UNAPPROVED GROUP RISK INSURANCE UMBRELLA POLICY

ISSUED TO

EMPLOYERS PARTICIPATING IN THE SANLAM UMBRELLA PENSION FUND OR THE SANLAM UMBRELLA PROVIDENT FUND

(Policy number SNMSTUNAP2018-01)

The Insurer must provide insurance in respect of the employees of certain employers in terms of this Policy (in which the attached Schedules are incorporated), provided that the provisions of the Policy are complied with by the employers.

The Insurer enters into this Policy on the basis of the information and documents provided to the Insurer relating to the risk relevant to the Policy.

This Policy is issued to each employer participating in the Policy for the benefit of its employees.

The insurance offered in terms of this Policy in respect of an employer takes effect as from the day that employer starts participating in the particular insurance offered in terms of the Policy.

The provisions of the previous policy effective from 1 January 2022 are replaced by the provisions of this Policy.

This Policy is effective from 1 September 2022.

Signed in Johannesburg on behalf of the Insurer on 26 July 2022.

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Catharina Carolina van Dyk
Head: Enablement and Change: Absa Life

UNAPPROVED GROUP RISK INSURANCE UMBRELLA POLICY

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EMPLOYERS PARTICIPATING IN THE SANLAM UMBRELLA PENSION FUND OR THE SANLAM UMBRELLA PROVIDENT FUND

(Policy number 19176933x0)

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The provisions of the previous policy effective from 1 January 2022 are replaced by the provisions of this Policy.

This Policy is effective from 1 September 2022.

Signed in Cape Town on behalf of the Insurer on 04 August 2022

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2 Strand Road, Bellville, South Africa
PO Box 1, Sanlamhof 7532, South Africa

T +27 (0) 21 947 9111

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SCHEDULE 1 DEFINITIONS

In this Policy, unless the context indicates otherwise,

- the singular also denotes the plural and vice versa; and
- the expressions below have the meanings indicated opposite them.

APPLICABLE LAWS means

(a) any law, statute, regulation, byelaw or subordinate legislation in force from time to time to which a party is subject and/or in any jurisdiction that the services in terms of the Policy, are provided to or in respect of;

(b) the common law and laws of equity as applicable to the parties from time to time;

(c) any binding court order, judgment or decree;

(d) any applicable industry code, policy or standard; or

(e) any applicable direction, policy, rule or order that is binding on a party and that is made or given by any regulatory body having jurisdiction over a party or any of that party's assets, resources or business.

BENEFIT ENTITLEMENT in regard to an INSURED means the benefit that would be provided by the INSURER in regard to him/her in terms of a particular Schedule but for the stipulations of that Schedule regarding proof of good health.

BENEFICIARY means the person(s) nominated by the INSURED, which person(s) may not include the EMPLOYER.

BUSINESS DAY in regard to an INSURED means a day on which he/she is obliged to work in terms of his/her employment contract.

CERTIFICATE OF PARTICIPATION means the certificate issued to the EMPLOYER by the INSURER confirming the EMPLOYER's participation in this Policy and the benefits selected by the EMPLOYER for the benefit of its EMPLOYEES. It may contain additional eligibility requirements for EMPLOYEES or other special terms and conditions agreed to by the EMPLOYER and the INSURER. The CERTIFICATE OF PARTICIPATION is effective from the PARTICIPATION DATE and forms part of the Policy.

COMPLAINT means a complaint or request relating to either party's obligations under DATA PRIVACY LAWS in terms of the Policy, including any compensation claim from a DATA SUBJECT or any notice, investigation or other action from a SUPERVISORY AUTHORITY.

CONSUMER PRICE INDEX means the "consumer price index for all urban areas" supplied by Statistics South Africa from time to time**.**

CONTRACT WORKER means an EMPLOYEE of the EMPLOYER who is subject to the provisions of the Policy applicable to CONTRACT WORKERS in terms of Schedule 3.

DATA PRIVACY LAWS mean any APPLICABLE LAWS relating to the processing, privacy, and use of PERSONAL INFORMATION, as applicable to SANLAM and the EMPLOYER in terms of the Policy, including:

(a) in Republic of South Africa:

(i) the POPIA including any regulations promulgated pursuant thereto; and/or

(ii) any other statute dealing with data privacy; and

(b) any judicial or administrative interpretation of any of the above, any guidance, guidelines, codes of practice, approved codes of conduct or approved certification mechanisms issued by any relevant SUPERVISORY AUTHORITY.

DATA SUBJECT means a person to whom PERSONAL INFORMATION relates.

EMPLOYEE means a person who -

(a) is in the service of the EMPLOYER; and

(b) is 15 years of age or older.

EMPLOYER means the EMPLOYER named in the CERTIFICATE OF PARTICIPATION that participates in the FUND and with the consent of the INSURER participates in this Policy, provided that the EMPLOYER is registered in the Republic of South Africa.

With regard to an EMPLOYEE, **EMPLOYER** means that EMPLOYER by whom the EMPLOYEE is or was last employed.

FREE COVER LIMIT means that part of the BENEFIT ENTITLEMENT regarding which proof of good health does not have to be submitted, as laid down from time to time by the INSURER and conveyed in writing to the EMPLOYER.

FUND means the Sanlam Umbrella Pension Fund or the Sanlam Umbrella Provident Fund, as the case may be.

INSURED means an EMPLOYEE who is insured in terms of this Policy.

INSURER means the INSURER registered in terms of the Long-term Insurance Act, 1998, that provides the insurance in terms of this Policy in respect of the EMPLOYERS that participate in this Policy.

MONTH means any of the twelve periods in which a year is divided.

MUNICIPALITY in regard to an INSURED has the meaning as defined in the Income Tax Act, Act 58 of 1962.

NORMAL RETIREMENT AGE in regard to an INSURED means the age as indicated in the CERTIFICATE OF PARTICIPATION.

NORMAL RETIREMENT DATE in regard to any INSURED means the last day of the MONTH in which he/she reaches the NORMAL RETIREMENT AGE.

PARTICIPATION DATE in regard to an EMPLOYER means the date indicated in the CERTIFICATE OF PARTICIPATION on which the EMPLOYER starts to participate in this Policy. If the EMPLOYER starts to participate in other benefits offered in terms of the Policy on a later date, PARTICIPATION DATE in respect of each benefit means the date agreed to by the EMPLOYER and the INSURER. With regard to a category of EMPLOYEES of the EMPLOYER that start to participate in this Policy on a different date, PARTICIPATION DATE in respect of that category means the date agreed to by the EMPLOYER and the INSURER.

PERSONAL INFORMATION means personal information as defined in POPIA and special personal information as defined in POPIA.

PERSONAL INFORMATION BREACH means any breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, any PERSONAL INFORMATION.

POPIA means the Protection of Personal Information Act, 4 of 2013.

REMUNERATION in regard to an INSURED means the total of –

(a) the amount of the basic cash remuneration the INSURED receives from the EMPLOYER, plus

(b) any amount, excluding incentive bonuses, determined by the EMPLOYER in terms of its human resources policy, and that is agreed to by the EMPLOYER and the INSURER,

provided that –

- unless the EMPLOYER and the INSURER agree otherwise, the annual REMUNERATION of an INSURED with a variable income is limited to the income which he/she received from the EMPLOYER during the twelve MONTHS immediately preceding the date on which the REMUNERATION is determined or, if less than twelve MONTHS, to his/her average monthly income during the number of MONTHS in which he/she received an income from the EMPLOYER multiplied by twelve; and

- the total of the INSURED's REMUNERATION may not exceed the total cost incurred (either conditionally or not) by the EMPLOYER in respect of the INSURED's service with the EMPLOYER.

RESPONSIBLE PARTY means a public or private body or any other person which, alone or in conjunction with others, determines the purpose of and means for processing PERSONAL INFORMATION.

RETIREMENT FUND WEB means the electronic communication tool used to provide information to the EMPLOYERS and the INSUREDS.

RISK SALARY in regard to an INSURED means the amount of the INSURED's REMUNERATION that, in terms of the EMPLOYER's human resources policy, the benefits and premiums in terms of this Policy in regard to the INSURED must be based on.

If the RISK SALARY of an INSURED is not based on the full amount of his/her REMUNERATION and is based only on a percentage of his/her REMUNERATION, the following applies:

- The applicable percentage of the REMUNERATION must be advised to the INSURER by the EMPLOYER and accepted by the INSURER in writing for the purposes of the Policy.

- The INSURER must be informed of the applicable percentage as on the PARTICIPATION DATE.

- The percentage must apply to all EMPLOYEES who are insured in terms of this Policy per defined categories.

- The INSURER must be advised in writing if the applicable percentage changes before the date that the change becomes applicable, and the change must be accepted by the INSURER in writing.

- Individual choices per INSURED will not be allowed, unless otherwise agreed between the EMPLOYER and the INSURER.

- If the INSURER identifies a discrepancy between the information provided and the above requirements, the INSURER may discuss the discrepancy with the EMPLOYER and, if the INSURER accepts the discrepancy, it must do so in writing for the purposes of the Policy.

Notwithstanding any provision to the contrary, RISK SALARY in regard to an INSURED who on the PARTICIPATION DATE, as a result of ill-health or disability, receives an income disability benefit from a fund or insurance instituted by the EMPLOYER for its EMPLOYEES, means his/her REMUNERATION immediately before his/her ill-health or disability commenced or such other amount that is agreed to by the EMPLOYER and the INSURER in writing.

SUPERVISORY AUTHORITY means any local, national or multinational agency, department, official, parliament, public or statutory person or any government or professional body, regulatory or supervisory authority, board or other body responsible for administering DATA PRIVACY LAWS.

UNDERLYING INSURANCE means the insurance by the INSURER of a death benefit of the INSURED in terms of this Policy or in terms of the policy insuring the death benefits provided by the FUND, and which is linked to the ‘qualifying spouse’s insurance in terms of Schedule 10, or, to which the accident benefit in terms of Schedule 12 is a rider, as the case may be.

SCHEDULE 2 PARTICIPATION

2.1 EMPLOYER

2.1(1) The EMPLOYER must apply to the INSURER to participate in the insurance offered in terms of this Policy.

2.1(2) If the INSURER approves the application the INSURER will issue a CERTIFICATE OF PARTICIPATION to the EMPLOYER validating its participation in this Policy.

2.1(3) The INSURER must make a copy of this Policy available to the EMPLOYER on the RETIREMENT FUND WEB.

2.1(4) The EMPLOYER will participate in only those benefits that are selected by the EMPLOYER and indicated in the CERTIFICATE OF PARTICIPATION.

2.2 INSURED

2.2(1) Every EMPLOYEE who –

(a) has not reached the age of 65 years; and

(b) is already a member of the FUND on the PARTICIPATION DATE or becomes a member of the FUND on or after the PARTICIPATION DATE,

qualifies for insurance in terms of this Policy subject to the provisions of the Policy.

2.2(2) If the FUND waived or waives any of the eligibility requirements for membership of the FUND or the INSURER waives any of the eligibility requirements for insurance in terms of this Policy in respect of an EMPLOYEE, such an EMPLOYEE will only become an INSURED on such conditions as the INSURER may lay down.

2.2(3) Every EMPLOYEE becomes an INSURED in terms of this Policy as from the date on which he/she qualifies for the insurance, provided that the EMPLOYER registers the EMPLOYEE with the INSURER timeously. If the EMPLOYER does not register the EMPLOYEE with the INSURER timeously, the EMPLOYEE will not qualify for the benefits offered in terms of this Policy before the date of such registration, unless the INSURER and the EMPLOYER agree otherwise.

2.2(4) The requirements referred to in this clause must be laid down by the EMPLOYER as a condition of employment of its EMPLOYEES.

2.3 CONTRACT WORKERS

A CONTRACT WORKER may qualify for insurance in terms of this Policy subject to the provisions of Schedule 3 in this regard.

2.4 Proof of good health

The following people will not qualify for the insurance in terms of this Policy until they have submitted proof of good heath to the satisfaction of the INSURER in terms of the relevant Schedule:

(a) A person who has the option of becoming a member of the FUND but fails to become a member within three MONTHS of becoming entitled to do so and becomes a member after three MONTHS.

(b) An employee of a MUNICIPALITY who is 55 years or older on the date on which he/she is insured for the first time for benefits in terms of this Policy.

(c) A person who is 50 years or older on the date on which he/she is insured for the first time for a ‘flexible amount’ of the death benefit in terms of Schedule 5 of the Policy.

2.5 Incapable of performing normal duties

If, in the opinion of the INSURER, an INSURED, as a result of a bodily injury or sickness, is incapable of performing his/her normal duties with the EMPLOYER on the latest date on which any insurance described in this Policy commences with the INSURER regarding the INSURED, he/she will not qualify for the insurance subject to the provisions in this regard in the rest of the Policy.

2.6 Replacement of existing insurance

If the INSURER replaces existing insurance that the EMPLOYER has for its EMPLOYEES by insurance offered in terms of this Policy, the provisions regarding the 'replacement of existing insurance' in the relevant Schedules in the Policy are applicable.

2.7 Termination of participation of an INSURED

An INSURED ceases to be an INSURED -

(a) at his/her death, or, in respect of the insurance on the life of his/her 'qualifying spouse' in terms of Schedule 10, the later of midnight on the last day of the month in which the INSURED dies and twenty-four hours after the death of the INSURED; or

(b) as soon as he/she ceases to be an EMPLOYEE for reasons other than his/her death, but not before he/she ceases to be entitled to a benefit in terms of the Policy, or

(c) at the cessation or cancellation of the insurance in respect of the INSURED in terms of the provisions of the Policy; or

(d) if the EMPLOYER's participation in the Policy is cancelled,

whichever event occurs first.

SCHEDULE 3 CONTRACT WORKERS

3.1 General

If an EMPLOYER employs a CONTRACT WORKER who it would like to participate in the benefits offered in terms of this Policy, the provisions below are applicable in respect of such a CONTRACT WORKER, notwithstanding any contrary provision in the rest of the Policy.

3.2 Participation

3.2(1) A CONTRACT WORKER must be employed on a fixed term contract of at least 12 consecutive MONTHS. Seasonal workers do not qualify as CONTRACT WORKERS.

3.2(2) Extended and renewed contract periods may not be joined together and treated as one contract. Each contract is treated individually even if there is no break between the contracts.

3.2(3) All pre-exclusion clauses in this Policy will apply afresh for each contract period. However, existing cover will be taken over without proof of good health if the contract is extended or renewed and the CONTRACT WORKER was insured by an insurer that participates in the approved or unapproved insurance of members of the FUND.

3.3 REMUNERATION and RISK SALARY

3.3(1) The annual REMUNERATION of a CONTRACT WORKER will be equal to the total income received during a 12 MONTH contract period as set out in the CONTRACT WORKER's contract, provided that –

(a) if a claim arises within the first 12 MONTHS of the commencement of the CONTRACT WORKER's contract, the annual REMUNERATION will be equal to the average monthly salary of the MONTHS worked multiplied by 12; and

(b) if a claim arises after the CONTRACT WORKER has received a salary increase, the annual REMUNERATION will be equal to the average monthly salary of the MONTHS worked since the increase multiplied by 12.

3.3(2) Subject to the provisions in the previous sub-clause the definitions of REMUNERATION and RISK SALARY in Schedule 1 apply mutatis mutandis in the case of a CONTRACT WORKER.

3.4 Benefits

3.4(1) The following provisions are applicable to a CONTRACT WORKER:

(a) If, during the first 3 MONTHS of the contract period, a claim arises owing to natural causes, illnesses, suicide or attempted suicide no benefits are payable. Benefits are only payable if the claim arises due to an accident during the first three MONTHS of the contract period. For purposes of this paragraph, 'accident' has the same meaning as its definition in each applicable Schedule and, for purposes of Schedule 13, it has the same meaning as its definition in Schedule 4 adapted so as to apply 'mutatis mutandis' in the case of the death of either the INSURED or a 'family member' as defined in Schedule 13.

(b) The number of multiples of RISK SALARY used to calculate the total amount of death cover of a CONTRACT WORKER may not be more than the number of multiples of RISK SALARY used to calculate the total amount of death cover of a permanent EMPLOYEE of the EMPLOYER in a corresponding category of employment. Similarly, a fixed amount of death cover for which a CONTRACT WORKER may be insured may not exceed the average fixed amount of death cover for which a corresponding category of permanent EMPLOYEES of the EMPLOYER are insured.

(c) The flexible death benefit in terms of Schedule 5 is not available to a CONTRACT WORKER.

(d) The DISABILITY SUM ASSURED in terms of Schedules 6 and 9 is subject to a maximum amount of twice a CONTRACT WORKER's annual RISK SALARY immediately before the WAITING PERIOD.

(e) If the TOTAL AND PERMANENT DISABILITY of a CONTRACT WORKER, in terms of Schedules 6 or 9, is determined by the INSURER to have commenced after the end of his/her contract period, the lump sum disability benefit is not payable.

(f) The income disability benefit in terms of Schedules 7 and 8 is only payable up to the end of the contract period of a CONTRACT WORKER.

(g) The options to apply for individual insurance in terms of Schedules 18, 19 and 20 are not available to a CONTRACT WORKER.

SCHEDULE 4 DEATH BENEFIT

4.1 Definitions

In this Schedule –

ACCIDENT means a bodily injury which –

(a) is caused by physical contact with violent, accidental, tangible and external means; and

(b) is the direct, effective, exclusive and proximate cause of the death of the INSURED; and

(c) is not attributable to the INSURED having negligently or willfully exposed himself/herself to danger, except in the interests of the law or to protect his/her or another's life or property.

PREVIOUS DEATH BENEFIT in regard to an INSURED means the death benefit (other than a benefit relating to contributions for retirement benefits) that would have been paid in terms of the insurance which on the PARTICIPATION DATE was replaced by the insurance provided in this Schedule, if he/she had remained insured in terms of that insurance. This includes any increase in the PREVIOUS DEATH BENEFIT that would have come into force, on or after the PARTICIPATION DATE, exclusively as a result of increases in the RISK SALARY and without proof of good health.

4.2 Benefit

4.2(1) If an INSURED die before or on the NORMAL RETIREMENT DATE while he/she is an EMPLOYEE, an amount as indicated in the CERTIFICATE OF PARTICIPATION becomes payable, unless the amount is reduced in terms of the proof of good health requirements in this Schedule.

4.2(2) The total amount of life cover that an INSURED may have at any time in terms of this Schedule is limited to a maximum multiple of ten times the INSURED's annual RISK SALARY.

4.3 Extended in-service death benefit

4.3(1) If an INSURED remains actively in service after his/her NORMAL RETIREMENT DATE, the INSURED's death benefit will, provided that this option is selected in the CERTIFICATE OF PARTICIPATION, remain in force until the earlier of the INSURED's actual retirement from service and the end of the MONTH in which he/she attains the age indicated in the CERTIFICATE OF PARTICIPATION. The age up to which the death cover may remain in force is subject to a maximum of 70 years.

4.3(2) The death benefit that remains in force in respect of an INSURED in terms of this clause will change in accordance with any changes in terms of the Policy to the death benefits of the group of EMPLOYEES of the EMPLOYER in the same category as the INSURED.

4.3(3) No increases in the benefit as a result of increases in the RISK SALARY in excess of the average increase in the benefit of all the EMPLOYEES of the EMPLOYER will be permitted after the INSURED's NORMAL RETIREMENT DATE unless satisfactory proof of good health is accepted by the INSURER. The cost of such proof of good health must be borne by the INSURED.

4.3(4) If such an INSURED is absent from service in terms of Schedule 21 after his/her NORMAL RETIREMENT DATE for any reason other than leave approved by the EMPLOYER excluding unpaid leave, his/her insurance in terms of this Policy will terminate immediately upon the commencement of such absence from service, and no further benefits will be payable in respect of such an INSURED.

4.4 Proof of good health

FREE COVER LIMIT

4.4(1) The insurance in this Schedule in regard to an INSURED is limited to the FREE COVER LIMIT, unless proof of good health to the satisfaction of the INSURER regarding that part of his/her BENEFIT ENTITLEMENT exceeding the FREE COVER LIMIT is submitted to the INSURER in the manner specified by the INSURER from time to time.

Insurance not limited to the FREE COVER LIMIT

4.4(2) The insurance in this Schedule is not limited to the FREE COVER LIMIT in the following instances –

(a) for the first three MONTHS after the INSURED becomes an INSURED; and

(b) for the first three MONTHS after an increase in the INSURED's BENEFIT ENTITLEMENT if the FREE COVER LIMIT is exceeded for the first time as a result of the increase,

provided that –

- the benefit which is provided in the three MONTHS referred to in paragraphs (a) and (b) above is only for a claim arising as a result of an ACCIDENT during those periods; and
- the benefit which is provided in the three MONTHS referred to in paragraphs (a) and (b) above may not exceed amounts determined by the INSURER from time to time; and
- paragraph (a) is not applicable if the INSURED becomes an INSURED as a result of the insurance provided in terms of this Schedule replacing other insurance in terms of which the INSURED was insured; and
- if the INSURED submits proof of good health to the satisfaction of the INSURER within the three MONTHS referred to in paragraphs (a) or (b) above, then the insurance that is agreed by the EMPLOYER and the INSURER in writing is applicable to the INSURED from the moment it is put in writing.

No insurance without proof of good health

4.4(3) Notwithstanding the provisions of the previous sub-clause, the persons and the amounts referred to in the following paragraphs will not be insured in terms of this Schedule, unless proof of good health is submitted to the INSURER in the manner specified by the INSURER from time to time. The persons referred to, the amounts involved and the responsibility for the costs of providing proof are as follows:

(a) A person who has the option of becoming a member of the FUND but fails to become a member within three MONTHS of becoming entitled to do so and becomes a member after three MONTHS. Proof must be provided for the full amount of his/her BENEFIT ENTITLEMENT. Provision of proof is at the expense of the person.

(b) An INSURED who, in terms of clauses 4.7(4), 21.2(2) or 22.4, does not qualify for the insurance of the benefit in terms of this Schedule, or any increase in it by virtue of an amendment to the Policy, and elects to submit proof of his/her good health to the INSURER. Proof must be provided for the full amount of his/her BENEFIT ENTITLEMENT or the increase in it, as the case may be. Provision of proof is at the expense of the INSURER.

(c) An employee of a MUNICIPALITY who is 55 years or older on the date on which he/she is insured for the first time for the death benefit in terms of this Schedule. Proof must be provided for the full amount of his/her BENEFIT ENTITLEMENT. Provision of proof is at the expense of the INSURER.

4.4(4) The EMPLOYER must advise the INSURER in writing immediately on the happening of a situation referred to in the previous sub-clause.

4.4(5) The INSURER will only request proof of good health in respect of the above persons upon being advised by the EMPLOYER in writing of a situation referred to above.

4.4(6) The INSURER will not be liable for any claim in respect of the above persons if the EMPLOYER does not advise the INSURER in writing of the particular situation referred to above where proof of good health is not submitted to the INSURER in the manner specified.

Satisfactory proof of good health

4.4(7) In deciding on medical grounds that the proof of good health that is submitted in a particular case in terms of the preceding sub-clauses is to its satisfaction, the INSURER may determine that the insurance of that part of the benefits for which the proof is submitted, and of future increases in those benefits, is not applicable in the case of causes of death as laid down by the INSURER.

Commencement of insurance requiring proof of good health

4.4(8) The part of the insurance described in this Schedule for which proof of good health in respect of an INSURED is required by the INSURER, will be insured as from the date on which the INSURER receives the last information taken into account in establishing the good health of the INSURED. But any such insurance for which the INSURER excludes certain causes of death, only commences after the EMPLOYER is informed of the excluded causes of death by the INSURER in writing.

Increases in insurance exceeding the FREE COVER LIMIT

4.4(9) Once proof of good health for that part of an INSURED's insurance exceeding the FREE COVER LIMIT is accepted by the INSURER, subsequent increases in the INSURED's BENEFIT ENTITLEMENT as a result of increases in the INSURED's RISK SALARY only, will apply without further proof of good health having to be submitted to the INSURER. However, further proof of good health must be provided in the following circumstances:

(a) if certain periods determined by the INSURER from time to time expire; or

(b) if the INSURED reaches a certain age determined by the INSURER from time to time; or

(c) if the death benefit exceeds amounts determined by the INSURER from time to time.

Reduction of the FREE COVER LIMIT

4.4(10) If the INSURER reduces the FREE COVER LIMIT at any specific time, the insurance that applies to an existing INSURED before such reduction will not be reduced accordingly, provided that the benefit remains applicable to the INSURED without interruption.

Temporary cessation of insurance

4.4(11) If the insurance in this Schedule ceases to apply to an INSURED temporarily, proof of good health that is submitted in respect of the INSURED before such cessation will, for the purposes of the preceding clauses, be deemed null and void.

4.5 Claims procedure

Notification

4.5(1) The INSURER must be notified in writing of a claim for a death benefit within six MONTHS after the INSURED's death or the INSURER will reject the claim.

Submission

4.5(2) The claim for a death benefit will not be assessed until the claim forms and other documentation required by the INSURER are submitted at its head office.

Proof

4.5(3) When a claim for a death benefit arises, the INSURER may require proof to its satisfaction as to any circumstance which may affect the recognition of the claim.

4.6 Payment of death benefit

4.6(1) The death benefit payable in terms of this Schedule must be paid to the INSURED's BENEFICIARIES and will be paid into a bank account held in the Republic of South Africa in the name of the BENEFICIARY. If there is no BENEFICIARY or no nomination form in respect of the death benefit or a portion of the benefit, the death benefit or part thereof must be paid to the estate of the INSURED.

Nomination of BENEFICIARIES

4.6(2) The EMPLOYER must arrange for a valid nomination form to be completed, signed, and updated as required by every INSURED and the EMPLOYER must securely store such nomination form.

4.6(3) A nomination by an INSURED of a BENEFICIARY to receive death benefits at his/her death is subject to the following terms and conditions:

(a) The nomination must be made in writing and recorded by the EMPLOYER.

(b) More than one nomination may be made in which event the INSURED must clearly indicate the proportions in which the death benefit must be divided between the different BENEFICIARIES.

(c) The INSURED may change or withdraw a nomination at any time provided that such change or withdrawal is made in writing on the prescribed nomination form.

(d) The appointment of a BENEFICIARY will automatically lapse in the event of the BENEFICIARY predeceasing the INSURED.

(e) No provision in any will or testamentary instrument will have the effect of appointing a BENEFICIARY or varying or invalidating the appointment of a BENEFICIARY.

Duties of EMPLOYER

4.6(4) At the death of the INSURED the EMPLOYER must provide the INSURER with the nomination form the EMPLOYER has on record.

4.6(5) If the death benefit, or a portion thereof is payable to the estate of the INSURED, the EMPLOYER must provide the INSURER with the details of the estate late to which the death benefit must be paid.

Payment to a guardian or trust

4.6(6) If a BENEFICIARY is a minor to whom the death benefit or a portion thereof is payable, the benefit will be paid to a trust or beneficiary fund designated by the INSURED for the benefit of such a minor beneficiary, provided that the benefit may only be paid to a beneficiary fund if the INSURED was a member of a retirement fund.

4.6(7) If the INSURED has not designated a trust or beneficiary fund, the death benefit in respect of such a minor beneficiary is payable to -

(a) his/her guardian or to a person in whose care such a minor beneficiary is; or

(b) the minor beneficiary directly.

4.6(8) The EMPLOYER must provide the INSURER with the details of the guardian or the person in whose care such minor beneficiary is.

4.7 General exclusions

4.7(1) Notwithstanding any other provision to the contrary in the Policy, no benefit is paid in terms of this Schedule if the INSURED's death –

(a) is a direct or indirect consequence of active participation in –

(i) war, invasion, acts of foreign enemies, hostilities, warlike operations (whether war be declared or not), civil war, rebellion, revolution, military or usurped power, insurrection, civil commotion assuming the proportions of or amounting to an uprising; or

(i) an act of terrorism; or

(ii) a riot; or

(iii) conduct during a strike (irrespective of whether the strike is lawful or unlawful) during which conduct lives are endangered, public or private property damaged, or an attempt or attempts are made to damage such property; or

(iv) any other unlawful act or conduct of whatever nature during which lives are endangered, public or private property damaged, or an attempt or attempts are made to damage such property.

(b) is a direct or indirect consequence of –

(i) any radioactive contamination, including accidental radioactive contamination; or

(ii) the use of nuclear, biological or chemical weapons; or

(iii) attacks on or sabotage of facilities (including, but not limited to, nuclear power plants, reprocessing plants, final repository sites and research reactors) and storage depots, which lead to the release of radioactivity or nuclear, biological or chemical warfare agents,

irrespective whether any of the aforesaid is performed with the specific use of information technology.

4.7(2) The death benefit described in this Schedule is not provided regarding an INSURED if the INSURED has the option of becoming a member of the FUND and, by so doing, becoming an INSURED and dies before the INSURER receives his/her full particulars.

4.7(3) Subject to sub-clauses 4.4(7) and 4.4(8), the death benefits described in this Schedule for which proof of good health in respect of an INSURED is required by the INSURER, are only provided if the INSURED dies on or after the date on which the INSURER receives the last information taken into account in establishing the good health of the INSURED.

4.7(4) If, in the opinion of the INSURER, an INSURED, as a result of a bodily injury or sickness, is incapable of performing his/her normal duties with the EMPLOYER on the latest date on which the insurance described in this Schedule, or any increase in that insurance by virtue of an amendment to the Policy, commences with the INSURER regarding the INSURED, he/she will not qualify for the insurance or the increase, as the case may be, until -

(a) he/she, in the opinion of the INSURER, resumes his/her normal duties and the premiums for the insurance or the increase, as the case may be, are paid in respect of him/her as from the resumption of those duties; and

(b) he/she performs his/her normal duties for 60 consecutive BUSINESS DAYS or he/she submits proof of good health to the INSURER in accordance with the provisions of this Schedule, whichever is the earlier.

