical proof. We will refund You in South African currency for an amount equal to what We usually pay for such medical proof in South Africa.
- You will be responsible for the cost of financial proof of loss of Income, where required.
- The amount paid will always be in the local currency of South Africa.

We will make Benefit payments for disability and loss of Income in a foreign country for a maximum period of 12 (twelve) months.

- Thereafter, We will consider the continuation of Benefit payments only after the Life Insured has been medically assessed by a doctor nominated by Us, which may require the Life Insured to travel back to South Africa for such an assessment.
- We will only cover the cost of the assessment.
- We will not cover any other costs associated, that is, costs for travel, accommodation, food and so on will not be covered.
- The Administrator/Insurer also reserves the right, from time to time and at their sole discretion, to call for continuous assessments, if so required.

Please note that when calculating the Pre-Claim Income at Claims stage, We will use the average exchange spot rate between the Life Insured's country of residence and South Africa, for the last 12 (twelve) months or any other period as required by the Insurer as per the Pre-Claim Income definition in section 1.2.

Please note that the above rules as specified throughout section 8.3 will be reviewed from time to time and may be amended by the Insurer and/or Administrator from time to time, at either's sole discretion.

9. Standalone Temporary Income Protection Benefit

9.1.1 What is the purpose of the Benefit?

The Standalone Temporary Income Protection Benefit pays out a regular income should the Life Insured experience an illness, disease, impairment or injury preventing the Life Insured from working and earning an Income upon becoming Temporarily Disabled and where the Life Insured is unable to perform Their own Nominated Occupation. This Benefit is used to replace lost Income when the Life Insured cannot work and cannot earn an Income as a result of a Temporary Disability.

The Benefit is designed to complement the Disability Cover Benefit, which pays out a lump sum on Permanent Disability. Please see section 7 for further details.

9.1.2 Overview

This Benefit may be selected instead of the Income Protection Benefit. A Policyholder cannot select both the Income Protection Benefit and the Standalone Temporary Income Protection Benefit on the same Policy.

The Standalone Temporary Income Protection Benefit may also only be selected if You also select the Disability Cover Benefit on the Policy.

All rules, terms, conditions and Benefit workings relating to the Temporary Income Protection Benefit, as described in section 8.1 and 8.3 will apply to the Standalone Temporary Income Protection Benefit.

10. Accidental Benefits

The following Benefits provide cover for Accidental Claims only.

10.1 THE ACCIDENT LIFE COVER BENEFIT

10.1.1 What is the purpose of the Benefit?

The Benefit will provide Life Cover for Accidental Deaths. These are deaths that are due to Accidents and will exclude all Natural Deaths Claims.

10.1.2 How does it work?

The Accidental Life Cover Benefit will have all the same rules applying to it as the Life Cover Benefit, as defined in section 5. The only difference is that only Accidental Deaths are protected under the Accidental Life Cover Benefit and no Natural Deaths will be covered.

10.1.3 Things to note

Please note that:

- The Life Insured cannot have both the Life Cover Benefit and the Accidental Life Cover Benefit on the same Policy.

10.2 THE ACCIDENT DISABILITY COVER BENEFIT

10.2.1 What is the purpose of the Benefit?

The Benefit will provide Disability Cover for Accidental Disability Claim Events. These are disabilities sustained that are due to Accidents and will exclude all Natural Disabilities.

10.2.2 How does it work?

The Accidental Disability Cover Benefit will have all the same rules applying to it as the Disability Cover Benefit, as defined in section 7. The only differences between the 2 (two) Benefits are as follows:

- Only Accidental Disabilities are protected under the Accidental Disability Cover Benefit and no Natural Disabilities will be covered under this Benefit.

- There is a 3 (three) month Survival and Waiting Period from the Claim Event Date for the Accidental Disability Benefit, and the disability must have endured continuously throughout the Waiting Period.

10.2.3 Things to note

Please note that:

- The Life Insured cannot have both the Disability Cover Benefit and the Accidental Disability Cover Benefit on the same Policy.
- In circumstances where the Life Insured discloses that they are HIV positive or have diabetes and takes both Accidental Life Cover and Accidental Disability Cover and where there is a valid Accidental Disability Claim, the Accidental Disability Benefit will remain a standalone Benefit and will not reduce the Accidental Life Cover Sum Assured on Claim.

10.3 RULES FOR BOTH THE ACCIDENTAL LIFE AND ACCIDENTAL DISABILITY BENEFIT

Accident Cover will be offered in circumstances where the Life Insured's does not qualify for the full Benefits under section 5 and 7.

Depending on the scenario, You may be able to unlock the full cover (including all natural Claim Events) if the Life Insured undergoes additional medical underwriting. Please refer to Your Schedule or contact OneSpark for more details.

The Accidental Life and Disability Accidental Benefits exclude any Claims from the Life Insured as a result of:

- The Life Insured being under the influence of alcohol, unless a registered Medical Practitioner has prescribed the drugs or narcotics. The Life Insured and their Dependants may not perform the role of registered Medical Practitioner.
- Participating in any type of aviation or airborne pursuit, except as a passenger travelling in, or a pilot piloting a registered passenger aircraft that is owned and operated by a licensed airline or air-transport company, or in a military passenger aircraft. The aircraft must be flown on a recognised route between licensed airfields, and the pilot must hold a current commercial pilot's license.
- Participating in hazardous pursuits.
- All other Exclusions as described in section 12.2.

11. Additional Benefits

The following Benefits are included in Your Policy, at no extra cost to You. They apply to all Benefits on the Policy, unless otherwise specified.

11.1 WORLD TRAVEL, HOLIDAY AND SECONDMENT BENEFIT

11.1.1 What is the purpose of the Benefit?

The Administrator/Insurer will provide protection if the Life Insured travels or decides to temporarily reside or temporarily work overseas. A valid Benefit Claim will be payable on the submission of a valid Claim during this period.

11.1.2 How does it work?

This Benefit provides coverage for all Benefits on Your Policy, when the Life Insured travels or decides to temporarily reside or work overseas for periods of less than 6 (six) consecutive months.

You will still need to pay the Premiums from a South African bank account for each relevant Benefit on Your Policy during the time the Life Insured is traveling, residing or working overseas, in order to receive coverage for those individual Benefits.

If the absence, including secondment, continues in excess of 6 (six) consecutive months, then the cover will end, unless the Insurer, at their sole discretion, approves up to a further 12 (twelve) consecutive months' absence, In Writing, after receiving the following data for the Life Insured: occupation, description of work, date of secondment start, term of secondment, country of secondment.

After 18 (eighteen) consecutive months' absence from the Republic of South Africa, the Life Insured's cover will automatically terminate, unless the Insurer approves a further extension In Writing, at their sole discretion.

Upon the return to the Republic of South Africa by the Life Insured after the cover has ended as described above, the Life Insured's cover will recommence as if they were a new Life Insured.

11.1.3 Claims

Only Claims where the Life Insured meets the Insurer's standard Claim requirements will be accepted. For example, if the Insurer requires a Medical Practitioner's report at Claim stage, a Claim will not be admitted until the report has been received, irrespective of where the Life Insured is in

the world. The Insurer will pay the South African medical scheme tariff rate for medical requirements and the Policyholder must pay any other costs.

The Insurer reserves the right, in certain cases, to require the Life Insured to return to South Africa for further assessment in terms of the payment of the Claim. These medical examinations are required to make sure that the Life Insured qualifies for a valid Claim. The Insurer will only be responsible for the cost associated with any medical examinations required to assess the validity of any Claim. All other costs incurred by the client (travel, transport, accommodation, food, etc), besides the required medical examinations, will be borne strictly by You, the Policyholder, or the Claimant. The parties responsible for the above costs will be reviewed annually and may be amended by the Insurer and/or Administrator, at either's sole discretion.

Coverage will not be provided, and Benefits will not paid out for Claim Events in certain countries where the risks, in the opinion of the Administrator/Insurer and at their sole discretion, are greater than those to which They would have been exposed in South Africa. This list will be reviewed and changed, from time to time, at the Administrator's/Insurer's sole discretion.

For the avoidance of doubt, it should be noted that Exclusions in sections 12.2 and 8.3.6 still apply for the Life Insured, while the Life Insured is absent from the Republic of South Africa, whether for reasons of work or otherwise.

11.1.4 Things to note

Please note that all rules, terms, conditions, costs (including parties responsible for the different cost) and Benefit workings specified throughout this section (section 11.1) will be reviewed from time to time and may be amended by the Insurer and/or Administrator, at either's sole discretion by giving the Life Insured 31 (thirty-one) days' written notice of its intention to do so..

11.2 LIFE COVER, DISABILITY COVER AND INCOME PROTECTION CONVERSION TO ILLNESS COVER

11.2.1 What is the purpose of the Benefit?

As the Life Insured gets older and retirement nears, Their need for financial protection typically reduces, meaning that the need for certain Benefits, such as Life Cover, Disability Cover and Income Protection reduces. In line with smart financial planning, our algorithm automatically converts unneeded cover on Your Policy into additional Illness Cover, which can be used to pay for additional healthcare costs as the Life Insured nears retirement as well as in retirement. This additional cover, provided with no additional underwriting, can be used to cover the costs of a nurse, a nursing home, or any new age technology and/or medicine that is required in retirement.

11.2.2 Overview

This is an automatic feature on the Policy. As the need for Life Cover, Disability Cover and Income Protection starts to reduce in line with the Life Insured's financial needs as the Life Insured nears retirement, We will seamlessly channel these unneeded Benefits into further Illness Cover, on an annual basis. This cover will be converted free of any medical underwriting and free of any further questionnaires.

11.2.3 How does it work?

The amount of Illness Cover that will be converted will depend on the reduction in the Life Cover, Disability Cover and Income Protection Premiums, as they change in line with the Life Insured's needs. The conversion will occur automatically each year at Your Policy Anniversary.

The amount of Illness Cover that will be converted will be equal to the cover (at new business rates at that point in time) that can be purchased at the time of conversion using the sum of the reduction in the Life Cover, Disability Cover and Income Protection (both Permanent and Temporary Income Protection Benefits, as well as the Standalone Temporary Income Protection Benefit) Premiums. For example:

> Amount of Illness Cover converted = Sum Assured that can be purchased at new business Illness Cover rates using the sum of the reduction in Life Cover, Disability Cover and Income Protection Premiums

This is an automatic Benefit on the Policy. The additional Illness Cover benefit can be used to purchase additional medical treatment, medicines and nursing help and can also be used to cover the costs of a nursing home after Claim. Please note that You can always reduce Your Illness Cover Benefit Sum Assured if You do not want the additional Illness Cover.

The additional converted Illness Cover will increase in line with the Dynamic Benefit Adjustments applied to the Illness Cover Benefit, as described in section 6.

Example

Example Details:

- When You turn age 60 (sixty), You have:
  - R1 000 000 Life Cover, with a Premium of R1 000
  - R1 500 000 Disability Cover, with a Premium of R1 500
  - R500 000 Illness Cover, with a Premium of R500
- You are both the Policyholder and Life Insured on the Policy.
- At Policy Anniversary, Your financial needs have reduced as You near retirement as You have paid off Your mortgage and Your children have become independent. Thus, the Dynamic Financial Needs Analysis proposes a reduction in the amount of Life and

Disability Cover that You have from R1 000 000 and R1 500 000, to R900 000 and R1 300 000, respectively.

- This corresponds to a reduction in Premium to:
  - Life Cover: R900
  - Disability: R1300
- The new business Illness Cover premiums are R100 for R50 000 of cover at the time of conversion.
- Your Illness Cover continues to increase with the Dynamic Benefit Adjustment.
- Assume CPI is equal to 5% in this example.

The amount of Illness Cover converted is:

Amount of Illness Cover converted = (Reduction in Disability Cover Premium + Reduction Illness Cover Premium) ÷ R100 x R50 000

= ((R1 000 - R900) + (R1 500 – R1 300)) ÷ R100 x R50 000

= R300 ÷ R100 x R50 000

= R150 000

Your new Illness Cover Sum Assured is:

New Illness Cover Sum Assured = Old Illness Cover Sum Assured x (1 + CPI) + Amount of Illness Cover converted

= R500 000 x (1 + 5%) + R150 000

= R525 000 + R150 000

= R675 000

The new additional R150 000 Sum Assured tranche will be purchased at the new business Premiums at that particular point in time.

Please note that all rules relating to the original Illness Cover will automatically apply to the converted Illness Cover Sum Assured. To remove any doubt:

- The converted Illness Cover will have the same Premium loadings and Exclusions, if applicable, (condition specific or heath (medical) related Exclusion, occupational or hazardous pursuit Exclusions, if applicable, as well as Exclusions found in section 12.2) that were applied to the Illness Cover Benefit on the Policy beforehand.
- The same Waiting and Survival Periods will be applied to the converted Illness Cover as was applied to the original Illness Cover Benefit on the Policy beforehand.
- Any other Exclusions that apply to other Benefits on Your Policy or at a Policy level will also apply to the converted Illness Cover. This means that if there is a condition-specific, Benefit specific or any other policy specific Exclusions on Your Policy, these same Exclusions will also apply to the converted Illness Cover.

This automatic conversion of Life Cover, Disability Cover and Income Protection to Illness Cover will apply on each Policy Anniversary starting from the first Policy Anniversary when either the Life Cover, Disability Cover, Permanent Income Protection or Temporary Income Protection (or Standalone Temporary Income Protection) Premiums begin to reduce. This will continue until the earliest of the relevant Benefit expiry age or the relevant Benefit Premium becoming zero in line with the Dynamic Financial Needs Analysis.

Please note that if there are any medical or health loadings and/or any medical or health related Exclusions on any of the Benefits on Your Policy, this conversion facility will not be available on Your Policy. Also, please note that if Illness Cover was at any point declined or deferred during any underwriting process with Us or at any other external insurer, the conversion option will not be available on the Policy.

Before Your cover converts, We will perform certain checks to ensure the Life Insured meets the minimum criteria for using the conversion:

- You must have held Your Policy for at least 1 (one) year;
    - You cannot use the cover conversion facility if You've held Your cover for less than 1 (one) year, counted from the Commencement Date.
- Your Premiums must be up to date; and
    - You must also be in good financial standing with Us.
    - If You owe Us any outstanding Premiums, You will not be able to use the cover conversion until this debt is settled.

The Illness Cover Conversion Option will not be available on a Policy with Accidental Life Cover and/or Accident Disability Cover Benefits.

11.2.4 Things to note

We will not allow the cover conversion If there has been a Claim on the Policy or if the Life Insured has claimed on any other life insurance policy previously:

- If You (or the Life Insured) have claimed on the Policy in the past, have submitted a Claim that is currently being assessed, or are currently in claim, it may affect Your ability to get cover using the cover conversion.
- When considering whether a Claim affects the cover conversion facility, We will always look at the Claim Event Date, and not the date on which the Claim is submitted or paid.
- If You (or the Life Insured) have claimed on the Policy:
    - If You (or the Life Insured) have received a pay-out from any Benefit on the Policy at any time before the conversion date, then the Illness Cover conversion option on the Policy will fall away from the Claim Event Date and no conversion will be allowed on the Policy after the Claim Event Date.
    - If You (or the Life Insured) are receiving a pay-out from the Income Protection Benefit or the Standalone Temporary Income Protection Benefit at the

conversion date, then the conversion option on the Policy will not be allowed and will fall away from the Claim Event Date.

- If You (or the Life Insured) have submitted a Claim that is still being assessed:
  - You will not be able to convert cover until the Claim decision has been finalised.
  - If the Claim is valid, then the conversion feature will fall away going forward backdated from the Claim Event Date, and no conversion will be allowed at that Policy Anniversary (when the Claim was still being assessed).
  - If the Claim is not valid, then the conversion feature will be allowed going forward. However, no conversion will be allowed at previous Policy Anniversary (when the Claim was still being assessed).

Please note that limits may apply to the cover that You convert with the cover conversion facility:

- Maximum value of converted cover:
  - These amounts are subject to the overall Illness Cover Benefit maximums, set by the Administrator/Insurer from time to time, at either's sole discretion.
- No previous Illness Cover was taken:
  - If You did not take out cover under the Illness Cover Benefit at Policy Commencement Date or at any time before the first conversion date, then the converted Illness Cover Benefit will exclude any claims for Pre-Existing Conditions or any claims for conditions, procedures or complications related to a Pre-Existing Condition.

Please note that the all terms, conditions, rules, Benefit workings, calculations and formulas specified in this section (section 11.2) will be reviewed from time to time and may be amended by the Insurer and/or Administrator, at either's sole discretion.

Please note that the conversion benefit, as specified in section 11.2, does not apply to Business Assurance policies.

12. General Benefit Terms and Conditions

This section specifies the general terms and conditions which apply to all Benefits on the Policy, unless otherwise specified.

12.1 NOMINATED OCCUPATION FOR DISABILITY BENEFITS

Your disability Benefits (Disability Cover, Accidental Disability Cover, Income Protection Benefit and Standalone Temporary Income Protection Benefit) use the Life Insured's Nominated Occupation when assessing the validity of the Claim.

For any disability Claim assessed against the ability to perform the Life Insured's Nominated Occupation, disability will only be measured against the tasks and duties of the Life Insured's Nominated Occupation. That is, for any Claim assessed against the ability to perform the Life Insured's Nominated Occupation, the ability (or inability) to perform Their Nominated Occupation will only be measured against the tasks and duties of Their Nominated Occupation.

The monthly Income amount that You insure/protect (for the Life Insured's Nominated Occupation) must be what the Life Insured derives from Their Nominated Occupation that has been specified, or must be the monthly Income in respect of the Life Insured's Nominated Occupation that has been specified.