4.8 Replacement of existing insurance

4.8(1) If, exclusively by virtue of sub-clause 4.7(4), the benefit in terms of this Schedule is not payable in regard to an INSURED who -

- immediately before the PARTICIPATION DATE was insured in terms of the insurance which was replaced by the insurance provided in terms of this Schedule; and
- since then has been an INSURED without interruption,

but a benefit would have been paid in terms of the replaced insurance had it still applied to the INSURED, then the INSURER provides either -

(a) the benefit in terms of this Schedule; or

(b) a lump sum equal to the value, as determined by the INSURER, of the PREVIOUS DEATH BENEFIT,

whichever of the benefits referred to in paragraphs (a) and (b) is, in the opinion of the INSURER, the lesser in the case of the INSURED.

4.8(2) Notwithstanding any provision to the contrary, the benefit which the INSURER provides in terms of sub-clause 4.8(1) above, also applies to an INSURED who on the PARTICIPATION DATE, as a result of ill-health or disability, receives an income disability benefit from a fund or insurance instituted by the EMPLOYER for its EMPLOYEES, provided that –

(a) the INSURER is notified of such a person in writing before the PARTICIPATION DATE;

(b) the INSURER agrees in writing that such a person becomes an INSURED; and

(c) the RISK SALARY in regard to such an INSURED is increased from the PARTICIPATION DATE on a basis agreed to by the EMPLOYER and the INSURER in writing.

4.9 Lump sum disability

The death benefit in terms of this Schedule in regard to an INSURED is reduced by all amounts that the INSURER has provided or must provide to someone owing to the INSURED'S disability in terms of disability benefits comprising the lump sum disability benefits which are based on the death benefit in terms of this Schedule or any death benefit insurance which is replaced by the death benefit in terms of this Schedule.

The stipulations in this Schedule in regard to proof of good health apply to the death benefit insurance before the deduction of the disability benefit described above.

4.10 Accident booster benefit

Refer to Schedule 14 for the terms and conditions regarding a claim where an INSURED's death benefit in terms of this Schedule is restricted to the FREE COVER LIMIT, but his/her full BENETIT ENTITLEMENT is payable if the claim is the result of an accident.

4.11 Option to apply for individual life insurance

Refer to Schedule 18 for the terms and conditions regarding the option to apply for individual life insurance.

4.12 Absence from service

Refer to Schedule 21 for the terms and conditions regarding the absence of the INSURED from the service of the EMPLOYER while insured in terms of this Schedule.

4.13 Territorial limitations

Refer to Schedule 22 for the terms and conditions regarding the absence of the INSURED from the Republic of South Africa while insured in terms of this Schedule.

4.14 Unclaimed benefits

Refer to Schedule 23 for the provisions regarding benefits that become payable and are not claimed.

4.15 Cancellation

4.15(1) If the insurance described in this Schedule is cancelled for a group of INSUREDS, the INSURER's liabilities in terms of this Schedule regarding each of those INSUREDS lapses, unless –

(a) an INSURED dies before the date of cancellation; and

(b) the claim for the benefit is submitted to the INSURER within six MONTHS after the date of cancellation; and

(c) the claim referred to is admitted by the INSURER.

4.15(2) For the purposes of this clause –

(a) the insurance described in this Schedule is also regarded as cancelled for a group of INSUREDS when –

(i) an EMPLOYER's participation in the Policy or in the benefit provided in terms of this Schedule is terminated; or

(ii) the participation of a category of EMPLOYEES of an EMPLOYER in the Policy or in the benefit provided in terms of this Schedule is terminated; or

(iii) the benefit which is insured in terms of this Schedule is cancelled owing to an amendment to the Policy,

and

(b) an INSURED is deemed to be a member of a group if he/she was a member of the relevant group immediately prior to his/her death.

SCHEDULE 5 FLEXIBLE DEATH BENEFIT

5.1 Definitions

In this Schedule –

ACCIDENT means a bodily injury which –

(a) is caused by physical contact with violent, accidental, tangible and external means; and

(b) is the direct, effective, exclusive and proximate cause of the death of the INSURED; and

(c) is not attributable to the INSURED having negligently or willfully exposed himself/herself to danger, except in the interests of the law or to protect his/her or another's life or property.

MARRIAGE means a marriage or union in accordance with the Marriage Act, 1961, the Recognition of Customary Marriages Act, 1998, or the Civil Union Act, 2006, or the tenets of a religion.

PREVIOUS DEATH BENEFIT in regard to an INSURED means the death benefit (other than a benefit relating to contributions for retirement benefits) that would have been paid in terms of the insurance which on the PARTICIPATION DATE was replaced by the insurance provided in this Schedule, if he/she had remained insured in terms of that insurance. This includes any increase in the PREVIOUS DEATH BENEFIT that would have come into force, on or after the PARTICIPATION DATE, exclusively as a result of increases in the RISK SALARY and without proof of good health.

5.2 Benefit

Core and flexible amounts provided in terms of this Policy

5.2(1) If an INSURED dies before or on the NORMAL RETIREMENT DATE while he/she is an EMPLOYEE, the following becomes payable, unless this benefit is reduced in terms of the proof of good health requirements in this Schedule:

(a) a core amount equal to the multiple of the INSURED's annual RISK SALARY indicated in the CERTIFICATE OF PARTICIPATION, plus

(b) if applicable, a flexible amount equal to the multiple of the INSURED's annual RISK SALARY as selected by the INSURED and decreased or increased in accordance with the options set out below. The flexible amount that the INSURED may choose is subject to the maximum multiple of the INSURED's annual RISK SALARY indicated in the CERTIFICATE OF PARTICIPATION.

'Core amount' in paragraph (a) above refers to the minimum amount of cover that must be effected by an INSURED and 'flexible amount' in paragraph (b) refers to the additional multiples of cover that may be selected by the INSURED.

5.2(2) The total of the core and flexible amounts of life cover that an INSURED may have at any time in terms of this Schedule is limited to a maximum multiple of ten times the INSURED's annual RISK SALARY. However, if an INSURED's core and flexible amounts of life cover which applied before 1 September 2022 exceeds the maximum multiple of ten times the INSURED's annual RISK SALARY, the higher maximum multiple which applied before such date remains in force for such INSURED.

Core or flexible amount provided in terms of the approved policy

5.2(3) Notwithstanding the provisions of this Schedule, the EMPLOYER, the FUND and the INSURER may agree that the core amount or the flexible amount of the flexible death benefit must be provided by the FUND in terms of the approved policy that the INSURER has with the FUND.

5.2(4) If the core amount or the flexible amount of the death benefit must be provided by the FUND, the terms and conditions of the approved policy of the INSURER in respect of the core amount or the flexible amount of the death benefit, as the case may be, will be applicable.

5.2(5) The CERTIFICATE OF PARTICIPATION must clearly indicate whether the core amount or the flexible amount of the flexible death benefit is provided in terms of this Policy, in which case the terms and conditions of this Policy in respect of that amount will be applicable.

5.2(6) The total of the core and flexible amounts of life cover that an INSURED may have at any time in terms of the approved policy of the INSURER and this Policy is limited to a maximum multiple of ten times the INSURED's annual RISK SALARY. However, if an INSURED's core and flexible amounts of life cover which applied before 1 September 2022 exceeds the maximum multiple of ten times the INSURED's annual RISK SALARY, the higher maximum multiple which applied before such date remains in force for such INSURED.

5.3 Option to select the flexible amount

An INSURED has the option to select a flexible amount of death cover in addition to his/her core amount of death cover, provided that -

(a) the option is exercised in a written notification to the EMPLOYER and the INSURER is advised thereof in writing before expiry of three MONTHS of the INSURED being insured for the first time for the death benefit in terms of this Schedule;

(b) the insurance of the flexible amount may not commence before the INSURER is advised thereof; and

(c) subject to paragraph (b) above and the applicable provisions regarding proof of good health in terms of clause 5.7, the commencement of the insurance of the flexible amount will be the first day of the MONTH that follows the date on which the INSURED selects his/her flexible amount in the written notification to the EMPLOYER, except if the date on which the INSURED selects his/her flexible amount in the written notification to the EMPLOYER is the first day of a MONTH, in which event the commencement of the insurance of the flexible amount will be the first day of that MONTH.

5.4 Option to decrease the flexible amount

An INSURED has the option to decrease his/her flexible amount by any multiple of 0,5 times his/her annual RISK SALARY once a year on a date agreed upon by the EMPLOYER and the INSURER in writing, provided that -

(a) the date referred to above is the same for all the INSUREDS;

(b) the option is exercised in a written notification to the EMPLOYER and the INSURER is advised thereof in writing before the date referred to above; and

(c) the commencement of the decrease is the date referred to above.

5.5 Option to increase the flexible amount

5.5(1) An INSURED may increase his/her flexible amount by any multiple of 0,5 times his/her annual RISK SALARY once a year on a date agreed upon by the EMPLOYER and the INSURER in writing, provided that –

(a) the date referred to above is the same date on which the flexible amount may be decreased in terms of clause 5.4;

(b) the option is exercised in a written notification to the EMPLOYER and the INSURER is advised thereof in writing before the date referred to above;

(c) the increase may not commence before the INSURER is advised thereof and the INSURED submits proof of good health in accordance with clause 5.7;

(d) the flexible amount may not increase to a level above the maximum level allowed in terms of clause 5.2(1)(b) at the time; and

(e) subject to paragraph (c) above, the commencement of the increase will be the date referred to above.

5.5(2) When an INSURED enters into a MARRIAGE or a child is born to an INSURED or he/she legally adopts a child he/she may increase his/her flexible amount by any multiple of 0,5 times his/her annual RISK SALARY, provided that –

(a) the option is exercised in a written notification to the EMPLOYER and the INSURER is advised thereof in writing within three MONTHS after the date of the MARRIAGE, birth or adoption, as the case may be;

(b) proof of the MARRIAGE, birth or adoption is provided to the INSURER and, in the case of –

- a MARRIAGE in terms of the Marriage Act, 1961, the Recognition of Customary Marriages Act, 1998, or the Civil Union Act, 2006, proof of the registration of the MARRIAGE in accordance with the applicable Act must be provided; and

- a MARRIAGE in accordance with the tenets of a religion, documentary proof of the MARRIAGE must be provided;

(c) the increase may not commence before the INSURER is advised thereof and proof of the MARRIAGE, birth or adoption is provided to the INSURER;

(d) the flexible amount may not increase to a level above the maximum level allowed in terms of clause 5.2(1)(b) at the time; and

(e) subject to paragraph (c) above and the applicable provisions regarding proof of good health in terms of clause 5.7, the commencement of the increase will be the first day of the MONTH that follows the date on which the INSURED increases his/her flexible amount in the written notification to the EMPLOYER, except if the date on which the INSURED increases his/her flexible amount in the written notification to the EMPLOYER is the first day of a MONTH, in which event the commencement of the increase will be the first day of that MONTH.

5.6 Extended in-service death benefit

5.6(1) If an INSURED remains actively in service after his/her NORMAL RETIREMENT DATE, the INSURED's death benefit will, provided that this option is selected in the CERTIFICATE OF PARTICIPATION, remain in force until the earlier of the INSURED's actual retirement from service and the end of the MONTH in which he/she attains the age indicated in the CERTIFICATE OF PARTICIPATION. The age up to which the death cover may remain in force is subject to a maximum of 70 years.

5.6(2) The death benefit that remains in force in respect of an INSURED in terms of this clause will change in accordance with any changes in terms of the Policy to the death benefits of the group of EMPLOYEES of the EMPLOYER in the same category as the INSURED.

5.6(3) No increases in the benefit as a result of increases in the RISK SALARY in excess of the average increase in the benefit of all the EMPLOYEES of the EMPLOYER will be permitted after the INSURED's NORMAL RETIREMENT DATE unless satisfactory proof of good health is accepted by the INSURER. The cost of such proof of good health must be borne by the INSURED.

5.6(4) Clauses 5.4 and 5.5 remain applicable to an INSURED who remains actively in service in terms of this clause.

5.6(5) If such an INSURED is absent from service in terms of Schedule 21 after his/her NORMAL RETIREMENT DATE for any reason other than leave approved by the

EMPLOYER excluding unpaid leave, his/her insurance in terms of this Policy will terminate immediately upon the commencement of such absence from service, and no further benefits will be payable in respect of such an INSURED.

5.7 Proof of good health

FREE COVER LIMIT

5.7(1) The insurance in this Schedule in regard to an INSURED is limited to the FREE COVER LIMIT, unless proof of good health to the satisfaction of the INSURER regarding that part of his/her BENEFIT ENTITLEMENT exceeding the FREE COVER LIMIT is submitted to the INSURER in the manner specified by the INSURER from time to time.

Insurance not limited to the FREE COVER LIMIT

5.7(2) The insurance in this Schedule is not limited to the FREE COVER LIMIT in the following instances -

(a) for the first three MONTHS after the INSURED becomes an INSURED; and

(b) for the first three MONTHS after an increase in the INSURED's BENEFIT ENTITLEMENT if the FREE COVER LIMIT is exceeded for the first time as a result of the increase,

provided that-

- the benefit which is provided in the three MONTHS referred to in paragraphs (a) and (b) above is only for a claim arising as a result of an ACCIDENT during those periods; and
- the benefit which is provided in the three MONTHS referred to in paragraphs (a) and (b) above may not exceed amounts determined by the INSURER from time to time; and
- paragraph (a) is not applicable if the INSURED becomes an INSURED as a result of the insurance provided in terms of this Schedule replacing other insurance in terms of which the INSURED was insured; and
- if the INSURED submits proof of good health to the satisfaction of the INSURER within the three MONTHS referred to in paragraphs (a) or (b) above, then the insurance that is agreed by the EMPLOYER and the INSURER in writing is applicable to the INSURED from the moment it is put in writing.

No insurance without proof of good health

5.7(3) Notwithstanding the provisions of the previous sub-clause, the persons and the amounts referred to in the following paragraphs will not be insured in terms of this Schedule, unless proof of good health is submitted to the INSURER in the manner specified by the INSURER from time to time. The persons referred to, the amounts involved and the responsibility for the costs of providing proof are as follows:

(a) A person who has the option of becoming a member of the FUND but fails to become a member within three MONTHS of becoming entitled to do so and becomes a member after three MONTHS. Proof must be provided for the full amount of his/her BENEFIT ENTITLEMENT. Provision of proof is at the expense of the person.

(b) An INSURED who, in terms of clauses 5.10(5), 21.2(2) or 22.4, does not qualify for the insurance of the benefit in terms of this Schedule, or any increase in it by virtue of an amendment to the Policy, and elects to submit proof of his/her good health to the INSURER. Proof must be provided for the full amount of his/her BENEFIT ENTITLEMENT or the increase in it, as the case may be. Provision of proof is at the expense of the INSURER.

(c) An employee of a MUNICIPALITY who is 55 years or older on the date on which he/she is insured for the first time for the death benefit in terms of this Schedule.

Proof must be provided for the full amount of his/her BENEFIT ENTITLEMENT. Provision of proof is at the expense of the INSURER.

(d) A person who is 50 years or older on the date on which he/she selects a flexible amount of risk insurance in terms of this Schedule for the first time. Proof must be provided for his/her flexible amount. Provision of proof is at the expense of the INSURER.

(e) An INSURED who elects to increase his/her flexible amount in terms of sub-clause 5.5(1) and an INSURED who is 50 years or older on the date on which he/she elects to increase his/her flexible amount in terms of sub-clause 5.5(2). Proof must be provided for the amount of the increase. Provision of proof is at the expense of the INSURER.

5.7(4) The EMPLOYER must advise the INSURER in writing immediately on the happening of a situation referred to in the previous sub-clause.

5.7(5) The INSURER will only request proof of good health in respect of the above persons upon being advised by the EMPLOYER in writing of a situation referred to above.

5.7(6) The INSURER will not be liable for any claim in respect of the above persons if the EMPLOYER does not advise the INSURER in writing of the particular situation referred to above where proof of good health is not submitted to the INSURER in the manner specified.

Satisfactory proof of good health

5.7(7) In deciding on medical grounds that the proof of good health that is submitted in a particular case in terms of the preceding sub-clauses is to its satisfaction, the INSURER may determine that the insurance of that part of the benefits for which the proof is submitted, and of future increases in those benefits, is not applicable in the case of causes of death as laid down by the INSURER.

Commencement of insurance requiring proof of good health

5.7(8) The part of the insurance described in this Schedule for which proof of good health in respect of an INSURED is required by the INSURER, will be insured as from the date on which the INSURER receives the last information taken into account in establishing the good health of the INSURED. But any such insurance for which the INSURER excludes certain causes of death, only commences after the EMPLOYER is informed of the excluded causes of death by the INSURER in writing.

Increases in insurance exceeding the FREE COVER LIMIT

5.7(9) Once proof of good health for that part of an INSURED's insurance exceeding the FREE COVER LIMIT is accepted by the INSURER, subsequent increases in the INSURED's BENEFIT ENTITLEMENT as a result of increases in the INSURED's RISK SALARY only, will apply without further proof of good health having to be submitted to the INSURER. However, further proof of good health must be provided in the following circumstances:

(a) if certain periods determined by the INSURER from time to time expire; or

(b) if the INSURED reaches a certain age determined by the INSURER from time to time; or

(c) if the death benefit exceeds amounts determined by the INSURER from time to time.

Reduction of the FREE COVER LIMIT

5.7(10) If the INSURER reduces the FREE COVER LIMIT at any specific time, the insurance that applies to an existing INSURED before such reduction will not be reduced accordingly, provided that the benefit remains applicable to the INSURED without interruption.

Temporary cessation of insurance

5.7(11) If the insurance in this Schedule ceases to apply to an INSURED temporarily, proof of good health that is submitted in respect of the INSURED before such cessation will, for the purposes of the preceding clauses, be deemed null and void.

5.8 Claims procedure

Notification

5.8(1) The INSURER must be notified in writing of a claim for a death benefit within six MONTHS after the relevant INSURED's death or the INSURER will reject the claim.

Submission

5.8(2) The claim for a death benefit will not be assessed until the claim forms and other documentation required by the INSURER are submitted at its head office.

Proof

5.8(3) When a claim for a death benefit arises, the INSURER may require proof to its satisfaction as to any circumstance which may affect the recognition of the claim.

5.9 Payment of death benefit

5.9(1) The death benefit payable in terms of this Schedule must be paid to the INSURED's BENEFICIARIES and will be paid into a bank account held in the Republic of South Africa in the name of the BENEFICIARY. If there is no BENEFICIARY or nomination form in respect of the death benefit or a portion of the benefit, the death benefit or a portion thereof must be paid into the estate of the INSURED.

Nomination of BENEFICIARIES

5.9(2) The EMPLOYER must arrange for a valid nomination form to be completed, signed, and updated as required by every INSURED and the EMPLOYER must securely store such nomination form.

5.9(3) A nomination by an INSURED of a BENEFICIARY to receive death benefits at his/her death is subject to the following terms and conditions:

(a) The nomination must be made in writing and recorded by the EMPLOYER.

(b) More than one nomination may be made in which event the INSURED must clearly indicate the proportions in which the death benefit must be divided between the different BENEFICIARIES.

(c) The INSURED may change or withdraw a nomination at any time provided that such change or withdrawal is made in writing on the prescribed nomination form.

(d) The appointment of a BENEFICIARY will automatically lapse in the event of the BENEFICIARY predeceasing the INSURED.

(e) No provision in any will or testamentary instrument will have the effect of appointing a BENEFICIARY or varying or invalidating the appointment of a BENEFICIARY.

Duties of EMPLOYER

5.9(4) At the death of the INSURED the EMPLOYER must provide the INSURER with the nomination form the EMPLOYER has on record.

5.9(5) If the death benefit, or a portion thereof is payable to the estate of the INSURED, the EMPLOYER must provide the INSURER with the details of the estate late to which the death benefit must be paid.

Payment to a guardian or trust

5.9(6) If a BENEFICIARY is a minor to whom the death benefit or a portion thereof is payable, the benefit will be paid to a trust or beneficiary fund designated by the INSURED for the benefit of such a minor beneficiary, provided that the benefit may only be paid to a beneficiary fund if the INSURED was a member of a retirement fund.

5.9(7) If the INSURED has not designated a trust or beneficiary fund, the benefit in respect of such a minor beneficiary, is payable to –

(a) his/her guardian or to a person in whose care such a minor beneficiary is; or

(b) the minor beneficiary directly.

5.9(8) The EMPLOYER must provide the INSURER with the details of the guardian or the person in whose care such minor beneficiary is.

5.10 General exclusions

5.10(1) Notwithstanding any other provision to the contrary in the Policy, no benefit is paid in terms of this Schedule if the INSURED's death -

(a) is a direct or indirect consequence of active participation in

(i) war, invasion, acts of foreign enemies, hostilities, warlike operations (whether war be declared or not), civil war, rebellion, revolution, military or usurped power, insurrection, civil commotion assuming the proportions of or amounting to an uprising; or

(ii) an act of terrorism; or

(iii) a riot; or

(iv) conduct during a strike (irrespective of whether the strike is lawful or unlawful) during which conduct lives are endangered, public or private property damaged, or an attempt or attempts are made to damage such property; or

(v) any other unlawful act or conduct of whatever nature during which lives are endangered, public or private property damaged, or an attempt or attempts are made to damage such property.

(b) is a direct or indirect consequence of –

(i) any radioactive contamination, including accidental radioactive contamination; or

(ii) the use of nuclear, biological or chemical weapons; or

(iii) attacks on or sabotage of facilities (including, but not limited to, nuclear power plants, reprocessing plants, final repository sites and research reactors) and storage depots, which lead to the release of radioactivity or nuclear, biological or chemical warfare agents,

irrespective whether any of the aforesaid is performed with the specific use of information technology.

5.10(2) The death benefit described in this Schedule is not provided regarding an INSURED if the INSURED has the option of becoming a member of the FUND and, by so doing, becoming an INSURED and dies before the INSURER receives his/her full particulars.

5.10(3) The flexible amount in terms of clause 5.2(1)(b), or any increase in it, is not provided regarding an INSURED if his/her death directly or indirectly is caused by or traceable to suicide or attempted suicide which occurs within two years of the date on which he/she is insured for the first time for a flexible amount in terms of this Schedule or of the date of the increase in his/her flexible amount, as the case may be.

5.10(4) Subject to sub-clauses 5.7(7) and 5.7(8), the death benefits described in this Schedule for which proof of good health in respect of an INSURED is required by the INSURER, are only provided if the INSURED dies on or after the date on which the INSURER receives the last information taken into account in establishing the good health of the INSURED.

5.10(5) If, in the opinion of the INSURER, an INSURED, as a result of a bodily injury or sickness, is incapable of performing his/her normal duties with the EMPLOYER on the latest date on which the insurance described in this Schedule, or any increase in that insurance by virtue of an amendment to the Policy, commences with the INSURER regarding the INSURED, he/she will not qualify for the insurance or the increase, as the case may be, until -

(a) he/she, in the opinion of the INSURER, resumes his/her normal duties and the premiums for the insurance or the increase, as the case may be, are paid in respect of him/her as from the resumption of those duties; and

(b) he/she performs his/her normal duties for 60 consecutive BUSINESS DAYS or he/she submits proof of his/her good health to the INSURER in accordance with the provisions of this Schedule, whichever is the earlier.

5.11 Replacement of existing insurance

5.11(1) If, exclusively by virtue of sub-clause 5.10(5), the benefit in terms of this Schedule is not payable in regard to an INSURED who –

- immediately before the PARTICIPATION DATE was insured in terms of the insurance which was replaced by the insurance provided in terms of this Schedule; and
- since then has been an INSURED without interruption,

but a benefit would have been paid in terms of the replaced insurance had it still applied to the INSURED, then the INSURER provides either -

(a) the benefit in terms of this Schedule; or

(b) a lump sum equal to the value, as determined by the INSURER, of the PREVIOUS DEATH BENEFIT,

whichever of the benefits referred to in paragraphs (a) and (b) is, in the opinion of the INSURER, the lesser in the case of the INSURED.

5.11(2) Notwithstanding any provision to the contrary, the benefit which the INSURER provides in terms of sub-clause 5.11(1) above, also applies to an INSURED who on the PARTICIPATION DATE, as a result of ill-health or disability, receives an income disability benefit from a fund or insurance instituted by the EMPLOYER for its EMPLOYEES, provided that –

(a) the INSURER is notified of such a person in writing before the PARTICIPATION DATE;

(b) the INSURER agrees in writing that such a person becomes an INSURED; and

(c) the RISK SALARY in regard to such an INSURED is increased from the PARTICIPATION DATE on a basis agreed to by the EMPLOYER and the INSURER in writing.

5.11(3) The flexible amount of an INSURED who was insured in terms of insurance which was replaced by the insurance provided in terms of this Schedule may not be more than his/her flexible amount immediately before the commencement of the insurance in terms of this Schedule, unless it is increased in accordance with the options set out in clause 5.5.

5.12 Lump sum disability

The death benefit in terms of this Schedule in regard to an INSURED is reduced by all amounts that the INSURER has provided or must provide to someone owing to the

INSURED'S disability in terms of disability benefits comprising the lump sum disability benefits which are based on the death benefit in terms of this Schedule or any death benefit insurance which was replaced by the death benefit in terms of this Schedule.

The stipulations in this Schedule in regard to proof of good health apply to the death benefit insurance before the deduction of the disability benefit described above.

5.13 Accident booster benefit

Refer to Schedule 14 for the terms and conditions regarding a claim where an INSURED's death benefit in terms of this Schedule is restricted to the FREE COVER LIMIT, but his/her full BENETIT ENTITLEMENT is payable if the claim is the result of an accident.

5.14 Option to apply for individual life insurance

Refer to Schedule 18 for the terms and conditions regarding the option to apply for individual life insurance.

5.15 Absence from service

Refer to Schedule 21 for the terms and conditions regarding the absence of the INSURED from the service of the EMPLOYER while insured in terms of this Schedule.

5.16 Territorial limitations

Refer to Schedule 22 for the terms and conditions regarding the absence of the INSURED from the Republic of South Africa while insured in terms of this Schedule.

5.17 Unclaimed benefits

Refer to Schedule 23 for the provisions regarding benefits that become payable and are not claimed.

5.18 Cancellation

5.18(1) If the insurance described in this Schedule is cancelled for a group of INSUREDS, the INSURER's liabilities in terms of this Schedule regarding each of those INSUREDS lapses, unless -

(a) an INSURED dies before the date of cancellation; and

(b) the claim for the benefit is submitted to the INSURER within six MONTHS after the date of cancellation; and

(c) the claim referred to is admitted by the INSURER.

5.18(2) For the purposes of this clause -

(a) the insurance described in this Schedule is also regarded as cancelled for a group of INSUREDS when –

(i) an EMPLOYER's participation in the Policy or in the benefit provided in terms of this Schedule is terminated; or

(ii) the participation of a category of EMPLOYEES of an EMPLOYER in the Policy or in the benefit provided in terms of this Schedule is terminated; or

(iii) the benefit which is insured in terms of this Schedule is cancelled owing to an amendment to the Policy;

and

(b) an INSURED is deemed to be a member of a group if he/she was a member of the relevant group immediately prior to his/her death

SCHEDULE 6 LUMP SUM DISABILITY BENEFIT

6.1 Definitions

In this Schedule –

ACCIDENT means a bodily injury which –

(a) is caused by physical contact with violent, accidental, tangible and external means; and

(b) is the direct, effective, exclusive and proximate cause of the TOTAL AND PERMANENT DISABILITY of the INSURED; and

(c) is not attributable to the INSURED having negligently or willfully exposed himself/herself to danger, except in the interests of the law or to protect his/her or another's life or property.

BENEFIT CESSATION DATE in regard to an INSURED means the earlier of his/her NORMAL RETIREMENT DATE and the last day of the MONTH in which he/she attains the age of –

- 65 years in the case of all INSUREDS other than PILOTS; and
- 60 years in the case of PILOTS.

DEATH SUM ASSURED in regard to an INSURED means the death benefit that would be paid in accordance with Schedules 4 or 5, as the case may be, but excluding the 'flexible amount' in the case of Schedule 5, in the event of his/her death while an EMPLOYEE and immediately before the WAITING PERIOD.

DISABILITY SUM ASSURED in regard to an INSURED means his/her DEATH SUM ASSURED or such lesser amount as must be indicated in the CERTIFICATE OF PARTICIPATION. The DISABILITY SUM ASSURED may not be more than the smaller of eight times the INSURED's annual RISK SALARY immediately before the WAITING PERIOD and R12 000 000, or such other maximum amount determined by the INSURER from time to time. If, however, the WAITING PERIOD elapses within the 60 MONTHS before the BENEFIT CESSATION DATE, the DISABILITY SUM ASSURED is equal to the amount as described, multiplied by t/60, where t represents the period, expressed in MONTHS, from the lapse of the WAITING PERIOD until the BENEFIT CESSATION DATE. A part of a MONTH is counted as a full MONTH.

DRIVER means an INSURED in respect of whose job one of the core functions is to drive or operate a vehicle or machine that is used for the transporting or conveying of goods or people. 'Core function' in this context means that if he/she is not able to perform this function, the EMPLOYER will be entitled to end his/her employment due to incapacity. A DRIVER must be in possession of a valid license to drive or operate the particular vehicle or machine.

PILOT means an INSURED in respect of whose job one of the core functions is to pilot an aeroplane or helicopter that is used for the transporting or conveying of goods or people or other purposes relating to the business of the EMPLOYER. 'Core function' in this context means that if he/she is not able to perform this function, the EMPLOYER will be entitled to end his/her employment due to incapacity. A PILOT must be in possession of a valid license to pilot the particular aeroplane or helicopter.

PREVIOUS DISABILITY BENEFIT in regard to an INSURED means the disability benefit that would have been provided to the INSURED in terms of the insurance which on the PARTICIPATION DATE was replaced by the insurance provided in this Schedule if he/she had remained insured in terms of that insurance. Included in this PREVIOUS DISABILITY BENEFIT is any increase in such a benefit that would have come into force in terms of the replaced insurance, on or after the PARTICIPATION DATE but prior to the WAITING PERIOD, exclusively as a result of increases in the RISK SALARY and without proof of

good health. A retirement benefit that was payable at retirement owing to ill-health, is not deemed to be a PREVIOUS DISABILITY BENEFIT.