Please note that the Life Insured's Nominated Occupation affects the Premiums You are charged. If the Life Insured's occupation changes, We request that You inform Us. We reserve the right to amend Your Premiums or Benefits if the change to the Life Insured's occupation, in the opinion of the Administrator or Insurer, is considered to be of higher risk than Their previous occupation.

12.2 EXCLUSIONS

These are the general Benefit Exclusions for the Life Insured on the Policy. All Exclusions below apply to Claims relating to the Life Insured on the Policy for the Life Cover, Disability Cover, Illness Cover, Income Protection Benefit (Temporary and Permanent Income Protection Benefits), Standalone Temporary Income Protection and Accidental Benefits (on death and disability), unless otherwise indicated.

The Insurer reserves the right to refuse Claims when:

- You/Life Insured fail to disclose information about physical disabilities or medical conditions that affect, or affected, the Life Insured at the time that cover starts;
- You/Life Insured fail to notify the Administrator/Insurer of the Life Insured's correct occupation and occupational duties at policy inception, or of a change in occupation from that nominated at policy inception or change in occupational duties where the new occupation or the change in occupational duties are classified by the Administrator/Insurer as falling into a risk category for which the relevant Benefit/s would not have been granted on the same terms and conditions to the Claimant/Life Insured;

- The Administrator is unable to obtain sufficient medical or financial (if applicable) evidence from You or the Life Insured or treating medical practitioner to fulfil our criteria for making a Benefit payment;
- The Claim was as a result of:
    - The Life Insured's willful and deliberate breaking of any law (whether the crime was committed or attempted to be committed) or the Life Insured's willful participation in the commission of a criminal activity or the Life Insured's willful involvement in any riot, insurrection, usurpation of power, act of terrorism martial law or war;
    - The Life Insured's regular participation in any hazardous sport or pursuit which was not disclosed to the Administrator at any point in time before the Claim;
    - The Life Insured's exposure to atomic energy, nuclear fission or reaction, terrorism, biological or chemical hazards and biological or chemical warfare agents;
    - The Life Insured's refusal to seek or follow medical advice;
    - Intentional and negligent consumption of poisons, drugs and narcotics by the Life Insured unless prescribed by a registered medical practitioner (neither You, nor the Life Insured, nor any of Your Family Members nor any of the Life Insured's family members may perform the role of registered medical practitioner in such a case);
- The Claim Event occurred outside of South Africa, in a country where the risks, in the opinion of the Administrator/Insurer, and at their sole discretion (at the time of Claim Event), are greater than those to which They would have been exposed to in South Africa. To remove any doubt, Claims will be excluded if the Life Insured is either travelling or temporality residing in any of these high-risk countries, as described above.
- The Life Insured's death is self-inflicted or is due to suicide (whether sane or insane) and occurs within 5 (five) years (60 (sixty) months) of cover commencing on Your Policy or within 5 (five) years (60 (sixty) months) of reinstatement of Your Policy or within 5 (five) years (60 (sixty) months) from adding additional Life Cover;
- The Life Insured's disability or illness Claim (for the Disability Cover, Illness Cover, Income Protection, Standalone Temporary Income Protection and Accidental Disability Benefits) was as a result of:
    - Any cosmetic procedure (reconstructive surgical procedures where a medical condition is present will be covered), as well as any complications associated with the procedure;
    - Organ donation, as well as any associated complications;
    - Excessive consumption of alcohol by the Life Insured that would be known by a reasonable person to be harmful or if the Life Insured drives any form of motorised vehicle on a public road whilst the Life Insured's blood alcohol level exceeds the legal limit;
    - The Claim was deliberately self-inflicted by the Life Insured.

Please note that the above list will be reviewed from time to time and may be amended by the Insurer and/or Administrator from time to time, at either's sole discretion.

All Benefits have automatic COVID-19 cover.

12.3 HIGH RISK OCCUPATIONS

Please note that there are certain high-risk occupations for which Premium loadings and/or Exclusions are applied to Benefits on the Policy. Please refer to Your Policy Schedule to see if there are any occupational loadings/Exclusions on Your Policy.

The Administrator/Insurer reserves the right, at its sole discretion, to amend Your Premiums or Benefits in the following instances:

- The Life Insured's occupation is altered such that Their occupation is deemed to be higher risk than Their previous/current occupation; or
- The Life Insured's occupation becomes a high-risk occupation.

Should You or the Life Insured change Their occupation, the Administrator or Insurer must be notified in writing of this change (within 6 (six) months of the Life Insured's change of occupation). If the Administrator or Insurer is not notified within a reasonable time, some or all of the Benefits may be adjusted or removed. The Administrator or Insurer may also adjust some or all of Your Premiums in this scenario.

Please note that the Administrator's/Insurer's Occupational Exclusion list will be reviewed from time to time and may be amended by the Insurer and/or Administrator from time to time, at either's sole discretion.

12.4 HAZARDOUS PURSUITS

Please note that there are certain hazardous pursuits for which Premium loadings and/or Exclusions are applied to Benefits on the Policy. Please refer to Your Policy Schedule to see if there are any hazardous pursuit loadings/Exclusions on Your Policy.

The Administrator/Insurer reserves the right, at either's sole discretion, to amend Your Premiums or Benefits should the Life Insured begin regular participation in a hazardous pursuit after the Commencement Date. This may affect the Premiums for any Benefit on the Policy as well as the Benefit themselves. Failure to notify Us if the Life Insured partakes in any hazardous pursuits could result in a Claim being Repudiated, Benefits removed or reduced and/or Premiums adjusted.

Please note that regular participation in a hazardous pursuit is defined as participating in the activity more than once a year.

12.5 FINANCIAL UNDERWRITING

The Administrator/Insurer reserves the right to request proof of Income, for the Life Insured at any point in time, if We feel that a reasonability check needs to be done. This will be performed on an adhoc basis and at Administrator's/Insurer's sole discretion. This may be performed at Commencement Date, at the addition or amendment of any Benefit on the Policy, on Claim or at any time during the Policy term that is deemed necessary by the Administrator/Insurer. Examples of proof of Income may be (but are not limited to) in the

form of a pay slip, financial statements or ITA 34 (for self- employed individuals). The form of proof of Income required, will be decided at the Administrator/Insurer's sole discretion, on a case-by-case basis.

The Administrator/Insurer also reserves the right to call for proof of Income if We suspect that You/Life Insured have intentionally (and falsely) inflated Your or the Life Insured's salary or intentionally lied or have hid material information pertaining to Your or the Life Insured's salary or Income. The Administrator/Insurer also reserves the right to call for proof of Income, at any time, if We suspect any fraud or Misrepresentation by the Life Insured/Policyholder (or any representative of the Life Insured or Policyholder) on the Policy, at any point during the Policy term.

12.6 ANNUAL RENEWABILITY OF COVER

Although the Policy provides lifetime protection (as long as Your Policy remains in force), Your cover and Premiums will be reviewed at least annually. The cover will change to account for the fact that the Life Insured's needs vary on an annual basis and should change in line with the Life Insured's evolving needs. This is in line with OneSpark's philosophy of not locking You into a static long-term contract, but rather varying cover every year to ensure that actual cover is equal to the Life Insured's needs at that point.

This will work by communicating to You 31 (thirty-one) Days prior to Your anniversary (see section 14) that You should review the Life Insured's financial needs to ensure the Cover Amounts are correct. The Life Insured will be asked to answer a few questions on the Dynamic Financial Needs Analysis about Their current circumstances. If They do not answer the questionnaire, then the cover will change in line with the Dynamic Financial Needs Analysis algorithm, that is, the relevant Sum Assureds (for each Benefit) will change with the proposed Dynamic Benefit Adjustments to align with the Life Insured's projected changing needs.

Example

You, aged 30, take out a OneSpark Policy, on 1 January 2021. You are both the Policyholder and Life Insured on the Policy. You are married but do not have any children. At Commencement Date, OneSpark's algorithm proposes R1,000,000 Life Cover and R500,000 Disability Cover to cover Your financial needs. Your monthly Premium would be R100 for your Life Cover benefit and R50 for Your Disability Cover Benefit. You decide to take out the recommended cover. You will pay these Premiums for the calendar year of 2021.

On 1 December 2021, You receive an Anniversary letter stating that You should review Your financial needs to ensure Your Cover Amounts remain relevant. You will have the choice to update these details or not.

The Anniversary letter will also contain what Your Cover Amounts will change to, based on OneSpark's unique algorithm if no input is received. The algorithm uses all Your unique characteristics and projects forward to try replicate Your unique situation as far as possible, to match Your changing needs.

Scenario 1

You decide to update the details around Your financial needs. In this scenario, all Your financial needs remain the same, except that You have a child during the year. This means Your financial needs have increased. If You were to pass away, You would need to leave money for Your Spouse as well as Your new born child.

Therefore, You will require more Life and Disability Cover to cover these needs. OneSpark's algorithm will take all these factors into account in re-assessing Your needs. In this example, it is proposed that You now require R1,200,000 Life Cover and R600,000 Disability Cover. Your Premium is expected to be R120 for Life Cover and R60 for Disability Cover. You can decide if You would like this cover or not. If not, you can keep your existing cover in place. If You decide to take the new cover, then a new Policy Anniversary letter will be sent to You confirming the changes.

Scenario 2

You decide to not update the details around Your financial needs. In this scenario, Your Cover Amounts and Premiums will automatically change in line with OneSpark's unique algorithm as indicated on Your Policy Anniversary letter. In this example (without inputs), the algorithm proposes that You require R1,180,000 Life Cover and R590,000 Disability Cover. Your Premium is expected to be R118 for Life Cover and R59 for Disability Cover.

Your Benefit and Premium will automatically adjust in line with the changes, but You can always amend Your cover, if so required.

Please note that section 12.6 will not apply to Business Assurance policies since they increase with CPI each year at Policy Anniversary.

12.7 CHANGE OF INDIVIDUAL DETAILS

If You would like to change certain individual details on Your Policy, then You must inform the Administrator/Insurer of these changes:

- Changing smoking status
- Change of highest education level
- Change of occupation
- Change of hazardous pursuits
- Change of Income

These changes may lead to a change of Premium or Benefits offered (for example, amendments may be made to the Occupational Claim Criteria).

When any of the factors influencing Your Premium change, Your Premium could increase (or decrease). For example, it's essential that You notify Us immediately should:

- The Life Insured ever take up smoking or use any other form of tobacco where You originally were paying non-smoking rates on Your Policy; or
- The Life Insured undertakes hazardous pursuits, such as extreme sport or dangerous hobbies on a regular basis, for example, motocross, skydiving, underwater diving, rock climbing, private aviation; or
- The Life Insured's occupation changes such that it now entails more travel or manual duties including travel outside the borders of South Africa.

In addition, if the Life Insured has indulged in or consumed narcotics (that were not prescribed by a Medical Practitioner) it is essential that You notify Us. The Administrator or Insurer may then adjust, review and amend Your Premiums accordingly. If the Administrator or Insurer is not notified within a reasonable time, some or all of Your Benefits may be adjusted or removed, and Claims may be repudiated.

13. ShareBack Benefit

13.1 WHAT IS THE PURPOSE OF THIS BENEFIT?

The OneSpark Life Policy works in a transparent manner. We take a flat percentage to cover expenses, pay taxes, set up actuarial reserves, help us grow and cover various other costs associated with administration of policies. During the year, all valid claims are paid out by the Insurer and at the end of the year, We will give back whatever's leftover after paying all valid claims, all reinsurance costs and setting up the required reserves and provisions.

13.2 HOW DOES IT WORK?

From each Premium paid to the Insurer, We take a flat percentage to cover expenses, pay taxes, set up actuarial reserves and cover various other costs associated with administration of policies. The remaining percentage is set aside and used to cover valid claims.

Whatever is left over after claims, reserves, provisions, and reinsurance costs at the ShareBack Payout Date, which we will determine in our sole discretion each year and if applicable in each year, will be paid proportionately back to qualifying Policyholders. The ShareBack payout, where applicable, will always made directly to the Policyholder.

The amount We will pay back to each policyholder is based on the premiums that each individual policyholder has paid during any ShareBack Calculation Period relative to the total premiums received by the Insurer (from policies who are eligible to receive ShareBacks) in the given ShareBack Calculation Period. Please note that only policyholders in force at the ShareBack Payout Date will receive an amount from the ShareBack Benefit.

Please refer to Your Policy Schedule to see the ShareBack Calculation Period on Your Policy.

The ShareBack Benefit payout remains discretionary and is dependent on the performance of the book of policies, including factors such as scale (number of policies) and claims experience. For example, if the annual claims experience is worse than expected (or as expected), then no ShareBacks will be paid out to the remaining policyholders. In this scenario, all valid claims will still be paid out. If the annual claims experience is better than expected, then whatever money is left, after deducting all relevant costs, will be distributed to the remaining policyholders.

The ShareBack payouts on Your Policy may be subject to taxation. It is Your responsibility to speak to a tax practitioner for advice. We are not responsible for any consequences if You fail to ask a tax practitioner for advice or if You fail to pay the applicable tax.

13.3 SCENARIOS WHERE NO PAYOUTS WILL BE MADE

If You cancel Your Policy during the year, before the ShareBack Payout Date has been determined, then You will not receive a payout at the ShareBack Payout Date. This means payouts will only be paid to clients who have their Policy in force at the ShareBack Payout Date. If You cancel and re-enter within a 2 (two) month period (that is, if You reinstate Your Policy within 2 (two) months from the original cancellation date) then You will be eligible for the ShareBack Benefit in that year. In all other scenarios, if You cancel and re-enter, then You will not be eligible for the ShareBack Benefit in that same year. However, for all other years going forward, You may still be eligible for the ShareBack Benefit.

ShareBacks are only paid to clients who haven't claimed in that particular year. This means that clients who have claimed will not receive a ShareBack payout if a ShareBack is applicable. 'A client who claims' is classified as a client who claims for any of the following Benefits (for any length of time), under any of their respective Benefit Claim Event definitions:

- Life Cover
- Disability Cover
- Illness Cover
- Income Protection Benefit (Temporary and Permanent Income Protection Benefits)
- Standalone Temporary Income Protection
- Accidental Benefits (Death and Disability)

Clients who have claimed under any of the Benefits above will not be eligible for ShareBacks in the years that they have claimed, but they may still be able to receive ShareBacks in the years going forward (provided they have stopped claiming and have sufficiently recovered and returned to work, where applicable).

Example 1

You start claiming under the Income Protection Benefit (under the Temporary Income Protection Benefit) on the 1st July 2020. You claim until the 30th November 2020. You are both the Policyholder and Life Insured on the Policy.

In this scenario, You will not be eligible for ShareBacks in 2020, but will be eligible for ShareBacks for the year 2021 (provided that You don't claim for any Benefit on the policy in that year and Your Policy is in force). You will also be eligible for ShareBacks for the years thereafter, provided that You do not claim for any Benefit on the policy in those years. Each year will be assessed in isolation.

Example 2

You start claiming under the Income Protection Benefit (under the Temporary Income Protection Benefit) on the 1st July 2020. You claim until the 30th November 2021. On 1 December 2021, You return to work since You has sufficiently recovered.

In this scenario, You will not be eligible for ShareBacks in 2020 and 2021 but will be eligible for ShareBacks for the year 2022 (provided that You do not claim for any Benefit on Your Policy in that year and Your Policy is in force). You will also be eligible for ShareBacks for the years thereafter, provided that You do not claim for any Benefit on the policy in those years. Each year will be assessed in isolation.

Please note that if You have submitted a Claim at the ShareBack Payout Date and no decision has been made as yet (at the ShareBack Payout Date), You will still receive a ShareBack payout for that particular year. If the Claim is valid in the following year and a Claim payout is made, then You will not be eligible to receive any ShareBacks in that year and the Claim payout amount made to You will be reduced by the ShareBack payout that You received whilst the Claim was being assessed. If the Claim is repudiated, then You will be eligible to receive ShareBacks in that year. In either scenario, You will be eligible for ShareBack payouts after the year that the Claim decision is finalised and where a Claim payout has been made.

Please note that when You remove a Benefit or reduce cover, You will still be eligible to receive a payout from the ShareBack Benefit at the ShareBack Payout Date. The return will be proportional to the Premiums You paid during that year relative to the total Premiums received by the Insurer.

Any cover increases or decreases during the year will be taken into account through the calculation described in the paragraph above.

If You have Premiums in arrears at the ShareBack Payout Date, then You will also not be eligible to receive any ShareBacks. If You pay back the outstanding Premiums prior to confirmation from Us of the Shareback Payout Date, then You will be eligible for ShareBacks. If You do not pay back the outstanding Premiums within the grace period and before the confirmation from Us of the Shareback Payout Date, then all ShareBacks that could be owing to You will be forfeited.

You will also not be eligible for ShareBacks if the Administrator and/or Insurer cancels Your Policy, for whatever reason, or suspects any form of Misrepresentation or fraud by You or the Life Insured or anyone acting on Your (or the Life Insured's) behalf (at any point up to and including the ShareBack Payout Date).

Please note that if there is no money left, after deducting all costs specified in sections 13.1 and 13.2, at the ShareBack Payout Date, then no ShareBacks will be paid out. This scenario could happen when, for example, the sum of all claims for all OneSpark policyholders are more than all premiums received from all policyholders. In this scenario, OneSpark's reinsurer will pay for all valid Claims, meaning that valid Claims will always be paid out.

This means that this Benefit is not guaranteed in any particular year and is solely dependent on the specified criteria confirmed above.

13.4 THINGS TO NOTE

The ShareBack Benefit is an automatic Benefit on Your Policy, at no extra cost to Yourself. The Benefit will be paid out to the Policyholder.