REGULAR OCCUPATION means the occupation regularly followed by the INSURED immediately before the commencement of his/her TOTAL AND PERMANENT DISABILITY, disregarding any duties not normally associated with an occupation of that nature.

TOTAL AND PERMANENT DISABILITY means a condition where the INSURED - directly and exclusively as a result of a bodily injury or an illness -

(a) totally and permanently and continuously is prevented - even with further in-service training -

(i) in the case of a PILOT/DRIVER, from following any occupation of whatever nature; and

(ii) in the case of any other INSURED,

- from following the REGULAR OCCUPATION which he/she practiced immediately before; and
- from following the occupations which he/she, in view of his/her training and experience, may reasonably be expected to follow,

and experiences loss of income;

or

(b) totally and permanently and continuously cannot use both eyes, or both hands, or both feet, or one hand and one foot,

provided that the condition -

- is not attributable to the INSURED's having negligently or willfully exposed himself/herself to danger, except in the interests of the law or to protect his/her or another's life or property; and
- is not attributable to intentional self-inflicted injury; and
- cannot be substantially removed by surgery or any other medical treatment which, taking into account the risk and the prospect of success of that treatment, can reasonably be expected of the INSURED to undergo,

and **TOTALLY AND PERMANENTLY DISABLED** has a corresponding meaning.

WAITING PERIOD means the period starting at the commencement of TOTAL AND PERMANENT DISABILITY and ending at the later of the end of the next six months and the date when the INSURER is satisfied that the INSURED is TOTALLY AND PERMANENTLY DISABLED. By special request of the EMPLOYER, the INSURER may agree to change the ‘six months’ referred to above to another number of months, in which event the number of months agreed on must be indicated in the CERTIFICATE OF PARTICIPATION.

6.2 Benefit at TOTAL AND PERMANENT DISABILITY

6.2(1) If an INSURED who is an EMPLOYEE, becomes TOTALLY AND PERMANENTLY DISABLED after the latest date on which the insurance described in this Schedule becomes applicable to him/her, but before the BENEFIT CESSATION DATE, the INSURER pays the DISABILITY SUM ASSURED to the INSURED.

6.2(2) The benefit in terms of this clause becomes payable only if and after -

- the INSURER is satisfied, in the way stipulated below, that the INSURED is TOTALLY AND PERMANENTLY DISABLED, and

- the TOTAL AND PERMANENT DISABILITY has lasted for the WAITING PERIOD.

No benefit is payable if -

(a) the INSURER is satisfied only on or after the BENEFIT CESSATION DATE that the INSURED is TOTALLY AND PERMANENTLY DISABLED; or

(b) the WAITING PERIOD expires after the BENEFIT CESSATION DATE.

6.3 Cessation of premiums

Premiums are payable until the end of the WAITING PERIOD. After the WAITING PERIOD and as long as the INSURED's TOTAL AND PERMANENT DISABILITY continues afterwards, no premiums are payable to the INSURER regarding the INSURED for the insurance described in this Schedule.

6.4 Death after the WAITING PERIOD

6.4(1) If an INSURED dies after the WAITING PERIOD, the INSURER pays the amount by which the DISABILITY SUM ASSURED was reduced in terms of the definition of DISABILITY SUM ASSURED as a result of the WAITING PERIOD elapsing within the 60 MONTHS before the BENEFIT CESSATION DATE, provided that -

(a) the INSURER is satisfied, in the way stipulated below, that the INSURED'S TOTAL AND PERMANENT DISABILITY continued until his/her death; and

(b) the death occurred -

(i) before or on the BENEFIT CESSATION DATE; and

(ii) before the cancellation with the INSURER of the insurance of the death benefit in respect of the group of EMPLOYEES to which the INSURED belonged immediately prior to his/her TOTAL AND PERMANENT DISABILITY.

6.4(2) The death benefit payable in terms of this clause is paid in accordance with Schedules 4 or 5, as the case may be.

6.5 Commencement of disability

For the purposes of this Schedule the INSURER, on the grounds of the medical and other information submitted, determines when the TOTAL AND PERMANENT DISABILITY commences. The INSURER may determine such commencement without taking into account the requirement that the INSURED has to experience loss of income before being considered TOTALLY AND PERMANENTLY DISABLED.

6.6 Special cases of disability

If an INSURED experiences TOTAL AND PERMANENT DISABILITY as described in paragraph (b) of the definition of TOTAL AND PERMANENT DISABILITY, it is not necessary for the INSURED to be TOTALLY AND PERMANENTLY DISABLED for the WAITING PERIOD before a benefit is payable in terms of this Schedule.

6.7 Proof of good health

FREE COVER LIMIT

6.7(1) The insurance in this Schedule in regard to an INSURED is limited to the FREE COVER LIMIT, unless proof of good health to the satisfaction of the INSURER regarding that part of his/her BENEFIT ENTITLEMENT exceeding the FREE COVER LIMIT is submitted to the INSURER in the manner specified by the INSURER from time to time. Different FREE COVER LIMITS may apply to this Schedule and Schedules 4 or 5, as the case may be.

Insurance not limited to the FREE COVER LIMIT

6.7(2) The insurance in this Schedule is not limited to the FREE COVER LIMIT in the following instances -

(a) for the first three MONTHS after the INSURED becomes an INSURED; and

(b) for the first three MONTHS after an increase in the INSURED's BENEFIT ENTITLEMENT if the FREE COVER LIMIT is exceeded for the first time as a result of the increase,

provided that –

- the benefit which is provided in the three MONTHS referred to in paragraphs (a) and (b) above is only for a claim arising as a result of an ACCIDENT during those periods; and
- the benefit which is provided in the three MONTHS referred to in paragraphs (a) and (b) above may not exceed amounts determined by the INSURER from time to time; and
- paragraph (a) is not applicable if the INSURED becomes an INSURED as a result of the insurance provided in terms of this Schedule replacing other insurance in terms of which the INSURED was insured; and
- if the INSURED submits proof of good health to the satisfaction of the INSURER within the three MONTHS referred to in paragraphs (a) or (b) above, then the insurance that is agreed by the EMPLOYER and the INSURER in writing is applicable to the INSURED from the moment it is put in writing.

No insurance without proof of good health

6.7(3) Notwithstanding the provisions of the previous sub-clause, the persons and the amounts referred to in the following paragraphs will not be insured in terms of this Schedule, unless proof of good health is submitted to the INSURER in the manner specified by the INSURER from time to time. The persons referred to, the amounts involved and the responsibility for the costs of providing proof are as follows:

(a) A person who has the option of becoming a member of the FUND but fails to become a member within three MONTHS of becoming entitled to do so and becomes a member after three MONTHS. Proof must be provided for the full amount of his/her BENEFIT ENTITLEMENT. Provision of proof is at the expense of the person.

(b) An INSURED who, in terms of clauses 6.10(6), 21.2(2) or 22.4, does not qualify for the insurance of the benefit in terms of this Schedule, or any increase in it by virtue of an amendment to the Policy, and elects to submit proof of his/her good health to the INSURER. Proof must be provided for the full amount of his/her BENEFIT ENTITLEMENT or the increase in it, as the case may be. Provision of proof is at the expense of the INSURER.

(c) An employee of a MUNICIPALITY who is 55 years or older on the date on which he/she is insured for the first time for the benefits in terms of this Schedule. Proof must be provided for the full amount of his/her BENEFIT ENTITLEMENT. Provision of proof is at the expense of the INSURER.

6.7(4) The EMPLOYER must advise the INSURER in writing immediately on the happening of a situation referred to in the previous sub-clause.

6.7(5) The INSURER will only request proof of good health in respect of the above persons upon being advised by the EMPLOYER in writing of a situation referred to above.

6.7(6) The INSURER will not be liable for any claim in respect of the above persons if the EMPLOYER does not advise the INSURER in writing of the particular situation referred to above where proof of good health is not submitted to the INSURER in the manner specified.

Satisfactory proof of good health

6.7(7) In deciding on medical grounds that the proof of good health that is submitted in a particular case in terms of the preceding sub-clauses is to its satisfaction, the INSURER may determine that the insurance of that part of the benefits for which the proof is submitted, and of future increases in those benefits, is not applicable in the case of causes of disability as laid down by the INSURER.

Commencement of insurance requiring proof of good health

6.7(8) The part of the insurance described in this Schedule for which proof of good health in respect of an INSURED is required by the INSURER, will be insured as from the date on which the INSURER receives the last information taken into account in establishing the good health of the INSURED. But any such insurance for which the INSURER excludes certain causes of disability, only commences after the EMPLOYER is informed of the excluded causes of disability by the INSURER in writing.

Increases in insurance exceeding the FREE COVER LIMIT

6.7(9) Once proof of good health for that part of an INSURED's insurance exceeding the FREE COVER LIMIT is accepted by the INSURER, subsequent increases in the INSURED's BENEFIT ENTITLEMENT as a result of increases in the INSURED's RISK SALARY only, will apply without further proof of good health having to be submitted to the INSURER. However, further proof of good health must be provided in the following circumstances:

(a) if certain periods determined by the INSURER from time to time expire; or

(b) if the INSURED reaches a certain age determined by the INSURER from time to time; or

(c) if the disability benefit exceeds amounts determined by the INSURER from time to time.

Reduction of the FREE COVER LIMIT

6.7(10) If the INSURER reduces the FREE COVER LIMIT at any specific time, the insurance that applies to an existing INSURED before such reduction will not be reduced accordingly, provided that the benefit remains applicable to the INSURED without interruption.

Temporary cessation of insurance

6.7(11) If the insurance in this Schedule ceases to apply to an INSURED temporarily, proof of good health that is submitted in respect of the INSURED before such cessation will, for the purposes of the preceding clauses, be deemed null and void.

6.8 Claims procedure

Notification

6.8(1) The INSURER must be notified in writing of a claim for a lump sum disability benefit within six MONTHS after the last day on which the relevant INSURED performed his/her occupation or the INSURER will reject the claim.

Submission

6.8(2) The claim for a lump sum disability benefit will not be assessed until the claim forms and other documentation required by the INSURER are submitted at its head office.

Proof

6.8(3) The INSURER has to be satisfied, by way of medical and other information which is required at its sole discretion, that the INSURED is TOTALLY AND PERMANENTLY DISABLED or has been during a specific period.

6.8(4) The INSURER may request additional information in order to satisfy itself that the INSURED is TOTALLY AND PERMANENTLY DISABLED. The INSURED must provide the additional information to the INSURER within 60 days of the INSURER's request.

Cost of providing proof

6.8(5) The EMPLOYER is informed in the administration guides on the RETIREMENT FUND WEB of the medical and other information which is required by the INSURER in respect of an INSURED in order for the INSURER to assess for the first time whether the INSURED is TOTALLY AND PERMANENTLY DISABLED. This information must be submitted at the expense of the INSURED. The provision of any additional information that the INSURER may require is at the expense of the INSURER.

Resubmission of a rejected claim

6.8(6) If the INSURER rejects a claim for the lump sum disability benefit in terms of this Schedule, the claim may be resubmitted with new evidence or submissions. Such a resubmitted claim must be made within 90 days of the rejection. If the INSURER again rejects the claim, no further resubmission of the claim will be considered by the INSURER. If any new medical evidence is submitted in order to have a claim reassessed, the cost of such medical evidence is for the INSURED's expense.

6.9 Payment of benefit

The lump sum disability benefit payable in terms of this Schedule must be paid to the INSURED.

6.10 General exclusions

6.10(1) If an INSURED is a professional sportsman, professional sportswoman or professional diver, no benefit is payable in terms of this Schedule.

6.10(2) Notwithstanding any other provision to the contrary in the Policy, no benefit is paid in terms of this Schedule if the TOTAL AND PERMANENT DISABILITY -

(a) is a direct or indirect consequence of active participation in

(i) war, invasion, acts of foreign enemies, hostilities, warlike operations (whether war be declared or not), civil war, rebellion, revolution, military or usurped power, insurrection, civil commotion assuming the proportions of or amounting to an uprising; or

(ii) an act of terrorism; or

(iii) a riot; or

(iv) conduct during a strike (irrespective of whether the strike is lawful or unlawful) during which conduct lives are endangered, public or private property damaged, or an attempt or attempts are made to damage such property; or

(v) any other unlawful act or conduct of whatever nature during which lives are endangered, public or private property damaged, or an attempt or attempts are made to damage such property.

(b) is a direct or indirect consequence of –

(i) any radioactive contamination, including accidental radioactive contamination; or

(ii) the use of nuclear, biological or chemical weapons; or

(iii) attacks on or sabotage of facilities (including, but not limited to, nuclear power plants, reprocessing plants, final repository sites and research reactors) and storage depots, which lead to the release of radioactivity or nuclear, biological or chemical warfare agents,

irrespective whether any of the aforesaid is performed with the specific use of information technology.

6.10(3) The benefit described in this Schedule is not payable in respect of an INSURED if he/she has the option of becoming a member of the FUND and, by so doing, becoming an INSURED and his/her TOTAL AND PERMANENT DISABILITY commences before the INSURER receives his/her full particulars.

6.10(4) Subject to sub-clauses 6.7(7) and 6.7(8), the disability benefits described in this Schedule for which proof of good health in respect of an INSURED is required by the INSURER, are only provided if the INSURED's TOTAL AND PERMANENT DISABILITY commences on or after the date on which the INSURER receives the last information taken into account in establishing the good health of the INSURED.

6.10(5) The benefit described in this Schedule is not payable in respect of an INSURED if his/her TOTAL AND PERMANENT DISABILITY commences during a period in which the INSURED is deliberately absent from the EMPLOYER's service without permission, unless the EMPLOYER and the INSURER agree otherwise in a particular case.

6.10(6) If, in the opinion of the INSURER, an INSURED, as a result of a bodily injury or sickness, is incapable of performing his/her normal duties with the EMPLOYER on the latest date on which the insurance described in this Schedule, or any increase in that insurance by virtue of an amendment to the Policy, commences with the INSURER regarding the INSURED, he/she will not qualify for the insurance or the increase, as the case may be, until –

(a) he/she, in the opinion of the INSURER, resumes his/her normal duties and the premiums for the insurance or the increase, as the case may be, are paid in respect of him/her as from the resumption of those duties; and

(b) he/she performs his/her normal duties for 60 consecutive BUSINESS DAYS or he/she submits proof of his/her good health to the INSURER in accordance with the provisions of this Schedule, whichever is the earlier.

6.10(7) The benefit described in this Schedule, or any increase in it by virtue of an amendment to the Policy, is also not payable in respect of an INSURED if the INSURED becomes TOTALLY AND PERMANENTLY DISABLED within twelve MONTHS after the latest date on which the insurance of the benefit or the insurance of the increase, as the case may be, commences with the INSURER in respect of the INSURED and such disability directly or indirectly arises from or is traceable to –

- a bodily injury which occurred; or
- a condition of which the INSURED was conscious or experienced symptoms or for which medical treatment was received

during the six MONTHS (twelve MONTHS in the case of an INSURED who is an EMPLOYEE of a MUNICIPALITY) immediately before that date. This provision does not apply to an INSURED in respect of whom proof of good health for the insurance or the increase in terms of this Schedule is submitted to the satisfaction of the INSURER after the mentioned date and in the manner specified by the INSURER from time to time.

6.11 Replacement of existing insurance

If, exclusively by virtue of sub-clauses 6.10(6) or 6.10(7), the benefit in terms of this Schedule is not paid in regard to an INSURED who –

- immediately before the PARTICIPATION DATE was insured in terms of the insurance which was replaced by the insurance provided in terms of this Schedule; and

- since then has been an INSURED without interruption,

but a benefit would have been paid in terms of the replaced insurance had it still applied to the INSURED, then the INSURER pays to the INSURED either –

(a) the benefit in terms of this Schedule; or

(b) a disability benefit on which the INSURER decides and which in its opinion is related to the value, as determined by it, of the PREVIOUS DISABILITY BENEFIT,

whichever of the benefits referred to in paragraphs (a) and (b) is, in the opinion of the INSURER, the lesser in the case of the INSURED.

6.12 Termination of service

If an INSURED's service is terminated with the EMPLOYER and he/she is TOTALLY AND PERMANENTLY DISABLED on the date of termination of service, he/she remains an INSURED as if he/she had remained an EMPLOYEE and the EMPLOYER had consented to his/her absence from work. He/she remains an INSURED, however, only until the earliest of –

- the expiry of two years;
- the date on which the benefit in terms of this Schedule becomes payable; or
- a claim for the benefit is declined.

6.13 Earlier occurrences of disability

The total sum payable by the INSURER in respect of an INSURED for all periods of disability, in terms of disability insurance comprising lump sum disability benefits, may not exceed the total sum for which the INSURER was liable when for the first time payments in respect of the INSURED were made in terms of the insurance described in this Schedule.

6.14 Maximum benefits from the INSURER

6.14(1) If an INSURED becomes entitled to a lump sum disability benefit in terms of this Schedule and also, by virtue of his/her employment with other employers, becomes entitled to other lump sum disability benefits, either in terms of this Policy or other group policies underwritten by the INSURER, the total amount of the lump sum disability benefits payable to the INSURED by the INSURER will be limited to the smaller of eight times the total amount of the INSURED's annual risk salaries in terms of the respective group policies and the largest of the maximum amounts that the INSURER is prepared to pay in terms of each policy.

6.14(2) If the total amount of the lump sum disability benefits payable by the INSURER must be reduced in terms of this clause, the benefit payable in terms of each policy will be reduced proportionately according to the amount of the benefit.

6.14(3) The final benefit payable in terms of each policy will be subject to any further reductions in terms of the provisions of each policy regarding the lapsing of any 'waiting period' in the 60 MONTH period before the insurance of the lump sum disability benefit in respect of the INSURED ceases.

6.15 Maximum benefits from all sources

6.15(1) The INSURER must limit an INSURED's disability benefit so that the INSURED's average monthly income after disability (as defined below) does not exceed 75% of his/her average monthly earnings before disability (as defined below).

6.15(2) The average monthly earnings of the INSURED before disability is taken as the average per MONTH of all income and remuneration which accrued to the INSURED from his/her engaging in his/her occupation during the twelve MONTHS before the commencement of TOTAL AND PERMANENT DISABILITY. Any form of fringe benefits of a non-recurrent

nature are, however, excluded. Further, all expenditure and costs incurred directly with a view to earning such income and remuneration are deducted from the said total income and remuneration.

6.15(3) For the purposes of this clause the INSURED's average monthly income after disability is determined by taking into account the following receipts:

(a) all income and remuneration payable to the INSURED directly or indirectly for services which he/she renders or rendered or in connection with an occupation which he/she follows or followed, decreased by all expenditure and costs incurred directly with a view to earning that income and remuneration; and

(b) any form of benefit or remuneration (whether in cash or not) to which somebody becomes entitled in connection with or as a result of the INSURED's disability or to which somebody would have been entitled if the benefit in terms of this Schedule had not existed. This includes any gratuity or other payment from a fund or scheme which provides benefits at retirement or disability and benefits in terms of the Compensation for Occupational Injuries and Diseases Act, 1993, as amended.

The following are not taken into account:

(i) the waiver of contributions to pension and provident funds in terms of group disability policies;

(ii) any benefits in terms of the Motor Vehicle Accidents Act, 1986, as amended, read together with section 3 of the Multilateral Motor Vehicle Accidents Fund Act, 1989, as amended;

(iii) the benefits in terms of any policy owned by the EMPLOYER from which no benefit consequent upon the disability of the INSURED becomes payable to the INSURED or to his/her spouse or to any member of the INSURED's family;

(iv) income disability benefits which are payable for not more than two years to cover continued business expenses;

(v) lump sum receipts of which the aggregate does not exceed the larger of R550 000, or any other amount determined by the INSURER, and 2,5 times the annual RISK SALARY of the INSURED before the commencement of disability;

(vi) any benefit payable at the surrender of a policy or at early retirement or withdrawal from any fund or scheme for reasons other than ill health. For this purpose a retirement annuity policy is deemed to have a surrender value;

(vii) benefits payable if the INSURED, due to an accident, experiences the total and permanent loss of the sight of one or both eyes or the use of any part of his/her body;

(viii) benefits payable due to the INSURED being permanently, continuously and totally prevented from performing the normal actions and functions with regard to the care of his/her body or from taking care of his/her personal interests; and

(ix) during the period of two years starting at the commencement of TOTAL AND PERMANENT DISABILITY, regular receipts which in total are not more than a monthly receipt of 25% of the INSURED's average monthly earnings before disability.

6.15(4) In the determination of the average monthly income after disability, lump sum receipts are (except as far as sub-clause (3)(ix) is concerned) deemed to be a regular monthly income equal to such lump sum receipts divided by 120.

6.15(5) Any receipt expressed as a capital amount payable by instalments over a period of 10 years or less, is also deemed to be a lump sum receipt.

6.15(6) Where a receipt is expressed as a capital amount payable by instalments over a period exceeding 10 years, only the instalments are taken into account.

6.15(7) At the request of the INSURER the INSURED must submit proof of the extent of his/her average monthly income after disability. If the INSURED fails to submit such proof to the INSURER's satisfaction, the payment in terms of this Schedule may be decreased at the INSURER's discretion.

6.15(8) The INSURER must limit the payments which are made in terms of this disability insurance according to this clause.

6.15(9) If an INSURED dies before or on the BENEFIT CESSATION DATE, the INSURER pays the amounts with which the disability benefit is limited in terms of this clause as a death benefit in accordance with Schedules 4 or 5, as the case may be.

6.16 Accident booster benefit

Refer to Schedule 14 for the terms and conditions regarding a claim where an INSURED's disability benefit in terms of this Schedule is restricted to the FREE COVER LIMIT, but his/her full BENETIT ENTITLEMENT is payable if the claim is the result of an accident.

6.17 Option to apply for individual lump sum disability insurance

Refer to Schedule 18 for the terms and conditions regarding the option to apply for individual lump sum disability life insurance.

6.18 Absence from service

Refer to Schedule 21 for the terms and conditions regarding the absence of the INSURED from the service of the EMPLOYER while insured in terms of this Schedule.

6.19 Territorial limitations

Refer to Schedule 22 for the terms and conditions regarding the absence of the INSURED from the Republic of South Africa while insured in terms of this Schedule.

6.20 Unclaimed benefits

Refer to Schedule 23 for the provisions regarding benefits that become payable and are not claimed.

6.21 Cancellation

6.21(1) If the insurance described in this Schedule is cancelled for a group of INSUREDS, the INSURER's liabilities in terms of this Schedule regarding each of those INSUREDS lapses, unless -

(a) the INSURED is TOTALLY AND PERMANENTLY DISABLED on the date of cancellation; and

(b) a claim for the benefit in terms of this Schedule is submitted to the INSURER within six MONTHS after the date of cancellation; and

(c) the claim is admitted by the INSURER; and

(d) if the WAITING PERIOD expires after the date of cancellation, the premium for this disability insurance and that part of the death insurance with the INSURER on which this disability insurance is based, is paid to the INSURER in regard to the INSURED until the end of the WAITING PERIOD.

6.21(2) For the purposes of this clause -

(a) the insurance described in this Schedule is also regarded as cancelled for a group of INSUREDS when –

(i) an EMPLOYER's participation in the Policy or in the benefit provided in terms of this Schedule is terminated; or

(ii) the participation of a category of EMPLOYEES of an EMPLOYER in the Policy or in the benefit provided in terms of this Schedule is terminated; or

(iii) the benefit which is insured in terms of this Schedule is cancelled owing to an amendment to the Policy; or

(iv) the insurance with the INSURER of the death benefits on which this disability insurance is based, is cancelled for a group of INSUREDS;

and

(b) an INSURED is deemed to be a member of a group if he/she was a member of the relevant group immediately prior to the commencement of his/her TOTAL AND PERMANENT DISABILITY.

SCHEDULE 7 INCOME DISABILITY BENFEIT

7.1 Definitions

7.1(1) In this Schedule –

ACCIDENT means a bodily injury which –

(a) is caused by physical contact with violent, accidental, tangible and external means; and

(b) is the direct, effective, exclusive and proximate cause of the TOTAL DISABILITY of the INSURED; and

(c) is not attributable to the INSURED having negligently or willfully exposed himself/herself to danger, except in the interests of the law or to protect his/her or another's life or property.

AVERAGE NET MONTHLY INCOME means the INSURED's gross monthly COST TO COMPANY PACKAGE immediately before the commencement of the WAITING PERIOD, less –

- the monthly contributions made in respect of the INSURED to the FUND that are insured by the CONTRIBUTION WAIVER BENEFIT; and
- the monthly premium in respect of the income disability insurance effected for the benefit of the INSURED in terms of this Schedule; and
- the monthly income tax paid by the INSURED.

BENEFIT CESSATION DATE in regard to an INSURED means the earlier of his/her NORMAL RETIREMENT DATE and the last day of the MONTH in which he/she attains the age of –

- 65 years in the case of all INSUREDS other than PILOTS; and
- 60 years in the case of PILOTS.

COMMENCEMENT OF DISABILITY in regard to an INSURED means the latest date on which the INSURED becomes TOTALLY DISABLED.

CONTRIBUTION WAIVER BENEFIT in regard to an INSURED and if so indicated in the CERTIFICATE OF PARTICIPATION means contributions that would be payable to the FUND after the COMMENCEMENT OF DISABILITY if the INSURED were to remain in the service of the EMPLOYER, but calculated according to a scale equal to a percentage, or such other percentage as agreed to between the EMPLOYER and the INSURER from time to time, of the INSURED's RISK SALARY immediately before the WAITING PERIOD and on the assumption that the contributions increase annually thereafter at the rate referred to in clause 7.4. But these contributions per MONTH may not exceed an amount determined by the INSURER from time to time, increased annually after the COMMENCEMENT OF DISABILITY at the rate referred to in the said clause 7.4. If the EMPLOYER and the INSURER agree to it, the above percentage also makes provision for the PREMIUM WAIVER BENEFIT.

COST TO COMPANY PACKAGE means the gross annual amount payable by the EMPLOYER in respect of the INSURED immediately before the commencement of the WAITING PERIOD, provided that:

- In the case of an INSURED who receives a variable income, COST TO COMPANY PACKAGE means the annual average gross amount which the EMPLOYER paid in respect of the INSURED during the thirty-six MONTHS immediately before the commencement of the WAITING PERIOD.
- In the case where such an INSURED was employed by the EMPLOYER for a period of less than thirty-six MONTHS, COST TO COMPANY PACKAGE means the

average gross monthly amount which the EMPLOYER paid in respect of the INSURED during the number of MONTHS the INSURED was employed by the EMPLOYER, multiplied by twelve.

- An INSURED's COST TO COMPANY PACKAGE includes the average discretionary bonus payments and commission of a recurrent nature over a period of thirty-six MONTHS or such shorter period for which the INSURED was employed by the EMPLOYER.

- All expenditure and costs incurred directly with a view to earning any of the aforesaid amounts are deducted from the said amounts.

CURRENT EMPLOYER means the EMPLOYER in whose service the INSURED is immediately before the COMMENCEMENT OF DISABILITY.

DRIVER means an INSURED in respect of whose job one of the core functions is to drive or operate a vehicle or machine that is used for the transporting or conveying of goods or people. 'Core function' in this context means that if he/she is not able to perform this function, the EMPLOYER will be entitled to end his/her employment due to incapacity. A DRIVER must be in possession of a valid license to drive or operate the particular vehicle or machine.

PILOT means an INSURED in respect of whose job one of the core functions is to pilot an aeroplane or helicopter that is used for the transporting or conveying of goods or people or other purposes relating to the business of the EMPLOYER. 'Core function' in this context means that if he/she is not able to perform this function, the EMPLOYER will be entitled to end his/her employment due to incapacity. A PILOT must be in possession of a valid license to pilot the particular aeroplane or helicopter.

PREMIUM WAIVER BENEFIT in regard to an INSURED and if so indicated in the CERTIFICATE OF PARTICIPATION means the premiums that would be payable in respect of insurance effected by the EMPLOYER for the benefit of the INSURED outside the FUND if the INSURED were to remain in the service of the EMPLOYER after the COMMENCEMENT OF DISABILITY.

PREVIOUS DISABILITY BENEFIT in regard to an INSURED means the disability benefit that would have been provided to the INSURED in terms of the insurance which on the PARTICIPATION DATE was replaced by the insurance provided in this Schedule if he/she had remained insured in terms of that insurance. Included in this PREVIOUS DISABILITY BENEFIT is any increase in such a benefit that would have come into force in terms of the replaced insurance, on or after the PARTICIPATION DATE, but prior to the WAITING PERIOD, exclusively as a result of increases in the RISK SALARY and without proof of good health. A retirement benefit that was payable at retirement owing to ill-health, is not deemed to be a PREVIOUS DISABILITY BENEFIT.

PROPORTIONAL DISABILITY INCOME means the income as determined in terms of sub-clause 7.2(3).

REGULAR OCCUPATION means the occupation regularly followed by the INSURED immediately before the COMMENCEMENT OF DISABILITY, disregarding any duties not normally associated with an occupation of that nature.

SUITABLE OCCUPATION means an occupation which the INSURED, by virtue of his/her training and experience, could reasonably be expected to follow - with or without further in-service training - if it were not for the INSURED's functional impairment.

SUITABLE REHABILITATION PROGRAMS means medical and surgical treatment, occupational and medical therapy, and rehabilitation and return to work programs reasonably deemed appropriate by the INSURER with the view of improving, or preventing a deterioration of, the INSURED's ability to work, taking into account the risk and the prospect of success of the treatment, therapy or program.

In deciding on the suitability or not of a rehabilitation program the INSURER will take into consideration the existence of appropriate services and facilities within reasonable proximity of the INSURED's place of employment or place of residence.

TOTAL DISABILITY means a condition where an INSURED - directly and exclusively as a result of a bodily injury or an illness - is continuously and totally prevented from following, -

(a) in the case of an INSURED who is not a PILOT/DRIVER, -

(i) his/her REGULAR OCCUPATION for the period of 24 MONTHS immediately following the COMMENCEMENT OF DISABILITY; and

(ii) a SUITABLE OCCUPATION thereafter, and

(b) in the case of an INSURED who is a PILOT/DRIVER, any occupation of whatever nature with or without further in-service training,

provided that the condition –

- is not attributable to the INSURED's having negligently or wilfully exposed himself/herself to danger, except in the interests of the law or to protect his/her or another's life or property; and
- is not attributable to intentional self-inflicted injury; and
- cannot be substantially removed by surgery or any other medical treatment which, taking into account the risk and the prospect of success of that treatment, the INSURED can reasonably be expected to undergo, and

TOTALLY DISABLED has a corresponding meaning.

TOTAL DISABILITY INCOME means the income as determined in terms of sub-clause 7.2(1).

WAITING PERIOD means the period indicated in the CERTIFICATE OF PARTICIPATION starting at the COMMENCEMENT OF DISABILITY, during which no benefit is paid.

If the **WAITING PERIOD** in the case of a PILOT/DRIVER is different from the other INSUREDS, it must be indicated in the CERTIFICATE OF PARTICIPATION.

7.1(2) In this Schedule '**the insurance described in this Schedule**' also includes the insurance of the income disability benefit that was provided immediately prior to the effective date of this Policy in terms of a policy that the EMPLOYER had with the INSURER that immediately preceded this Policy.

7.2 Income disability benefit

7.2(1) If an INSURED who is an EMPLOYEE, becomes TOTALLY DISABLED after the latest date on which the insurance described in this Schedule becomes applicable to him/her, but before the BENEFIT CESSATION DATE, the TOTAL DISABILITY INCOME in terms of paragraphs (a), (b) or (c) below, as selected in the CERTIFICATE OF PARTICIPATION, becomes payable.

(a) The TOTAL DISABILITY INCOME is equal to the sum of –

(i) 75% of the first R12 000 of the INSURED's monthly RISK SALARY; plus

(ii) 50% of the INSURED's monthly RISK SALARY in excess of R12 000; plus

(iii) during the period before the expiry of the two years after the COMMENCEMENT OF DISABILITY, 25% of the first R12 000 of the INSURED's monthly RISK SALARY;

subject to a monthly maximum benefit of R15 000, or such other amount determined by the INSURER from time to time.

(b) The TOTAL DISABILITY INCOME is equal to 75% of the INSURED's monthly RISK SALARY subject to a monthly maximum benefit of R220 000, or such other amount determined by the INSURER from time to time.

(c) The TOTAL DISABILITY INCOME is equal to the sum of -

(i) 75% of the first R10 000 of the INSURED's monthly RISK SALARY; plus

(ii) 60% of the next R30 000 of the INSURED's monthly RISK SALARY; plus

(iii) 50% of the INSURED's monthly RISK SALARY in excess of R40 000;

subject to a monthly maximum benefit of R220 000, or such other amount determined by the INSURER from time to time.

In determining the TOTAL DISABILITY INCOME, RISK SALARY means the RISK SALARY immediately before the WAITING PERIOD.

7.2(2) Notwithstanding any provision to the contrary contained in the Policy, the TOTAL DISABILITY INCOME referred to in paragraphs (b) and (c) in the previous sub-clause, as at the commencement of payment of the TOTAL DISABILITY INCOME, will be limited to the smaller of 100% of the INSURED’s AVERAGE NET MONTHLY INCOME and R220 000 per MONTH, or such other amount determined by the INSURER from time to time.

7.2(3) In the following situations the INSURER pays, instead of the TOTAL DISABILITY INCOME, a PROPORTIONAL DISABILITY INCOME -

(a) if the INSURED, whilst a benefit is paid in respect of him/her in terms of this Schedule, receives earnings from an occupation which he/she follows; or

(b) if an INSURED who is not a PILOT/DRIVER, after expiry of the WAITING PERIOD, in the opinion of the INSURER has recovered to such an extent that he/she is capable of partially resuming the REGULAR OCCUPATION that he/she followed immediately before the COMMENCEMENT OF DISABILITY; or

(c) if the INSURER, after twenty-four MONTHS have elapsed since the COMMENCEMENT OF DISABILITY, is of the opinion that an INSURED who is not a PILOT/DRIVER is capable of partially following an occupation which he/she, in view of his/her training and experience, may reasonably be expected to follow - with or without further in-service training; or

(d) if an INSURED who is a PILOT/DRIVER, after expiry of the WAITING PERIOD, in the opinion of the INSURER has recovered to such an extent that he/she is capable of partially resuming any occupation of whatever nature - with or without further in-service training.

7.2(4) The PROPORTIONAL DISABILITY INCOME is the INSURED's TOTAL DISABILITY INCOME, multiplied by (A - B) divided by A, where –

A represents the INSURED's monthly RISK SALARY immediately before the WAITING PERIOD (such RISK SALARY having been adjusted in accordance with the increase in the CONSUMER PRICE INDEX at intervals determined by the INSURER, but not exceeding 18 MONTHS);

B represents the average monthly earnings that the INSURED derives after the COMMENCEMENT OF DISABILITY from an occupation that he/she follows or the average monthly income that, in the opinion of the INSURER, the INSURED is capable of earning from the occupations which in terms of this Schedule are taken into account in considering if the PROPORTIONAL DISABILITY INCOME must be paid, with a maximum value for B equal to A.

7.3 Cessation of premiums

Premiums are payable until the end of the WAITING PERIOD. During the period in which a disability income is paid in respect of an INSURED in terms of this Schedule, no premiums for the insurance described in this Schedule, are payable to the INSURER in respect of that INSURED.

7.4 Growth of disability income

7.4(1) After payment of the disability income has commenced, the TOTAL DISABILITY INCOME, except the part of it set out in sub-paragraph (a)(iii) of sub-clause 7.2(1), is increased annually at a time agreed to by the INSURER and the EMPLOYER and at a rate as selected in the CERTIFICATE OF PARTICIPATION compounded annually.

7.4(2) The increase in terms of this clause is limited so that the annual increase in the disability income does not exceed the increase in the CONSUMER PRICE INDEX for the year ending three MONTHS prior to the increase date.

7.5 COMMENCEMENT OF DISABILITY

The INSURER determines the COMMENCEMENT OF DISABILITY on grounds of the medical and other information submitted.

7.6 Proof of good health

FREE COVER LIMIT

7.6(1) The insurance provided in terms of this Schedule regarding an INSURED is limited to the FREE COVER LIMIT, unless proof of good health to the satisfaction of the INSURER regarding that part of his/her BENEFIT ENTITLEMENT exceeding the FREE COVER LIMIT is submitted to the INSURER in the manner specified by the INSURER from time to time.

Insurance not limited to the FREE COVER LIMIT

7.6(2) The insurance in terms of this Schedule is not limited to the FREE COVER LIMIT in the following instances -

(a) for the first three MONTHS after the INSURED becomes an INSURED; and

(b) for the first three MONTHS after an increase in the INSURED's BENEFIT ENTITLEMENT if the FREE COVER LIMIT is exceeded for the first time as a result of the increase,

provided that –

- the benefit which is provided in the three MONTHS referred to in paragraphs (a) and (b) above is only for a claim arising as a result of an ACCIDENT during those periods; and
- the benefits which are provided in the three MONTHS referred to in paragraphs (a) and (b) above may not exceed amounts determined by the INSURER from time to time; and
- paragraph (a) is not applicable if the INSURED becomes an INSURED as a result of the insurance provided in terms of this Schedule replacing other insurance in terms of which the INSURED was insured; and
- if the INSURED submits proof of good health to the satisfaction of the INSURER within the three MONTHS referred to in paragraphs (a) or (b) above, then the insurance that is agreed to by the EMPLOYER and the INSURER in writing is applicable to the INSURED from the moment it is put in writing.

No insurance without proof of good health

7.6(3) Notwithstanding the provisions of the previous sub-clause, the persons and the amounts referred to in the following paragraphs will not be insured in terms of this Schedule, unless proof of good health is submitted to the INSURER in the manner specified by the INSURER from time to time. The persons referred to, the amounts involved and the responsibility for the costs of providing proof are as follows:

(a) A person who has the option of becoming a member of the FUND but fails to become a member within three MONTHS of becoming entitled to do so and becomes a member after three MONTHS. Proof must be provided for the full amount of his/her BENEFIT ENTITLEMENT. Provision of proof is at the expense of the person.

(b) An INSURED who, in terms of clauses 7.9(6), 21.2(2) or 22.4, does not qualify for the insurance of the benefit in terms of this Schedule, or any increase in it by virtue of an amendment to the Policy, and elects to submit proof of his/her good health to the INSURER. Proof must be provided for the full amount of his/her BENEFIT ENTITLEMENT or the increase in it, as the case may be. Provision of proof is at the expense of the INSURER.

(c) An employee of a MUNICIPALITY who is 55 years or older on the date on which he/she is insured for the first time for the benefits in terms of this Schedule. Proof must be provided for the full amount of his/her BENEFIT ENTITLEMENT. Provision of proof is at the expense of the INSURER.

7.6(4) The EMPLOYER must advise the INSURER in writing immediately on the happening of a situation referred to in the previous sub-clause.

7.6(5) The INSURER will only request proof of good health in respect of the above persons upon being advised by the EMPLOYER in writing of a situation referred to above.

7.6(6) The INSURER will not be liable for any claim in respect of the above persons if the EMPLOYER does not advise the INSURER in writing of the particular situation referred to above where proof of good health is not submitted to the INSURER in the manner specified.

Satisfactory proof of good health

7.6(7) In deciding on medical grounds that the proof of good health that is submitted in a particular case in terms of the preceding sub-clauses is to its satisfaction, the INSURER may determine that the insurance of that part of the benefits for which the proof is submitted, and of future increases in those benefits, is not applicable in the case of causes of disability as laid down by the INSURER.

Commencement of insurance requiring proof of good health

7.6(8) The part of the insurance described in this Schedule for which proof of good health in respect of an INSURED is required by the INSURER, will be insured as from the date on which the INSURER receives the last information taken into account in establishing the good health of the INSURED. But any such insurance for which the INSURER excludes certain causes of disability, only commences after the EMPLOYER is informed of the excluded causes of disability by the INSURER in writing.

Increases in insurance exceeding the FREE COVER LIMIT

7.6(9) Once proof of good health for that part of an INSURED's insurance exceeding the FREE COVER LIMIT is accepted by the INSURER, subsequent increases in the INSURED's BENEFIT ENTITLEMENT, as a result of increases in the INSURED's RISK SALARY only, will apply without further proof of good health having to be submitted to the INSURER. However, further proof of good health must be provided in the following circumstances:

(a) if certain periods determined by the INSURER from time to time expire; or

(b) if the INSURED reaches a certain age determined by the INSURER from time to time; or

(c) if the disability benefit exceeds amounts determined by the INSURER from time to time.

Reduction of the FREE COVER LIMIT

7.6(10) If the INSURER reduces the FREE COVER LIMIT at any specific time, the insurance that applies to an existing INSURED before such reduction will not be reduced accordingly, provided that the benefit remains applicable to the INSURED without interruption.

Temporary cessation of insurance

7.6(11) If the insurance in this Schedule ceases to apply to an INSURED temporarily, proof of good health that is submitted in respect of the INSURED before such cessation will, for the purposes of the preceding clauses, be deemed null and void.

Increases in FREE COVER LIMIT while benefit payments are restricted

7.6(12) If the FREE COVER LIMIT laid down in general is increased while payments in terms of this Schedule are being made in respect of an INSURED whose benefits have been restricted in terms of the preceding clauses regarding proof of good health, such payments are not increased accordingly.

7.7 Claims procedure

Notification

7.7(1) The INSURER must be notified in writing of a claim for an income disability benefit within six MONTHS after the last day on which the relevant INSURED performed his/her occupation or the INSURER may reject the claim.

Submission

7.7(2) The claim for an income disability benefit will not be assessed until the claim forms and other documentation required by the INSURER are submitted at its head office.

Proof of claim

7.7(3) The INSURER has to be satisfied, by way of medical and other information which is required at its sole discretion, that the INSURED is TOTALLY DISABLED.

7.7(4) If the INSURER admits a claim for the payment of an income disability benefit, it may, at any time afterwards and as frequently as it deems necessary, require the INSURED to again submit medical and other information so that it may consider whether he/she continues to be TOTALLY DISABLED.

7.7(5) The INSURER may at its sole discretion require an INSURED residing or travelling outside the Republic of South Africa to submit to an examination by a medical doctor (other than the INSURED himself/herself) practicing in the Republic of South Africa or any other country indicated by the INSURER. The INSURER may also require such an INSURED to provide it with satisfactory proof of existence on a periodic basis.

7.7(6) The INSURER may request additional information in order to satisfy itself that the INSURED is TOTALLY DISABLED. The INSURED must provide the additional information to the INSURER within 60 days of the INSURER's request.

Cost of providing proof

7.7(7) The EMPLOYER is informed in the administration guides on the RETIREMENT FUND WEB of the medical and other information which is required by the INSURER in respect of an INSURED in order for the INSURER to assess for the first time whether the INSURED is TOTALLY DISABLED. This information must be submitted at the expense of the INSURED. The provision of any additional information that the INSURER may require and proof of the continuation of his/her TOTAL DISABILITY thereafter and in the case of sub-clause 7.7(4) is at the expense of the INSURER.

Resubmission of a rejected claim

7.7(8) If the INSURER rejects a claim for the income disability benefit in terms of this Schedule, the claim may be resubmitted with new evidence or submissions. Such a resubmitted claim must be made within 90 days of the rejection. If the INSURER again rejects the claim, no further resubmission of the claim will be considered by the INSURER. If any new medical evidence is submitted in order to have a claim reassessed, the cost of such medical evidence is for the INSURED's expense.

7.8 Payment of benefit

Payment

7.8(1) The income disability benefit payable in terms of this Schedule must be paid to the INSURED.

Commencement of benefit payments

7.8(2) The first MONTH for which the income disability benefit is payable is –

- the MONTH in which the INSURED's WAITING PERIOD expires, in the case of an INSURED whose WAITING PERIOD expires before the fifteenth of a MONTH; and
- the MONTH that follows on the MONTH in which the INSURED's WAITING PERIOD expires, in the case of an INSURED whose WAITING PERIOD expires on or after the fifteenth of a MONTH.

7.8(3) The income disability benefit is payable on the last day of the MONTH.

Cessation of benefit payments

7.8(4) The payment of the income disability benefit ceases as soon as the first of the following occurs:

(a) the INSURED dies;

(b) the INSURER is of the opinion that the INSURED is no longer - directly and exclusively as a result of bodily injury or illness - totally or partially prevented

(i) in the case of an INSURED who is not a PILOT/DRIVER -

- from following his/her REGULAR OCCUPATION; and
- after a period of 24 MONTHS has elapsed, also from following a SUITABLE OCCUPATION;

(ii) in the case of an INSURED who is a PILOT/DRIVER, from following any occupation of whatever nature;

(c) the INSURED receives retirement benefits from the EMPLOYER or from a fund to which the EMPLOYER contributes or contributed for its EMPLOYEES;

(d) the BENEFIT CESSATION DATE.

7.9 General exclusions

7.9(1) If an INSURED is a professional sportsman, professional sportswoman or professional diver, no benefit is payable in terms of this Schedule.

7.9(2) Notwithstanding any other provision to the contrary in the Policy, no benefit is paid in terms of this Schedule if the TOTAL DISABILITY -

(a) is a direct or indirect consequence of active participation in

(i) war, invasion, acts of foreign enemies, hostilities, warlike operations (whether war be declared or not), civil war, rebellion, revolution, military or usurped power, insurrection, civil commotion assuming the proportions of or amounting to an uprising; or

(ii) an act of terrorism; or

(iii) a riot; or

(iv) conduct during a strike (irrespective of whether the strike is lawful or unlawful) during which conduct lives are endangered, public or private property damaged, or an attempt or attempts are made to damage such property; or

(v) any other unlawful act or conduct of whatever nature during which lives are endangered, public or private property damaged, or an attempt or attempts are made to damage such property.

(b) is a direct or indirect consequence of –

(i) any radioactive contamination, including accidental radioactive contamination; or

(ii) the use of nuclear, biological or chemical weapons; or

(iii) attacks on or sabotage of facilities (including, but not limited to, nuclear power plants, reprocessing plants, final repository sites and research reactors) and storage depots, which lead to the release of radioactivity or nuclear, biological or chemical warfare agents,

irrespective whether any of the aforesaid is performed with the specific use of information technology.

7.9(3) The benefit described in this Schedule is not payable in respect of an INSURED if he/she has the option of becoming a member of the FUND and, by so doing, becoming an INSURED and his/her TOTAL DISABILITY commences before the INSURER receives his/her full particulars.

7.9(4) Subject to sub-clauses 7.6(7) and 7.6(8), the disability benefits described in this Schedule for which proof of good health in respect of an INSURED is required by the INSURER, are only provided if the INSURED's TOTAL DISABILITY commences on or after the date on which the INSURER receives the last information taken into account in establishing the good health of the INSURED.

7.9(5) No claim for the benefit in terms of this Schedule is admitted if the TOTAL DISABILITY arises during a period in which the INSURED concerned is deliberately absent from the EMPLOYER's service without permission, unless the EMPLOYER and the INSURER agree otherwise in a particular case.

7.9(6) If, in the opinion of the INSURER, an INSURED, as a result of a bodily injury or sickness, is incapable of performing his/her normal duties with the EMPLOYER on the latest date on which the insurance described in this Schedule, or any increase in that insurance by virtue of an amendment to the Policy, commences with the INSURER regarding the INSURED, he/she will not qualify for the insurance or the increase, as the case may be, until -

(a) he/she, in the opinion of the INSURER, resumes his/her normal duties and the premiums for the insurance or the increase, as the case may be, are paid in respect of him/her as from the resumption of those duties; and

(b) he/she performs his/her normal duties for 60 consecutive BUSINESS DAYS or he/she submits proof of his/her good health to the satisfaction of the INSURER in accordance with the provisions of this Schedule, whichever is the earlier.

7.9(7) The benefit described in this Schedule, or any increase in it by virtue of an amendment to the Policy, is also not payable in respect of an INSURED if the INSURED becomes TOTALLY DISABLED within twelve MONTHS after the latest date on which the insurance

of the benefit or the insurance of the increase, as the case may be, commences with the INSURER in respect of the INSURED and such disability directly or indirectly arises from or is traceable to –

- a bodily injury which occurred, or
- a condition of which the INSURED was conscious or experienced symptoms or for which medical treatment was received

during the six MONTHS (twelve MONTHS in the case of an INSURED who is an EMPLOYEE of a MUNICIPALITY) immediately before the mentioned date. This provision does not apply to an INSURED in respect of whom proof of good health for the insurance in terms of this Policy is submitted to the satisfaction of the INSURER after the mentioned date and in the manner specified by the INSURER from time to time.

7.10 Replacement of existing insurance

If, exclusively by virtue of sub-clauses 7.9(6) or 7.9(7), the benefit in terms of this Schedule is not paid in regard to an INSURED who –

- immediately before the PARTICIPATION DATE was insured in terms of the insurance which was replaced by the insurance provided in terms of this Schedule; and
- since then has been an INSURED without interruption,

but a benefit would have been paid in terms of the replaced insurance had it still applied to the INSURED, then the INSURER pays to the INSURED either –

(a) the benefit in terms of this Schedule; or

(b) a disability benefit on which the INSURER decides and which in its opinion is related to the value, as determined by it, of the PREVIOUS DISABILITY BENEFIT,

whichever of the benefits referred to in paragraphs (a) and (b) is, in the opinion of the INSURER, the lesser in the case of the INSURED.

7.11 Medical treatment

7.11(1) Payment in terms of this Schedule ceases if the INSURED refuses to undergo regular treatment by a medical doctor (other than the INSURED himself/herself) if there are reasonable prospects that medical treatment may improve the INSURED's ability to work.

7.11(2) Notwithstanding any other provision to the contrary in the Policy, no benefit is paid in terms of this Schedule in respect of an INSURED who resides or travels outside the Republic of South Africa if he/she, as a result thereof, is unable to undergo suitable medical treatment.

7.12 Rehabilitation programs

7.12(1) No benefit is paid unless, before and after the COMMENCEMENT OF DISABILITY,

- the INSURED undergoes SUITABLE REHABILITATION PROGRAMS if he/she is employed in the Republic of South Africa if deemed necessary by the INSURER; and
- the INSURED submits to medical examination, vocational, return to work assessments and SUITABLE REHABILITATION PROGRAMS when required by the INSURER to do so; and
- the CURRENT EMPLOYER causes the workplace of the INSURED to be adapted to a reasonable extent to enable the INSURED to follow his/her REGULAR or a SUITABLE OCCUPATION.

7.12(2) Should an INSURED for any reason other than medical reasons fail to complete a SUITABLE REHABILITATION PROGRAM arranged and paid for by the INSURER, the disability income paid to the INSURED in terms of this Policy will be suspended.

7.13 Termination of service

If an INSURED's service is terminated with the EMPLOYER and he/she is TOTALLY DISABLED on the date of termination of service, he/she is deemed to remain an INSURED and the EMPLOYER to have consented to his/her absence from work. He/She is, however, deemed to remain an INSURED only until the earliest of –

- the expiry of two years;
- the date on which the benefit in terms of this Schedule becomes payable; or
- a claim for the benefit is declined.

7.14 Subsequent periods of disability

7.14(1) If an INSURED is TOTALLY DISABLED and in receipt of monthly income disability payments and, in the opinion of the INSURER, is no longer considered to be TOTALLY DISABLED, his/her monthly income disability payments will cease. If the INSURED is re-employed by the EMPLOYER premiums in respect of the INSURED for the insurance in terms of this Schedule must be resumed.

7.14(2) If, after the monthly income disability payments have ceased, the INSURED again experiences TOTAL DISABILITY, the claim will be treated as a new claim and there will be a WAITING PERIOD before the monthly income disability payments are continued, provided that, if –

- the subsequent period of TOTAL DISABILITY commences before the monthly income disability payments have ceased for a continuous period of six MONTHS; and
- the subsequent period of TOTAL DISABILITY, in the opinion of the INSURER, arises from the same medical condition that caused the previous period of TOTAL DISABILITY,

the claim will be treated as a recurrence of the previous period of TOTAL DISABILITY and there will be no WAITING PERIOD before the monthly income disability payments are continued.

7.15 Maximum benefits from the INSURER

7.15(1) If an INSURED becomes entitled to an income disability benefit in terms of this Schedule and also, by virtue of his/her employment with other employers, becomes entitled to other income disability benefits of the same product offering, either in terms of this Policy or other group policies underwritten by the INSURER, the total amount of the income disability benefits payable to the INSURED by the INSURER will be limited to the largest of the maximum amounts that the INSURER is prepared to pay in terms of each policy.

7.15(2) If the total amount of the income disability benefits payable by the INSURER must be reduced in terms of this clause, the benefit payable in terms of each policy will be reduced proportionately according to the amount of the benefit.

7.16 Maximum benefits from all sources

7.16(1) In this clause, wherever ‘AVERAGE NET MONTHLY INCOME’ is referred to it is adjusted in accordance with the increase in the CONSUMER PRICE INDEX after two years and thereafter at intervals determined by the INSURER but not exceeding 18 MONTHS.

7.16(2) The INSURER must limit an INSURED’s disability benefit so that the INSURED's average monthly income after disability (as defined below) does not exceed 100% of his/her AVERAGE NET MONTHLY INCOME.

7.16(3) For the purposes of this clause the INSURED's average monthly income after disability is determined by taking into account the following receipts -

(a) all income and remuneration payable to the INSURED directly or indirectly for services which he/she renders or rendered in connection with an occupation which he/she follows or followed, decreased by all expenditure and costs incurred directly with a view to earning that income and remuneration; and

(b) any form of benefits or remuneration (whether in cash or not) to which somebody becomes entitled in connection with or as a result of the INSURED's disability or to which somebody would have been entitled if the benefit in terms of this Schedule had not existed. This includes any gratuity or other payment from a fund or scheme which provides benefits at retirement or disability and benefits in terms of the Compensation for Occupational Injuries and Diseases Act, 1993, as amended.

The following are not taken into account:

(i) the waiver of contributions to pension and provident funds in terms of group disability policies;

(ii) any benefits in terms of the Motor Vehicle Accidents Act, 1986, as amended, read together with section 3 of the Multilateral Motor Vehicle Accidents Fund Act, 1989, as amended;

(iii) income disability benefits which are payable for not more than two years to cover continued business expenses;

(iv) lump sum receipts of which the aggregate does not exceed the larger of R550 000, or any other amount determined by the INSURER, and 2,5 times the annual RISK SALARY of the INSURED before the WAITING PERIOD;

(v) any benefit payable at the surrender of a policy or at early retirement or withdrawal from any fund or scheme for reasons other than ill health. For this purpose a retirement annuity policy is deemed to have a surrender value;

(vi) benefits payable if the INSURED, due to an accident, experiences the total and permanent loss of the sight of one or both eyes or the use of any part of his/her body; and

(vii) benefits payable due to the INSURED being permanently, continuously and totally prevented from performing the normal actions and functions with regard to the care of his/her body or from taking care of his/her personal interests.

7.16(4) In the determination of the average monthly income after disability, lump sum receipts are deemed to be a regular monthly income equal to such lump sum receipts divided by 120.

7.16(5) Any receipt expressed as a capital amount payable by instalments over a period of 10 years or less, is also deemed to be a lump sum receipt.

7.16(6) Where a receipt is expressed as a capital amount payable by instalments over a period exceeding 10 years, only the instalments are taken into account.

7.16(7) If a PROPORTIONAL DISABILITY INCOME is granted in terms of this Schedule, the INSURER must limit the PROPORTIONAL DISABILITY INCOME payable in respect of the INSURED so that the INSURED's average monthly income after disability (as described above) does not exceed Y.

7.16(8) For the purposes of the preceding sub-clause Y means, for the first two years of disability, 100% of the INSURED's AVERAGE NET MONTHLY INCOME. After expiry of the first two years of disability, Y however means 75% of the said AVERAGE NET MONTHLY INCOME, plus 25% of the average monthly earnings of the INSURED from the occupation (if any) that he/she follows, subject to a maximum value of Y equal to the mentioned AVERAGE NET MONTHLY INCOME.

7.16(9) At the request of the INSURER the INSURED must submit proof of the extent of his/her average monthly income after disability. If the INSURED fails to submit such proof to the

INSURER's satisfaction, the disability income payable in terms of this Schedule may be decreased at the INSURER's discretion.

7.16(10) The INSURER must limit the payments which are made in terms of this disability insurance according to this clause.

7.16(11) The amounts by which the INSURER limits the income continuation benefits by virtue of income from other sources (other than the income taken into account in the determination of the PROPORTIONAL DISABILITY INCOME) are taken into account by the INSURER at the next revision of the rate at which premiums are payable in terms of the Policy.

7.17 Waiver of contributions and premiums during disability

7.17(1) If a CONTRIBUTION WAIVER BENEFIT and a PREMIUM WAIVER BENEFIT have been selected in the CERTIFICATE OF PARTICIPATION, the INSURER will, during the period in which an income disability benefit is paid in respect of an INSURED in terms of this Schedule, pay the CONTRIBUTION WAIVER BENEFIT to the FUND and the PREMIUM WAIVER BENEFIT to the relevant insurers.

7.17(2) The PREMIUM WAIVER BENEFIT is paid via the FUND to the respective insurers.

7.17(3) If the income disability benefit commences within twelve MONTHS after the date on which the contribution rates in respect of the INSURED to the FUND are increased and the INSURED's disability directly or indirectly arises from or is traceable to -

- a bodily injury which occurred; or
- a condition of which the INSURED was conscious or experienced symptoms or for which medical treatment was received

during the six MONTHS immediately before the increase, the CONTRIBUTION WAIVER BENEFIT is determined as if the increase is not applicable to the INSURED.

7.18 Accident booster benefit

Refer to Schedule 14 for the terms and conditions regarding a claim where an INSURED's disability benefit in terms of this Schedule is restricted to the FREE COVER LIMIT, but his/her full BENETIT ENTITLEMENT is payable if the claim is the result of an accident.

7.19 Option to apply for individual income disability insurance

Refer to Schedule 19 for the terms and conditions regarding the option to apply for individual income disability life insurance.

7.20 Absence from service

Refer to Schedule 21 for the terms and conditions regarding the absence of the INSURED from the service of the EMPLOYER while insured in terms of this Schedule.

7.21 Territorial limitations

Refer to Schedule 22 for the terms and conditions regarding the absence of the INSURED from the Republic of South Africa while insured in terms of this Schedule.

7.22 Deductions and unclaimed benefits

Refer to Schedule 23 for the provisions regarding the allowable deductions from benefits payable in terms of the Policy and for the provisions regarding benefits that become payable and are not claimed.

7.23 Cancellation

7.23(1) If the insurance described in this Schedule is cancelled for a group of INSUREDS, the INSURER's liabilities in terms of this Schedule regarding each of those INSUREDS lapse, unless -

(a) an INSURED is TOTALLY DISABLED on the date of cancellation; and

(b) a claim for the benefits in terms of this Schedule is submitted to the INSURER within six MONTHS after the date of cancellation; and

(c) the claim is admitted by the INSURER; and

(d) if the WAITING PERIOD expires after the date of cancellation, the premiums in respect of the INSURED for the benefits in terms of this Schedule, are paid to the INSURER until the end of the WAITING PERIOD.

7.23(2) If the INSURER's liabilities do not lapse in terms of the preceding sub-clause, the INSURER must apply the CONTRIBUTION WAIVER BENEFIT and the PREMIUM WAIVER BENEFIT as if the insurance described in this Schedule has not been cancelled and on a basis on which the INSURER decides in consultation with the EMPLOYER.

7.23(3) For the purposes of this clause -

(a) the insurance described in this Schedule is also regarded as cancelled for a group of INSUREDS when –

(i) an EMPLOYER's participation in the Policy or in the benefit provided in terms of this Schedule is terminated; or

(ii) the participation of a category of EMPLOYEES of an EMPLOYER in the Policy or in the benefit provided in terms of this Schedule is terminated; or

(iii) the benefit which is insured in terms of this Schedule is cancelled owing to an amendment to the Policy;

and

(b) an INSURED is deemed to be a member of a group if he/she was a member of the relevant group immediately prior to the commencement of his/her TOTAL DISABILITY.