Please note that all the rules, terms, conditions, calculations and workings (including, but not limited to, the percentage of each Premium that is taken to cover expenses, taxes, reserves, growth of the business, reinsurance and various other costs, the method to calculate the ShareBack Benefit as well as the ShareBack Payout Date and ShareBack Calculation Period), as defined throughout section 13, will be reviewed annually by the Administrator and may be amended from time to time, at its sole discretion.

Please note that the ShareBack Benefit as described in section 13, will not apply to Business Assurance policies.

14. Dynamic Financial Needs Analysis

14.1 WHAT IS IT?

The Dynamic Financial Needs Analysis is the smart algorithm that calculates the required cover on an ongoing basis, based on the Life Insured's individual and unique circumstances. The algorithm dynamically adjusts to match the Life Insured's changing needs as Their life and financial needs change.

The Dynamic Financial Needs Analysis utilises the latest technology to meet the Life Insured's evolving financial needs as closely as possible. It increases faster than inflation in the Life Insured's younger years as Their earning potential increases and liabilities accrue, and less than inflation in Their older years as liabilities are settled and expenses reduce. Eventually, it starts to reduce as liabilities are paid off and the Life Insured approaches retirement. It attempts to cover the Life Insured as optimally as possible (assuming Cover is selected as suggested by the algorithm) such that if the Life Insured suffers a Claim Event, the Life Insured (or Their family) will be left in the same financial position as if the Life Insured didn't experience the Claim Event.

The Dynamic Financial Needs Analysis will propose a certain amount of cover for Benefits on the OneSpark Life Policy, depending on the Life Insured's unique circumstances at each point in time. Benefits will run for a duration of 1 (one) year from Policy Anniversary to Policy Anniversary (unless You updated the Life Insured's individual details or make Policy changes during the year). Thereafter, at each Policy Anniversary, Benefits will recalculate and re-adjust to match the Life Insured's updated financial Needs at that point. This ensures that the Life Insured is always as optimally protected as possible, given Their circumstances at that point in time as well as the information supplied to Us by You.

The Dynamic Financial Needs Analysis will not apply to any Business Assurance Policies. In those cases, the Cover Amounts will increase with CPI at Policy Anniversary.

14.2 DYNAMIC BENEFIT ADJUSTMENTS

Each year at the Policy Anniversary, each Benefit on the Policy will adjust in line with the Life Insured's changing circumstances. The annual adjustment percentage is called the Dynamic Benefit Adjustment, which will adjust to the level proposed by the algorithm of the Dynamic Financial Needs Analysis.

In line with the fact that different needs require different Benefit adjustments, each Benefit on the Policy will receive a different Dynamic Benefit Adjustment each year to ensure that the Life Insured's financial needs are holistically updated, so that the Life Insured and Their family are as optimally protected as possible throughout Their life.

You may also elect for your cover to increase at CPI at Your Policy Anniversary.

14.3 DYNAMIC PREMIUM ADJUSTMENTS

Please note that the Premiums for each Benefit will adjust each year, at the Policy Anniversary, in line with the changing Dynamic Benefit Adjustments for that specific Benefit, as well as a factor to take into account the Life Insured's increasing age. The Dynamic Premium Adjustments will be different for each Benefit, depending on how the specific Benefit is adjusted each year in line with the Life Insured's changing needs.

14.4 DYNAMIC SALARY INCREASES

The algorithm is smart and will automatically adjust the Life Insured's salary each year, at Policy Anniversary, if no input is received, which will be based on the Life Insured's specific occupation, Their age and the various economic factors (this includes, but is not limited to, inflation). The adjustments have been calculated for people just like Them, at Their current life stage and for Their specific occupation, to replicate as far as possible the salary growth patterns of Their specific occupation, taking into account such things as Their expected promotional increases and various economic factors. This ensures that even if no input is received from You regarding the Life Insured's updated monthly salary at Your Policy Anniversary each year, the algorithm will still provide (as close to possible) the optimal amount of coverage for someone in the Life Insured's unique circumstance.

As the Life Insured's gross salary increases each year, the Life Insured's net of tax salary will also increase. The increases to the Life Insured's gross salary may be different to the increases to the Life Insured's net salary. This is because as Their gross salary increases, the tax bracket that They fall into may change and thus the tax the They pay may change.

14.5 INFLATION

CPI is used in most calculations in some form or another.

The CPI figure used throughout the Policy and in all the calculations is subject to an overall maximum of 10% each year, unless otherwise specified. This maximum will be reviewed, for each individual Benefit, annually by the Administrator and may be amended by the Administrator, at its sole discretion. This means that the Administrator reserves the right to change this maximum CPI percentage for different Benefits, at its sole discretion.

14.6 GENERAL RULES

The Dynamic Financial Needs Analysis is the algorithm which dynamically adjusts the Life Insured's cover to match Their changing needs, as Their life and financial needs change.

However, it is in Your and the Life Insured's interest to:

- Provide true and accurate information at all points in time during Your Policy term;
- Ensure that, prior to each Anniversary, the information that We have on record for the Life Insured that is required for the Dynamic Financial Needs Analysis to re-calculate is accurate and up-to-date;
- Inform the Administrator/Insurer of any lifestyle changes, as well as any changes to the Life Insured's financial circumstances. Examples are as follows (but not limited to):
    - Changes to the Life Insured's monthly Income;
    - Occupational changes or promotions;
    - Changes to the Life Insured's debt levels;
    - Changes to the number of financial dependants that the Life Insured has;
    - Changes to the Life Insured's contribution to Their total household income;
    - Changes to the level of protection the Life Insured has at other insurers; or
    - Any other changes that may affect the Life Insured's financial situation;

      as and when the changes occur; and
- Answer any and all questions sent to You from the Administrator/Insurer;
  in order to make sure that the cover and Benefits suggested by the Dynamic Financial Needs Analysis are in line with the Life Insured's changing needs.

Please note that rules, terms, conditions and calculations specified in section 14 will be reviewed from time to time by the Administrator/ and or Insurer and may be amended, at either's sole discretion.

15. Claims

15.1 OVERVIEW

OneSpark was started with the sole purpose of creating a transparent, fair and objective life insurance structure that optimally aligns the client and the Insurer's interests. Additionally, with our innovative and transparent structure, We return all unused risk premiums at the end of the year (where it is determined to be applicable) through the ShareBack Benefit, as described in section 13.

It is also why We have comprehensive Claims criteria covering both Objective Medical Criteria, which removes any subjectivity from the claims decision process, as well as Benefit specific criteria, covering such things as the inability to perform the Life Insured's Nominated Occupation, Loss of Income and Activities of Daily Living Criteria. Our broad range of Claims underpins ensures maximum protection for the Life Insured and Their family.

15.2 POST-CLAIM BENEFITS AND PREMIUMS

This section describes what happens on Your Policy after a specific Benefit Claim has occurred.

Please note that for Benefits which remain on the Policy post Claim, Premiums for those Benefits must be paid in order for those Benefits to remain on the Policy (unless specified otherwise in this Policy). If Premiums are no longer paid for those Benefits, those Benefits will fall away and no further protection will be provided by them.

After a Life Cover Claim Event

Life Cover payouts will always be a 100% pay-out and therefore the Life Cover Premiums will cease after a Life Cover Claim. The Policy and all other Benefit will be cancelled thereafter.

After an Illness Cover Claim Event

After an Illness Cover Benefit Claim, the Illness Cover Benefit as well as the Illness Cover Premiums will continue. Please note that the Illness Cover Premiums will not reduce after a valid Claim. After a valid Illness Cover Benefit Claim, the following will occur:

- The Policy will not be cancelled; and
- All other Benefits on the Policy will remain on the Policy.

Example

Example Details

- You have R 1 000 000 Illness Cover and R 500 000 Life Cover.
- You are both the Policyholder and Life Insured on the Policy.
- Your monthly Illness Cover Premium is R 100.
- Your monthly Life Cover premium is R 50.

You claim 75% for a heart and artery Claim. You are paid out R750 000 (R1 000 000 x 75%).

After Your Claim, Your Illness Cover Benefit is reinstated to R1 000 000 since You are still protected for R 1 000 000 for all future Unrelated Claims. You will continue to pay Your Illness Cover Premium of R100 per month. Additionally, You will continue to pay Your Life Cover Premium of R 50 and You will retain Your full Life Cover Sum Assured of R 500 000.

After a Disability Cover Claim Event

Disability Cover payouts will always be a 100% pay-out and the Disability Cover Benefit and Premiums will cease after a valid Disability Cover Claim. After a valid Disability Cover Claim, the following will occur:

- The Policy will not be cancelled;
- The Disability Cover Benefit will cease on the Policy;
- The Standalone Temporary Income Protection Benefit will cease on the Policy; and
- All other Benefits on the Policy will remain on the Policy.

Income Protection Benefit Claim Event

After a Temporary Income Protection Benefit Claim Event

The Temporary Income Protection Benefit will pay up to 100% of the Life Insured's salary, depending on the salary You choose to protect, and the Premiums will cease whilst in claim. After a Claim, the following will occur:

- The Policy will not be cancelled; and
- All other Benefits on the Policy (including the Temporary Income Protection Benefit) will remain on the Policy.

After a Permanent Income Protection Benefit Claim Event

The Permanent Income Protection Benefit will pay up to 100% the Life Insured's salary, depending on the salary You choose to protect. The Premiums will cease whilst in claim. After a Claim, the following will occur:

- The Policy will not be cancelled; and
- All other Benefits on the Policy will remain on the Policy, except for the Disability Cover Benefit and the Temporary Income Protection Benefit which will both fall away thereafter.

The below table summarises what happens to Your Benefits after a Claim, excluding the Accidental Death and Disability Benefits:

	After a valid Claim, what happens?				
Claimed Benefit	Life Cover	Disability Cover	Illness Cover	Temporary Income Protection / Standalone Temporary Income Protection	Permanent Income Protection
Life Cover	Remove	Remove	Remove	Remove	Remove
Disability Cover	Keep	Remove	Keep	Remove	Keep
Illness Cover	Keep	Keep	Keep	Keep	Keep
Temporary Income Protection / Standalone Temporary Income Protection	Keep	Keep	Keep	Keep	Keep
Permanent Income Protection	Keep	Remove	Keep	Remove	Keep

For Policies with Accidental Benefits, the following will occur:

	After a valid Claim, what happens?	
Claimed Benefit	Accidental Life Cover	Accidental Disability Cover
Accidental Life Cover	Remove	Remove
Accidental Disability Cover	Keep	Remove

Please note that above rules, terms and conditions will be reviewed on an annual basis by the Administrator and/or Insurer and may be amended, at either's sole discretion.

15.3 MULTIPLE CLAIMS

There are 3 (three) types of subsequent multiple Claims (please see the definitions in section 1.2):

- Unrelated
- Related
- Progressive

The payment of the subsequent Claim is dependent on whether the Claim Event is Progressive, Related or Unrelated.

The Disability Benefit and the Accidental Disability Benefit will not have any multiple Claims since 100% is paid out on the first Claim. The Permanent Income Protection Benefit will not have any multiple Claims since 100% is paid out on a valid Claim Event, subject to the aggregation rules as can be found in section 8.3.7.

The multiple Claims rules under the Temporary Income Protection Benefit and the Standalone Temporary Income Protection Benefit will be unlimited. If Related or Progressive Claims are made during the Off Period, then no Waiting Period will apply. For all Unrelated Claims, the full Waiting Period will always apply.

Multiple Claims for the Illness Cover Benefit work as follows:

- Unrelated Claims: A subsequent Unrelated Claim will be paid out, regardless if the severity of the new Unrelated Claim is higher or lower than the previous Unrelated Claim severity. In this case, the Claim payout amount is calculated as the full percentage payout, multiplied by the Benefit Amount.
- Related and Progressive Claims: A subsequent Claim will only be paid if the Claim Event is more severe than a previous Related or Progressive Claim. The Claim Amount that We pay is based on the difference between the percentage payout for the new Claim and the highest percentage paid for the previous Claim/s. In this case, the Claim amount is calculated as the additional percentage payout, multiplied by the Benefit Amount.

  Please see the summary of how Claims will work in the different Benefits.

Benefit	Progressive	Related	Unrelated
Income Protection Permanent Income Protection	*Not applicable.*	No subsequent Claims will be paid. 100% payout is made on the first Claim.	No subsequent Claims will be paid. 100% payout is made on the first Claim.
Temporary Income Protection	Unlimited Claims allowed.	Unlimited Claims allowed.	Unlimited Claims allowed.
Standalone Temporary Income Protection	Unlimited Claims allowed.	Unlimited Claims allowed.	Unlimited Claims allowed.

Disability Cover	*Not applicable.*	No subsequent Claims will be paid. 100% payout is made on the first Claim. Maximum payout is 100% of the Benefit Amount.	No subsequent Claims will be paid. 100% payout is made on the first Claim. Maximum payout is 100% of the Benefit Amount.
Accidental Disability Cover	*Not applicable.*	No subsequent Claims will be paid. 100% payout is made on the first Claim. Maximum payout is 100% of the Benefit Amount.	No subsequent Claims will be paid. 100% payout is made on the first Claim. Maximum payout is 100% of the Benefit Amount.
Illness Cover	Claims allowed, only when severity is higher. Difference in severity is paid. Maximum payout is 100% of the Benefit Amount (or the highest percentage of all the Progressive Claims).	Claims allowed, only when severity is higher. Difference in severity is paid. Maximum payout is 100% of the Benefit Amount (or the highest percentage of all the Related Claims).	Unlimited Claims allowed. Benefit Amount multiplied by full severity percentage is paid on each Claim.

Please note that various symptoms and signs of a syndrome, overlapping syndromes, associated conditions or treatments thereof, will be regarded as one condition.

- Manifestations of other conditions as a result of the original condition will also be regarded as part of the original condition.
    - Examples are kidney failure due to severe systemic lupus erythematosus or manifestations of metastases in various organs.
- A syndrome is defined as a group of symptoms that frequently occur together or a condition characterized by a set of associated symptoms.
- In addition, all cardiac and nervous system pathologies or procedures that occur within 30 (thirty) Days of each other will be regarded as a single event.

15.4 MULTIPLE BENEFIT CLAIMS AND SIMULTANEOUS SAME BENEFIT CLAIMS

15.4.1 Multiple Benefit Claims

Multiple Benefit Claims arise when the Life Insured qualifies for payments from 2 (two) or more Benefits, as a result of the same incident or Claim Event. In this case, both Benefits will be paid i.e. The Life Insured qualifies for both an Illness Cover and Disability Cover payment.

Example

Example Details:

- You take out a policy with Life Cover, Illness Cover and Disability Cover.
- You are both the Policyholder and Life Insured on the Policy.
- The Life Cover Sum Assured is R1 000 000.
- The Disability Cover Sum Assured is R1 000 000.
- The Illness Cover Sum Assured is R500 000.

Unfortunately, You get diagnosed with a stage IV cancer 2 (two) years later. In this scenario, both the Sum assureds relating to the Illness Cover and Disability Cover Benefit will be paid out to You (both qualify for a 100% payment in this scenario), that is, the Disability Cover Sum Assured of R1 000 000 and the Illness Cover Sum Assured of R500 000 will be paid out to You.

Please note that if the 2 (two) Claims arise from the same incident or the same Claim Event and one of the Claims is for death, then the rules with respect to Waiting and Survival periods will apply, as detailed through this Policy.

15.4.2 Simultaneous Same Benefit Claims

Simultaneous Same Benefit claims are defined as the submission of Claims within 3 (three) months of each other, where the Claims were as a result of the same incident or Claim Event. This refers to Claims within the same Benefit category (i.e. 2 (two) Illness Cover Benefit Claims or 2 (two) Disability Cover Benefit Claims). Please note that when this occurs for lump sum disability Benefit Claims (Disability Cover and Accidental Disability Cover Claims), We will only pay 1 (one) Disability Benefit Claim since the maximum overall payout is 100% and therefore no pay out will be made for the second Claim.

Unrelated, Related and Progressive Illness Cover Benefit Claims

- In this scenario, we will pay the maximum of the 2 (two) Claims.
- If the first Claim is bigger than the second Claim, then no payment will be made to You.
  If the second Claim is bigger than the first Claim, then the difference between the 2 (two) Claims will be paid out to You.

Example

You take out a Policy with R1 000 00 Illness Cover. You are both the Policyholder and Life Insured. Unfortunately, You are involved in a terrible car accident and suffer the loss of use of both arms, where You qualify for a 150% payment. You get paid out R1 500 000.

A month later, some of the injuries result in You becoming a quadriplegic, which qualifies for a 200% payment. In this scenario, a payout or R500 00 (200% -150% = 50% x R1 000 000) is made. If the new ailment was at 100%, then no payout would have been made, since 150% is larger than 100%.

Please note that this section (section 15.4) relates only to lump sum Benefits. This means that this section applies to all Benefits, except the Income Protection Benefit and Standalone Temporary Income Protection Benefit.

15.5 HOW TO CLAIM

If You or Your Beneficiaries or Cessionary (or other nominated person, such as the executor of the Life Insured's estate) needs to report a Claim, please contact the Administrator at:

Telephone : 080 0000 123
Email : claims@onespark.co.za

When the Policyholder or the Claimant wants to submit a Claim, We will send the Policyholder or the Claimant the forms to complete (the claim forms can also be found online at www.onespark.co.za.

The Policyholder or the Claimant must let Us know about the Claim Event within 3 (three) months from the Claim Event Date, unless there are extenuating circumstances for the late notice thereof (these extenuating circumstances will be examined and judged on a case by case basis). All relevant claim documents must be completed and submitted within 3 (three) months of the Claim Event Date, unless there are extenuating circumstances for the late completion and submission thereof. Please note that the Insurer/Administrator will decide, at their sole discretion, what constitutes an 'extenuating circumstance' on a case by case basis. If no notification is made to Administrator or Insurer within this period, no payout will be considered.

A Claim will be paid out once both the Administrator and Insurer are satisfied. There is no specified timeframe for this, unless specifically mentioned in the section relating to the relevant Benefit.

In the event that We need to request for further evidence, the Policyholder (or the Claimant) will be required to supply such further evidence to Us within 6 (six) months of Our request. In terms of requesting further evidence, the Insurer also reserves the right, at Our sole discretion, to request an independent Medical Practitioner's diagnosis and report to determine validity of any Claim. The cost of obtaining medical information required by the Administrator/Insurer at Claim stage must be paid by the Claimant or Policyholder. If the Administrator/Insurer requires additional medical evidence thereafter, the Insurer will cover those costs.

The Claim will be paid out once the Administrator/Insurer is satisfied that the specific claims definitions have been satisfied. There are no specified or regulated timeframes for this – please see the rules around Waiting and Survival Periods in as specified in sections 5, 6, 7, 8, 9 and 10.

In the event We request for further evidence, You (or the Claimant) will be required to supply such further evidence to the Us within 6 (six) months of the request.

If We Repudiate a Claim but subsequently agree to pay a Goodwill Payment, such payment action will not constitute a precedent and will be applied on fairness principals and equity based on merit. We, even though the Policyholder or any Insured Life have not fulfilled conditions of this Policy, are not prevented from Repudiating any future Claim for any similar or condition for which We apply the full terms and conditions of this Policy.

15.6 MISREPRESENTION, NON-DISCLOSURE AND FRAUD

15.6.1 Misrepresentation and non-disclosure

If any information given by You, the Life Insured or anyone acting on Your (or the Life Insured's) behalf or by any Claimants under this Policy is in any way Misrepresented by You, the Life Insured or anyone acting on Your (or the Life Insured's) behalf (or by any Claimants) or any material information has been omitted under this Policy, all Policy Benefits under the Policy will be voided.

It is Your responsibility to inform the Administrator or the Insurer if any of Your or the Life Insured's (if different) circumstances change and where this could affect the outcome of a potential Claim and/or invalidate this Policy and its Benefits.

In addition, in the event of Misrepresentation, mis-description or non-disclosure by You, the Life Insured or anyone acting on behalf of You or the Insured Life, of anything material to the assessment of the risk, the Policy will be voided ab initio and all Benefits under this Policy will be forfeited. Paid Premiums will be refunded by applying the legal remedy of rescission.

Should any Benefits have been paid out on the basis of the information provided by the Policyholder to the Administrator or Insurer, and such information, at the sole discretion of the Insurer subsequently proves to be deliberately incorrect in any material respect, the Insurer and Administrator both retain the right to take such steps as may be required to put them in the position that they would have been in if the correct information had been received timeously.

Please note that any Misrepresentation of age for any of the Lives Insured on the Policy will not invalidate the Policy or any of its Benefits. This scenario will result in an adjustment to the Policy and its Benefits to be commensurate with the correct age(s) and Premium(s).

Furthermore, should You or the Life Insured (or anyone acting on Your or the Life Insured's behalf) Misrepresent any information when applying for Your Policy, the Insurer will be entitled to suspend Your cover from the Commencement Date of Your Policy. In addition to this, the Insurer will also be entitled to:

- Refuse to pay out any current or future Claims that are related to the Misrepresentation or non-disclosure
- Adjust Your Premium from the date of the Misrepresentation or non-disclosure
- Recover monies already paid to You for Claims that relate to the Misrepresentation or non-disclosure
- Cancel or reduce certain Benefits or Your entire Policy with immediate effect.

15.6.2 Fraud

If any fraudulent means are used by You, the Life Insured or anyone acting on Your or the Life Insured's behalf (or by any Claimants) to obtain any Benefit Amount or to Claim under this Policy, all Policy Benefits under the Policy and all Premiums paid in terms of the Policy will be forfeited and the Policy will be voidable at Our option. Appropriate action will be taken as deemed necessary by the Insurer. Paid Premiums will not be refunded in this scenario.

Should any Benefits have been paid out on the basis of the information provided by the Policyholder to the Administrator or Insurer, and such information, at the sole discretion of the Insurer subsequently proves to be deliberately incorrect in any material respect, the Insurer and Administrator both retain the right to take such steps as may be required to put them in the position that they would have been in if the correct information had been received timeously.

15.6.3 Intentional Acts

If any of the Claim Events insured against are occasioned by You or the Life Insured's (if different) intentional act, or with Your or the Life Insured's (if different) connivance (or by anyone acting on Your or the Life Insured (if different) behalf), all Policy Benefits under the Policy and all Premiums paid in terms of the Policy will be forfeited and the Policy will be voidable at Our option. Appropriate action will be taken as deemed necessary by the Insurer. Paid Premiums will not be refunded in this scenario.

15.6.4 Consent for Disclosure

You and the Life Insured (if different) hereby consent to the exchange of information, including medical information, between the Administrator/Insurer, any medical practitioner the Life Insured has consulted or any other life office. You and the Life Insured (if different) hereby give

the Administrator/Insurer permission to access this information on the application form. This does not remove or reduce Your and the Life Insured's (if different) obligation to provide full disclosure in the application form.

15.6.5 Set-Off

The Insurer and/or the Administrator has a right to deduct (set-off) from any Benefit payment due to You, any amount which You may owe to the Administrator and/or the Insurer as a result of any erroneous payment or overpayment of any Claim.

15.7 BENEFICIARIES

You may appoint a Beneficiary (or Beneficiaries, if requested by You) at any time to receive any of the Benefits payable on the Life Insured's Death. Beneficiaries are not entitled to any Benefits during the Life Insured's lifetime.

You may remove or change Your Beneficiary (or Beneficiaries) at any time. Notice of any changes must be made In Writing. Please refer to Your Schedule to see the Nominated Beneficiaries on Your Policy.

The appointment or removal of a Beneficiary will only be binding if We let You know In Writing that We have recorded Your Beneficiary nomination. An updated Schedule will be issued upon such a change being made.

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

15.8 CESSIONS

Your Policy may be ceded. This is the process where all the rights, title and interest in Your Policy are transferred or made over to another person or entity and who becomes the new owner (in the case of an Absolute Cession) or where all the rights to the benefit are transferred or made over to another person or entity (in the case of a Collateral Cession).

Cessions are permitted at policy level. That means We do not allow the cession of individual Benefits under this Policy. Please note that no cession will be valid unless the cession is recorded by Us and confirmed in writing. Any Shareback coming from the Policy will always be made to the Policyholder (to the Cessionary in the case of an Absolute Cession).

It is the responsibility of the Cedent to provide the Cessionary with the full Policy, including all documents and terms and conditions.

There are two types of cessions.

15.8.1 Absolute Cession

An Absolute Cession is where the Cessionary takes ownership of the Policy and becomes liable for the payment of Premiums on the Policy. All rights, title and interest to the Policy are permanently transferred. The Cedent has no further rights in respect of the Policy and cannot deal with the Policy. The prior Beneficiary nominations made by the Cedent will fall away (they are automatically revoked) and may be replaced by the Beneficiary nominations of the Cessionary, if any. For all Benefit payouts, if no Beneficiary nominations are made by the Cessionary then any proceeds payable on the death of the Life Insured (death Benefits) will be paid to the estate of the Cessionary (if the Cessionary and Life Insured are the same person) or to the Cessionary as the Policyholder. Benefits other than Death Benefits will be paid to the Cessionary. All terms and conditions agreed to by the Cedent will apply to the Cessionary in relation to the Policy.

Where the Income Protection Benefit is included on a Policy, an Absolute Cession could have adverse tax consequences. Tax advice should be sought.

15.8.2 Collateral Cession

A Collateral Cession is where the right to Death, Illness and Disability Benefits in the Policy are transferred to a third party as security for an unpaid debt or obligation (usually a bank). While the debt or obligation remains unpaid or outstanding the Cedent remains the owner of the Policy and responsible to pay Premiums but cannot deal in any way with the Policy without the permission of the Cessionary. When the debt or obligation is settled then full ownership automatically reverts to the Cedent.

The Income Protection Benefit and any ShareBacks will not form any part of a collateral cession agreement.

15.9 REPUDIATION OF THE CLAIM AND TIME BAR

In the event of a Claim being repudiated or the Claimant disputes the quantum of the Benefit Amount paid by Us, the Claimant is entitled to make representation to Us in respect of Our decision to repudiate the Claim or as to the manner in which the quantum of the Benefit Amount was calculated for a period of 180 (one hundred and eighty) Days from the date of receipt of the letter of repudiation or the date of the Claim payment.

If the representation is unsuccessful or the dispute is not resolved at the end of this 180 (one hundred and eighty) Day period then the Claimant has an additional 6 (six) months to institute legal action against Us by way of a summons, failing which We will no longer be liable in respect of the Claim and such legal action will no longer be possible.

Representation must be submitted In Writing to Guardrisk Life:

Address:	PO Box 786015, Sandton, 2146
Email:	LifeClaims@Guardrisk.co.za or info@Guardrisk.co.za
Tel:	011 669 1000

Where the Claimant is not satisfied with the response from Us, the Claimant is entitled to escalate the matter/a complaint to the National Financial Ombud Scheme on:

Physical address:	Claremont Central Building, 6th Floor, 6 Vineyard Road, Claremont, 7708
Email:	info@nfosa.co.za
Tel:	0860 800 900
Website:	www.nfosa.co.za

In terms of Section 15 of the Financial Services Ombudsman Schemes Act No. 37 of 2004, that on receipt of the official referral to the aforementioned Ombudsman, any applicable time barring clause in terms of this Policy or the running of prescription in terms of the Prescription Act No 68 of 1969 from the date of referral to the date of withdrawal of the referral, or determination of the referral by the Ombudsman, shall be stayed. If the dispute is not satisfactorily resolved in this manner, legal action may be instituted against the Insurer for the enforcement of the Claim by way of the service of summons against the Insurer. Summons must be served on the Insurer within 6 (six) months from the date the Claimant receives the outcome in respect of the representations made, failing which all Benefits in respect of such Claim shall be forfeited and no liability can arise in terms of such Claim.

Additionally, if any person affected by a decision of the Insurer is dissatisfied with the decision, such person shall have the right to refer the matter for arbitration. Referrals to arbitration shall be in accordance with the provisions of the Arbitration Act, 1965. Notice of intention to excuse this right shall be given by the person concerned to the Insurer within 90 (ninety) Days of the Insurer's decision. Before the arbitration commences, the person concerned shall furnish such security for the costs of arbitration as the Insurer may reasonably require. The costs of the arbitration shall follow the award of the Arbitrator.

15.10 UNCLAIMED BENEFITS

If a Benefit under this Policy is an Unclaimed Benefit, We will take action to determine if the Principal Insured/Nominated Beneficiary is alive and/or aware of the Benefit payable to him/her under this Policy. Specifically, in the 3 (three) year period after the Unclaimed Benefit arises, We may:

- attempt to contact the Principal Insured/Nominated Beneficiary telephonically and electronically to advise them of the Unclaimed Benefit; or
- determine the last known contact information of the Principal Insured/Nominated Beneficiary by comparing internal and external databases, including the use of internet search engines and/or social media; or

- appoint an external tracing company to locate the Principal Insured/Nominated Beneficiary.

Before the end of the 3 (three) year period referred to above, We will confirm the Unclaimed Benefit and transfer the amount of the Unclaimed Benefit to an account in the name of the Insurer, and the Insurer will accept liability for the Unclaimed Benefit.

16. Premiums

16.1 PREMIUM PAYMENT

The owner of the Life Policy must pay the Premium of the total amount stated in the Policy Schedule. Premiums are payable monthly in advance on or before the first day of each calendar month for the duration of the Policy.

The monthly Premium will automatically be debited from Your selected payment method by Us on Your selected payment date (this also includes the Discount Activation Premium, if the No Cancel Benefit is selected on the Policy). If Your selected payment date falls on a weekend or recognised South African Public Holiday, Your Premium payment date may change, and We may debit Your selected payment method on a different date. If a DebiCheck debit order is selected as the preferred payment method, then the monthly Premium may be deducted on a date different to the selected payment date. Your monthly instalment may also be debited earlier in December and / or April because of public holidays or on other days. If there are insufficient funds in Your account to cover Your Debit Order, we may track Your account until sufficient funds are available for Us to deduct.

A Premium will be debited from Your selected payment method on Your Date of Commencement. That is, once You have concluded the onboarding process, a deduction from Your selected payment method will be made on Your selected payment date (Commencement Date). If Your Commencement Date is during a month, a pro-rated Premium will be deducted and this will be paid to Us. This deduction will occur on the day that the Policy was taken out.

We will only consider the Premium as paid when it is confirmed received by the Insurer. This is provided that the Premium is not reversed later. You will only have rights to ownership of the Policy when the first Premium is received. This means that the Insurer will only become liable to provide Policy Benefits, once the first Premium is received.

16.2 NO CANCEL DISCOUNT

This Benefit gives You a Premium discount if You agree not to cancel or lapse Your Policy up until the next No Cancel End Date.

This option can be selected at the Commencement Date or at any point during Your Policy term.

The discount can be maintained for the entire duration of the Policy if You continue to select the No Cancel Discount option each year. If in any year, You do not make a decision around the No Cancel Option, You will be defaulted to the option that You selected in the previous year. You can remove the Benefit option at any point in time. In this circumstance, the No Cancel Discount percentage will no longer apply to Your Premium and this will take effect from the next No Cancel End Date.

The discount, applicable to Your Policy, can be found on Your Policy Schedule. This discount will apply to all risk Benefits on the Policy from the date that the Benefit option is selected. If the date when this Benefit is selected on the Policy differs to the date when it applies on the Policy, then the latter will be considered to be the date on which the Benefit was selected.

If You select the No Cancel Discount, You will be debited Your monthly Policy Premium as well as an additional Premium (called the Discount Activation Premium) in the month where the No Cancel Discount is first selected on Your Policy. The No Cancel Discount will apply until the No Cancel End Date.

What happens if I do/do not cancel my Policy before the No Cancel End Date?

If You cancel Your Policy before the No Cancel End Date, You will forego this Discount Activation Premium.

If You do not cancel Your Policy before the No Cancel End Date, the Discount Activation Premium will be deducted off the Premium You pay in the Deduction Month (the month before the No Cancel End Date). Please note that the Discount Activation Premium will be used to pay for the partial or total Premium in the Deduction Month (subject to the maximum value of the Discount Activation Premium) and excludes any premium increases on the Policy between the date on which the option was selected and the No Cancel End Date, either from the Dynamic Financial Analysis or from any elective increases.

If, for any reason, Your Premium increases between the date on which the No Cancel Option was selected and the No Cancel End Date, We may also deduct an additional Premium equal to the size of the Premium change in order to cover the additional Discount Activation Premium required such that the discount would also apply to the Premium increase.

The following scenario may have the discount applied for periods other than the stipulated 12 (twelve) month period:

- If Your Commencement Date is during a month, then the No Cancel Discount will apply from the Anniversary Start Date until the next Policy Anniversary Date.

Example 1

Example Details

- Assume You take out a OneSpark Policy when You are 42 (forty-two) years old, and You select to add the No Cancel Discount.
- You are both the Policyholder and the Life Insured on the Policy.
- The normal monthly Premium is R100. The No-Cancel Discount percentage is 15% and therefore the premium reduces to R85 [R100 x (100 – 15%)].

At Commencement Date, Your payment method will be debited R170, instead of R85.

Scenario 1

You do not cancel Your Policy during the year. In this scenario, You will not pay for Your 12th month's Premium as You were doubled debited upfront and that Premium will be used to cover the 12th month's Premium.

You will keep the 15% discount until the end of the year (to Your next Policy Anniversary). At that point in time, You can re-select the No Cancel Discount Option and thus lock in the discount for another year. You can do this every year for Your entire Policy duration, thereby locking in the 15% discount forever. Each year when re-selected, You will be doubled debited on Your first month's Premium payment date.

The Premiums You will pay each month look as follows (assume the Premium increase, at Policy Anniversary, is 0% in this example):

Duration (Months)	Nominal Premium	Actual Premium paid
1	R100	R170 = R85 (R100 x 85%) x 2
2	R100	R85
3	R100	R85
4	R100	R85
5	R100	R85
6	R100	R85
7	R100	R85
8	R100	R85
9	R100	R85
10	R100	R85
11	R100	R85
12 (Deduction Month)	R100	R0 (R85 – R85)
13 (No Cancel End Date)	R100	R170 = R85 (R100 x 85%) x 2
14	R100	R85
15	R100	R85
--	…	…

Scenario 2

You decide to cancel Your Policy 6 (six) months after the Policy Commencement Date. Here, You will be allowed to cancel and You will forgo the extra monthly Premium of R85 that You paid upfront

Example 2

Example Details

- You take out a OneSpark policy on 1 January 2020
- You do not decide to take the No Cancel Option at Commencement Date.
- The normal monthly Premium is R100.
- You pay R100 for 6 (six) months and then, on the 1 June 2020, You decide to take out the No Cancel Discount.
- In this example, You qualify for a 15% discount.
- Your Premium goes down to R85.
- You are debited by R170 at this point in time, and the Discount Activation Premium is R85.
- On 1 January 2021, Your Premium would have increased from R100 to R110, in line with Your changing needs and the Dynamic Premium Adjustment.
- Benefit option start date = Month 6 (June 2020)
- Deduction Month = Month 24 (December 2021)
- No Cancel End Date = Month 25 (January 2022)

In this example, You do not cancel Your Policy, therefore the Premium You pay in the Deduction Month (the month before Your No Cancel End Date) will be the full Policy Premium at that time minus the Discount Activation Premium of R85.