SCHEDULE 8 TEMPORARY INCOME DISABILITY BENEFIT (BEFORE LUMP SUM DISABILITY BENEFIT)

8.1 Definitions

8.1(1) In this Schedule –

ACCIDENT means a bodily injury which –

(a) is caused by physical contact with violent, accidental, tangible and external means; and

(b) is the direct, effective, exclusive and proximate cause of the TOTAL DISABILITY of the INSURED; and

(c) is not attributable to the INSURED having negligently or willfully exposed himself/herself to danger, except in the interests of the law or to protect his/her or another's life or property.

AVERAGE NET MONTHLY INCOME means the INSURED's gross monthly COST TO COMPANY PACKAGE immediately before the commencement of the WAITING PERIOD, less

- the monthly contributions made in respect of the INSURED to the FUND that are insured by the CONTRIBUTION WAIVER BENEFIT; and
- the monthly premium in respect of the income disability insurance effected for the benefit of the INSURED in terms of this Schedule; and
- the monthly income tax paid by the INSURED.

BENEFIT CESSATION DATE in regard to an INSURED means the earlier of his/her NORMAL RETIREMENT DATE and the last day of the MONTH in which he/she attains the age of –

- 65 years in the case of all INSUREDS other than PILOTS; and
- 60 years in the case of PILOTS.

COMMENCEMENT OF DISABILITY in regard to an INSURED means the latest date on which the INSURED becomes TOTALLY DISABLED.

CONTRIBUTION WAIVER BENEFIT in regard to an INSURED means contributions that would be payable to the FUND after the COMMENCEMENT OF DISABILITY if the INSURED were to remain in the service of the EMPLOYER, but calculated according to a scale equal to the percentage referred to in the CERTIFICATE OF PARTICIPATION, or such other percentage as agreed to between the EMPLOYER and the INSURER from time to time, of the INSURED's RISK SALARY immediately before the WAITING PERIOD. But these contributions per MONTH may not to exceed an amount determined by the INSURER from time to time. If the EMPLOYER and the INSURER agree to it, the above percentage also makes provision for the PREMIUM WAIVER BENEFIT.

COST TO COMPANY PACKAGE means the gross annual amount payable by the EMPLOYER in respect of the INSURED immediately before the commencement of the WAITING PERIOD, provided that:

- In the case of an INSURED who receives a variable income, COST TO COMPANY PACKAGE means the annual average gross amount which the EMPLOYER paid in respect of the INSURED during the thirty-six MONTHS immediately before the commencement of the WAITING PERIOD.
- In the case where such an INSURED was employed by the EMPLOYER for a period of less than thirty six MONTHS, COST TO COMPANY PACKAGE means the average gross monthly amount which the EMPLOYER paid in respect of the

INSURED during the number of MONTHS the INSURED was employed by the EMPLOYER, multiplied by twelve.

- An INSURED's COST TO COMPANY PACKAGE includes the average discretionary bonus payments and commission of a recurrent nature over a period of thirty-six MONTHS or such shorter period for which the INSURED was employed by the EMPLOYER.

- All expenditure and costs incurred directly with a view to earning any of the aforesaid amounts are deducted from the said amounts.

CURRENT EMPLOYER means the EMPLOYER in whose service the INSURED is immediately before the COMMENCEMENT OF DISABILITY.

DRIVER means an INSURED in respect of whose job one of the core functions is to drive or operate a vehicle or machine that is used for the transporting or conveying of goods or people. 'Core function' in this context means that if he/she is not able to perform this function, the EMPLOYER will be entitled to end his/her employment due to incapacity. A DRIVER must be in possession of a valid license to drive or operate the particular vehicle or machine.

PILOT means an INSURED in respect of whose job one of the core functions is to pilot an aeroplane or helicopter that is used for the transporting or conveying of goods or people or other purposes relating to the business of the EMPLOYER. 'Core function' in this context means that if he/she is not able to perform this function, the EMPLOYER will be entitled to end his/her employment due to incapacity. A PILOT must be in possession of a valid license to pilot the particular aeroplane or helicopter.

PREMIUM WAIVER BENEFIT in regard to an INSURED means the premiums that would be payable in respect of insurance effected by the EMPLOYER for the benefit of the INSURED outside the FUND if the INSURED were to remain in the service of the EMPLOYER after the COMMENCEMENT OF DISABILITY.

PREVIOUS DISABILITY BENEFIT in regard to an INSURED means the disability benefit that would have been provided to the INSURED in terms of the insurance which on the PARTICIPATION DATE was replaced by the insurance provided in this Schedule if he/she had remained insured in terms of that insurance. Included in this PREVIOUS DISABILITY BENEFIT is any increase in such a benefit that would have come into force in terms of the replaced insurance, on or after the PARTICIPATION DATE, but prior to the WAITING PERIOD, exclusively as a result of increases in the RISK SALARY and without proof of good health. A retirement benefit that was payable at retirement owing to ill-health, is not deemed to be a PREVIOUS DISABILITY BENEFIT.

PROPORTIONAL DISABILITY INCOME means the income as determined in terms of sub-clause 8.2(3).

REGULAR OCCUPATION means the occupation regularly followed by the INSURED immediately before the COMMENCEMENT OF DISABILITY, disregarding any duties not normally associated with an occupation of that nature.

SUITABLE OCCUPATION means an occupation which the INSURED, by virtue of his/her training and experience, could reasonably be expected to follow - with or without further in-service training - if it were not for the INSURED's functional impairment.

SUITABLE REHABILITATION PROGRAMS means medical and surgical treatment, occupational and medical therapy, and rehabilitation and return to work programs reasonably deemed appropriate by the INSURER with the view of improving, or preventing a deterioration of, the INSURED's ability to work, taking into account the risk and the prospect of success of the treatment, therapy or program.

In deciding on the suitability or not of a rehabilitation program the INSURER will take into consideration the existence of appropriate services and facilities within reasonable proximity of the INSURED's place of employment or place of residence.

TOTAL DISABILITY means a condition where an INSURED - directly and exclusively as a result of a bodily injury or an illness - is continuously and totally prevented from following, -

(a) in the case of an INSURED who is not a PILOT/DRIVER, his/her REGULAR OCCUPATION; and

(b) in the case of an INSURED who is a PILOT/DRIVER, any occupation of whatever nature with or without further in-service training,

provided that the condition –

- is not attributable to the INSURED's having negligently or wilfully exposed himself/herself to danger, except in the interests of the law or to protect his/her or another's life or property; and
- is not attributable to intentional self-inflicted injury; and
- cannot be substantially removed by surgery or any other medical treatment which, taking into account the risk and the prospect of success of that treatment, the INSURED can reasonably be expected to undergo, and

TOTALLY DISABLED has a corresponding meaning.

TOTAL DISABILITY INCOME means the income as determined in terms of sub-clause 8.2(1).

WAITING PERIOD means a period of three months starting at the COMMENCEMENT OF DISABILITY, during which no benefit is paid.

8.1(2) In this Schedule '**the insurance described in this Schedule**' also includes the insurance of the income disability benefit that was provided immediately prior to the effective date of this Policy in terms of a policy that the EMPLOYER had with an INSURER that immediately preceded this Policy.

8.2 Income benefit

8.2(1) If an INSURED who is an EMPLOYEE, becomes TOTALLY DISABLED after the latest date on which the insurance described in this Schedule becomes applicable to him/her, but before the BENEFIT CESSATION DATE, the TOTAL DISABILITY INCOME, as described below, becomes payable.

The TOTAL DISABILITY INCOME is equal to 75% of the INSURED's monthly RISK SALARY subject to a monthly maximum benefit of R220 000, or such other amount determined by the INSURER from time to time.

In determining the TOTAL DISABILITY INCOME, RISK SALARY means the RISK SALARY immediately before the WAITING PERIOD.

The TOTAL DISABILITY INCOME is payable monthly for a period of twenty-one MONTHS.

8.2(2) Notwithstanding any provision to the contrary contained in the Policy, the TOTAL DISABILITY INCOME as at the commencement of payment of the TOTAL DISABILITY INCOME will be limited to the smaller of 100% of the INSURED's AVERAGE NET MONTHLY INCOME and R220 000 per MONTH, or such other amount determined by the INSURER from time to time.

8.2(3) In the following situations the INSURER pays, instead of the TOTAL DISABILITY INCOME, a PROPORTIONAL DISABILITY INCOME –

(a) if the INSURED, whilst a benefit is paid in respect of him/her in terms of this Schedule, receives earnings from an occupation which he/she follows; or

(b) if an INSURED who is not a PILOT/DRIVER, after expiry of the WAITING PERIOD, in the opinion of the INSURER has recovered to such an extent that he/she is capable of partially resuming the REGULAR OCCUPATION that he/she followed immediately before the COMMENCEMENT OF DISABILITY; or

(c) if an INSURED who is a PILOT/DRIVER, after expiry of the WAITING PERIOD, in the opinion of the INSURER has recovered to such an extent that he/she is capable of partially resuming any occupation of whatever nature - with or without further in-service training.

8.2(4) The PROPORTIONAL DISABILITY INCOME is the INSURED's TOTAL DISABILITY INCOME, multiplied by (A - B) divided by A, where –

A represents the INSURED's monthly RISK SALARY immediately before the WAITING PERIOD (such RISK SALARY having been adjusted in accordance with the increase in the CONSUMER PRICE INDEX at intervals determined by the INSURER, but not exceeding 18 MONTHS);

B represents the average monthly earnings that the INSURED derives after the COMMENCEMENT OF DISABILITY from an occupation that he/she follows or the average monthly income that, in the opinion of the INSURER, the INSURED is capable of earning from the occupations which in terms of this Schedule are taken into account in considering if the PROPORTIONAL DISABILITY INCOME must be paid, with a maximum value for B equal to A.

8.3 Cessation of premiums

Premiums are payable until the end of the WAITING PERIOD. During the period in which a disability income is paid in respect of an INSURED in terms of this Schedule, no premiums for the insurance described in this Schedule, are payable to the INSURER in respect of that INSURED.

8.4 COMMENCEMENT OF DISABILITY

The INSURER determines the COMMENCEMENT OF DISABILITY on grounds of the medical and other information submitted.

8.5 Proof of good health

FREE COVER LIMIT

8.5(1) The insurance provided in terms of this Schedule regarding an INSURED is limited to the FREE COVER LIMIT, unless proof of good health to the satisfaction of the INSURER regarding that part of his/her BENEFIT ENTITLEMENT exceeding the FREE COVER LIMIT is submitted to the INSURER in the manner specified by the INSURER from time to time.

Insurance not limited to the FREE COVER LIMIT

8.5(2) The insurance in terms of this Schedule is not limited to the FREE COVER LIMIT in the following instances -

(a) for the first three MONTHS after the INSURED becomes an INSURED; and

(b) for the first three MONTHS after an increase in the INSURED’s BENEFIT ENTITLEMENT if the FREE COVER LIMIT is exceeded for the first time as a result of the increase,

provided that –

- the benefit which is provided in the three MONTHS referred to in paragraphs (a) and (b) above is only for a claim arising as a result of an ACCIDENT during those periods; and

- the benefits which are provided in the three MONTHS referred to in paragraphs (a) and (b) above may not exceed amounts determined by the INSURER from time to time; and

- paragraph (a) is not applicable if the INSURED becomes an INSURED as a result of the insurance provided in terms of this Schedule replacing other insurance in terms of which the INSURED was insured; and

- if the INSURED submits proof of good health to the satisfaction of the INSURER within the three MONTHS referred to in paragraphs (a) or (b) above, then the insurance that is agreed to by the EMPLOYER and the INSURER in writing is applicable to the INSURED from the moment it is put in writing.

No insurance without proof of good health

8.5(3) Notwithstanding the provisions of the previous sub-clause, the persons and the amounts referred to in the following paragraphs will not be insured in terms of this Schedule, unless proof of good health is submitted to the INSURER in the manner specified by the INSURER from time to time. The persons referred to, the amounts involved and the responsibility for the costs of providing proof are as follows:

(a) A person who has the option of becoming a member of the FUND but fails to become a member within three MONTHS of becoming entitled to do so and becomes a member after three MONTHS. Proof must be provided for the full amount of his/her BENEFIT ENTITLEMENT. Provision of proof is at the expense of the person.

(b) An INSURED who, in terms of clauses 8.8(6), 21.2(2) or 22.4, does not qualify for the insurance of the benefit in terms of this Schedule, or any increase in it by virtue of an amendment to the Policy, and elects to submit proof of his/her good health to the INSURER. Proof must be provided for the full amount of his/her BENEFIT ENTITLEMENT or the increase in it, as the case may be. Provision of proof is at the expense of the INSURER.

(c) An employee of a MUNICIPALITY who is 55 years or older on the date on which he/she is insured for the first time for the benefit in terms of this Schedule. Proof must be provided for the full amount of his/her BENEFIT ENTITLEMENT. Provision of proof is at the expense of the INSURER.

8.5(4) The EMPLOYER must advise the INSURER in writing immediately on the happening of a situation referred to in the previous sub-clause.

8.5(5) The INSURER will only request proof of good health in respect of the above persons upon being advised by the EMPLOYER in writing of a situation referred to above.

8.5(6) The INSURER will not be liable for any claim in respect of the above persons if the EMPLOYER does not advise the INSURER in writing of the particular situation referred to above where proof of good health is not submitted to the INSURER in the manner specified.

Satisfactory proof of good health

8.5(7) In deciding on medical grounds that the proof of good health that is submitted in a particular case in terms of the preceding sub-clauses is to its satisfaction, the INSURER may determine that the insurance of that part of the benefits for which the proof is submitted, and of future increases in those benefits, is not applicable in the case of causes of disability as laid down by the INSURER.

Commencement of insurance requiring proof of good health

8.5(8) The part of the insurance described in this Schedule for which proof of good health in respect of an INSURED is required by the INSURER, will be insured as from the date on which the INSURER receives the last information taken into account in establishing the good health of the INSURED. But any such insurance for which the INSURER excludes certain causes of disability, only commences after the EMPLOYER is informed of the excluded causes of disability by the INSURER in writing.

Increases in insurance exceeding the FREE COVER LIMIT

8.5(9) Once proof of good health for that part of an INSURED's insurance exceeding the FREE COVER LIMIT is accepted by the INSURER, subsequent increases in the INSURED's BENEFIT ENTITLEMENT, as a result of increases in the INSURED's RISK SALARY only, will apply without further proof of good health having to be submitted to the INSURER. However, further proof of good health must be provided in the following circumstances:

(a) if certain periods determined by the INSURER from time to time expire; or

(b) if the INSURED reaches a certain age determined by the INSURER from time to time; or

(c) if the disability benefit exceeds amounts determined by the INSURER from time to time.

Reduction of the FREE COVER LIMIT

8.5(10) If the INSURER reduces the FREE COVER LIMIT at any specific time, the insurance that applies to an existing INSURED before such reduction will not be reduced accordingly, provided that the benefit remains applicable to the INSURED without interruption.

Temporary cessation of insurance

8.5(11) If the insurance in this Schedule ceases to apply to an INSURED temporarily, proof of good health that is submitted in respect of the INSURED before such cessation will, for the purposes of the preceding clauses, be deemed null and void.

Increases in FREE COVER LIMIT while benefit payments are restricted

8.5(12) If the FREE COVER LIMIT laid down in general is increased while payments in terms of this Schedule are being made in respect of an INSURED whose benefits have been restricted in terms of the preceding clauses regarding proof of good health, such payments are not increased accordingly.

8.6 Claims procedure

Notification

8.6(1) The INSURER must be notified in writing of a claim for an income disability benefit in terms of this Schedule within the WAITING PERIOD or the INSURER may reject the claim.

Submission

8.6(2) The claim forms and other documentation required by the INSURER must also be submitted at its head office within the WAITING PERIOD.

Proof of claim

8.6(3) The INSURER has to be satisfied, by way of medical and other information which is required at its sole discretion, that the INSURED is TOTALLY DISABLED.

8.6(4) If the INSURER admits a claim for the payment of an income disability benefit, it may, at any time afterwards and as frequently as it deems necessary, require the INSURED to

again submit medical and other information so that it may consider whether he/she continues to be TOTALLY DISABLED.

8.6(5) The INSURER may at its sole discretion require an INSURED residing or travelling outside the Republic of South Africa to submit to an examination by a medical doctor (other than the INSURED himself/herself) practicing in the Republic of South Africa or any other country indicated by the INSURER. The INSURER may also require such an INSURED to provide it with satisfactory proof of existence on a periodic basis.

8.6(6) The INSURER may request additional information in order to satisfy itself that the INSURED is TOTALLY DISABLED. The INSURED must provide the additional information to the INSURER within 60 days of the INSURER's request.

Cost of providing proof

8.6(7) The EMPLOYER is informed in the administration guides on the RETIREMENT FUND WEB of the medical and other information which is required by the INSURER in respect of an INSURED in order for the INSURER to assess for the first time whether the INSURED is TOTALLY DISABLED. This information must be submitted at the expense of the INSURED. The provision of any additional information that the INSURER may require and proof of the continuation of his/her TOTAL DISABILITY thereafter and in the case of sub-clause 8.6(5) is at the expense of the INSURER.

Resubmission of a rejected claim

8.6(8) If the INSURER rejects a claim for the income disability benefit in terms of this Schedule, the claim may be resubmitted with new evidence or submissions. Such a resubmitted claim must be made within 90 days of the rejection. If the INSURER again rejects the claim, no further resubmission of the claim will be considered by the INSURER. If any new medical evidence is submitted in order to have a claim reassessed, the cost of such medical evidence is for the INSURED's expense.

8.7 Payment of benefit

Payment

8.7(1) The income disability benefit payable in terms of this Schedule must be paid to the INSURED.

Commencement of benefit payments

8.7(2) The first MONTH for which the income disability benefit is payable is –

- the MONTH in which the INSURED's WAITING PERIOD expires, in the case of an INSURED whose WAITING PERIOD expires before the fifteenth of a MONTH; and
- the MONTH that follows on the MONTH in which the INSURED's WAITING PERIOD expires, in the case of an INSURED whose WAITING PERIOD expires on or after the fifteenth of a MONTH.

8.7(3) The income disability benefit is payable on the last day of the MONTH.

Cessation of benefit payments

8.7(4) The payment of the income disability benefit ceases as soon as the first of the following occurs:

(a) the INSURED dies;

(b) the INSURER is of the opinion that the INSURED is no longer - directly and exclusively as a result of bodily injury or illness - totally or partially prevented -

(i) in the case of an INSURED who is not a PILOT/DRIVER from following his/her REGULAR OCCUPATION; and

(ii) in the case of an INSURED who is a PILOT/DRIVER, from following any occupation of whatever nature;

(c) twenty-one monthly income disability payments are made in respect of the INSURED in terms of this Schedule;

(d) the INSURED receives retirement benefits from the EMPLOYER or from a fund to which the EMPLOYER contributes or contributed for its EMPLOYEES;

(e) the BENEFIT CESSATION DATE.

8.8 General exclusions

8.8(1) If an INSURED is a professional sportsman, professional sportswoman or professional diver, no benefit is payable in terms of this Schedule.

8.8(2) Notwithstanding any other provision to the contrary in the Policy, no benefit is paid in terms of this Schedule if the TOTAL DISABILITY -

(a) is a direct or indirect consequence of active participation in

(i) war, invasion, acts of foreign enemies, hostilities, warlike operations (whether war be declared or not), civil war, rebellion, revolution, military or usurped power, insurrection, civil commotion assuming the proportions of or amounting to an uprising; or

(ii) an act of terrorism; or

(iii) a riot; or

(iv) conduct during a strike (irrespective of whether the strike is lawful or unlawful) during which conduct lives are endangered, public or private property damaged, or an attempt or attempts are made to damage such property; or

(v) any other unlawful act or conduct of whatever nature during which lives are endangered, public or private property damaged, or an attempt or attempts are made to damage such property.

(b) is a direct or indirect consequence of –

(i) any radioactive contamination, including accidental radioactive contamination; or

(ii) the use of nuclear, biological or chemical weapons; or

(iii) attacks on or sabotage of facilities (including, but not limited to, nuclear power plants, reprocessing plants, final repository sites and research reactors) and storage depots, which lead to the release of radioactivity or nuclear, biological or chemical warfare agents,

irrespective whether any of the aforesaid is performed with the specific use of information technology.

8.8(3) The benefit described in this Schedule is not payable in respect of an INSURED if he/she has the option of becoming a member of the FUND and, by so doing, becoming an INSURED and his/her TOTAL DISABILITY commences before the INSURER receives his/her full particulars.

8.8(4) Subject to sub-clauses 8.5(7) and 8.5(8), the disability benefits described in this Schedule for which proof of good health in respect of an INSURED is required by the INSURER, are only provided if the INSURED's TOTAL DISABILITY commences on or after the date on which the INSURER receives the last information taken into account in establishing the good health of the INSURED.

8.8(5) No claim for the benefit in terms of this Schedule is admitted if the TOTAL DISABILITY arises during a period in which the INSURED concerned is deliberately absent from the

EMPLOYER's service without permission, unless the EMPLOYER and the INSURER agree otherwise in a particular case.

8.8(6) If, in the opinion of the INSURER, an INSURED, as a result of a bodily injury or sickness, is incapable of performing his/her normal duties with the EMPLOYER on the latest date on which the insurance described in this Schedule, or any increase in that insurance by virtue of an amendment to the Policy, commences with the INSURER regarding the INSURED, he/she will not qualify for the insurance or the increase, as the case may be, until –

(a) he/she, in the opinion of the INSURER, resumes his/her normal duties and the premiums for the insurance or the increase, as the case may be, are paid in respect of him/her as from the resumption of those duties; and

(b) he/she performs his/her normal duties for 60 consecutive BUSINESS DAYS or he/she submits proof of his/her good health to the satisfaction of the INSURER in accordance with the provisions of this Schedule, whichever is the earlier.

8.8(7) The benefit described in this Schedule, or any increase in it by virtue of an amendment to the Policy, is also not payable in respect of an INSURED if the INSURED becomes TOTALLY DISABLED within twelve MONTHS after the latest date on which the insurance of the benefit or the insurance of the increase, as the case may be, commences with the INSURER in respect of the INSURED and such disability directly or indirectly arises from or is traceable to –

- a bodily injury which occurred, or
- a condition of which the INSURED was conscious or experienced symptoms or for which medical treatment was received

during the six MONTHS (twelve MONTHS in the case of an INSURED who is an EMPLOYEE of a MUNICIPALITY) immediately before the mentioned date. This provision does not apply to an INSURED in respect of whom proof of good health for the insurance in terms of this Policy is submitted to the satisfaction of the INSURER after the mentioned date and in the manner specified by the INSURER from time to time.

8.9 Replacement of existing insurance

If, exclusively by virtue of sub-clauses 8.8(6) or 8.8(7), the benefit in terms of this Schedule is not paid in regard to an INSURED who -

- immediately before the PARTICIPATION DATE was insured in terms of the insurance which was replaced by the insurance provided in terms of this Schedule; and
- since then has been an INSURED without interruption,

but a benefit would have been paid in terms of the replaced insurance had it still applied to the INSURED, then the INSURER pays to the INSURED either -

(a) the benefit in terms of this Schedule; or

(b) a disability benefit on which the INSURER decides and which in its opinion is related to the value, as determined by it, of the PREVIOUS DISABILITY BENEFIT,

whichever of the benefits referred to in paragraphs (a) and (b) is, in the opinion of the INSURER, the lesser in the case of the INSURED.

8.10 Medical treatment

8.10(1) Payment in terms of this Schedule ceases if the INSURED refuses to undergo regular treatment by a medical doctor (other than the INSURED himself/herself) if there are reasonable prospects that medical treatment may improve the INSURED's ability to work.

8.10(2) Notwithstanding any other provision to the contrary in the Policy, no benefit is paid in terms of this Schedule in respect of an INSURED who resides or travels outside the

Republic of South Africa if he/she, as a result thereof, is unable to undergo suitable medical treatment.

8.11 Rehabilitation programs

8.11(1) No benefit is paid unless, before and after the COMMENCEMENT OF DISABILITY,

- the INSURED undergoes SUITABLE REHABILITATION PROGRAMS if he/she is employed in the Republic of South Africa if deemed necessary by the INSURER; and
- the INSURED submits to medical examination, vocational, return to work assessments and SUITABLE REHABILITATION PROGRAMS when required by the INSURER to do so; and
- the CURRENT EMPLOYER causes the workplace of the INSURED to be adapted to a reasonable extent to enable the INSURED to follow his/her REGULAR or a SUITABLE OCCUPATION.

8.11(2) Should an INSURED for any reason other than medical reasons fail to complete a SUITABLE REHABILITATION PROGRAM arranged and paid for by the INSURER, the disability income paid to the INSURED in terms of this Policy will be suspended.

8.12 Termination of service

If an INSURED's service is terminated with the EMPLOYER and he/she is TOTALLY DISABLED on the date of termination of service, he/she is deemed to remain an INSURED and the EMPLOYER to have consented to his/her absence from work. He/She is, however, deemed to remain an INSURED only until the earliest of –

- the expiry of two years;
- the date on which the benefit in terms of this Schedule becomes payable; or
- a claim for the benefit is declined.

8.13 Subsequent periods of disability

8.13(1) If an INSURED is TOTALLY DISABLED and in receipt of monthly income disability payments and, in the opinion of the INSURER, is no longer considered to be TOTALLY DISABLED, his/her monthly income disability payments will cease. If the INSURED is re-employed by the EMPLOYER premiums in respect of the INSURED for the insurance in terms of this Schedule must be resumed.

8.13(2) If, after the monthly income disability payments have ceased, the INSURED again experiences TOTAL DISABILITY, the claim will be treated as a new claim and there will be a WAITING PERIOD followed by twenty-one monthly income disability payments, provided that, if –

- the subsequent period of TOTAL DISABILITY commences before the monthly income disability payments have ceased for a continuous period of six MONTHS; and
- the subsequent period of TOTAL DISABILITY, in the opinion of the INSURER, arises from the same medical condition that caused the previous period of TOTAL DISABILITY,

the claim will be treated as a recurrence of the previous period of TOTAL DISABILITY and there will be no WAITING PERIOD before the balance only of the twenty-one monthly income disability payments are made.

8.14 Maximum benefits from the INSURER

8.14(1) If an INSURED becomes entitled to an income disability benefit in terms of this Schedule and also, by virtue of his/her employment with other employers, becomes entitled to other income disability benefits of the same product offering, either in terms of this Policy or

other group policies underwritten by the INSURER, the total amount of the income disability benefits payable to the INSURED by the INSURER will be limited to the largest of the maximum amounts that the INSURER is prepared to pay in terms of each policy.

8.14(2) If the total amount of the income disability benefits payable by the INSURER must be reduced in terms of this clause, the benefit payable in terms of each policy will be reduced proportionately according to the amount of the benefit.

8.15 Maximum benefits from all sources

8.15(1) The INSURER must limit an INSURED's disability benefit so that the INSURED's average monthly income after disability (as defined below) does not exceed 100% of his/her AVERAGE NET MONTHLY INCOME.

8.15(2) For the purposes of this clause the INSURED's average monthly income after disability is determined by taking into account the following receipts -

(a) all income and remuneration payable to the INSURED directly or indirectly for services which he/she renders or rendered in connection with an occupation which he/she follows or followed, decreased by all expenditure and costs incurred directly with a view to earning that income and remuneration; and

(b) any form of benefits or remuneration (whether in cash or not) to which somebody becomes entitled in connection with or as a result of the INSURED's disability or to which somebody would have been entitled if the benefit in terms of this Schedule had not existed. This includes any gratuity or other payment from a fund or scheme which provides benefits at retirement or disability and benefits in terms of the Compensation for Occupational Injuries and Diseases Act, 1993, as amended.

The following are not taken into account:

(i) the waiver of contributions to pension and provident funds in terms of group disability policies;

(ii) any benefits in terms of the Motor Vehicle Accidents Act, 1986, as amended, read together with section 3 of the Multilateral Motor Vehicle Accidents Fund Act, 1989, as amended;

(iii) income disability benefits which are payable for not more than two years to cover continued business expenses;

(iv) lump sum receipts of which the aggregate does not exceed the larger of R550 000, or any other amount determined by the INSURER, and 2,5 times the annual RISK SALARY of the INSURED before the WAITING PERIOD;

(v) any benefit payable at the surrender of a policy or at early retirement or withdrawal from any fund or scheme for reasons other than ill health. For this purpose a retirement annuity policy is deemed to have a surrender value;

(vi) benefits payable if the INSURED, due to an accident, experiences the total and permanent loss of the sight of one or both eyes or the use of any part of his/her body; and

(vii) benefits payable due to the INSURED being permanently, continuously and totally prevented from performing the normal actions and functions with regard to the care of his/her body or from taking care of his/her personal interests.

8.15(3) In the determination of the average monthly income after disability, lump sum receipts are deemed to be a regular monthly income equal to such lump sum receipts divided by 120.

8.15(4) Any receipt expressed as a capital amount payable by instalments over a period of 10 years or less, is also deemed to be a lump sum receipt.

8.15(5) Where a receipt is expressed as a capital amount payable by instalments over a period exceeding 10 years, only the instalments are taken into account.

8.15(6) If a PROPORTIONAL DISABILITY INCOME is granted in terms of this Schedule, the INSURER must limit the PROPORTIONAL DISABILITY INCOME payable in respect of the INSURED so that the INSURED's average monthly income after disability (as described above) does not exceed 100% of the INSURED's AVERAGE NET MONTHLY INCOME.

8.15(7) At the request of the INSURER the INSURED must submit proof of the extent of his/her average monthly income after disability. If the INSURED fails to submit such proof to the INSURER's satisfaction, the disability income payable in terms of this Schedule may be decreased at the INSURER's discretion.

8.15(8) The INSURER must limit the payments which are made in terms of this disability insurance according to this clause.

The amounts by which the INSURER limits the income disability benefits by virtue of income from other sources (other than the income taken into account in the determination of PROPORTIONAL DISABILITY INCOME) are taken into account by the INSURER at the next revision of the rate at which premiums are payable in terms of the Policy.