You can keep the 15% discount until Your No Cancel End Date (Policy Anniversary at 1 January 2022). At that point in time, You can re-select the one year No Cancel Option and thus lock in the discount for another year. At this point, the Premium increases from R110 to R125. If You choose the No Cancel Discount Option at that point in time, then You will pay R106.25 (R125 x 85%) plus the Discount Activation Premium of R106.25, and R106.25 thereafter.

Your Premium payments will look as follows:

Month	Nominal Premium	Actual Premium paid
1 (1 January 2020)	R100	R100
2	R100	R100
3	R100	R100
4	R100	R100
5	R100	R100
6 (1 June 2020) (Date on which option was selected)	R100	R170 (R85 x 2)
7	R100	R85
8	R100	R85
9	R100	R85

10	R100	R85
11	R100	R85
12	R100	R85
13 (1st Policy Anniversary, 1 January 2021)	R110	R93.5 (R110 x 85%)
14	R110	R93.5
15	R110	R93.5
…	…	R93.5
23	R110	R93.5
24 (Deduction Month)	R110	R8.5 (R93.5 – R85) (Current premium – Discount Activation Premium)
25 (2nd Policy Anniversary, 1 January 2022) (No Cancel End Date)	R125	R212.50 = R106.25 (R125 x 85%) x 2
26	R125	R106.25
…	R125	R106.25

Please note that:

- The Cooling-Off Period and all the rules therefore still apply, even if the Policyholder selects the No Cancel Option. If the Policyholder cancels during the Cooling-Off Period, all Premiums paid up to that point will be refunded (this includes the Discount Activation Premium), provided no Benefit Amount has been paid or claimed as yet or the Claim Events insured against have not yet occurred.
- The No Cancel Discount applied to Your Premium may be adjusted in line with the Life Insured's age throughout the Policy duration.
- The No Cancel Benefit (section 16.2) will reviewed from time to time by the Administrator/Insurer and may be changed or amended, from time to time, at the Administrator/Insurer's sole discretion

16.3 WHAT HAPPENS IF MY PREMIUMS ARE NOT PAID ON THE DUE DATE? (GRACE PERIOD)

If We do not receive Your Premium on the due date, a period of 31 (thirty-one) Days (grace period) will be given to You in which to make a payment to keep the Policy up to date. We will let You know In Writing if We do not receive Your Premium. Should a Premium remain unpaid for a period longer than the grace period, a double Premium will be submitted for collection the following month. Any Claim lodged in a month where

one Premium has not been paid will be considered and if approved, the outstanding Premium will be deducted from the Benefit Amount.

Should a second Premium not be received (in other words, You fail to pay two consecutive Premiums), the Benefits on Your Policy will be suspended and no Benefit would be payable should a Claim Event occur whilst the Policy is two consecutive payments in arrears.

Should Premiums remain unpaid for a period equal to the grace period plus another full calendar month, the Policy will lapse automatically, and all Benefits on this Policy will cease. In this circumstance, the ShareBack Benefit (or any payments that are owed to You from the ShareBack Benefit) will also fall away. Any Claim lodged in a month after the Policy has either lapsed or cancelled will be declined.

16.4 WHAT IF I CANNOT AFFORD MY PREMIUMS INCREASES?

Each year, 31 (thirty-one) Days before Your Policy Anniversary date, the Administrator will inform You of how Your Policy will change after Your Anniversary Date. If for any reason You are unable to afford the premium increases, You should notify Us before the Anniversary Date. If You cannot afford the changes, for whatever reason, You may adjust Your policy by reducing or removing Benefits to allow for a lower Premium, to suit Your individual situation and what You can afford at that point in time. A new Policy Schedule will be sent to You confirming the changes made.

16.5 PREMIUM ESCALATION

For each Benefit on the Policy, the monthly Premium (relating to that specific Benefit) may escalate annually by factor at Your Policy Anniversary, specified by the Administrator each year, which takes into account the Dynamic Benefit Adjustment for that specific Benefit, as well the age of the Life Insured at that point in time. This is termed the Dynamic Premium Adjustment. The Life Insured will receive a notification of such increase 31 (thirty-one) Days before the Policy Anniversary date.

16.6 PREMIUM ADJUSTMENT

In the event that the Premium(s) actually paid to the Insurer are incorrectly calculated so that they are in fact insufficient to pay for the Benefits as set out in the Schedule, then:

- The error may be corrected and subject to payment of the additional Premium, the full Sum Assured will be maintained.
- If no adjustment is effected within 31 (thirty-one) Days of the date of the original proposal as reflected in the Schedule, the Insurer's liability shall be reduced by the ratio which the shortfall of the Premium bears to the total Premium due.

Premiums are not guaranteed, will be reviewed annually by the Administrator and/or the Insurer and may be amended or changed, based on the following factors: past and future expected economic factors (for example, but not limited to, interest rates, tax and inflation), any past or expected future anti-selection or moral hazard exhibited by the Life Insured on the Policy, past and future expected lapse experience, past and future expected mortality and morbidity experience, expected future reinsurance, administrative and operational costs of the Administrator, any other expected future costs to be incurred by the Administrator, any regulatory and legislative changes impacting this Policy or any other factor impacting the Premium that the Administrator/Insurer deems material at the time.

Any changes to the Premium will be notified to the Policyholder 31 (thirty-one) Days prior to the change taking effect. Such notification will confirm the reason for the change to the Premium.

17. Reinstatements

If You cancel Your Policy or Your Policy lapses, and thereafter (within 2 (two) months only) decide to re-instate it at or below the original levels, the reinstatement will only be permitted on the receipt of all Your outstanding Premiums, together with the satisfactory completion of Our Declaration of Health form or whatever underwriting requirements the Administrator or Insurer may deem necessary from time to time. Your cover will be reinstated to the original levels just before You cancelled Your Policy or just before Your Policy lapsed. However, all Waiting Periods (such as the 60 (sixty) month suicide Waiting Period) will start again from the reinstatement date.

No reinstatement will be allowed after 2 (two) months from originally cancelling Your Policy. In this scenario, You will be treated as a new business client with all new business rules, terms and conditions applying.

Please note that:

- You can cancel Your Policy and then subsequently reinstate it a maximum of 2 (two) times over the entire duration of Your Policy term. Thereafter, this Policy will be treated as a new policy, with all the rules, terms and conditions applicable for a new policy.
- Reinstatements will only be allowed if You pay any and all outstanding Premiums before the reinstatement occurs.

18. General Policy Rules

18.1 SPECIFIC RESTRICTIONS ON LIABILITY

The Insurer's liability in terms of the Policy shall cease in the event of a Claim settlement being made for the Life Cover Benefit of the Life Insured. This is applicable to a once-off Claim payment.

The Insurer's liability in terms of the Policy shall cease in the event of a Claim settlement being made for a Benefit of the Life Insured which depletes all the Life Insured's remaining cover and no further Benefits remain on the Policy.

18.2 TERMINATION OF THE POLICY

This Policy will terminate or end on the earliest of the following scenarios:

- On the last day of the billing cycle in which You paid Us a Premium;
- On the last day of the billing cycle in which You paid Us a Premium, where You have provided a cancellation instruction In Writing to the Administrator or Insurer;
    - No Benefits are payable on or after the cancellation date of Your Policy.
- Your Benefits are depleted due to a Benefit payment and You have no other Benefits on the policy. This will be the date when the last Benefit has been paid;
- The Policy is terminated with immediate effect due to non-disclosure or Misrepresentation as described in section 15.6;
- You have failed to pay Your Premiums for a second month in a row (please refer to section 16.3);
- We cancel the Policy by giving the Policyholder 31 (thirty-one) Days' notice; or
- We may immediately cancel this Policy or place it on hold, refuse any transaction or instructions, or take any other action considered necessary in order to comply with the law and prevent or stop any undesirable or criminal behaviour.

18.3 COOLING OFF PERIOD

This Policy can be cancelled by You, the Policyholder, within the Cooling-off Period by informing the Administrator In Writing of Your requested cancellation, provided no Benefit Amount has been paid or claimed or the Claim Event insured against has not yet occurred on the Policy. In this scenario, any Premium paid during this Cooling-off Period up to the date of receipt of the cancellation request will be refunded to You in full. All cover for the Life Insured on the Policy will cease immediately upon receipt of this cancellation request.

18.4 CANCELLATION PROCEDURE

Should You wish to cancel Your Policy at any time after the initial Cooling-off Period, You must provide a cancellation instruction In Writing to the Administrator or Insurer. We will provide cover until the end of the same billing cycle in which a Premium has already been paid in which the cancellation instruction has been received. Please note that such cancellations, after the initial 31 (thirty-one) Day Cooling-off Period, will not attract a refund of any Premiums paid.

18.5 NO SURRENDER, PAID-UP OR LOAN VALUES

This Policy acquires no surrender, paid-up or loan values. There is no cumulative effect of Premiums paid and each monthly Premium is used to cover the risk for that specific month. Each month a Premium is required to be paid to renew the cover.

There is no surrender value in respect of the ShareBack Benefit and nothing will be paid out when the Policyholder cancels their Policy.

18.6 CONDITION PRECEDENT

Strict compliance by an Insured Life with all the provisions, conditions and terms of this Policy shall be a condition precedent to liability on the part of the Insurer hereunder.

18.7 INTERPRETATION

The decision of the Insurer as to the meaning of or interpretation of the Policy shall be final and binding on the Policyholder and every person claiming to be entitled to a Benefit in terms of this Policy.

18.8 DYNAMIC NATURE OF THE ONESPARK LIFE POLICY

The OneSpark Life Policy is a living, dynamic policy which changes as the Life Insured does. It adapts to the Life Insured's life during the entire Policy term as well as on Claim. Due to the dynamic nature, the Administrator reserves the right to review, from time to time, and at their sole discretion change/amend any rules, terms, conditions, calculations, Premiums, formulas, Benefit workings, Benefit Claim criteria (Claim categories/definitions), Exclusions, term of the Policy or Benefits, Benefit Expiry Ages, workings of the ShareBack Benefit as well as any other workings (or wording extracts) stated or specified throughout this Policy. 31 (thirty-one) Days' notice will be given to the Policyholder if any of the above changes are made on the Policy.

Additionally, in order to give optimal cover and stay protected at every point in the Life Insured's life, please note that the Life Insured's personalised cover will continually be updated with changes in tax laws and tax exemptions (and allowances), the changing nature of occupations and the remuneration attached to each occupation, any regulatory or legislative changes impacting this Policy and calculations underpinning it, as well as changes to economic factors (such as, but not limited to interest rates and inflation), different asset class returns, investor risk profiles and investment management fees.

Please note that We rely on You to:

- Provide Us with true and accurate information at all points in time during Your Policy term;
- Ensure that, prior to each Policy Anniversary, the information that We have on record that is required for the Dynamic Financial Needs Analysis to re-calculate is accurate and up-to-date;
- Inform Us of any lifestyle changes , as well as any changes to the Life Insured's financial circumstances. Examples are as follows (but not limited to):
    - Changes to the Life Insured's latest monthly Income;
    - Occupational changes or promotions;
    - Changes to the Life Insured's debt levels;
    - Changes to the Life Insured's financial dependant situation;
    - Changes to the level of protection the Life Insured may have at other insurers; or
    - Any other changes that may affect the Life Insured's financial situation;

    as and when changes occur; and
- Answer any and all questions sent to You form the Administrator/Insurer;

  to make sure that the cover and Benefits suggested are in line with the Life Insured's changing needs.

  We rely on the above information to be timeously received to ensure that Dynamic Financial Needs Analysis provide accurate and personalised cover.

Pease note that the Administrator and Insurer cannot and will not be held liable in the event that the cover suggested does not match the Life Insured's Financial Needs if You and/or the Life Insured have not provided truthful or correct information or have omitted material information or have not answered the Dynamic Financial Needs Analysis at least on an annual basis or You have not informed the Administrator when the Life Insured experiences life events which materially affect Their financial needs, as discussed in the above paragraph.

18.9 PERSONAL LIABILITY

No director or employee of either the Insurer or Administrator shall be personally liable in respect of any Claim, any ShareBack amount or demand in terms of this Policy.

18.10 POLICYHOLDER'S CONSENT TO DISCLOSURE

You, the Policyholder, and the Life Insured (if different) hereby consent to the exchange of information, including medical information, between the Administrator/Insurer, any Medical Practitioner the Life Insured has consulted and any other life office. You and the Life Insured (if different) hereby give the Administrator/Insurer permission to access this information on the application form or on the online application/onboarding process. This does not remove or reduce Your and the Life Insured's (if different) obligations to provide full disclosure in Your application form.

You, the Policyholder, and the Life Insured (if different) hereby consent to the exchange of information, including that of debt levels and the like, between the Administrator/Insurer and any second- or third-party data source. You and the Life Insured (if different) hereby give the Administrator/Insurer permission to access this data to assist in calculating the proposed cover for the Dynamic Financial Needs Analysis, on an ongoing basis, to make sure Your cover is up to date and in line with ever-changing financial needs.

18.11 CUSTODY OF POLICY

A copy of this Policy shall be held by the Policyholder and the Insurer who shall both attach thereto such Schedules as may form part of this Policy from time to time. In the event of any discrepancy arising between the Policy held by the Policyholder and the Insurer, the Policy and Schedules held by the Insurer, shall constitute prima facie proof of the applicable terms and conditions in force at any specific point in time.

18.12 BENEFIT NOT ASSIGNABLE

A Policyholder may not pledge or otherwise alienate the Benefits (or any ShareBack payouts) or the rights to Benefits (or any ShareBack payouts) in terms of this Policy and such Benefits (and any ShareBack payouts) shall not be subject to any form of execution or judgment and shall not, on insolvency, or on surrender form part of the estate of the Life Insured.

18.13 POLICY VARIATION

The Insurer reserves the right to Vary this Policy by giving the Administrator Written Notice of such intention at least 31 (thirty-one) Days before any Premium adjustment and 31 (thirty-one) Days' notice before any other Policy Variation (for example changes to any terms; any conditions; any Policy Benefits; any ShareBack Benefit workings; any Exclusion(s); or the term of this Policy/Benefits), unless the Variation is to increase the Policy Benefits without increasing the Premium, in which case no advance notice will be required. The Administrator will inform You, the Policyholder, of any material Variation of the terms and conditions. Any Variations made after the Policy has been in force in excess of 12 (twelve) months will be binding on the

Insurer, the Administrator and the Policyholder and can be applied at any time after the first 12 (twelve) months from the Commencement Date to the existing terms and conditions after Written Communication of these changes has been sent to You, the Policyholder.

No Variation to this Policy will be binding on the Insurer unless made In Writing and signed by a duly authorized officer of the Insurer and confirmed thereafter by payment of the Policyholder of the Premium whether varied or not. No act or omission to act by the Insurer or any officer or employee of the Insurer shall be deemed to be a representation on behalf of the Insurer upon which the Insured Life's heirs, executors or assigns are entitled to act.

This Policy is issued on the basis that the statements and information made and set forth in the application and all declarations made in respect thereof are true and correct and constitute a full disclosure of all facts and circumstances likely to materially affect the assessment of the risk at the time of the issue of this Policy.

18.14 REMUNERATION PAYABLE TO THE ADMINISTRATOR AND INTERMEDIAIRES

Commission will be earned by the Administrator and is part of the Premium. The commission is 3.25% of each Premium over the lifetime of the Benefit, where the lifetime is subject to a minimum of 10 years and a maximum of 25.64 years. The Commission is regulated in terms of the Insurance Act. The Administrator also earns a 9% binder fee and a 12.5% outsourcing fee for performing activities on behalf of the Insurer which is included in the monthly Premium and payable to the Administrator.

Any commission payable to any brokers or financial intermediaries will be specified in the Schedule.

19. General Legal Compliance

19.1 INDULGENCE, LENIENCY OR EXTENSION

No indulgence, leniency or extension of time which the Administrator or the Insurer may grant or show to an Insured Life, shall in any way prejudice the Administrator or the Insurer, or preclude the Administrator or the Insurer, from exercising any of their rights in the future.

19.2 JURISDICTION AND GOVERNING LAW

Only the courts of South Africa shall have jurisdiction to entertain any Claims arising out of or in respect of this Policy and the law of South Africa shall apply to this Policy.

The parties hereby consent to the jurisdiction of the High Court of South Africa (South Gauteng Division, Johannesburg), in respect of all Claims and causes of action between them, whether now or in the future, arising out of or in respect of this Policy.

19.3 PROCESSING AND PROTECTION OF PERSONAL INFORMATION

Your privacy (and that of the Life Insured, if different) is of utmost importance to the Administrator/Insurer. We will take the necessary measures to ensure that any and all information, including Personal Information (as defined in the Protection of Personal Information Act 4 of 2013) provided by You (or the Life Insured, if different) which is collected from You (or the Life Insured, if different) is processed in accordance with the provisions of the Protection of Personal Information Act 4 of 2013 and further, is stored in a safe and secure manner.

You (and the Life Insured, if different) hereby agree to give honest, accurate and up-to-date Personal Information and to maintain and update such information when necessary.

You (and the Life Insured, if different) accept that all Personal Information collected by the Administrator/Insurer may be used for the following reasons:

1. to establish and verify Your (and the Life Insured's, if different) identity in terms of the Applicable Laws;
2. to enable the Administrator/Insurer to fulfil its obligations in terms of this Policy;
3. to enable the Administrator/Insurer to take the necessary measures to prevent any suspicious or fraudulent activity in terms of the Applicable Laws; and
4. reporting to the relevant Regulatory Authority/Body, in terms of the Applicable Laws.

We may share Your (and the Life Insured's, if different) information for further processing with the following third parties, which third parties have an obligation to keep Your (and the Life Insured's, if different) Personal Information secure and confidential:

1. Payment processing service providers, merchants, banks and other persons that assist with the processing of Your payment instructions;
2. Law enforcement and fraud prevention agencies and other persons tasked with the prevention and prosecution of crime;
3. Regulatory authorities, industry ombudsmen, governmental departments, local and international tax authorities, and other persons that We, in accordance with the Applicable Laws, are required to share Your (and the Life Insured's, if different) Personal Information with;
4. Credit Bureau's;
5. Our service providers, agents and sub-contractors that We have contracted with to offer and provide products and services to any policyholder in respect of this Policy; and
6. Persons to whom We cede Our rights or delegate Our authority to in terms of this Policy.

You acknowledge that any Personal Information supplied to the Administrator/Insurer in terms of this Policy is provided according to the Applicable Laws.

Unless consented to by Yourself, the Administrator/Insurer will not sell, exchange, transfer, rent or otherwise make available Your (and the Life Insured's, if different) Personal Information (such as Your (and the Life Insured's, if different) name, address, email address, telephone or fax number) to any other parties and You indemnify the Administrator/Insurer from any claims resulting from disclosures made with Your consent.

The Administrator/Insurer will only send Personal Information outside of South Africa, for further processing and storage, in adherence with the requirements in section 72 of POPIA. Currently data is being stored and processed in the European Union and the United States for the purpose of cloud storage, monitoring of our systems and administering policies. The Personal Information is transferred to foreign countries that has the same privacy protection laws similar to South Africa and the data subject has provided consent.

You understand that if the Administrator/Insurer has utilised Your (and the Life Insured's, if different) Personal Information contrary to the Applicable Laws, You have the right to lodge a complaint with Guardrisk. Should Guardrisk not resolve the complaint to Your satisfaction, You have the right to escalate the complaint to the Information Regulator.

20. Complaint Resolution Process

If You have a complaint or if You believe You did not receive enough information about the Policy, please contact the Administrator at:

Telephone:	080 0000 123
Email:	complaints@onespark.co.za

If You remain dissatisfied with the response, You may escalate a complaint to the Insurer at:

Telephone:	0860 333 361
Email:	complaints@guardrisk.co.za

If You are unhappy with any terms of the Policy or anything We have done in relation to the Policy, You can contact the Ombudsman at:

National Financial Ombud Scheme (for claims / service related matters)

Physical Address:	Claremont Central Building, 6th Floor, 6 Vineyard Road, Claremont, 7708
Tel:	0860 800 900
Email:	info@nfosa.co.za
Website:	www.nfosa.co.za

FAIS Ombudsman (for product / advice related matters)

Postal Address:	PO Box 41, Menlyn Park, 0063
Tel:	(012) 762-5000
Sharecall:	(086) 066 3274
Email:	info@faisombud.co.za

Financial Sector Conduct Authority (for market conduct related matters)

Postal Address:	PO Box 35655, Menlo Park, 0102
Tel:	(012) 428-8000
Fax:	(012) 346 6941
Email:	info@fsca.co.za

Information Regulator (for complaints relating to the use of Personal Information)

Postal Address:	PO Box 31533, Braamfontein, Johannesburg, 2017
Tel:	+27- 010- 023- 5200
Email:	POPIAComplaints@inforegulator.org.za

21. Treating Customers Fairly Principles

The Treating Customers Fairly principles are viewed seriously by the Insurer and Administrator, and all 6 (six) outcomes are practiced at all times. We will, in all Our interactions with You, endeavour to deliver excellent customer experiences which We will achieve through the ongoing review of all Our business practices and analysis of complaints. It is Our objective to be fair in Our treatment of all clients and partners and being compliant, in all aspects, of the 6 (six) outcomes of the Treating Customers Fairly framework. These Outcomes are:

1. You are confident that Your (and the Life Insured's, if different) fair treatment is key to Our culture;
2. Products and services are designed to meet Your (and the Life Insured's, if different) needs;
3. We will communicate clearly, appropriately and on time;
4. We provide advice which is suitable to Your (and the Life Insured's, if different) needs and circumstances;
5. Our products and services meet Your (and the Life Insured's, if different) standards and are of an acceptable level; and
6. There are no barriers to access Our services, change Benefits, switch providers, make a Claim or to lodge any complaints.

22. Appendices

22.1 APPENDIX 1

22.1.1 Objective Medical Criteria for Disability Cover and Permanent Income Protection Benefits

GENERAL PROVISIONS

All changes reflected in the below definitions (Claim Events) must be total, permanent (and irreversible) despite treatment according to recognized medical protocols.

The diagnosis of the disease causing the impairment must be confirmed by an appropriate Specialist. The diagnosis must be supported by the appropriate objective investigations and test results.

Please note that these definitions described below must have occurred since the Commencement Date of Your Policy, as well as since the start date of the applicable Benefit.

Please also note that the Activities of Daily living categories and definitions are described in Appendix 3.

Please note that for all organ transplants, the Life Insured must be the organ receiver and not the organ donor.

1. CANCER

All the below definitions are paid out at 100%.

DEFINITION	PAY-OUT
Stage IV Cancer	100%
Stage III Cancer scoring 4 on the ECOG performance scale continuously for a period of over six months	100%
Leukaemia scoring 4 on the ECOG performance scale continuously for a period of over six months	100%
Brain Tumour WHO Grade III	100%
Brain Tumour WHO Grade IV	100%
Stage III Multiple Myeloma*	100%

*Permanence will be re-assessed 5 (five) years from the Date of Disability.

2. MUSCULOSKELETAL SYSTEM*

All the below definitions are paid out at 100%.

DISEASE	DEFINITION	PAY-OUT
Upper Limbs	Total and permanent loss of use of both upper limbs at the level of the wrists or higher (proximal to the wrist)	100%
	Amputation of both upper limbs at the level of the wrists or higher (proximal to the wrist)	100%
Lower Limbs	Total and permanent loss of use of both lower limbs at the level of the ankle or higher (proximal to the ankle)	100%
	Amputation of both lower limbs at the level of the ankle or higher (proximal to the ankle)	100%
Upper and lower limb	Total and permanent loss of use of one upper limb above (proximal to) the wrist and one lower limb above (proximal to) the ankle	100%
	Amputation of one upper limb above (proximal to) the wrist and one lower limb above (proximal to) the ankle	100%
Spine	Cauda equina Syndrome	100%
	Loss of bowel integrity consequent upon irreversible neurologic damage.	100%
	Loss of bladder integrity consequent upon irreversible neurologic damage.	100%
	Paraplegia	100%
	Quadriplegia	100%
	Cervical spine impairment resulting in 30% WPI after surgery unless surgery is medically contra-indicated	100%

	Thoracic spine impairment resulting in 22% WPI after surgery unless surgery is medically contra-indicated	100%
	Lumbar spine impairment resulting in 33% WPI after surgery unless surgery is medically contra-indicated	100%
	Permanent inability to perform 3 Self-Care Activities of Daily Living	100%
Soft tissue	Severe facial disfigurement as per AMA guide Class four**	100%
	25% body surface area full thickness burns resulting in contractures with 50% WPI**	100%

* Disorders include muscle, bone, nerve or joint impairments.

** Based on AMA guides to the Evaluation of Permanent Impairment; latest edition - examining doctor will be provided with specific valuating protocols.

WPI - Whole person impairment

3. CARDIOVASCULAR

All the below definitions are paid out at 100%.

DISEASE	DEFINITION	PAY-OUT
Heart failure due to Myocardial Infarction or Valvular heart disease or Cardiomyopathy or Cardiac Arrhythmias or Congenital heart disease or Hypertensive heart disease	NYHA III and EF less than 40%	100%
	Maximum METs achieved on effort ECG less than 2	100%
	Awaiting cardiac transplantation	100%
	NYHA IV confirmed by a cardiologist	100%
Hypertension	Cardiac end organ damage as defined by an estimated LV mass Males: more than 255 g (greater than 131g/m2) Females: more than 193g (greater than 113g/m2) or Inter-ventricular septum or posterior	100%

	wall thickness of more than 17mm	
Constrictive Pericarditis	Constrictive pericarditis as confirmed on transthoracic echocardiography with all of the following: Dilatation of the inferior vena cava and hepatic veins, calcifications in the pericardium, abnormal septal wall motion and atrial enlargement.	100%
Peripheral arterial disease	Permanent ABI less than 0.4 following vascular surgery unless surgery is medically contra-indicated	100%
	Gangrene of a limb	100%
	Amputation of a limb	100%

4. NERVOUS SYSTEM

All the below definitions are paid out at 100%.

DEFINITION	PAY-OUT
Total and permanent loss of speech	100%
Total and permanent loss of comprehension of language	100%
Permanent inability to perform four or more categories of Activities of Daily Living	100%
Permanent inability to perform three or more Self-care Activities of Daily Living	100%
Persistent vegetative state for more than three months	100%
Permanent loss of memory recall or orientation to person, place and time, confirmed by a persistent MMSE score of less than 21	100%

Permanent non-progressive cognitive impairment with a MMSE score of less than 21	100%
Dementia with progressive neurocognitive disorders with a permanent CDR score of 2 or more	100%
Persistent quadriplegia	100%
Persistent hemiplegia	100%
Persistent paraplegia	100%
Visual Impairment* defined as best corrected binocular Snellen rating of less than 20/200	100%
Hearing loss* (deafness) of 90db or more in both ears measured over the frequencies (500, 1000, 2000 Hz) in two measurements over six months with a hearing aid	100%

All changes must be total, permanent and irreversible. All definitions to be confirmed by corresponding findings on specialist investigation.

* All measurements are with appropriate aids.

5. RESPIRATORY SYSTEM

All the below definitions are paid out at 100%.

DISEASE	DEFINITION	PAY-OUT
Chronic obstructive airways disease (chronic bronchitis emphysema)	FVC less than 40% of predicted* or FEV1 less than 40% of predicted* or Dco less than 40% predicted*, and all with constant use of prescribed oxygen due to blood oxygen saturation levels below 88%	100%

Asthma	FVC less than 40% of predicted* or FEV1 less than 40% of predicted* or Dco less than 40% predicted*, and all with constant use of prescribed oxygen due to blood oxygen saturation levels below 88%	100%
Restrictive or Mixed Lung Disease	FVC less than 40% of predicted* or FEV1 less than 40% of predicted* or Dco less than 40% predicted*, and all with constant use of prescribed oxygen due to blood oxygen saturation levels below 88%	100%

* Pulmonary function tests should be performed by a pulmonologist, including post-bronchodilatation testing, and show less than 5% variation between three successful readings - these tests must be technically acceptable to the treating Specialist as well as to the Insurer's medical panel.

6. DIGESTIVE SYSTEM

All the below definitions are paid out at 100%.

DISEASE	DEFINITION	PAY-OUT
Upper and lower digestive tract disease*	Anatomical loss and alteration in the gastrointestinal tract with medical evidence of established gastrointestinal pathology and weight loss of more than 25% below the lower limit of normal BMI or BMI of less than 14, if unable to be corrected medically	100%
	Faecal incontinence defined as permanent, continuous uncontrolled passage of faecal material. Colostomies and ileostomies are not covered under this definition	100%

	Permanent disturbance of bowel function resulting in a malabsorption syndrome with evidence of any two of the following: 1) Steatorrhoea or more than 20g of fat in the stool 2) Refractory anaemia of Hb less than 9g/dl 3) Refractory hypoalbuminaemia of less than 28g/l	100%
	Irreparable hernia with previous bowel obstruction and the permanent inability to perform 4 or more categories of Activities of Daily Living.	100%
	Permanent inability to swallow due to an anatomical or neurological abnormality as confirmed by abnormal oesophageal manometry or imaging studies	100%
Liver and biliary disease	Chronic liver disease classified as Child-Pugh Class C	100%
	Awaiting liver transplant on a recognised SA or international transplant list	100%

*Functional disorders with no demonstrable gastrointestinal pathology are excluded under this Benefit.

7. MENTAL AND BEHAVIOURAL DISORDERS

This Benefit category covers mental and behavioural disorders.

DEFINITION	PAY-OUT
Any mental illness that has resulted in all of the following: • Institutionalisation* in a registered psychiatric facility at least 3 times during the last 12 months, with each admission lasting for longer than 4 weeks; and • Chronic unremitting symptoms; and • Has not responded to comprehensive management and treatment which the person has completed based on best	100%

clinical practice for more than 24 months; and • Has resulted in the inability to perform any type of work for payment or reward for a period of at least 24 months; and • Diagnosis and impairment to be confirmed by two independent specialists.	

* Excluding institutionalisation for drug or alcohol abuse or a violation of South African criminal law.

8. ENDOCRINE SYSTEM

All the below definitions are paid out at 100%.

DISEASE	DEFINITION	PAY-OUT
Diabetes mellitus	Claims as a result of type 1 or type 2 diabetes mellitus with evidence of end-organ damage are assessed under the relevant body systems	100%
Cushing's syndrome	Claims as a result of any endocrine disease are assessed under the relevant body systems	100%
Phaeochromocytoma	Claims as a result of any endocrine disease are assessed under the relevant body systems	100%
Syndrome of inappropriate anti-diuretic hormone secretion (SIADH)	Claims as a result of any endocrine disease are assessed under the relevant body systems	100%
Chronic adrenal insufficiency	Claims as a result of any endocrine disease are assessed under the relevant body systems	100%
Parathyroid associated chronic hypo- or hypercalcaemia	Claims as a result of any endocrine disease are assessed under the relevant body systems	100%
Chronic hyperaldosteronism	Claims as a result of any endocrine disease are assessed under the relevant body systems	100%

9. HAEMATOLOGY

All the below definitions are paid out at 100%.

DEFINITION	PAY-OUT
A permanent treatment resistant pancytopaenia (anaemia leukopenia, thrombocytopenia) resulting in ongoing monthly transfusions of at least 4 units of blood or blood products. This excludes cancer-related pancytopaenias	100%

10. ADVANCED AIDS

All the below definitions are paid out at 100%.

DEFINITION	PAY-OUT
Despite optimal treatment and full adherence to prescribed antiretroviral therapy for at least one year, a permanent CD4 count less than 50 and a positive PCR	100%
OR	
Despite optimal treatment and full adherence to prescribed antiretroviral therapy for at least 2 years, a CD4 cell count of less than 200 and a positive PCR	100%
And	
At least one of the following diseases must be diagnosed:	
1) Kaposi's sarcoma	
2) Pneumocystis jirovecii pneumonia (PJP)	
3) Confirmed progressive multifocal leukoencephalopathy	
4) Active extra-pulmonary tuberculosis	
5) Cryptococcosis	
6) Disseminated non-tuberculous mycobacteria infection	
7) Confirmed diagnosis of any other condition as defined as stage 4 on the WHO clinical criteria list	

11. OTHER

This category provides for diseases or conditions that do not fall into any other listed category, or combination of signs and symptoms resulting in ADL impairment. All changes must be total,

permanent and irreversible. Mental and Behavioural related conditions are not covered under this section.

All the below definitions are paid out at 100%.

DEFINITION	PAY-OUT
Permanent inability to perform 4 or more categories of Activities of Daily Living	100%
Permanent inability to perform 3 Self-care activities of Daily Living	100%

12. NON - OCCUPATIONAL CLAIMS CRITERIA

This category provides specific coverage for diseases or conditions for lives insured who do not qualify for coverage under for the Occupational Claims Criteria. All changes must be total, permanent and irreversible.

DISEASE	DEFINITION	PAY-OUT
Hand	Total loss of use of dominant hand at the level of the wrist or higher.	100%
Renal	Permanent kidney dysfunction with a GFR of less than 15ml / min / 1.73m^2 according to the internationally recommended GFR equation, requiring dialysis	100%
	Ongoing peritoneal dialysis haemodialysis	100%
	Total and continuous permanent urinary incontinence	100%

22.2 APPENDIX 2

22.2.1 Objective Medical Criteria for Illness Cover

GENERAL PROVISIONS

- The Claim Events described in this section must have occurred after the commencement of the Benefit in order to be eligible for a Claim pay-out.
- Symptoms and signs must be compatible with the diagnosis and the relevant Specialist investigations (including blood tests, imaging, histology and other tests) must confirm the diagnosis.
- Inability to perform Activities of Daily Living must be due to and compatible with the diagnosis of the Claim Event. The Activities of Daily living categories and definitions can be found in Appendix 3.
- Psychiatric illness, chronic fatigue syndrome (and synonyms) and fibromyalgia (and synonyms) and related terms are not covered under the Illness Cover Benefit.
- Major organ transplant Claims include being on an official South African or international transplant waiting list for the relevant transplant.
- Specialist reports are required to assess all Claims.
- The Claims definitions in the OneSpark Illness Cover Benefit are compliant with the Standardised Critical Illness definitions Project (SCIDEP). The document is available at https://www.asisa.org.za/asisadocs/Standards/SCIDEP
- Please note that Claims relating to conditions which may have been identified as a result of screening tests (e.g. genetic tests) but where there are no medical symptoms of the disease will not be covered under these definitions.
- Please note that for all organ transplants, the Life Insured must be the organ receiver and not the organ donor.

1. CANCER

This Benefit covers certain cancers, as specified below.

Cancer is a malignant tumour characterised by the uncontrolled growth of cells, invasion of normal tissue and spread to distant organs. The term malignant tumour includes leukaemia, lymphoma and sarcoma.