8.16 Waiver of contributions and premiums during disability

8.16(1) If a CONTRIBUTION WAIVER BENEFIT and a PREMIUM WAIVER BENEFIT have been selected in the CERTIFICATE OF PARTICIPATION, the INSURER will, during the period in which an income disability benefit is paid in respect of an INSURED in terms of this Schedule, pay the CONTRIBUTION WAIVER BENEFIT to the FUND and the PREMIUM WAIVER BENEFIT to the relevant insurers.

8.16(2) The PREMIUM WAIVER BENEFIT is paid via the FUND to the respective insurers.

8.16(3) If the income disability benefit commences within twelve MONTHS after the date on which the contribution rates in respect of the INSURED to the FUND are increased and the INSURED's disability directly or indirectly arises from or is traceable to –

- a bodily injury which occurred; or
- a condition of which the INSURED was conscious or experienced symptoms or for which medical treatment was received

during the six MONTHS immediately before the increase, the CONTRIBUTION WAIVER BENEFIT is determined as if the increase is not applicable to the INSURED.

8.17 Accident booster benefit

Refer to Schedule 14 for the terms and conditions regarding a claim where an INSURED's disability benefit in terms of this Schedule is restricted to the FREE COVER LIMIT, but his/her full BENETIT ENTITLEMENT is payable if the claim is the result of an accident.

8.18 Absence from service

Refer to Schedule 21 for the terms and conditions regarding the absence of the INSURED from the service of the EMPLOYER while insured in terms of this Schedule.

8.19 Territorial limitations

Refer to Schedule 22 for the terms and conditions regarding the absence of the INSURED from the Republic of South Africa while insured in terms of this Schedule.

8.20 Deductions and unclaimed benefits

Refer to Schedule 23 for the provisions regarding the allowable deductions from benefits payable in terms of the Policy and for the provisions regarding benefits that become payable and are not claimed.

8.21 Cancellation

8.21(1) If the insurance described in this Schedule is cancelled for a group of INSUREDS, the INSURER's liabilities in terms of this Schedule regarding each of those INSUREDS lapse, unless -

(a) an INSURED is TOTALLY DISABLED on the date of cancellation; and

(b) a claim for the benefits in terms of this Schedule is submitted to the INSURER within three MONTHS after the COMMENCEMENT OF DISABILITY; and

(c) the claim is admitted by the INSURER; and

(d) if the WAITING PERIOD expires after the date of cancellation, the premiums in respect of the INSURED for the benefits in terms of this Schedule, are paid to the INSURER until the end of the WAITING PERIOD.

8.21(2) If the INSURER's liabilities do not lapse in terms of the preceding sub-clause, the INSURER must apply the CONTRIBUTION WAIVER BENEFIT and the PREMIUM WAIVER BENEFIT as if the insurance described in this Schedule has not been cancelled and on a basis on which the INSURER decides in consultation with the EMPLOYER.

8.21(3) For the purposes of this clause -

(a) the insurance described in this Schedule is also regarded as cancelled for a group of INSUREDS when –

(i) an EMPLOYER's participation in the Policy or in the benefit provided in terms of this Schedule is terminated; or

(ii) the participation of a category of EMPLOYEES of an EMPLOYER in the Policy or in the benefit provided in terms of this Schedule is terminated; or

(iii) the benefit which is insured in terms of this Schedule is cancelled owing to an amendment to the Policy;

and

(b) an INSURED is deemed to be a member of a group if he/she was a member of the relevant group immediately prior to the commencement of his/her TOTAL DISABILITY.

SCHEDULE 9 LUMP SUM DISABILITY BENEFIT (AFTER TEMPORARY INCOME DISABILITY BENEFIT)

9.1 Definitions

In this Schedule –

ACCIDENT means a bodily injury which –

(a) is caused by physical contact with violent, accidental, tangible and external means; and

(b) is the direct, effective, exclusive and proximate cause of the TOTAL AND PERMANENT DISABILITY of the INSURED; and

(c) is not attributable to the INSURED having negligently or willfully exposed himself/herself to danger, except in the interests of the law or to protect his/her or another's life or property.

BENEFIT CESSATION DATE in regard to an INSURED means the earlier of his/her NORMAL RETIREMENT DATE and the last day of the MONTH in which he/she attains the age of –

- 65 years in the case of all INSUREDS other than PILOTS; and
- 60 years in the case of PILOTS.

DEATH SUM ASSURED in regard to an INSURED means the death benefit that would be paid in accordance with Schedules 4 or 5, as the case may be, but excluding the 'flexible amount' in the case of Schedule 5, in the event of his/her death while an EMPLOYEE and immediately before the WAITING PERIOD.

DISABILITY SUM ASSURED in regard to an INSURED means his/her DEATH SUM ASSURED or such lesser amount as must be indicated in the CERTIFICATE OF PARTICIPATION. The DISABILITY SUM ASSURED may not be more than the smaller of eight times the INSURED's annual RISK SALARY immediately before the WAITING PERIOD and R12 000 000, or such other maximum amount determined by the INSURER from time to time. If, however, the WAITING PERIOD elapses within the 60 MONTHS before the BENEFIT CESSATION DATE and the benefit described in this Schedule is payable in a lump sum, the DISABILITY SUM ASSURED is equal to the amount as described, multiplied by t/60, where t represents the period, expressed in MONTHS, from the lapse of the WAITING PERIOD until the BENEFIT CESSATION DATE. A part of a MONTH is counted as a full MONTH.

DRIVER means an INSURED in respect of whose job one of the core functions is to drive or operate a vehicle or machine that is used for the transporting or conveying of goods or people. 'Core function' in this context means that if he/she is not able to perform this function, the EMPLOYER will be entitled to end his/her employment due to incapacity. A DRIVER must be in possession of a valid license to drive or operate the particular vehicle or machine.

PILOT means an INSURED in respect of whose job one of the core functions is to pilot an aeroplane or helicopter that is used for the transporting or conveying of goods or people or other purposes relating to the business of the EMPLOYER. 'Core function' in this context means that if he/she is not able to perform this function, the EMPLOYER will be entitled to end his/her employment due to incapacity. A PILOT must be in possession of a valid license to pilot the particular aeroplane or helicopter.

PREVIOUS DISABILITY BENEFIT in regard to an INSURED means the disability benefit that would have been provided to the INSURED in terms of the insurance which on the PARTICIPATION DATE was replaced by the insurance provided in this Schedule if he/she had remained insured in terms of that insurance. Included in this PREVIOUS DISABILITY BENEFIT is any increase in such a benefit that would have come into force in terms of the replaced insurance, on or after the PARTICIPATION DATE, but prior to the WAITING

PERIOD, exclusively as a result of increases in the RISK SALARY and without proof of good health. A retirement benefit that was payable at retirement owing to ill-health, is not deemed to be a PREVIOUS DISABILITY BENEFIT.

REGULAR OCCUPATION means the occupation regularly followed by the INSURED immediately before the commencement of his/her TOTAL AND PERMANENT DISABILITY, disregarding any duties not normally associated with an occupation of that nature.

TEMPORARY INCOME DISABILITY BENEFIT means the temporary income disability benefit payable to the INSURED in terms of the unapproved temporary income disability group life insurance in which the EMPLOYER participates for the benefit of its EMPLOYEES.

TOTAL AND PERMANENT DISABILITY means a condition where the INSURED - directly and exclusively as a result of a bodily injury or an illness -

(a) totally and permanently and continuously is prevented - even with further in-service training -

(i) in the case of a PILOT/DRIVER, from following any occupation of whatever nature; and

(ii) in the case of any other INSURED,

- from following the REGULAR OCCUPATION which he/she practised immediately before; and
- from following the occupations which he/she, in view of his/her training and experience, may reasonably be expected to follow,

and experiences loss of income;

or

(b) totally and permanently and continuously cannot use both eyes, or both hands, or both feet, or one hand and one foot,

provided that the condition -

- is not attributable to the INSURED's having negligently or willfully exposed himself/herself to danger, except in the interests of the law or to protect his/her or another's life or property; and
- is not attributable to intentional self-inflicted injury; and
- cannot be substantially removed by surgery or any other medical treatment which, taking into account the risk and the prospect of success of that treatment, can reasonably be expected of the INSURED to undergo,

and **TOTALLY AND PERMANENTLY DISABLED** has a corresponding meaning.

WAITING PERIOD means the period starting at the commencement of the INSURED's disability to the extent required for the TEMPORARY INCOME DISABILITY BENEFIT to become payable and ending at the later of the end of the period during which the TEMPORARY INCOME DISABILITY BENEFIT must be paid and the date when the INSURER is satisfied that the INSURED is TOTALLY AND PERMANENTLY DISABLED.

9.2 Benefit at TOTAL AND PERMANENT DISABILITY

9.2(1) If an INSURED who is an EMPLOYEE, becomes TOTALLY AND PERMANENTLY DISABLED after the latest date on which the insurance described in this Schedule becomes applicable to him/her, but before the BENEFIT CESSATION DATE, the INSURER pays the DISABILITY SUM ASSURED to the INSURED.

9.2(2) The benefit in terms of this clause become payable only if and after –

- the INSURER is satisfied, in the way stipulated below, that the INSURED is TOTALLY AND PERMANENTLY DISABLED, and
- the disability of the INSURED to the extent required for the TEMPORARY INCOME DISABILITY BENEFIT to be payable has lasted for the WAITING PERIOD.

No benefit is payable if -

(a) the commencement of the TOTAL AND PERMANENT DISABILITY is after the end of the period during which the TEMPORARY INCOME DISABILITY BENEFIT must be paid; or

(b) the INSURER is satisfied only after the BENEFIT CESSATION DATE that the INSURED is TOTALLY AND PERMANENTLY DISABLED; or

(c) the WAITING PERIOD expires after the BENEFIT CESSATION DATE.

9.3 Cessation of premiums after the WAITING PERIOD

Premiums are payable until the end of the WAITING PERIOD. After the WAITING PERIOD and as long as the INSURED's TOTAL AND PERMANENT DISABILITY continues afterwards, no premiums are payable to the INSURER regarding the INSURED for the insurance described in this Schedule.

9.4 Death after the WAITING PERIOD

9.4(1) If an INSURED dies after the WAITING PERIOD, the INSURER pays the amount by which the DISABILITY SUM ASSURED was reduced in terms of the definition of DISABILITY SUM ASSURED as a result of the WAITING PERIOD elapsing within the 60 MONTHS before the BENEFIT CESSATION DATE, provided that -

(a) the INSURER is satisfied, in the way stipulated below, that the INSURED'S TOTAL AND PERMANENT DISABILITY continued until his/her death; and

(b) the death occurred -

(i) before or on the BENEFIT CESSATION DATE; and

(ii) before the cancellation with the INSURER of the insurance of the death benefit in respect of the group of EMPLOYEES to which the INSURED belonged immediately prior to his/her TOTAL AND PERMANENT DISABILITY.

9.4(2) The death benefit payable in terms of this clause is paid in accordance with Schedules 4 or 5, as the case may be.

9.5 Commencement of disability

For the purposes of this Schedule the INSURER, on the grounds of the medical and other information submitted, determines when the TOTAL AND PERMANENT DISABILITY commences. The INSURER may determine such commencement without taking into account the requirement that the INSURED has to experience loss of income before being considered TOTALLY AND PERMANENTLY DISABLED.

9.6 Special cases of disability

If an INSURED experiences TOTAL AND PERMANENT DISABILITY as described in paragraph (b) of the definition of TOTAL AND PERMANENT DISABILITY, it is not necessary for the INSURED to be TOTALLY AND PERMANENTLY DISABLED for the WAITING PERIOD before a benefit is payable in terms of this Schedule.

9.7 Proof of good health

FREE COVER LIMIT

9.7(1) The insurance provided in terms of this Schedule regarding an INSURED is limited to the FREE COVER LIMIT, unless proof of good health to the satisfaction of the INSURER regarding that part of his/her BENEFIT ENTITLEMENT exceeding the FREE COVER LIMIT is submitted to the INSURER in the manner specified by the INSURER from time to time. Different FREE COVER LIMITS may apply to this Schedule and Schedules 4 or 5, as the case may be.

Insurance not limited to the FREE COVER LIMIT

9.7(2) The insurance in terms of this Schedule is not limited to the FREE COVER LIMIT in the following instances -

(a) for the first three MONTHS after the INSURED becomes an INSURED; and

(b) for the first three MONTHS after an increase in the INSURED's BENEFIT ENTITLEMENT if the FREE COVER LIMIT is exceeded for the first time as a result of the increase,

provided that -

- the benefit which is provided in the three MONTHS referred to in paragraphs (a) and (b) above is only for a claim arising as a result of an ACCIDENT during those periods; and
- the benefits which are provided in the three MONTHS referred to in paragraphs (a) and (b) above may not exceed amounts determined by the INSURER from time to time; and
- paragraph (a) is not applicable if the INSURED becomes an INSURED as a result of the insurance provided in terms of this Schedule replacing other insurance in terms of which the INSURED was insured; and
- if the INSURED submits proof of good health to the satisfaction of the INSURER within the three MONTHS referred to in paragraphs (a) or (b) above, then the insurance that is agreed to by the EMPLOYER and the INSURER in writing is applicable to the INSURED from the moment it is put in writing.

No insurance without proof of good health

9.7(3) Notwithstanding the provisions of the previous sub-clause, the persons and the amounts referred to in the following paragraphs will not be insured in terms of this Schedule, unless proof of good health is submitted to the INSURER in the manner specified by the INSURER from time to time. The persons referred to, the amounts involved and the responsibility for the costs of providing proof are as follows:

(a) A person who has the option of becoming a member of the FUND but fails to become a member within three MONTHS of becoming entitled to do so and becomes a member after three MONTHS. Proof must be provided for the full amount of his/her BENEFIT ENTITLEMENT. Provision of proof is at the expense of the person.

(b) An INSURED who, in terms of clauses 9.10(6), 21.2(2) or 22.4, does not qualify for the insurance of the benefit in terms of this Schedule, or any increase in it by virtue of an amendment to the Policy, and elects to submit proof of his/her good health to the INSURER. Proof must be provided for the full amount of his/her BENEFIT ENTITLEMENT or the increase in it, as the case may be. Provision of proof is at the expense of the INSURER.

(c) An employee of a MUNICIPALITY who is 55 years or older on the date on which he/she is insured for the first time for the benefit in terms of this Schedule. Proof must be provided for the full amount of his/her BENEFIT ENTITLEMENT. Provision of proof is at the expense of the INSURER.

9.7(4) The EMPLOYER must advise the INSURER in writing immediately on the happening of a situation referred to in the previous sub-clause.

9.7(5) The INSURER will only request proof of good health in respect of the above persons upon being advised by the EMPLOYER in writing of a situation referred to above.

9.7(6) The INSURER will not be liable for any claim in respect of the above persons if the EMPLOYER does not advise the INSURER in writing of the particular situation referred to above where proof of good health is not submitted to the INSURER in the manner specified.

Satisfactory proof of good health

9.7(7) In deciding on medical grounds that the proof of good health that is submitted in a particular case in terms of the preceding sub-clauses is to its satisfaction, the INSURER may determine that the insurance of that part of the benefits for which the proof is submitted, and of future increases in those benefits, is not applicable in the case of causes of disability as laid down by the INSURER.

Commencement of insurance requiring proof of good health

9.7(8) The part of the insurance described in this Schedule for which proof of good health in respect of an INSURED is required by the INSURER, will be insured as from the date on which the INSURER receives the last information taken into account in establishing the good health of the INSURED. But any such insurance for which the INSURER excludes certain causes of disability, only commences after the EMPLOYER is informed of the excluded causes of disability by the INSURER in writing.

Increases in insurance exceeding the FREE COVER LIMIT

9.7(9) Once proof of good health for that part of an INSURED's insurance exceeding the FREE COVER LIMIT is accepted by the INSURER, subsequent increases in the INSURED's BENEFIT ENTITLEMENT, as a result of increases in the INSURED's RISK SALARY only, will apply without further proof of good health having to be submitted to the INSURER. However, further proof of good health must be provided in the following circumstances:

(a) if certain periods determined by the INSURER from time to time expire; or

(b) if the INSURED reaches a certain age determined by the INSURER from time to time; or

(c) if the disability benefit exceeds amounts determined by the INSURER from time to time.

Reduction of the FREE COVER LIMIT

9.7(10) If the INSURER reduces the FREE COVER LIMIT at any specific time, the insurance that applies to an existing INSURED before such reduction, will not be reduced accordingly, provided that the benefit remains applicable to the INSURED without interruption.

Temporary cessation of insurance

9.7(11) If the insurance in this Schedule ceases to apply to an INSURED temporarily, proof of good health that is submitted in respect of the INSURED before such cessation will, for the purposes of the preceding clauses, be deemed null and void.

9.8 Claims procedure

Notification

9.8(1) At the same time as the insurer of the TEMPORARY INCOME DISABILITY BENEFIT is notified of a claim for such a benefit, the INSURER must be notified in writing of the potential claim for the lump sum disability benefit in terms of this Schedule.

Submission

9.8(2) The claim forms and other documentation required by the INSURER must also be submitted at its head office at the same time as the claim forms and other documentation required by the insurer of the TEMPORARY INCOME DISABILITY BENEFIT are submitted to that insurer.

Proof

9.8(3) The INSURER monitors the disability of the INSURED for the duration of the WAITING PERIOD. At the end of the WAITING PERIOD the INSURER has to be satisfied, by way of medical and other information, that the INSURED is TOTALLY AND PERMANENTLY DISABLED

9.8(4) The INSURER may request additional information in order to satisfy itself that the INSURED is TOTALLY AND PERMANENTLY DISABLED. The INSURED must provide the additional information to the INSURER within 60 days of the INSURER's request.

Cost of providing proof

9.8(5) The EMPLOYER is informed in the administration guides on the RETIREMENT FUND WEB of the medical and other information which is required by the INSURER in respect of an INSURED in order for the INSURER to assess for the first time whether the INSURED is TOTALLY AND PERMANENTLY DISABLED. This information must be submitted at the expense of the INSURED. The provision of any additional information that the INSURER may require is at the expense of the INSURER.

Resubmission of a rejected claim

9.8(6) If the INSURER rejects a claim for the lump sum disability benefit in terms of this Schedule, the claim may be resubmitted with new evidence or submissions. Such a resubmitted claim must be made within 90 days of the rejection. If the INSURER again rejects the claim, no further resubmission of the claim will be considered by the INSURER. If any new medical evidence is submitted in order to have a claim reassessed, the cost of such medical evidence is for the INSURED's expense.

9.9 Payment of benefit

The lump sum disability benefit payable in terms of this Schedule must be paid to the INSURED.

9.10 General exclusions

9.10(1) If an INSURED is a professional sportsman, professional sportswoman or professional diver, no benefit is payable in terms of this Schedule.

9.10(2) Notwithstanding any other provision to the contrary in the Policy, no benefit is paid in terms of this Schedule if the TOTAL AND PERMANENT DISABILITY -

(a) is a direct or indirect consequence of active participation in

(i) war, invasion, acts of foreign enemies, hostilities, warlike operations (whether war be declared or not), civil war, rebellion, revolution, military or usurped power, insurrection, civil commotion assuming the proportions of or amounting to an uprising; or

(i) an act of terrorism; or

(ii) a riot; or

(iii) conduct during a strike (irrespective of whether the strike is lawful or unlawful) during which conduct lives are endangered, public or private property damaged, or an attempt or attempts are made to damage such property; or

(iv) any other unlawful act or conduct of whatever nature during which lives are endangered, public or private property damaged, or an attempt or attempts are made to damage such property.

(b) is a direct or indirect consequence of –

(i) any radioactive contamination, including accidental radioactive contamination; or

(ii) the use of nuclear, biological or chemical weapons; or

(iii) attacks on or sabotage of facilities (including, but not limited to, nuclear power plants, reprocessing plants, final repository sites and research reactors) and storage depots, which lead to the release of radioactivity or nuclear, biological or chemical warfare agents,

irrespective whether any of the aforesaid is performed with the specific use of information technology.

9.10(3) The benefit described in this Schedule is not payable in respect of an INSURED if he/she has the option of becoming a member of the FUND and, by so doing, becoming an INSURED and his/her TOTAL AND PERMANENT DISABILITY commences before the INSURER receives his/her full particulars.

9.10(4) Subject to sub-clauses 9.7(7) and 9.7(8), the disability benefits described in this Schedule for which proof of good health in respect of an INSURED is required by the INSURER, are only provided if the INSURED's TOTAL AND PERMANENT DISABILITY commences on or after the date on which the INSURER receives the last information taken into account in establishing the good health of the INSURED.

9.10(5) The benefit described in this Schedule is not payable in respect of an INSURED if his/her TOTAL AND PERMANENT DISABILITY commences during a period in which the INSURED is deliberately absent from the EMPLOYER's service without permission, unless the EMPLOYER and the INSURER agree otherwise in a particular case.

9.10(6) If, in the opinion of the INSURER, an INSURED, as a result of a bodily injury or sickness, is incapable of performing his/her normal duties with the EMPLOYER on the latest date on which the insurance described in this Schedule, or any increase in that insurance by virtue of an amendment to the Policy, commences with the INSURER regarding the INSURED, he/she will not qualify for the insurance or the increase, as the case may be, until -

(a) he/she, in the opinion of the INSURER, resumes his/her normal duties and the premiums for the insurance or the increase, as the case may be, are paid in respect of him/her as from the resumption of those duties; and

(b) he/she performs his/her normal duties for 60 consecutive BUSINESS DAYS or he/she submits proof of his/her good health to the satisfaction of the INSURER in accordance with the provisions of this Schedule, whichever is the earlier.

9.10(7) The benefit described in this Schedule, or any increase in it by virtue of an amendment to the Policy, is also not payable in respect of an INSURED if the INSURED becomes TOTALLY AND PERMANENTLY DISABLED within twelve MONTHS after the latest date on which the insurance of the benefit or the insurance of the increase, as the case may be, commences with the INSURER in respect of the INSURED and such disability directly or indirectly arises from or is traceable to –

- a bodily injury which occurred; or
- a condition of which the INSURED was conscious or experienced symptoms or for which medical treatment was received

during the six MONTHS (twelve MONTHS in the case of an INSURED who is an EMPLOYEE of a MUNICIPALITY) immediately before that date. This provision does not apply to an INSURED in respect of whom proof of good health for the insurance or the

increase in terms of this Schedule is submitted to the satisfaction of the INSURER after the mentioned date and in the manner specified by the INSURER from time to time.

9.11 Replacement of existing insurance

If, exclusively by virtue of sub-clauses 9.10(6) or 9.10(7), the benefit in terms of this Schedule is not paid in regard to an INSURED who –

- immediately before the PARTICIPATION DATE was insured in terms of the insurance which was replaced by the insurance provided in terms of this Schedule; and
- since then has been an INSURED without interruption,

but a benefit would have been paid in terms of the replaced insurance had it still applied to the INSURED, then the INSURER pays to the INSURED either –

(a) the benefit in terms of this Schedule; or

(b) a disability benefit on which the INSURER decides and which in its opinion is related to the value, as determined by it, of the PREVIOUS DISABILITY BENEFIT,

whichever of the benefits referred to in paragraphs (a) and (b) is, in the opinion of the INSURER, the lesser in the case of the INSURED.

9.12 Termination of service

If an INSURED's service is terminated with the EMPLOYER and he/she is TOTALLY AND PERMANENTLY DISABLED on the date of termination of service, he/she remains an INSURED as if he/she had remained an EMPLOYEE and the EMPLOYER had consented to his/her absence from work. He/she remains an INSURED, however, only until the earliest of -

- the expiry of two years;
- the date on which the benefit in terms of this Schedule becomes payable; or
- a claim for the benefit is declined.

9.13 Earlier occurrences of disability

The total sum payable by the INSURER in respect of an INSURED for all periods of disability, in terms of disability insurance comprising lump sum disability benefits, may not exceed the total sum for which the INSURER was liable when for the first time payments in respect of the INSURED were made in terms of the insurance described in this Schedule.

9.14 Maximum benefits from the INSURER

9.14(1) If an INSURED becomes entitled to a lump sum disability benefit in terms of this Schedule and also, by virtue of his/her employment with other employers, becomes entitled to other lump sum disability benefits, either in terms of this Policy or other group policies underwritten by the INSURER, the total amount of the lump sum disability benefits payable to the INSURED by the INSURER will be limited to the smaller of eight times the total amount of the INSURED's annual risk salaries in terms of the respective group policies and the largest of the maximum amounts that the INSURER is prepared to pay in terms of each policy.

9.14(2) If the total amount of the lump sum disability benefits payable by the INSURER must be reduced in terms of this clause, the benefit payable in terms of each policy will be reduced proportionately according to the amount of the benefit.

9.14(3) The final benefit payable in terms of each policy will be subject to any further reductions in terms of the provisions of each policy regarding the lapsing of any 'waiting period' in the 60 MONTH period before the insurance of the lump sum disability benefit in respect of the INSURED ceases.

9.15 Maximum benefits from all sources

9.15(1) The INSURER limits an INSURED's disability benefit so that the INSURED's average monthly income after disability (as defined below) does not exceed 75% of his/her average monthly earnings before disability (as defined below).

9.15(2) The average monthly earnings of the INSURED before disability is taken as the average per MONTH of all income and remuneration which accrued to the INSURED from his/her engaging in his/her occupation during the twelve MONTHS before the commencement of TOTAL AND PERMANENT DISABILITY. Any form of fringe benefits of a non-recurrent nature are, however, excluded. Further, all expenditure and costs incurred directly with a view to earning such income and remuneration are deducted from the said total income and remuneration.

9.15(3) For the purposes of this clause the INSURED's average monthly income after disability is determined by taking into account the following receipts:

(a) all income and remuneration payable to the INSURED directly or indirectly for services which he/she renders or rendered or in connection with an occupation which he/she follows or followed, decreased by all expenditure and costs incurred directly with a view to earning that income and remuneration; and

(b) any form of benefit or remuneration (whether in cash or not) to which somebody becomes entitled in connection with or as a result of the INSURED'S disability or to which somebody would have been entitled if the benefit in terms of this Schedule had not existed. This includes any gratuity or other payment from a fund or scheme which provides benefits at retirement or disability and benefits in terms of the Compensation for Occupational Injuries and Diseases Act, 1993, as amended.

The following are not taken into account:

(i) the waiver of contributions to pension and provident funds in terms of group disability policies;

(ii) any benefits in terms of the Motor Vehicle Accidents Act, 1986, as amended, read together with section 3 of the Multilateral Motor Vehicle Accidents Fund Act, 1989, as amended;

(iii) the benefits in terms of any policy owned by the EMPLOYER from which no benefit consequent upon the disability of the INSURED becomes payable to the INSURED or to his/her spouse or to any member of the INSURED's family;

(iv) income disability benefits which are payable for not more than two years to cover continued business expenses;

(v) lump sum receipts of which the aggregate does not exceed the larger of R550 000, or any other amount determined by the INSURER, and 2,5 times the annual RISK SALARY of the INSURED before the commencement of disability;

(vi) any benefit payable at the surrender of a policy or at early retirement or withdrawal from any fund or scheme for reasons other than ill health. For this purpose a retirement annuity policy is deemed to have a surrender value;

(vii) benefits payable if the INSURED, due to an accident, experiences the total and permanent loss of the sight of one or both eyes or the use of any part of his/her body;

(viii) benefits payable due to the INSURED being permanently, continuously and totally prevented from performing the normal actions and functions with regard to the care of his/her body or from taking care of his/her personal interests; and

(ix) during the period of two years starting at the commencement of TOTAL AND PERMANENT DISABILITY, regular receipts which in total are not more than a

monthly receipt of 25% of the INSURED's average monthly earnings before disability.

9.15(4) In the determination of the average monthly income after disability, lump sum receipts are (except as far as sub-clause (3)(ix) is concerned) deemed to be a regular monthly income equal to such lump sum receipts divided by 120.

9.15(5) Any receipt expressed as a capital amount payable by instalments over a period of 10 years or less, is also deemed to be a lump sum receipt.

9.15(6) Where a receipt is expressed as a capital amount payable by instalments over a period exceeding 10 years, only the instalments are taken into account.

9.15(7) At the request of the INSURER the INSURED must submit proof of the extent of his/her average monthly income after disability. If the INSURED fails to submit such proof to the INSURER's satisfaction, the payment in terms of this Schedule may be decreased at the INSURER's discretion.

9.15(8) The INSURER must limit the payments which are made in terms of this disability insurance according to this clause.

9.15(9) If an INSURED dies before or on the BENEFIT CESSATION DATE, the INSURER pays the amounts with which the disability benefit is limited in terms of this clause as a death benefit in accordance with Schedules 4 or 5, as the case may be.

9.16 Accident booster benefit

Refer to Schedule 14 for the terms and conditions regarding a claim where an INSURED's disability benefit in terms of this Schedule is restricted to the FREE COVER LIMIT, but his/her full BENETIT ENTITLEMENT is payable if the claim is the result of an accident.

9.17 Option to apply for individual lump sum disability insurance

Refer to Schedule 18 for the terms and conditions regarding the option to apply for individual lump sum disability life insurance.

9.18 Absence from service

Refer to Schedule 21 for the terms and conditions regarding the absence of the INSURED from the service of the EMPLOYER while insured in terms of this Schedule.

9.19 Territorial limitations

Refer to Schedule 22 for the terms and conditions regarding the absence of the INSURED from the Republic of South Africa while insured in terms of this Schedule.

9.20 Unclaimed benefits

Refer to Schedule 23 for the provisions regarding benefits that become payable and are not claimed.

9.21 Cancellation

9.21(1) If the insurance described in this Schedule is cancelled for a group of INSUREDS, the INSURER's liabilities in terms of this Schedule regarding each of those INSUREDS lapses, unless -

(a) an INSURED is disabled to the extent required for the TEMPORARY INCOME DISABILITY BENEFIT to be payable by the relevant insurer on the date of cancellation or, the INSURED is TOTALLY AND PERMANENTLY DISABLED in terms of this Schedule on the date of cancellation; and

(b) the INSURER is notified in writing of the potential claim for the lump sum disability benefit in terms of this Schedule at the earlier of –

(i) the same time the insurer of the TEMPORARY INCOME DISABILITY BENEFIT is notified of the claim for that benefit; and

(ii) the end of the third MONTH following the date of cancellation;

and

(c) the claim forms and other documentation required by the INSURER are submitted at its head office at the earlier of –

(i) the same time the claim forms and other documentation required by the insurer of the TEMPORARY INCOME DISABILITY BENEFIT are submitted to that insurer; and

(ii) the end of the third MONTH following the date of cancellation;

and

(d) the claim for the disability benefit in terms of this Schedule is admitted by the INSURER; and

(e) if the WAITING PERIOD expires after the date of cancellation, the premium for this lump sum disability insurance and that part of the death insurance with the INSURER on which this lump sum disability insurance is based, is paid to the INSURER in regard to the INSURED until the end of the WAITING PERIOD.