SEVERITY A

Malignant Melanoma Stage III	120%
Malignant Melanoma Stage IV	120%

SEVERITY B

Stage IV cancer	100%
Stage III cancer unless specified elsewhere	100%
Acute Myelocytic Leukemia	100%
Chronic Lymphocytic Leukemia: Stage III or IV on the Rai classification system	100%
Chronic Myelocytic Leukemia	100%
Acute Lymphoblastic Leukemia	100%
Bone marrow transplant or stem cell transplant	100%
Severe Aplastic Anaemia as defined by the International Aplastic Anaemia Study Group	100%
Multiple myeloma: Stage III on the Durie-Salmon scale or equivalent on an appropriate international staging system	100%
Hodgkin's or Non-Hodgkin's lymphoma: Stage III on the Ann-Arbor staging system or equivalent on an appropriate staging system	100%
Hodgkin's or Non-Hodgkin's lymphoma: Stage IV on the Ann-Arbor staging system or equivalent on an appropriate staging system	100%
Prostate cancer T4N0M0 or with affected lymph nodes or distant metastases	100%
Neuroendocrine tumour stage III	100%
Neuroendocrine tumour stage IV	100%
Carcinoid syndrome with evidence of liver metastasis	100%
Borderline Ovarian Tumours Stage III	100%
Borderline Ovarian Tumours Stage IV	100%
Pseudomyxoma Peritonei with Disseminated Peritoneal Adenomucinosis	100%
Post organ transplant lympho-proliferative disorders	100%
Gastrointestinal Stromal Tumours Stage III	100%
Gastrointestinal Stromal Tumours Stage IV	100%
Dermatofibrosarcoma Protuberans stage III	100%
Dermatofibrosarcoma Protuberans stage IV	100%

Malignant Melanoma stage II	100%
Neuroendocrine tumour stage II	100%

Further Notes

Pre-malignancy and carcinoma-in-situ tumours except for carcinoma-in-situ of the breast treated by mastectomy are not covered under this Benefit.

A current internationally recognised staging system will be used to assess the Claim Event.

A report from the treating Specialist, including the histology and stage of the cancer, the relevant imaging reports and other tests must confirm the diagnosis.

Once a payment for a cancer listed under Severity A or Severity B cancer has been made, further cancer claims will only be considered for unrelated cancers. An unrelated cancer is a cancer that is not regarded as being of the same tissue and the same organ. The unrelated cancer will be considered as a new Life Changing Event.

Where stem cell or bone marrow transplants are performed as treatment for cancer, only one Severity A or B Claim will be paid. Only one bone marrow or stem cell transplant will be paid during the lifetime of the Policy.

If two cancers of two different tissue types are present and have manifested independently of each other then, subject to the limits of the Policy as well as the terms of the Policy payment rules, each cancer will be considered as a separate Life Changing Event. These two claims will be regarded as claims within the same body system.

2. HEART AND ARTERY

This Benefit covers conditions of the heart and arteries as specified below.

SEVERITY A

Heart and lung transplant	200%
Peripheral arterial disease with gangrene, where the severity of the impairment is in line with a Musculoskeletal severity A condition, as found in Musculoskeletal section in Appendix 2.	200%
Peripheral arterial disease with amputation, where the severity of the impairment is in line with a Musculoskeletal severity A condition, as found in Musculoskeletal section in Appendix 2.	200%
Heart transplant	175%

SEVERITY B

Bilateral carotid artery endarterectomy or bypass surgery	100%
Coronary artery bypass graft to three or more vessels	100%
Permanent ejection fraction of less than 40%	100%
Severe myocardial infarction with an ejection fraction of less than 40% at least 14 Days	100%

after the acute myocardial infarction	
SCIDEP Level A Heart Attack	100%
SCIDEP Level A Coronary artery bypass graft	100%
Chronic diastolic heart failure NYHA class 4 with raised Pro-BNP levels according to age bands. Ages under 50 years Pro-BNP more than 450 µg/mL; ages 50 years and older Pro-BNP more than 900 µg/mL	100%
Heart valve replacement	100%
Surgical repair of the Aortic Root	100%
Surgical repair of Thoracic Aortic Aneurysm	100%
Surgical repair of Thoracoabdominal Aortic Aneurysm	100%

SEVERITY C

Peripheral arterial disease with absent doppler readings, persistent claudication and leg ulcers	75%

Further Notes

Only one payment will be made per coronary event. A single coronary event is defined as incorporating all cardiac pathologies or procedures that occur within 30 Days of each other.

The diagnosis must be confirmed by a cardiologist, cardiothoracic surgeon, neurosurgeon, vascular surgeon or specialist physician. Relevant special investigations such as ECGs, echocardiograms, other imaging studies and blood tests must confirm the diagnosis.

All measurements and assessments are done while the Claimant is alive.

For a Claim under the heart attack definitions above, establishment of the severity of the Claim Event will depend on the assessment of the Claimant at least 30 Days post infarction.

Permanence of the ejection fraction Impairment will be established in two measurements taken three months apart unless otherwise proven to the satisfaction of the Insurer/Administrator.

3. NERVOUS SYSTEM

This Benefit covers specified conditions of the brain, spinal cord nerves and arteries to the brain.

SEVERITY A

Quadriplegia	200%
Paraplegia	200%
Definite diagnosis of Motor Neuron Disease	200%
Stroke with permanent inability to perform four or more categories of the Activities of Daily Living Score Sheet (as defined in the ADL section below)	125%
Permanent inability to perform four or more categories of the Activities of Daily Living Score Sheet (as defined in the ADL section below)	125%
Permanent inability to perform three or more of the Self-Care Activities of Daily Living (as defined in the ADL section below)	125%

Total permanent loss of speech including expressive or receptive aphasia	125%
Hemiplegia or diplegia	125%

SEVERITY B

Glasgow Coma Scale of less than 8/15 lasting longer than 96 hours	100%
WHO Grade III and IV brain tumours	100%
Definite diagnosis of dementia with permanent MMSE score of 10/30 or less as confirmed by formal neuropsychometric testing	100%

SEVERITY C

The permanent inability to perform three categories of Activities of Daily Living	75%
The permanent inability to perform two Self Care Activities of Daily Living	75%
Extracranial monoplegia	75%

SEVERITY D

Definite diagnosis of dementia with permanent MMSE score of 20/30 or less as confirmed by formal neuropsychometric testing	50%

Further Notes

The Claimant must be treated by a neurologist or neurosurgeon registered as such with the Health Professions Council of South Africa.

Stroke is defined as death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in neurological deficit lasting longer than 24 hours, confirmed by neuro-imaging investigation and appropriate clinical findings by a specialist neurologist.

Symptoms and signs as well as imaging (Computerised Tomography or magnetic resonance imaging) must confirm a new stroke. Transient ischaemic attacks are specifically excluded.

Neurological deficits and ADL Impairments must be compatible with the diagnosis and objective medical evidence.

Permanence, including permanent inability to perform any Activities of Daily Living, will be established after 90 Days unless otherwise proven to the satisfaction of the Insurer/Administrator. Establishment of permanence is made while the Claimant is alive.

Brain tumours are assessed according the World Health Organisation's grading. Pituitary microadenomas are specifically excluded under this Benefit.

4. GASTROINTESTINAL

This Benefit covers specified conditions of the liver, pancreas, biliary system, upper and lower gastrointestinal system.

SEVERITY A

Liver transplant	150%
Pancreas transplant	150%

SEVERITY B

Chronic liver disease classified as Child Pugh Class C	100%
Primary Sclerosing Cholangitis	100%
Fulminant hepatic failure	100%
Portal hypertension with either varices, or refractory ascites and splenomegaly, or refractory pancytopenia	100%
Primary billiary cirrhosis	100%
Complete pancreatectomy	100%

SEVERITY C

Chronic liver disease classified as Child Pugh Class B	75%

Further Notes

Conditions related to drug or alcohol abuse are not covered under this Benefit.

The Claimant must be treated by a specialist physician, gastroenterologist or surgeon registered as such with the Health Professions Council of South Africa.

The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations such as blood tests, histology or imaging.

5. CONNECTIVE TISSUE DISEASES

This Benefit covers the following connective tissue diseases:

SEVERITY A

Multiple organ dysfunction meeting two defined Severity C criteria under 2 or more body systems due to a connective tissue disease	200%

SEVERITY B

Permanent inability to perform four or more categories of the Activities of Daily Living Score Sheet due to a listed connective tissue disease	100%
Permanent inability to perform three or more Self-Care Activities of Daily Living due to a listed connective tissue disease	100%

SEVERITY C

Definite objective evidence of involvement of two or more organs excluding the skin as an organ	75%
Permanent inability to perform 2 Self-Care Activities of Daily Living	75%

Further Notes

The Claimant must be treated by a specialist rheumatologist registered as such with the Health Professions Council of South Africa. The diagnosis must be made in accordance with current internationally recognised criteria and supported by the relevant histology, serology and imaging.

6. UROGENITAL TRACT AND KIDNEY

This Benefit covers specified conditions of the urogenital tract and kidneys.

SEVERITY A

Renal transplant	150%
Ongoing permanent peritoneal dialysis	150%

SEVERITY B

Chronic renal failure with ongoing, permanent haemodialysis or a GFR of less than 15ml/min/1.73m^2 according to the internationally recommended GFR equation	100%

Further Notes

Surgery for gender reassignment is not covered under this Benefit.

The Claimant must be treated by a specialist nephrologist or urologist registered as such with the Health Professions Council of South Africa.

The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations such as blood tests, histology or imaging.

7. RESPIRATORY DISEASE

This Benefit covers specified conditions of the respiratory system.

SEVERITY A

Heart and lung transplant	200%
Lung transplant	150%

SEVERITY B

Presence of irreversible cor pulmonale	100%

Confirmed diagnosis of pulmonary hypertension groups 1 to 5, including pulmonary veno-occlusive disease	100%

SEVERITY C

Requiring removal of more than one lobe of the lung	75%
Pulmonary venous occlusive disease not specified elsewhere	75%

SEVERITY D

Chronic obstructive or restrictive lung disease with a permanent FEV1 or FVC or Dco of 40% or less than predicted	50%
Chronic obstructive or restrictive lung disease with a permanent FEV1 or FVC or Dco of 41% to 45% of predicted	50%

Further Notes

The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations such as lung function tests, blood tests, histology or imaging.

The Claimant must be treated by a pulmonologist registered as such with the Health Professions Council of South Africa. Lung function tests should be performed by a pulmonologist. The test should include pre and post dilatation measurements and show less than 5% variation between three successive FVC or FEV_1 readings. Two Dco tests must be done with results within three units. Corrections must be made for anaemia and carboxyhaemoglobin on the Dco test.

8. ADVANCED AIDS/ACCIDENTAL HIV

This Benefit covers advanced AIDS and accidental HIV seroconversion as specified below.

SEVERITY B

Advanced AIDS evidenced by positive blood tests as specified above and a CD4 cell count of less than 50 while on antiretroviral therapy for at least six months	100%
Advanced AIDS evidenced by positive blood tests as specified above and a CD4 cell count of less than 200 while on antiretroviral therapy for at least three months AND diagnosis of at least one of the following diseases :	100%
- Kaposi's sarcoma	
- Pneumocystis jirovecii pneumonia (PJP)	
- Confirmed progressive multifocal leukoencephalopathy	
- Active extra-pulmonary tuberculosis	
- Cryptococcosis	
- Disseminated non-tuberculous mycobacteria infection	
- Confirmed diagnosis of any other condition as defined as stage 4 on the WHO clinical criteria list	

Advanced AIDS evidenced by positive blood tests as specified above and a CD4 cell count of less than 200 while on antiretrovial therapy for at least three months, with definite diagnosis of any three conditions defined as stage 3 AIDS on the WHO clinical criteria list	100%

Further Notes

A positive Human Immunodeficiency Virus antibody test and confirmatory Polymerase Chain Reaction test is required to confirm the diagnosis.

The diagnosis of the specified AIDS defining conditions must be supported by compatible signs and symptoms and confirmed by relevant special investigations such as blood tests, antibody test and histology or imaging.

9. MUSCULOSKELETAL

This Benefit covers specified conditions of the muscle, bones, joints and nerves.

SEVERITY A

Total and permanent loss of use of both lower limbs at the level of the ankle or higher (proximal to the ankle)	150%
Amputation of both lower limbs at the level of the ankle or higher (proximal to the ankle)	150%
Total and permanent loss of use of both upper limbs at the level of the wrists or higher (proximal to the wrist)	150%
Amputation of both upper limbs at the level of the wrists or higher (proximal to the wrist)	150%
Total and permanent loss of use of one upper limb above (proximal to) the wrist and one lower limb above (proximal to) the ankle	150%
Amputation of one upper limb above (proximal to) the wrist and one lower limb above (proximal to) the ankle	150%

SEVERITY B

More than 25% full thickness body surface area burns	100%

SEVERITY C

Full thickness burns involving 15 to 25% of the body surface area	75%
Total and permanent loss of use of a lower limb at the level of the ankle or higher (proximal to the ankle)	75%
Amputation of a lower limb at the level of the ankle or higher (proximal to the ankle)	75%
Total and permanent loss of use of the upper limb above (proximal to) the wrist or higher	75%
Amputation of the upper limb above (proximal to) the wrist or higher	75%

SEVERITY D

Total and permanent loss of use of a hand below (distal to) the wrist	50%

Amputation of a hand below (distal to) the wrist	50%
More than 10% full thickness body surface area burns	50%

Further Notes

The Claimant must be treated by a Specialist registered as such with the Health Professions Council of South Africa. The diagnosis must be supported by the relevant investigations and reports.

10. EYE

This Benefit covers specified conditions of the globe, retina, optic nerve, cornea and orbit.

SEVERITY A

Complete Blindness	150%

SEVERITY C

Best corrected binocular Snellen rating of less than 20/125 (as defined by the AMA* guide)	75%

Further Notes

The Claimant must be treated by an ophthalmologist registered as such with the Health Professions Council of South Africa. The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations such as visual acuity tests or imaging.

* American Medical Association Guides to the Evaluation of Permanent Impairment

11. EAR, NOSE AND THROAT

This Benefit covers specified conditions of the ear and neural pathways that relate to hearing as well as specified conditions of the nose, paranasal sinuses and venous sinuses of the brain.

SEVERITY B

Hearing loss of 90dB or more in both ears measured over the frequencies 500Hz, 1000Hz, 2000Hz and 3000Hz in 2 measurements six months apart, with a hearing aid	100%

SEVERITY C

Binaural hearing loss of more than 75% (as defined by the AMA guide)	75%
Hearing loss of 70dB in both ears measured over the frequencies 500Hz, 1000Hz, 2000Hz, 3000Hz in 2 measurements six months apart, with a hearing aid	75%

Further Notes

The Claimant/Life Insured must be treated by a specialist ear, nose and throat surgeon, registered as such with the Health Professions Council of South Africa.

The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations such as blood tests, histology or imaging.

12. INTENSIVE CARE

This Benefit covers ICU stay for various durations.

SEVERITY B

ICU admission for more than five weeks with assisted mechanical ventilation for more than three weeks	100%

SEVERITY C

ICU admission for more than four weeks with assisted mechanical ventilation for more than two weeks	75%

Further Notes

The Claimant must be treated by a specialist in a recognised trauma or intensive care unit. The intensive care unit must be a recognised ICU unit as defined by the Critical Care Society of South Africa.

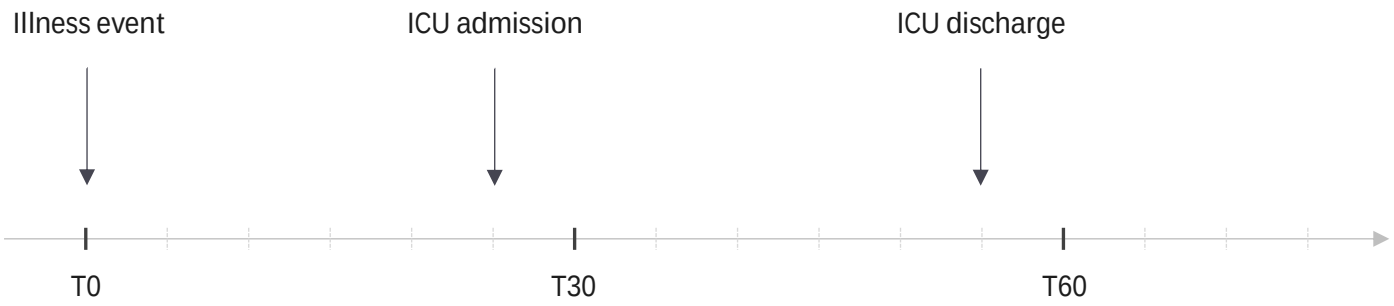
Please note that, if the ICU stay criteria are met, then in the case of the ICU stay:

- Being related to any other Illness Cover Benefit claims criteria claimed under,
- Starting within 30 Days after the Claimant becomes eligible for any other Illness Cover claims criteria claimed under,
- Ending within 60 Days before the Claimant becomes eligible for any other Illness Cover claims criteria claimed under,

Then only the highest severity Claim Event will be paid for (and not the sum of the payments of the ICU and the other Claim Event).

For example, if the Life Insured is admitted to ICU 27 Days after a 4-vessel CABG and stay in ICU for twenty-nine Days with assisted mechanical ventilation for fifteen Days, then only the Severity B CABG will be paid, and not the Severity C ICU Benefit.

The timeline below illustrates the progression of events.


Illness event
ICU admission
ICU discharge
T0
T30
T60

22.3 APPENDIX 3

22.3.1 Activities of Daily Living Definitions

GENERAL PROVISIONS

The Activities of Daily Living (ADLs) is an internationally used scoring system that assesses the functional ability of a person including the physical, cognitive and interactive abilities. OneSpark uses the ADLs to assess functioning in the Illness Cover, Disability Cover and Income Protection Benefits when objective criteria of impairment are needed – for example when neurological and connective tissue diseases are assessed. Changes to the ADLs must be permanent, must have occurred after the Commencement Date of the Policy, and must be due to the condition, illness or event that is being claimed for.

OneSpark reserves the right to request an occupational therapist's or neuropsychologist's assessment of ADL functioning, using standardised assessment methods.

THERE ARE SIX CATEGORIES OF ADLS:

- Self-care
- Communication
- Physical Activity
- Sensory Function
- Hand Function
- Advanced Activities.

SCORING OF THE CATEGORIES:

The terms 'no impairment', 'moderately impaired', 'severely impaired' and 'very severely impaired' are used in the Advanced Activities category. The terms 'independent', 'impaired', 'unable' are used in all the other categories. These terms are defined in the Activities of Daily Living Score Sheet below.

SELF-CARE

- If a person is unable to do one activity within this category, it is scored as the inability to perform the Self-care category of the ADL Score Sheet.
- If a person is impaired in doing two activities within this category, it is scored as the inability to perform the Self-care category of the ADL Score Sheet.

COMMUNICATION

- If a person is unable to do one activity within this category, it is scored as the inability to perform the Communication category of the ADL Score Sheet.
- If a person is impaired in doing two activities within this category, it is scored as the inability to perform the Communication category of the ADL Score Sheet.

PHYSICAL ACTIVITY

- If a person is unable to do three activities within this category, it is scored as the inability to perform the Physical Activity category of the ADL Score Sheet.
- If a person is impaired in doing six activities within this category, it is scored as the inability to perform the Physical Activity category of the ADL Score Sheet.

SENSORY FUNCTION

- If a person is unable to do one activity within this category, it is scored as the inability to perform the Sensory Function category of the ADL Score Sheet.
- If a person is impaired in doing two activities within this category, it is scored as the inability to perform the Sensory Function category of the ADL Score Sheet.

HAND FUNCTION

- If a person is unable to do one activity within this category, it is scored as the inability to perform the Hand Function category of the ADL Score Sheet.
- If a person is impaired in doing two activities within this category, it is scored as the inability to perform the Hand Function category of the ADL Score Sheet.

ADVANCED ACTIVITIES

It is scored as the inability to perform the Advanced Activity category if:

- A person is moderately impaired in all four areas; or
- A person is severely impaired in two of the four areas; or
- A person is very severely impaired in one of the four areas.

ACTIVITIES OF DAILY LIVING SCORE SHEET

SELF-CARE

ACTIVITY	INDEPENDENT	IMPAIRED	UNABLE
Bathing	• No assistance is required, or • The Life Insured is able to perform bathing or showering independently with the aid of hand rails and a non-slip bath mat.	• Hands-on assistance is required, or • Assistive devices such as an electronic bath bench is required when getting in or out of the tub or shower, or • The Life Insured generally baths Themself but needs some assistance with cleaning hard to reach areas.	• The Life Insured is totally dependent on others in all areas of bathing; The Life Insured would be at risk if left alone.
Grooming	• No assistance is required.	• Hands-on assistance is required with some activities of personal hygiene.	• The Life Insured is totally dependent on others in all areas of grooming.
Dressing	• No assistance is required, or • The Life Insured may perform dressing with an adapted method (such as sitting to dress lower limbs).	• Hands-on assistance is required with some activities, or • The Life Insured is unable to dress Themself completely (e.g. tying shoes, zipping or buttoning) without the help of another person.	• The Life Insured is totally dependent on others in all areas of dressing.
Eating and feeding	• No assistance is required, or • The Life Insured is able to perform the activity independently with the aid of modified cutlery.	• Hands-on assistance is required, e.g. help with cutting up food or pushing food within reach, or help with applying an assistive device (such as a universal cuff).	• The Life Insured is totally dependent on others in all areas of eating.
Toilet use and continence	• No assistance is required with toilet use, and the Life Insured has no incontinence.	• Hands-on assistance is required with some activities, e.g. transferring onto the toilet, but the constant presence of another person while toileting is not necessary, or • Intermitted	• The Life Insured is totally dependent on others in all areas of toileting, or • The Life Insured has no control of bowel or bladder, or • Permanent catheter, or • Permanent colostomy.

		catheterising.	
Mobility in home	• The Life Insured goes about the home independently.	• Walking and transferring requires the assistance of another person, or a railing, cane, walker or wheelchair.	• The Life Insured sits unsupported in a chair or wheelchair, but cannot propel Themself alone or transfer from bed to chair alone, or • The Life Insured is bedridden.

COMMUNICATION

ACTIVITY	INDEPENDENT	IMPAIRED	UNABLE
Listening	• The Life Insured is able to comprehend verbal communication in Their first language.	• The Life Insured is significantly impaired to comprehend verbal communication in Their first language.	• The Life Insured is permanently unable to comprehend verbal communication in Their first language.
Speaking	• The Life Insured is functionally able to communicate verbally in Their first language.	• The Life Insured is significantly impaired to communicate verbally in Their first language.	• The Life Insured is permanently unable to communicate verbally in Their first language.
Reading	• The Life Insured is able to comprehend written language in Their first language.	• The Life Insured is significantly impaired to comprehend written language in Their first language.	• The Life Insured is permanently unable to comprehend written language in Their first language.
Writing	• The Life Insured is able to complete personal information documents in Their first language independently.	• The Life Insured requires assistance when completing forms in Their first language.	• The Life Insured is permanently unable to write in Their first language.
Keyboard use	• The Life Insured can use a cell phone, keyboard, ATM and credit card machine independently.	• The Life Insured requires assistance when using a cell phone, keyboard, ATM or credit card machine.	• The Life Insured is permanently unable to use a cell phone, keyboard, ATM or credit card machine.

PHYSICAL ACTIVITY

ACTIVITY	INDEPENDENT	IMPAIRED	UNABLE

Standing	• The Life Insured can stand independently for longer than 10 minutes.	• The Life Insured needs external support or assistive devices (such as a walking frame), to stand, or • The Life Insured can stand independently but not for longer than 10 minutes.	• The Life Insured is unable to stand independently and therefore require hands-on support when standing; The Life Insured would be at risk if unassisted.
Sitting	• The Life Insured can sit independently for longer than 20 minutes.	• The Life Insured needs support to sit, or • The Life Insured can sit independently but not for longer than 20 minutes.	• The Life Insured is unable to sit independently.
Walking	• The Life Insured can walk independently (even though some difficulty or discomfort may be experienced) for six minutes, covering a distance of more than 300 metres.	• The Life Insured needs assistive devices (such as a walking frame) to walk, or • The Life Insured can walk independently but the distance covered in six minutes is less than 300 metres.	• The Life Insured is totally dependent on others for walking, or • The Life Insured must be pushed in a wheelchair or gurney at all times.
Crouching	• The Life Insured is able to assume and maintain the crouching position independently.	• The Life Insured requires external support getting in or out of the crouching position, or in maintaining the crouching position.	• The Life Insured is unable to assume the crouching position.
Squatting	• The Life Insured is able to perform five repetitive knee squats.	• The Life Insured is able to perform repetitive knee squats but are unable to perform five, or • The Life Insured requires external support when squatting.	• The Life Insured is unable to perform a knee squat.
Kneeling	• The Life Insured is able to assume and maintain the kneeling position independently.	• The Life Insured requires external support getting in or out of the kneeling position, or in maintaining the kneeling position.	• The Life Insured is unable to assume the kneeling position.

Reaching	• The Life Insured is able to reach to full arm length (above head height).	• The Life Insured is able to reach past eye level height, but unable to reach to full arm length.	• The Life Insured is unable to reach past eye level height.
Bending	• The Life Insured is able to bend forward independently.	• The Life Insured requires external support when bending forward.	• The Life Insured is unable to bend forward.
Carrying	• The Life Insured is able to carry 4.5kg for 5 meters with both hands, and • The Life Insured is able to carry 2kg with the left hand for 5 meters, and • The Life Insured is able to carry 2kg with the right hand for 5 meters.	• The Life Insured is able to carry some weight with both hands but are unable to carry 4.5kg with both hands for 5 meters, or • The Life Insured is unable to carry 2kg with the left hand for 5 meters, or • The Life Insured is unable to carry 2kg with the right hand for 5 meters	• The Life Insured is unable to carry any weight.
Lifting	• The Life Insured is able to lift (from floor to waist) 4.5kg with both hands, and • The Life Insured is able to lift (from floor to waist) 2kg with the left hand, and • The Life Insured is able to lift (from floor to waist) 2kg with the right hand.	• The Life Insured is able to lift some weight with both hands but is unable to lift (from floor to waist) 4.5kg with both hands, or • The Life Insured is unable to lift (from floor to waist) 2kg with the left hand, or • The Life Insured is unable to lift (from floor to waist) 2kg with the right hand.	• The Life Insured is unable to lift any weight.
Stair use	• The Life Insured is able to climb 20 steps independently, during which a handrail may be used and one step at a time is climbed.	• The Life Insured requires hands-on assistance when climbing stairs, or • The Life Insured is unable to climb 20 or more steps.	• The Life Insured is unable to negotiate stairs.

Travel (driving, riding)	• The Life Insured is able to drive a vehicle independently, or • The Life Insured is able to use public transport independently.	• The Life Insured requires assistance when using public transport, or • The Life Insured requires a driver if They had previously been able to drive a motor vehicle independently.	• The Life Insured is unable to travel.

SENSORY FUNCTION

ACTIVITY	INDEPENDENT	IMPAIRED	UNABLE
Hearing	• The Life Insured has functional hearing with or without the use of a hearing aid.	• The Life Insured's best corrected, permanent binaural hearing loss exceeds 50%.	• The Life Insured 's best corrected, permanent hearing loss exceeds 70dB as measured over the frequencies 500Hz, 1000Hz, 2000Hz and 3000 Hz.
Seeing	• The Life Insured has normal vision with or without correction.	• The Life Insured has a permanent visual field defect of 25% or more in one eye due to a scotoma.	• The Life Insured has a permanent visual field defect of 25% or more in both eyes due to scotomas or permanent quadrantanopia.
Tactile sensation	• The Life Insured has normal sensory function (sensation of the hands is assessed under hand function).	• The Life Insured has impaired sensory function in a dermatome corresponding with objective pathology (sensation of the hands is assessed under hand function).	• The Life Insured has complete loss of sensory function in a dermatome corresponding with objective pathology (sensation of the hands is assessed under hand function).
Tasting and Smelling	• The Life Insured has normal ability to taste and smell.	• The Life Insured has significant Impairment to taste or smell as a result of an injury or disease.	• The Life Insured is permanently unable to taste, or permanently unable to smell, as a result of an injury or disease.

HAND FUNCTION

ACTIVITY	INDEPENDENT	IMPAIRED	UNABLE
Grasping and Holding	• The Life Insured has grip strength better than 2 standard deviations below the average age and	• The Life Insured has grip strength weaker than 2 standard deviations below average age and	• The Life Insured is unable to grasp.

	gender values (according to Mathiowetz normative data for adults).	gender values (according to Mathiowetz normative data for adults).	
Pinching/Tip pinch	• The Life Insured has pinch strength better than 2 standard deviations below average age and gender values (according to Mathiowetz normative data for adults).	• The Life Insured has pinch strength weaker than 2 standard deviations below average age and gender values (according to Mathiowetz normative data for adults).	• The Life Insured is unable to pinch.
Coordination/Dexterity	• This is better than two standard deviations below the norm according to standardised hand coordination tests (for example the Minnesota Rate of Manipulation).	• This is two standard deviations below the norm according to coordination test (for example the Minnesota Rate of Manipulation).	• The Life Insured is unable to perform percussive movements (finger touching or diadochokinesis).
Sensory discrimination/Tactile sensation	• The Life Insured has normal sensory function in hands.	• The Life Insured has impairment of sensory function, but retained protective sensibility in the hands.	• The Life Insured has no sensation in hands.

ADVANCED ACTIVITIES

The following areas are assessed under this category:

- Concentration
- Memory
- Problem solving, judgement and reasoning
- Executive function including planning, initiation, organizing, error monitoring.

The above four areas can be tested by a neuropsychologist and stratified according to percentiles.

ACTIVITY	NO IMPAIRMENT	MODERATELY IMPAIRED	SEVERELY IMPAIRED	VERY SEVERELY IMPAIRED

Memory	• Neuropsychological testing results fall above the 30th percentile, or higher than half a standard deviation below the norm.	• Neuropsychological testing results fall between the 15th and 30th percentile, or between half and 1 standard deviation below the norm.	• Neuropsychological testing results fall between the 5th and 15th percentile, or between 1 and 2 standard deviations below the norm.	• Neuropsychological testing results fall below the 5th percentile, or 2 standard deviations below the norm (or worse).
Concentration	• Neuropsychological testing results fall above the 30th percentile, or higher than half a standard deviation below the norm.	• Neuropsychological testing results fall between the 15th and 30th percentile, or between half and 1 standard deviation below the norm.	• Neuropsychological testing results fall between the 5th and 15th percentile, or between 1 and 2 standard deviations below the norm.	• Neuropsychological testing results fall below the 5th percentile, or 2 standard deviations below the norm (or worse).
Problem solving, judgment and reasoning	• Neuropsychological testing results fall above the 30th percentile, or higher than half a standard deviation below the norm.	• Neuropsychological testing results fall between the 15th and 30th percentile, or between half and 1 standard deviation below the norm.	• Neuropsychological testing results fall between the 5th and 15th percentile, or between 1 and 2 standard deviations below the norm.	• Neuropsychological testing results fall below the 5th percentile, or 2 standard deviations below the norm (or worse)./
Executive function including planning, initiation, organizing and error monitoring	• Neuropsychological testing results fall above the 30th percentile, or higher than half a standard deviation below the norm.	• Neuropsychological testing results fall between the 15th and 30th percentile, or between half and 1 standard deviation below the norm.	• Neuropsychological testing results fall between the 5th and 15th percentile, or between 1 and 2 standard deviations below the norm.	• Neuropsychological testing results fall below the 5th percentile, or 2 standard deviations below the norm (or worse).

22.4 APPENDIX 4

22.4.1 HIV specific ongoing adherence rules

GENERAL PROVISIONS

This section only relates to a Life Insured who is HIV positive and who has received cover with the Insurer. This section specifies rules around constant adherence for a Life Insured on their ART (Antiretroviral therapy) treatment regime. The Insurer and/or Administrator reserves the right to enforce

all rules stated in Appendix 4 at either of their sole discretions.

BENEFIT RULES

If the Life Insured fails to adhere to Their HIV treatment regime, Benefit cover levels will reduce. Depending on the level of non-adherence, the Life and Disability Cover will reduce based on the Tier of non-adherence. There are 3 (three) Tier Levels. If the Life Insured is on Tier 2 or Tier 3, their Sum Assured will be the lesser of the Benefit amounts after the reduction and R1.5 million, whichever is less.

TIERING STRUCTURE

The below table shows the Tiering structure. It monitors the CD4+ count as well as the RNA viral loads and shows the corresponding Benefit reduction in the Life Cover and Disability Cover Benefits in each Tier. If either of the CD4+ count or the RNA viral loads land in a higher Tier (2 or 3), then that higher Tier will be used (that is, We take the worst Tier from the CD4+ count and RNA viral loads in assessing what Tier the Life Insured falls into).

Benefit Tier	CD4+ Count (cells/mm3)	RNA viral load (copies/mL)	Benefit Reduction
1	>=350	<=100	0%
2	200-350	100-500	50%
3	<=200	500+	75%

ADHERENCE RULES

The following adherence protocols must be met to avoid the reduction of Benefit amounts.

While the Insurer requires that the Life Insured goes for tests every 12 (twelve) months, the HIV Clinicians Society recommends testing every 3 (three) months. The Life Insured is required to be tested for, and to provide the Administrator with their RNA viral load and CD4+ count every 12 (twelve) months. The Life Insured should discuss more regular testing with Their treating doctor and/or managed health care company.

The Life Insured is required to go for regular blood tests, and to ensure that the Administrator is provided with copies of these test results. The Life Insured must include "OneSpark" as a "copy doctor" when filling in the form at the testing Laboratory in order to allow the testing Laboratory to forward a copy of the Life Insured's results to the Administrator.

Although the Administrator and Insurer will endeavor to access all blood test results directly from the testing laboratory or the Life Insured's managed health care company (if any), it will be the responsibility of the Life Insured to provide the test results to the Administrator on a 12 (twelve) monthly basis. If the Administrator does not receive the blood test results, the Life Insured will automatically be moved to Tier 3 and the resulting Benefit reduction will apply. The Benefit reductions will apply until they return to Tier 1 based on accurate and up to date blood tests providing confirmation of both the CD4+ Count and RNA Viral Load that meet the requirements of Tier 1.

In cases where laboratory results are unusual or discrepant in the opinion of the Administrator, these

will be evaluated on a case-by-case basis by the Administrator and, if necessary, repeat tests may be required. The cost will be borne by the Policyholder.

Please note that:

- All CD4+ Count and RNA Viral Load tests must be done at SANAS or ASISA approved laboratories.
- The Administrator also reserves the right, from time to time and at their sole discretion, to adjust any rules, requirements or Benefit workings as specified in this section, if so required.

Example

Example Details:

- You are HIV positive and take out a OneSpark Policy.
- You take out Life Cover and Disability Cover, both at R1 000 000.
- You are both the Policyholder and Life Insured on the Policy.
- At commencement Date your CD4+ count is at 500 cells/mm3 and your RNA viral load is at 50 copies/mL. You will be in Tier 1 and You will be protected for 100% of Your Life and Disability Cover amounts.

After 12(twelve) months, You go for an HIV test to see your CD4+ count as well as RNA viral load. Your results come back that your CD4+ count is at 500 cells/mm3 and your RNA viral loads are 1 000 copies/mL. Here, We take the worst Tier of the two and you will now fall into Tier 3. Your Life and Disability Benefits will reduce by 75% and You will only have Life and Disability Cover of R250 000. This will remain as is until You manage Your CD4+ count and RNA viral load back to levels within Tier 1.