9.21(2) For the purposes of this clause -

(a) the insurance described in this Schedule is also regarded as cancelled for a group of INSURED's when –

(i) an EMPLOYER's participation in the Policy or in the benefit provided in terms of this Schedule is terminated; or

(ii) the participation of a category of EMPLOYEES of an EMPLOYER in the Policy or in the benefit provided in terms of this Schedule is terminated; or

(iii) the benefit which is insured in terms of this Schedule is cancelled owing to an amendment to the Policy; or

(iv) the insurance with the INSURER of the death benefits on which this disability insurance is based, is cancelled for a group of INSUREDS;

and

(b) an INSURED is deemed to be a member of a group if he/she was a member of the relevant group immediately prior to the commencement of his/her TOTAL AND PERMANENT DISABILITY.

SCHEDULE 10 DEATH BENEFIT ON QUALIFYING SPOUSE'S LIFE

10.1 Definitions

In this Schedule –

ACCIDENT means a bodily injury which –

(a) is caused by physical contact with violent, accidental, tangible and external means; and

(b) is the direct, effective, exclusive and proximate cause of the death of the QUALIFYING SPOUSE; and

(c) is not attributable to the QUALIFYING SPOUSE having negligently or willfully exposed himself/herself to danger, except in the interests of the law or to protect his/her or another's life or property.

BENEFIT ENTITLEMENT in regard to a QUALIFYING SPOUSE means the benefit that would be provided by the INSURER in regard to him/her in terms of this Schedule but for the stipulations of this Schedule regarding proof of good health.

MARRIAGE means –

(a) a marriage or union in accordance with the Marriage Act, 1961, the Recognition of Customary Marriages Act, 1998, or the Civil Union Act, 2006, or the tenets of a religion; or

(b) a union where two persons are living together as if married, with the commitment of continuing to do so permanently provided that -

- they have been doing so for at least six MONTHS; and
- in the format prescribed by the EMPLOYER from time to time, they successfully applied in writing to the EMPLOYER, before the death of any one of them, for their union to be registered by the EMPLOYER; and
- one or both of them are not joined in a marriage or union as contemplated in paragraph (a) above with another person.

PREVIOUS DEATH BENEFIT in regard to a QUALIFYING SPOUSE means the death benefit that would have been paid in terms of the insurance which on the PARTICIPATION DATE was replaced by the insurance provided in this Schedule, if he/she had remained insured in terms of that insurance. This includes any increase in the PREVIOUS DEATH BENEFIT that would have come into force, on or after the said date, exclusively as a result of increases in the RISK SALARY of the INSURED and without proof of good health of the QUALIFYING SPOUSE.

QUALIFYING SPOUSE in regard to an INSURED means the person with whom he/she is joined in MARRIAGE, provided that such person, at the time of qualifying for the insurance, has already reached the age of 15 years and is not yet 70 years of age. If an INSURED is joined in MARRIAGE with two or more persons, QUALIFYING SPOUSE means –

(a) only that one of them whom the INSURED nominated in writing to the EMPLOYER during the person's life; or

(b) if the EMPLOYER advises the INSURER that the INSURED has failed to nominate only one of them in terms of paragraph (a), only the one with whom he/she is joined in MARRIAGE first.

Once a nomination has been made in terms of paragraph (a), it remains in force as long as the INSURED is joined in MARRIAGE with the relevant spouse.

A QUALIFYING SPOUSE who is joined in a union referred to in paragraph (b) of the definition of MARRIAGE must, in terms of clause 10.5(3), submit proof of good health to the satisfaction of the INSURER to qualify for the insurance in terms of this Schedule.

Notwithstanding any provision to the contrary in the Policy, the provision in the above paragraph does not apply to a QUALIFYING SPOUSE who immediately before the PARTICIPATION DATE was insured in terms of insurance which is replaced by the insurance provided in terms of this Schedule.

10.2 Benefit

If the QUALIFYING SPOUSE of an INSURED dies before the end of the MONTH in which the QUALIFYING SPOUSE attains the age of 70 years and before or on the INSURED's NORMAL RETIREMENT DATE while the INSURED is an EMPLOYEE, a death benefit is payable. The death benefit is equal to once or twice the INSURED's annual RISK SALARY, as indicated in the CERTIFICATE OF PARTICIPATION, but not more than R8 000 000 or such other maximum amount determined by the INSURER from time to time. The death benefit may be reduced in terms of the proof of good health requirements below.

10.3 Extended in-service QUALIFYING SPOUSE's death benefit

10.3(1) If an INSURED's cover in terms of the UNDERLYING INSURANCE is allowed to remain in force while the INSURED remains actively in service after his/her NORMAL RETIREMENT DATE, the QUALIFYING SPOUSE's death benefit will, provided that this option has been selected in the CERTIFICATE OF PARTICIPATION, remain in force until the earlier of –

- the INSURED's actual retirement from service;
- the end of the MONTH in which the INSURED attains the age indicated in the CERTIFICATE OF PARTICIPATION, which is subject to a maximum of 70 years; and
- the end of the MONTH in which his/her QUALIFYING SPOUSE attains the age of 70 years.

10.3(2) The death benefit that remains in force in respect of the QUALIFYING SPOUSE of an INSURED in terms of this clause will change in accordance with any changes in terms of the Policy to the death benefits of the QUALIFYING SPOUSES of the group of EMPLOYEES of the EMPLOYER in the same category as the INSURED.

10.3(3) No increases in the death benefit of the QUALIFYING SPOUSE as a result of increases in the RISK SALARY in excess of the average increase in the death benefits of all the EMPLOYEES of the EMPLOYER will be permitted after the INSURED's NORMAL RETIREMENT DATE until such time as satisfactory proof of good health of the QUALIFYING SPOUSE is accepted by the INSURER. The cost of any such proof of good health must be borne by the INSURED.

10.3(4) If an INSURED is absent from service in terms of Schedule 21 after his/her NORMAL RETIREMENT DATE for any reason other than leave approved by the EMPLOYER excluding unpaid leave, his/her insurance in terms of this Schedule will terminate immediately upon the commencement of such absence from service, and no further benefit will be payable in respect of such an INSURED.

10.4 Effect of a lump sum disability benefit on the benefit

For purposes of this Schedule it is deemed that an INSURED, in regard to whom a lump sum disability benefit becomes payable in terms of this Policy, ceases to be an INSURED on the date on which the lump sum disability benefit becomes payable.

10.5 Proof of good health

FREE COVER LIMIT

10.5(1) The insurance in this Schedule in regard to a QUALIFYING SPOUSE is limited to the FREE COVER LIMIT, unless proof of good health to the satisfaction of the INSURER regarding that part of his/her BENEFIT ENTITLEMENT exceeding the FREE COVER LIMIT is submitted to the INSURER in the manner specified by the INSURER from time to time.

Insurance not limited to the FREE COVER LIMIT

10.5(2) The insurance in this Schedule in regard to a QUALIFYING SPOUSE is not limited to the FREE COVER LIMIT in the following instances –

(a) for the first three MONTHS after the insurance in terms of this Schedule becomes applicable to the QUALIFYING SPOUSE; and

(b) for the first three MONTHS after an increase in the QUALIFYING SPOUSE's BENEFIT ENTITLEMENT if the FREE COVER LIMIT is exceeded for the first time as a result of the increase,

provided that –

- the benefit which is provided in the three MONTHS referred to in paragraphs (a) and (b) above is only for a claim arising as a result of an ACCIDENT during those periods; and
- the benefit which is provided in the three MONTHS referred to in paragraphs (a) and (b) above may not exceed amounts determined by the INSURER from time to time; and
- paragraph (a) is not applicable if the insurance provided in terms of this Schedule replaces other insurance in terms of which the QUALIFYING SPOUSE was insured; and
- if the QUALIFYING SPOUSE submits proof of good health to the satisfaction of the INSURER within the three MONTHS referred to in paragraphs (a) or (b) above, then the insurance that is agreed by the EMPLOYER and the INSURER in writing is applicable to the QUALIFYING SPOUSE from the moment it is put in writing.

No insurance without proof of good health

10.5(3) Notwithstanding the provisions of the previous sub-clause, the persons and the amounts referred to in the following paragraphs will not be insured in terms of this Schedule, unless proof of good health is submitted to the INSURER in the manner specified by the INSURER from time to time. The persons referred to, the amounts involved and the responsibility for the costs of providing proof of good health are as follows:

(a) The QUALIFYING SPOUSE of an INSURED who has the option of becoming a member of the FUND but fails to become a member within three MONTHS of becoming entitled to do so and becomes a member after three MONTHS. Proof must be provided for the full amount of the QUALIFYING SPOUSE's BENEFIT ENTITLEMENT. Provision of proof is at the expense of the INSURED.

(b) An INSURED who in terms of sub-clauses 10.8(4) or 21.2(2), and an INSURED or his/her QUALIFYING SPOUSE who in terms of clause 22.4, does not qualify for the insurance of the benefit in terms of this Schedule, or any increase in it by virtue of an amendment to the Policy, and elects to submit proof of his/her good health to the INSURER. Proof must be provided for the full amount of his/her BENEFIT ENTITLEMENT, or any increase in it, as the case may be. Provision of proof is at the expense of the INSURER.

(c) A QUALIFYING SPOUSE who is joined in a union referred to in paragraph (b) of the definition of MARRIAGE other than such a QUALIFYING SPOUSE who immediately before the PARTICIPATION DATE was insured in terms of insurance which is replaced by the spouses insurance provided in terms of this Schedule. Proof must be

provided for the full amount of the QUALIFYING SPOUSE's BENEFIT ENTITLEMENT. Provision of proof is at the expense of the INSURER.

10.5(4) The EMPLOYER must advise the INSURER in writing immediately on the happening of a situation referred to in the previous sub-clause.

10.5(5) The INSURER will only request proof of good health upon being advised by the EMPLOYER in writing of a situation referred to above.

10.5(6) The INSURER will not be liable for any claim in respect of a QUALIFYING SPOUSE if the EMPLOYER does not advise the INSURER in writing of the particular situation referred to above where proof of good health is not submitted to the INSURER in the manner specified.

Satisfactory proof of good health

10.5(7) In deciding on medical grounds that the proof of good health that is submitted in a particular case in terms of the preceding sub-clauses is to its satisfaction, the INSURER may determine that the insurance of that part of the benefits for which the proof is submitted, and of future increases in those benefits, is not applicable in the case of causes of death as laid down by the INSURER.

Commencement of insurance requiring proof of good health

10.5(8) The part of the insurance described in this Schedule for which proof of good health in respect of the QUALIFYING SPOUSE is required by the INSURER, will be insured as from the date on which the INSURER receives the last information taken into account in establishing the good health of the QUALIFYING SPOUSE. But any such insurance for which the INSURER excludes certain causes of death, only commences after the EMPLOYER is informed of the excluded causes of death by the INSURER in writing.

Increases in insurance exceeding the FREE COVER LIMIT

10.5(9) Once proof of good health for that part of a QUALIFYING SPOUSE's insurance exceeding the FREE COVER LIMIT is accepted by the INSURER, subsequent increases in the QUALIFYING SPOUSE'S BENEFIT ENTITLEMENT, as a result of increases in the INSURED's RISK SALARY only, will apply without further proof of good health having to be submitted to the INSURER. However, further proof of good health must be provided in the following circumstances:

(a) if certain periods determined by the INSURER from time to time expire; or

(b) if the QUALIFYING SPOUSE reaches a certain age determined by the INSURER from time to time; or

(c) if the death benefit exceeds amounts determined by the INSURER from time to time.

Reduction of the FREE COVER LIMIT

10.5(10) If the INSURER reduces the FREE COVER LIMIT at any specific time, the insurance that applies to an existing QUALIFYING SPOUSE before such reduction will not be reduced accordingly, provided that the benefit remains applicable to the QUALIFYING SPOUSE without interruption.

Temporary cessation of insurance

10.5(11) If the insurance in this Schedule ceases to apply to a QUALIFYING SPOUSE temporarily, proof of good health that is submitted in respect of the QUALIFYING SPOUSE before such cessation will, for the purposes of the preceding clauses, be deemed null and void.

10.6 Claims procedure

Notification

10.6(1) The INSURER must be notified in writing of a claim for a death benefit within six MONTHS after the QUALIFYING SPOUSE's death or the INSURER will reject the claim.

Submission

10.6(2) The claim for the death benefit will not be assessed until the claim forms and other documentation required by the INSURER are submitted at its head office.

Proof

10.6(3) When a claim for a death benefit arises, the INSURER may require proof to its satisfaction as to any circumstance which may affect the recognition of the claim.

10.7 Payment of benefit

Notwithstanding any provision to the contrary in the Policy, the INSURER pays the benefit payable in terms of this Schedule to the INSURED and if the INSURED is deceased, into the INSURED's estate.

10.8 General exclusions

10.8(1) Notwithstanding any other provision to the contrary in the Policy, no benefit is paid in terms of this Schedule if the QUALIFYING SPOUSE'S death -

(a) is a direct or indirect consequence of active participation in

(i) war, invasion, acts of foreign enemies, hostilities, warlike operations (whether war be declared or not), civil war, rebellion, revolution, military or usurped power, insurrection, civil commotion assuming the proportions of or amounting to an uprising; or

(ii) an act of terrorism; or

(iii) a riot; or

(iv) conduct during a strike (irrespective of whether the strike is lawful or unlawful) during which conduct lives are endangered, public or private property damaged, or an attempt or attempts are made to damage such property; or

(v) any other unlawful act or conduct of whatever nature during which lives are endangered, public or private property damaged, or an attempt or attempts are made to damage such property.

(b) is a direct or indirect consequence of –

(i) any radioactive contamination, including accidental radioactive contamination; or

(ii) the use of nuclear, biological or chemical weapons; or

(iii) attacks on or sabotage of facilities (including, but not limited to, nuclear power plants, reprocessing plants, final repository sites and research reactors) and storage depots, which lead to the release of radioactivity or nuclear, biological or chemical warfare agents,

irrespective whether any of the aforesaid is performed with the specific use of information technology.

10.8(2) The death benefit described in this Schedule is not provided regarding an INSURED if the INSURED has the option of becoming a member of the FUND and, by so doing, becoming

an INSURED and his/her QUALIFYING SPOUSE dies before the INSURER receives full particulars regarding the INSURED and his/her QUALIFYING SPOUSE.

10.8(3) Subject to sub-clauses 10.5(7) and 10.5(8), the death benefits described in this Schedule for which proof of good health in respect of a QUALIFYING SPOUSE is required by the INSURER, are only provided if the QUALIFYING SPOUSE dies on or after the date on which the INSURER receives the last information taken into account in establishing the good health of the QUALIFYING SPOUSE.

10.8(4) If, in the opinion of the INSURER, an INSURED, as a result of a bodily injury or sickness, is incapable of performing his/her normal duties with the EMPLOYER on the latest date on which the insurance described in this Schedule or any increase in that insurance by virtue of an amendment to the Policy, commences with the INSURER regarding the INSURED, he/she will not qualify for the insurance or the increase, as the case may be, until -

(a) he/she, in the opinion of the INSURER, resumes his/her normal duties and the premiums for the insurance or the increase, as the case may be, are paid in respect of him/her as from the resumption of those duties; and

(b) he/she performs his/her normal duties for 60 consecutive BUSINESS DAYS or he/she submits proof of his/her good health to the satisfaction of the INSURER in accordance with the provisions of the UNDERLYING INSURANCE, whichever is the earlier.

10.9 Replacement of existing insurance

10.9(1) If, exclusively by virtue of sub-clause 10.8(4), the benefit in terms of this Schedule is not payable in regard to an INSURED who –

- immediately before the PARTICIPATION DATE was insured in terms of the insurance which was replaced by the insurance provided in terms of this Schedule; and
- since then has been an INSURED without interruption,

but a benefit would have been paid in terms of the replaced insurance had it still applied to the INSURED, then the INSURER provides either –

(a) the benefit in terms of this Schedule; or

(b) a lump sum equal to the value, as determined by the INSURER, of the PREVIOUS DEATH BENEFIT,

whichever of the benefits referred to in paragraphs (a) and (b) is, in the opinion of the INSURER, the lesser in the case of the INSURED.

10.9(2) Notwithstanding any provision to the contrary, the benefit which the INSURER provides in terms of sub-clause 10.9(1) above, also applies to an INSURED who on the PARTICIPATION DATE, as a result of ill-health or disability, receives an income disability benefit from a fund or insurance instituted by the EMPLOYER for its EMPLOYEES, provided that –

(a) the INSURER is notified of such a person in writing before the PARTICIPATION DATE;

(b) the INSURER agrees in writing that such a person becomes an INSURED; and

(c) the RISK SALARY in regard to such an INSURED is increased from the PARTICIPATION DATE on a basis agreed to by the EMPLOYER and the INSURER in writing.

10.10 Maximum benefits from the INSURER

10.10(1) If an INSURED becomes entitled to a death benefit in terms of this Schedule and also, by virtue of his/her employment with other employers, becomes entitled to other death benefits on the life of his/her QUALIFYING SPOUSE, either in terms of this Policy or other

group policies underwritten by the INSURER, the total amount of the death benefits payable to the INSURED by the INSURER will be limited to the smaller of twice the total amount of the INSURED's annual risk salaries in terms of the respective group policies and the largest of the maximum amounts that the INSURER is prepared to pay in terms of each policy.

10.10(2) If the total amount of the death benefits payable by the INSURER must be reduced in terms of this clause, the benefit payable in terms of each policy will be reduced proportionately according to the amount of the benefit.

10.11 Option to apply for individual spouse's life insurance

Refer to Schedule 20 for the terms and conditions regarding the option to apply for individual spouse's life insurance.

10.12 Absence from service

Refer to Schedule 21 for the terms and conditions regarding the absence of the INSURED from the service of the EMPLOYER while insured in terms of this Schedule.

10.13 Territorial limitations

Refer to Schedule 22 for the terms and conditions regarding the absence of the INSURED or his/her QUALIFYING SPOUSE from the Republic of South Africa while the life of his/her QUALIFYING SPOUSE is insured in terms of this Schedule.

10.14 Deductions and unclaimed benefits

Refer to Schedule 23 for the provisions regarding the allowable deductions from benefits payable in terms of the Policy and for the provisions regarding benefits that become payable and are not claimed.

10.15 Cancellation

10.15(1) If the insurance described in this Schedule is cancelled for a group of INSUREDS, the INSURER's liabilities in terms of this Schedule regarding each of those INSUREDS lapses, unless –

(a) a QUALIFYING SPOUSE dies before the date of cancellation; and

(b) the claim for the benefit is submitted to the INSURER within six MONTHS after the date of cancellation; and

(c) the claim referred to is admitted by the INSURER.

10.15(2) For the purposes of this clause –

(a) the insurance described in this Schedule is also regarded as cancelled for a group of INSUREDS when –

(i) an EMPLOYER's participation in the Policy or in the benefit provided in terms of this Schedule is terminated; or

(ii) the participation of a category of EMPLOYEES of an EMPLOYER in the Policy or in the benefit provided in terms of this Schedule is terminated; or

(iii) the benefit which is insured in terms of this Schedule is cancelled owing to an amendment to the Policy;

and

(b) an INSURED is deemed to be a member of a group if he/she was a member of the relevant group immediately prior to the death of his/her QUALIFYING SPOUSE.

SCHEDULE 11 CRITICAL ILLNESS BENEFIT

11.1 Definitions

In this Schedule -

ACCIDENT means a bodily injury which –

(a) is caused by physical contact with violent, accidental, tangible and external means; and

(b) is the direct, effective, exclusive and proximate cause of the CRITICAL ILLNESS of the INSURED; and

(c) is not attributable to the INSURED having negligently or willfully exposed himself/herself to danger, except in the interests of the law or to protect his/her or another's life or property.

BENEFIT CESSATION DATE in regard to an INSURED means the earlier of his/her NORMAL RETIREMENT DATE and the last day of the MONTH in which he/she attains the age of 65 years.

BLINDNESS means the total, permanent and irrecoverable loss of the vision of two eyes, or irreversible visual acuity loss in two eyes with Snellen equivalent of 6/30 after correction, or worse.

CANCER means a malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukaemia, lymphoma and sarcoma.

The following conditions are excluded from this definition:

- any cancers in situ and any pre-malignant condition, or
- any tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0, or
- any skin cancers, other than malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis(outer layer of skin), or Clark level 2 or more depth invasion.

CHRONIC RENAL FAILURE means chronic irreversible end-stage renal failure, as a result of which regular peritoneal dialysis or haemodialysis is required on a long-term basis.

CORONARY ARTERY BYPASS SURGERY means the undergoing of surgery to correct the narrowing of, or blockage to, any one coronary artery by means of a bypass graft.

Coronary artery bypass graft, if it is only an insertion of a stent, is excluded from this definition.

CRITICAL ILLNESS means BLINDNESS, CANCER, CHRONIC RENAL FAILURE, CORONARY ARTERY BYPASS SURGERY, DEEP COMA, MAJOR BURNS, MYOCARDIAL INFARCTION, ORGAN TRANSPLANT, PARAPLEGIA or STROKE.

DEEP COMA means a condition of unconsciousness where the INSURED

- presents with a Glascow Coma Scale of 8 or less, and
- is dependent on life-sustaining aids, such as a ventilator and intravenous infusion for an uninterrupted period of at least 96 hours.

A coma which is artificially induced for purposes of ventilation, such as applied for a flail chest, is excluded for benefits.

FREE COVER LIMIT means that part of the CRITICAL ILLNESS benefit for which proof of good health does not have to be submitted as laid down from time to time by the INSURER and conveyed in writing to the EMPLOYER.

MAJOR BURNS means third-degree burns (not first-degree nor second-degree burns), i.e. full skin thickness, which cover at least 20% (as determined by international standards) of the surface area of the body.

MYOCARDIAL INFARCTION means a heart attack of specified severity.

A heart attack is the death of heart muscle, due to the inadequate supply of blood, as evidenced by all of the following three criteria:

- compatible clinical symptoms, and
- characteristic electrocardiographical (ECG) changes, which can be either of the following:
    - new pathological Q waves, or
    - ST segment and T wave changes indicative of myocardial injury, but only when accompanied by diagnostic raised cardiac markers, and
- raised cardiac markers, which include the following:
    - Troponin T greater than 0.5ng/ml or Troponin I greater than 0.25ng/ml, or
    - CK-MB mass above the normal reference values, or
    - Total CPK elevation of more than the normal values, with at least 6% being CK-MB.

The evidence must show a definite acute myocardial infarction. Other acute coronary syndromes, including but not limited to angina, are not covered by this definition.

ECG, ST segment and T wave changes indicative of myocardial ischaemia that may progress to myocardial infarction in patients

- with ST segment elevation, are new or presumed new ST segment elevation at the J point in two or more contiguous leads with the cut-off points greater than or equal to 0.2mV in leads V1,V2 or V3, and greater than or equal to 0.1mV in other leads. Contiguity in the frontal plane is defined by the lead sequence AVL, I and II, AVF and III.
- without ST segment elevation, are
    - ST segment depression of at least 0.1mV, or
    - T wave abnormalities only.

New pathological Q waves refer to

- any new Q wave in leads V1 through V3, or
- a new Q wave greater than or equal to 40 ms (0.04 s) in leads I, II, AVL, AVF, V4, V5 or V6, or
- the appearance of a new complete bundle branch block.

Both the first two new Q-wave must be present in any two contiguous leads, and must be greater than or equal to 1mm in depth.

ORGAN TRANSPLANT means the undergoing of an organ transplant as recipient of a kidney, heart, lung, liver, pancreas or bone marrow.

PARAPLEGIA means the total, permanent and irrecoverable loss of function of both lower extremities, with or without loss of bowel or bladder function.

PREVIOUS CRITICAL ILLNESS BENEFIT in regard to an INSURED means the critical illness benefit that would have been paid in terms of the insurance which on the PARTICIPATION DATE was replaced by the insurance provided in this Schedule, if he/she had remained insured in terms of that insurance. This includes any increase in the PREVIOUS CRITICAL ILLNESS BENEFIT that would have come into force, on or after the said date, exclusively as a result of increases in the RISK SALARY and without proof of good health.

STROKE means the 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 neurologist.

For the above definition, the following are not covered:

- a transient ischaemic attack (TIA), or
- a vascular disease affecting the eye or optic nerve, or
- migraine and vestibular disorders, or
- a traumatic injury to brain tissue or blood vessels.

A full neurological examination by a neurologist three months or later after the event, must confirm that the INSURED has a whole person impairment (WPI) of class 1 (1%-10%) or more.

WPI figures are calculated according to the principles and ratings of the latest edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment.

SURVIVAL PERIOD means a period of fourteen days immediately following the date of contracting the CRITICAL ILLNESS.

11.2 Benefit

11.2(1) If an INSURED contracts a CRITICAL ILLNESS while he/she is an EMPLOYEE and before the BENEFIT CESSATION DATE and does not die before the end of the SURVIVAL PERIOD, a CRITICAL ILLNESS benefit is payable. The benefit is equal to the multiple, as indicated in the CERTIFICATE OF PARTICIPATION, of the INSURED's annual RISK SALARY applicable immediately before the contracting of the CRITICAL ILLNESS, but not exceeding the lesser of three times the INSURED's annual RISK SALARY and R2 800 000, or such other amount determined by the INSURER from time to time.

11.2(2) The benefit payable in the event of a CRITICAL ILLNESS is limited so that the aggregate amount which is paid in terms of similar benefits from all sources regarding the INSURED does not exceed R6 900 000, or such other amount determined by the INSURER from time to time.

11.2(3) Once an amount has been paid in terms of this Schedule regarding an INSURED owing to a CRITICAL ILLNESS, no further benefit is payable with regard to the INSURED in terms of this Schedule.

11.3 Time of contracting a CRITICAL ILLNESS

11.3(1) The INSURER determines the time of contracting a CRITICAL ILLNESS taking into account the medical proof submitted, provided that -

(a) in the case of CANCER the date of contracting the CRITICAL ILLNESS is taken as the date of the first diagnosis thereof; and

(b) in the case of any surgery and transplant the date of contracting the CRITICAL ILLNESS is taken as the date on which the need for the surgery or transplant is first diagnosed by a registered medical practitioner.

11.3(2) The preceding sub-clause must not be construed as meaning that the CRITICAL ILLNESS benefit is payable for surgery or transplant before the actual undergoing of the surgery or transplant.

11.4 Proof of good health

FREE COVER LIMIT

11.4(1) The CRITICAL ILLNESS benefit regarding an INSURED is limited to the FREE COVER LIMIT, unless proof of good health to the satisfaction of the INSURER regarding that part of his/her CRITICAL ILLNESS benefit exceeding the FREE COVER LIMIT is submitted to the INSURER in the manner specified by the INSURER from time to time.

Insurance not limited to the FREE COVER LIMIT

11.4(2) The CRITICAL ILLNESS benefit is not limited to the FREE COVER LIMIT in the following instances-

(a) for the first three MONTHS after the INSURED becomes an INSURED; and

(b) for the first three MONTHS after an increase in the INSURED's CRITICAL ILLNESS benefit if the FREE COVER LIMIT is exceeded for the first time as a result of the increase,

provided that –

- the benefit which is provided in the three MONTHS referred to in paragraphs (a) and (b) above is only for a claim arising as a result of an ACCIDENT during those periods; and
- paragraph (a) is not applicable if the INSURED becomes an INSURED as a result of the insurance provided in terms of this Schedule replacing other insurance in terms of which the INSURED was insured; and
- if the INSURED submits proof of good health to the satisfaction of the INSURER within the three MONTHS referred to in paragraphs (a) or (b) above, then the CRITICAL ILLNESS benefit that is agreed to by the EMPLOYER and the INSURER in writing is applicable to the INSURED from the moment it is put in writing.

No insurance without proof of good health

11.4(3) Notwithstanding the provisions of the previous sub-clause, the persons and the amounts referred to in the following paragraphs will not be insured in terms of this Schedule, unless proof of good health is submitted to the INSURER in the manner specified by the INSURER from time to time. The persons referred to, the amounts involved and the responsibility for the costs of providing proof are as follows:

(a) A person who has the option of becoming a member of the FUND but fails to become a member within three MONTHS of becoming entitled to do so and becomes a member after three MONTHS. Proof must be provided for the full amount of his/her CRITICAL ILLNESS benefit. Provision of proof is at the expense of the person.

(b) An INSURED who, in terms of clauses 11.7(6), 21.2(2) or 22.4, does not qualify for the insurance of the benefit in terms of this Schedule, or any increase in it by virtue of an amendment to the Policy, and elects to submit proof of his/her good health to the INSURER. Proof must be provided for the full amount of his/her BENEFIT ENTITLEMENT or the increase in it, as the case may be. Provision of proof is at the expense of the INSURER.

(c) An employee of a MUNICIPALITY who is 55 years or older on the date on which he/she is insured for the first time for the benefit in terms of this Schedule. Proof

must be provided for the full amount of his/her BENEFIT ENTITLEMENT, Provision of proof is at the expense of the INSURER.

11.4(4) The EMPLOYER must advise the INSURER in writing immediately on the happening of each of the situations referred to in the previous sub-clause.

11.4(5) The INSURER will only request proof of good health in respect of the above persons upon being advised by the EMPLOYER in writing of any of the situations referred to above.

11.4(6) The INSURER will not be liable for any claim in respect of the above persons if the EMPLOYER does not advise the INSURER in writing of the particular situation and the person involved in respect of whom proof of good health to the satisfaction of the INSURER is not submitted to the INSURER in the manner specified.

Satisfactory proof of good health

11.4(7) In deciding on medical grounds that the proof of good health that is submitted in a particular case in terms of the preceding sub-clauses is to its satisfaction, the INSURER may lay down special conditions regarding the insurance of that part of the benefits for which the proof is submitted, and of future increases in those benefits.

Commencement of insurance requiring proof of good health

11.4(8) The part of the insurance described in this Schedule for which proof of good health in respect of the INSURED is required by the INSURER, will be insured as from the date on which the INSURER receives the last information taken into account in establishing the good health of the INSURED. But any such insurance for which the INSURER laid down special conditions, only commences after the EMPLOYER is informed of the special conditions by the INSURER in writing.

Increases in insurance exceeding the FREE COVER LIMIT

11.4(9) Once proof of good health for that part of an INSURED's insurance exceeding the FREE COVER LIMIT is accepted by the INSURER, subsequent increases in the INSURED's BENEFIT ENTITLEMENT, as a result of increases in the INSURED's RISK SALARY only, will apply without further proof of good health having to be submitted to the INSURER. However, further proof of good health must be provided in the following circumstances:

(a) if certain periods determined by the INSURER from time to time expire; or

(b) if the INSURED reaches a certain age determined by the INSURER from time to time; or

(c) if the CRITICAL ILLNESS benefit exceeds amounts determined by the INSURER from time to time.

Reduction of the FREE COVER LIMIT

11.4(10) If the INSURER reduces the FREE COVER LIMIT at any specific time, the insurance that applies to an existing INSURED before such reduction will not be reduced accordingly, provided that the benefit remains applicable to the INSURED without interruption.

Temporary cessation of insurance

11.4(11) If the insurance in this Schedule ceases to apply to an INSURED temporarily, proof of good health that is submitted in respect of the INSURED before such cessation will, for the purposes of the preceding clauses, be deemed null and void.

11.5 Claims procedure

Notification

11.5(1) The INSURER must be notified in writing of a claim for a CRITICAL ILLNESS benefit within six MONTHS of the time of contracting the particular CRITICAL ILLNESS or the INSURER will reject the claim.

Submission

11.5(2) The claim for the CRITICAL ILLNESS benefit will not be assessed until the claim forms and other documentation required by the INSURER are submitted at its head office.

Proof of claim

11.5(3) The INSURER has to be satisfied, by way of medical and other information which is required at its sole discretion and which is submitted at its head office on behalf of the INSURED, that the INSURED has contracted a CRITICAL ILLNESS.

11.5(4) If the INSURER requests additional information in order to satisfy itself that the INSURED has contracted a CRITICAL ILLNESS, the additional information must be submitted to the INSURER within 60 days of the INSURER's request.

Cost of providing proof

11.5(5) The EMPLOYER is informed in the administration guides on the RETIREMENT FUND WEB of the medical and other information which is required by the INSURER in respect of an INSURED in order for the INSURER to assess for the first time whether the INSURED has contracted a CRITICAL ILLNESS. This information must be submitted at the expense of the INSURED. The provision of any additional information that the INSURER may require thereafter is at the expense of the INSURER.

Resubmission of a rejected claim

11.5(6) If the INSURER rejects a claim for the CRITICAL ILLNESS benefit in terms of this Schedule, the claim may be resubmitted with new evidence or submissions. Such a resubmitted claim must be made within 90 days of the rejection. If the INSURER again rejects the claim, no further resubmission of the claim will be considered by the INSURER. If any new medical evidence is submitted in order to have a claim reassessed, the cost of such medical evidence is for the INSURED's expense.

11.6 Payment of benefit

The CRITICAL ILLNESS benefit payable in terms of this Schedule must be paid to the INSURED.

11.7 General exclusions

11.7(1) Notwithstanding any other provision to the contrary in the Policy, no benefit is paid in terms of this Schedule if the INSURED's CRITICAL ILLNESS -

(a) is a direct or indirect consequence of active participation in

(i) war, invasion, acts of foreign enemies, hostilities, warlike operations (whether war be declared or not), civil war, rebellion, revolution, military or usurped power, insurrection, civil commotion assuming the proportions of or amounting to an uprising; or

(ii) an act of terrorism; or

(iii) a riot; or

(iv) conduct during a strike (irrespective of whether the strike is lawful or unlawful) during which conduct lives are endangered, public or private property damaged, or an attempt or attempts are made to damage such property; or

(v) any other unlawful act or conduct of whatever nature during which lives are endangered, public or private property damaged, or an attempt or attempts are made to damage such property.

(b) is a direct or indirect consequence of –

(i) any radioactive contamination, including accidental radioactive contamination; or

(ii) the use of nuclear, biological or chemical weapons; or

(iii) attacks on or sabotage of facilities (including, but not limited to, nuclear power plants, reprocessing plants, final repository sites and research reactors) and storage depots, which lead to the release of radioactivity or nuclear, biological or chemical warfare agents,

irrespective whether any of the aforesaid is performed with the specific use of information technology.

11.7(2) The benefit described in this Schedule is not provided regarding an INSURED if the INSURED has the option of becoming a member of the FUND and, by so doing, becoming an INSURED and contracts a CRITICAL ILLNESS before the INSURER receives his/her full particulars.

11.7(3) Subject to sub-clauses 11.4(7) and 11.4(8), the benefit described in this Schedule for which proof of good health in respect of an INSURED is required by the INSURER, is only provided if the INSURED contracts a CRITICAL ILLNESS on or after the date on which the INSURER receives the last information taken into account in establishing the good health of the INSURED.

11.7(4) The CRITICAL ILLNESS benefit, or any increase in the benefit by virtue of an amendment to the Policy, is not paid for a CRITICAL ILLNESS if the INSURED contracted that CRITICAL ILLNESS before the latest date on which the insurance of this benefit or the increase, as the case may be, commences with regard to him/her.

11.7(5) No benefit is payable in respect of a CRITICAL ILLNESS if the INSURED at any time prior to the latest date on which the insurance of the benefit in terms of this Schedule commences with the INSURER in respect of the INSURED contracted a similar CRITICAL ILLNESS which would have entitled him/her to a CRITICAL ILLNESS benefit had the insurance already applied to him/her at that stage.

11.7(6) If, in the opinion of the INSURER, an INSURED, as a result of a bodily injury or sickness, is incapable of performing his/her normal duties with the EMPLOYER on the latest date on which the insurance described in this Schedule or any increase in that insurance by virtue of an amendment to the Policy, commences with the INSURER regarding the INSURED, he/she will not qualify for the insurance or the increase, as the case may be, until -

(a) he/she, in the opinion of the INSURER, resumes his/her normal duties and the premiums for the insurance or the increase, as the case may be, are paid in respect of him/her as from the resumption of those duties; and

(b) he/she performs his/her normal duties for 60 consecutive BUSINESS DAYS or he/she submits proof of his/her good health to the satisfaction of the INSURER in accordance with the provisions of this Schedule, whichever is the earlier.

11.7(7) The benefit described in this Schedule, or any increase in it by virtue of an amendment to the Policy, is also not payable for a CRITICAL ILLNESS contracted by an INSURED within two years after the latest date on which the insurance of the benefit or the increase, as the case may be, commences with the INSURER in respect of the INSURED and that CRITICAL ILLNESS directly or indirectly arises from or is traceable to a condition of which the INSURED was aware or experienced symptoms or for which medical treatment was received during the two years immediately before that date.

11.8 Replacement of existing insurance

11.8(1) If, exclusively by virtue of sub-clauses 11.7(6) and 11.7(7), the benefit in terms of this Schedule is not payable in regard to an INSURED who –

- immediately before the PARTICIPATION DATE was insured in terms of the insurance which was replaced by the insurance provided in terms of this Schedule; and
- since then has been an INSURED without interruption,

but a benefit would have been paid in terms of the replaced insurance had it still applied to the INSURED, then the INSURER provides either -

(a) the benefit in terms of this Schedule; or

(b) a lump sum equal to the value, as determined by the INSURER, of the PREVIOUS CRITICAL ILLNESS BENEFIT,

whichever of the benefits referred to in paragraphs (a) and (b) is, in the opinion of the INSURER, the lesser in the case of the INSURED.

11.8(2) Notwithstanding any provision to the contrary, the benefit which the INSURER provides in terms of sub-clause 11.8(1) above, also applies to a person who on the PARTICIPATION DATE, as a result of ill-health or disability, receives an income disability benefit from a fund or insurance instituted by the EMPLOYER for its EMPLOYEES, provided that –

(a) the INSURER is notified of such a person in writing before the PARTICIPATION DATE;

(b) the INSURER agrees in writing that such a person becomes an INSURED; and

(c) the RISK SALARY in regard to such an INSURED will be increased from the PARTICIPATION DATE on a basis agreed to by the EMPLOYER and the INSURER in writing.

11.9 Maximum benefits from the INSURER

11.9(1) If an INSURED becomes entitled to a CRITICAL ILLNESS benefit in terms of this Schedule and also, by virtue of his/her employment with other employers, becomes entitled to other critical illness benefits, either in terms of this Policy or other group policies underwritten by the INSURER, the total amount of the critical illness benefits payable to the INSURED by the INSURER will be limited to the smaller of three times the total amount of the INSURED's annual risk salaries in terms of the respective group policies and the largest of the maximum amounts that the INSURER is prepared to pay in terms of each policy.

11.9(2) If the total amount of the critical illness benefits payable by the INSURER must be reduced in terms of this clause, the benefit payable in terms of each policy will be reduced proportionately according to the amount of the benefit.

11.10 ASISA critical illness disclosure

11.10(1) The benefits in terms of this Schedule are aligned with the critical illness definitions recommended by the Association for Savings and Investment South Africa (ASISA). This ensures that the benefits are objective and consistent with the minimum industry standards.

11.10(2) The following table discloses the INSURER's benefit payment criteria in each CRITICAL ILLNESS severity level in terms of ASISA's recommended critical illness definitions:

CRITICAL ILLNESS	**Severity level and % of benefit payable**			
	A	**B**	**C**	**D**
	Most Severe	**Moderate impairment**	**Mild impairment**	**Almost Full Recovery**
Cancer	100%	100%	100%	100%
Myocardial infarction (heart attack)	100%	100%	100%	100%

Coronary artery bypass surgery (heart bypass)	100%	100%	100%	100%
Stroke	100%	100%	100%	100%

11.11 Absence from service

Refer to Schedule 21 for the terms and conditions regarding the absence of the INSURED from the service of the EMPLOYER while insured in terms of this Schedule.

11.12 Territorial limitations

Refer to Schedule 22 for the terms and conditions regarding the absence of the INSURED from the Republic of South Africa while insured in terms of this Schedule.

11.13 Deductions and unclaimed benefits

Refer to Schedule 23 for the provisions regarding the allowable deductions from benefits payable in terms of the Policy and for the provisions regarding benefits that become payable and are not claimed.

11.14 Cancellation

11.14(1) If the insurance described in this Schedule is cancelled for a group of INSUREDS, the INSURER's liabilities in terms of this Schedule regarding each of those INSUREDS lapses, unless –

(a) an INSURED contracts a CRITICAL ILLNESS before the date of cancellation; and

(b) the claim for the benefit is submitted to the INSURER within six MONTHS after the date of cancellation; and

(c) the claim referred to is admitted by the INSURER.

11.14(2) For the purposes of this clause -

(a) the insurance described in this Schedule is also regarded as cancelled for a group of INSUREDS when –

(i) an EMPLOYER’s participation in the Policy or in the benefit provided in terms of this Schedule is terminated; or

(ii) the participation of a category of EMPLOYEES of an EMPLOYER in the Policy or in the benefit provided in terms of this Schedule is terminated; or

(iii) the benefit which is insured in terms of this Schedule is cancelled owing to an amendment to the Policy;

and

(b) an INSURED is deemed to be a member of a group if he/she was a member of the relevant group immediately prior to his/her contracting a CRITICAL ILLNESS.

SCHEDULE 12 ACCIDENT BENEFIT

12.1 Definitions

In this Schedule –

ACCIDENT SUM ASSURED in regard to an INSURED means a percentage of his/her DEATH SUM ASSURED as indicated in the CERTIFICATE OF PARTICIPATION, but not more than the smaller of six times the INSURED's annual RISK SALARY and R3 800 000, or such other amount determined by the INSURER from time to time.

AS A RESULT OF AN ACCIDENT means that -

(a) bodily injury caused by physical contact with violent accidental tangible external means is the direct, effective, exclusive and proximate cause of the death concerned; and

(b) the death is not attributable to the INSURED having negligently or willfully exposed himself/herself to danger, except in the interests of the law or to protect his/her or another's life or property; and

(c) the injury referred to occurs after the latest date on which the INSURED becomes entitled to the benefit in terms of this Schedule and while he/she is an EMPLOYEE; and

(d) the death occurs within 12 MONTHS of that injury.

BENEFIT CESSATION DATE in regard to an INSURED means the earlier of his/her NORMAL RETIREMENT DATE and the last day of the MONTH in which he/she attains the age of 65 years.

DEATH SUM ASSURED in regard to an INSURED means the amount of the UNDERLYING INSURANCE that would have been paid in the event of his/her death immediately before the accident concerned, provided that, -

(a) if the INSURED is insured for a death benefit in terms of both this Policy and the policy of the INSURER insuring the risk benefits of the FUND then the UNDERLYING INSURANCE means the total amount of both death benefits; and

(b) if a death benefit is a flexible death benefit, then the UNDERLYING INSURANCE includes only the 'core amount' of the flexible death benefit.

PREVIOUS ACCIDENT BENEFIT in regard to an INSURED means the accident benefit that would have been paid in terms of the insurance which on the PARTICIPATION DATE was replaced by the insurance provided in this Schedule, if he/she had remained insured in terms of that insurance. This includes any increase in the PREVIOUS ACCIDENT BENEFIT that would have come into force, on or after the said date, exclusively as a result of increases in the RISK SALARY and without proof of good health.

12.2 Benefit

If an INSURED who is an EMPLOYEE, dies AS A RESULT OF AN ACCIDENT after the latest date on which the insurance described in this Schedule becomes applicable to him/her, but before the BENEFIT CESSATION DATE, the ACCIDENT SUM ASSURED becomes payable in accordance with the provisions of this Schedule.

12.3 Proof of good health

As the benefit provided in terms of this Schedule is a rider to the INSURED's death benefit in terms of the UNDERLYING INSURANCE, the INSURED must qualify in accordance with the provisions regarding proof of good health for purposes of the UNDERLYING INSURANCE in order to qualify for the benefit provided in terms of this Schedule.

12.4 Claims procedure

Notification

12.4(1) The INSURER must be notified in writing of a claim for an accident benefit within six MONTHS after the date of the death AS A RESULT OF AN ACCIDENT or the INSURER will reject the claim.

Submission

12.4(2) The claim for the accident benefit will not be assessed until the claim forms and other documentation required by the INSURER are submitted at its head office.

Proof

12.4(3) When a claim for an accident benefit arises, the INSURER may require proof to its satisfaction as to any circumstance which may affect the recognition of the claim.

12.5 Payment of benefit

The accident benefit payable in terms of this Schedule must be paid in accordance with the provisions regarding the payment of the death benefits in terms of Schedules 4 or 5.

12.6 General exclusions

12.6(1) No benefit is paid in terms of this Schedule -

(a) if the death of the INSURED directly or indirectly arises from or is traceable to -

(i) a deliberate unlawful act committed by the INSURED that includes but is not limited to committing or attempting to commit the crime of murder, assault, housebreaking, theft, robbery, kidnapping or the INSURED committing a crime involving a sexual act;

(ii) intentional self-inflicted injury, self-inflicted injury while the INSURED is mentally disordered or deliberate failure to obtain the best medical assistance reasonably available;

(iii) an act by the INSURED while he/she is under the influence of alcoholic drink or drugs;

(iv) the driving of a mechanically driven vehicle by the INSURED while the alcohol content of his/her blood is more than the legal limit;

(v) taking of medicaments by the INSURED, except in accordance with medical prescription;

(vi) poison, radioactivity or nuclear explosion;

(vii) participation in gliding or parachuting, or participation in speed tests or races in any mechanically driven vehicle;

(viii) in any manner or form, any natural disease of the body or of the mind;

(ix) aviation, except if the INSURED is a passenger in an aircraft which may transport twenty or more passengers or in a smaller aircraft of a registered company which is piloted by qualified pilots;

or

(b) if, notwithstanding any other provision to the contrary in the Policy, the INSURED'S death –

(i) is a direct or indirect consequence of active participation in -

- war, invasion, acts of foreign enemies, hostilities, warlike operations (whether war be declared or not), civil war, rebellion, revolution, military or usurped power, insurrection, civil commotion assuming the proportions of or amounting to an uprising; or

- an act of terrorism; or

- a riot; or

- conduct during a strike (irrespective of whether the strike is lawful or unlawful) during which conduct lives are endangered, public or private property damaged, or an attempt or attempts are made to damage such property; or

- any other unlawful act or conduct of whatever nature during which lives are endangered, public or private property damaged, or an attempt or attempts are made to damage such property.

(ii) is a direct or indirect consequence of –

- any radioactive contamination, including accidental radioactive contamination; or

- the use of nuclear, biological or chemical weapons; or

- attacks on or sabotage of facilities (including, but not limited to, nuclear power plants, reprocessing plants, final repository sites and research reactors) and storage depots, which lead to the release of radioactivity or nuclear, biological or chemical warfare agents,

irrespective whether any of the aforesaid is performed with the specific use of information technology.

12.6(2) The benefit described in this Schedule is not provided regarding an INSURED if the INSURED has the option of becoming a member of the FUND and, by so doing, becoming an INSURED and the accident concerned takes place before the INSURER receives his/her full particulars.

12.6(3) If, in the opinion of the INSURER, an INSURED, as a result of a bodily injury or sickness, is incapable of performing his/her normal duties with the EMPLOYER on the latest date on which the insurance described in this Schedule or any increase in that insurance by virtue of an amendment to the Policy, commences with the INSURER regarding the INSURED, he/she will not qualify for the insurance or the increase, as the case may be, until –

(a) he/she, in the opinion of the INSURER, resumes his/her normal duties and the premiums for the insurance or the increase, as the case may be, are paid in respect of him/her as from the resumption of those duties; and

(b) he/she performs his/her normal duties for 60 consecutive BUSINESS DAYS or he/she submits proof of his/her good health to the satisfaction of the INSURER in accordance with the provisions of the UNDERLYING INSURANCE, whichever is the earlier.

12.7 Replacement of existing insurance

12.7(1) If, exclusively by virtue of sub-clause 12.6(3), the benefit in terms of this Schedule is not payable in regard to an INSURED who –

- immediately before the PARTICIPATION DATE was insured in terms of the insurance which was replaced by the insurance provided in terms of this Schedule; and

- since then has been an INSURED without interruption,

but a benefit would have been paid in terms of the replaced insurance had it still applied to the INSURED, then the INSURER provides either –

(a) the benefit in terms of this Schedule; or

(b) a lump sum equal to the value, as determined by the INSURER, of the PREVIOUS ACCIDENT BENEFIT,

whichever of the benefits referred to in paragraphs (a) and (b) is, in the opinion of the INSURER, the lesser in the case of the INSURED.

12.7(2) Notwithstanding any provision to the contrary, the benefit which the INSURER provides in terms of sub-clause 12.7(1) above, also applies to a person who on the PARTICIPATION DATE, as a result of ill-health or disability, receives an income disability benefit from a fund or insurance instituted by the EMPLOYER for its EMPLOYEES, provided that –

(a) the INSURER is notified of such a person in writing before the PARTICIPATION DATE;

(b) the INSURER agrees in writing that such a person becomes an INSURED; and

(c) the RISK SALARY in regard to such an INSURED will be increased from the PARTICIPATION DATE on a basis agreed to by the EMPLOYER and the INSURER in writing.

12.8 Maximum benefits from the INSURER

12.8(1) If an INSURED becomes entitled to an accident benefit in terms of this Schedule and also, by virtue of his/her employment with other employers, becomes entitled to other accident benefits, either in terms of this Policy or other group policies underwritten by the INSURER, the total amount of the accident benefits payable to the INSURED by the INSURER will be limited to the smaller of six times the total amount of the INSURED's annual risk salaries in terms of the respective group policies and the largest of the maximum amounts that the INSURER is prepared to pay in terms of each policy.

12.8(2) If the total amount of the accident benefits payable by the INSURER must be reduced in terms of this clause, the benefit payable in terms of each policy will be reduced proportionately according to the amount of the benefit.

12.9 Absence from service

Refer to Schedule 21 for the terms and conditions regarding the absence of the INSURED from the service of the EMPLOYER while insured in terms of this Schedule.

12.10 Territorial limitations

Refer to Schedule 22 for the terms and conditions regarding the absence of the INSURED from the Republic of South Africa while insured in terms of this Schedule.

12.11 Unclaimed benefits

Refer to Schedule 23 for the provisions regarding benefits that become payable and are not claimed.

12.12 Cancellation

12.12(1) If the insurance described in this Schedule is cancelled for a group of INSUREDS, the INSURER's liabilities in terms of this Schedule regarding each of those INSUREDS lapses, unless –

(a) an INSURED has the accident concerned before the date of cancellation; and

(b) the INSURER is notified of a potential claim for the accident benefit within 6 MONTHS after the date of cancellation, and

(c) the claim for the benefit is submitted to the INSURER within 6 MONTHS after the date of the death of the INSURED; and

(d) the claim referred to is admitted by the INSURER.

12.12(2) For the purposes of this clause –

(a) the insurance described in this Schedule is also regarded as cancelled for a group of INSUREDS when –

(i) an EMPLOYER's participation in the Policy or in the benefit provided in terms of this Schedule is terminated; or

(ii) the participation of a category of EMPLOYEES of an EMPLOYER in the Policy or in the benefit provided in terms of this Schedule is terminated; or

(iii) the benefit which is insured in terms of this Schedule is cancelled owing to an amendment to the Policy; or

(iv) the insurance with the INSURER of the death benefits on which this accident insurance is based, is cancelled for a group of INSUREDS;

and

(b) an INSURED is deemed to be a member of a group if he/she was a member of the relevant group immediately prior to the accident concerned.

SCHEDULE 13 FUNERAL BENEFIT

13.1 Definitions

In this Schedule –

FAMILY MEMBER in regard to an INSURED means –

(a) a QUALIFYING SPOUSE; and

(b) a QUALIFYING CHILD.

ILL-HEALTH in regard to an INSURED means a condition where the INSURED - directly and exclusively as a result of a bodily injury or an illness - totally and permanently and continuously is prevented - even with further in-service training –

- from following the regular occupation which he/she practiced immediately before; and
- from following the occupations which he/she, in view of his/her training and experience, may reasonably be expected to follow,

and experiences loss of income.

MARRIAGE means –

(a) a marriage or union in accordance with the Marriage Act, 1961, the Recognition of Customary Marriages Act, 1998, or the Civil Union Act, 2006, or the tenets of a religion; or

(b) a union where two persons are living together as if married, with the commitment of continuing to do so permanently provided that –

- they have been doing so for at least six MONTHS; and
- in the format prescribed by the EMPLOYER from time to time, they successfully applied in writing to the EMPLOYER, before the death of any one of them, for their union to be registered by the EMPLOYER; and
- one or both of them are not joined in a marriage or union as contemplated in paragraph (a) above with another person.

PREVIOUS FUNERAL BENEFIT in regard to an INSURED or his/her FAMILY MEMBER means the funeral benefit that would have been paid in terms of the insurance which on the PARTICIPATION DATE was replaced by the insurance provided in this Schedule, if he/she had remained insured in terms of that insurance.

QUALIFYING CHILD in regard to an INSURED or his/her QUALIFYING SPOUSE means –

(a) a biological child, legally adopted child, stepchild, and foster child, provided that –

- the child is unmarried;
- the child is under the age of 21 years;
- if the child is 21 years or older, but under the age of 26 years, such child is a full-time student at an educational institution, meaning that he/she must be enrolled for at least 75% of the standard course load of a course that is normally done on a full-time basis, and that he/she must actively participate in such a course;
- if the child is incapacitated by a physical or mental infirmity from maintaining himself/herself, such incapacity commenced when the child was either under the age of 21 or under the age of 26 years while a full-time student at an educational institution.

and

(b) a still-born child.

For purposes of this definition –

- 'stepchild' means a child who is the biological child of the INSURED's QUALIFYING SPOUSE, which child was born from a previous relationship between the QUALIFYING SPOUSE and a person other than the INSURED;
- 'foster child' means a child placed in foster care as envisaged in terms of applicable legislation;
- 'adopted child' means a child formally adopted in terms of applicable legislation; and
- 'still-born child' means a child that has had at least 26 weeks of intra-uterine existence but showed no sign of life after complete birth.

QUALIFYING SPOUSE in regard to an INSURED means the person with whom he/she is joined in MARRIAGE, provided that such person, at the time of qualifying for the insurance, has already reached the age of 15 years and is not yet 70 years of age. If an INSURED is joined in MARRIAGE with two or more persons, QUALIFYING SPOUSE means –

(a) only that one of them whom the INSURED nominated in writing to the EMPLOYER during the person's life; or

(b) if the EMPLOYER advises the INSURER that the INSURED has failed to nominate only one of them in terms of paragraph (a), only the one with whom he/she is joined in MARRIAGE first.

Once a nomination has been made in terms of paragraph (a), it remains in force as long as the INSURED is joined in MARRIAGE with the relevant spouse.

Notwithstanding any provision to the contrary in the Policy, the maximum age restriction referred to above, does not apply to a QUALIFYING SPOUSE who immediately before the PARTICIPATION DATE was insured in terms of insurance which was replaced by the funeral insurance provided in terms of this Policy.

13.2 Restriction on participation

Notwithstanding any provision to the contrary in the Policy the benefits described in this Schedule will not apply to an INSURED who is aged 65 years or more on the date the insurance in terms of this Schedule becomes applicable to him/her.

13.3 Participation of FAMILY MEMBERS

13.3(1) A FAMILY MEMBER of an INSURED is insured in terms of this Schedule from the moment the INSURED is insured in terms of this Schedule, provided that, the insurance of a FAMILY MEMBER who has to be nominated by the INSURED commences on the first day of the MONTH following the date on which the nomination in writing is received by the EMPLOYER, unless the INSURER and the EMPLOYER agree otherwise in the case of a particular FAMILY MEMBER.

13.3(2) On the death of the INSURED the insurance of his/her FAMILY MEMBERS in terms of this Schedule ceases at midnight on the last day of the month in which the INSURED dies.

13.4 Benefits before or on the NORMAL RETIREMENT DATE

13.4(1) If an INSURED dies before or on his/her NORMAL RETIREMENT DATE while he/she is an EMPLOYEE, an amount as indicated in the CERTIFICATE OF PARTICIPATION is paid.

13.4(2) If a FAMILY MEMBER of an INSURED dies before or on the INSURED's NORMAL RETIREMENT DATE and while the INSURED is an EMPLOYEE, the amount as indicated

in the CERTIFICATE OF PARTICIPATION is paid, provided that the amount which is payable in respect of a QUALIFYING CHILD is limited as indicated in clause 13.10.

13.4(3) For purposes of the payment of benefits in terms of this clause an INSURED whose service is terminated owing to ILL-HEALTH, is still regarded as an EMPLOYEE until he/she reaches his/her NORMAL RETIREMENT DATE if the EMPLOYER informs the INSURER in writing of such termination of service and proof of such ILL-HEALTH is submitted to the INSURER's satisfaction. While the INSURED is absent from service owing to ILL-HEALTH, the monthly premium in respect of the INSURED remains payable.

13.5 Benefits after the NORMAL RETIREMENT DATE

13.5(1) The benefits in respect of an INSURED and his/her FAMILY MEMBERS in terms of clause 13.4 are continued after the INSURED reaches his/her NORMAL RETIREMENT DATE, provided that –

(a) the INSURED remains in the active service of the EMPLOYER; and

(b) the monthly premium as determined by the INSURER is paid.

13.5(2) The benefits which are payable in terms of this clause in respect of the INSURED or one of his/her FAMILY MEMBERS remain payable until –

(a) the end of the MONTH in which the INSURED attains the age indicated in the CERTIFICATE OF PARTICIPATION, subject to a maximum age of 70 years; or

(b) the INSURED retires from service; or

(c) the INSURED terminates service owing to ILL-HEALTH; or

(d) the INSURED dies,

whichever event occurs first.

13.6 Claims procedure

Notification

13.6(1) The INSURER must be notified in writing of a claim for a benefit in terms of this Schedule within six MONTHS after the death of the INSURED or a FAMILY MEMBER or the INSURER will reject the claim.

Submission

13.6(2) The claim for the benefit will not be assessed until the claim forms and other documentation required by the INSURER are submitted at its head office.

Proof

13.6(3) When a claim for a benefit arises, the INSURER may require proof to its satisfaction as to any circumstance which may affect the recognition of the claim.

13.7 Payment of benefit

13.7(1) The funeral benefits payable in terms of this Schedule must be paid to the INSURED and if the INSURED is deceased, to the INSURED's BENEFICIARY and will be paid into a bank account held in the Republic of South Africa in the name of the BENEFICIARY.

13.7(2) If there is no BENEFICIARY, or no nomination form in respect of the funeral benefit or a portion of the benefit, the benefit or part thereof must be paid into the estate of the deceased INSURED.

13.7(3) The EMPLOYER must arrange for a valid nomination form to be completed, signed, and updated as required by every INSURED and the EMPLOYER must securely store such nomination form.

13.7(4) At the death of the INSURED the EMPLOYER must provide SANLAM with the nomination form the EMPLOYER has on record.

13.7(5) If the funeral benefit, or a portion thereof is payable to the estate of the INSURED, the EMPLOYER must provide SANLAM with the details of the estate late to which the benefits must be paid.

13.8 General exclusions

13.8(1) Notwithstanding any other provision to the contrary in the Policy, no benefit is paid in terms of this Schedule if the INSURED'S or a FAMILY MEMBER'S death -

(a) is a direct or indirect consequence of active participation in

(i) war, invasion, acts of foreign enemies, hostilities, warlike operations (whether war be declared or not), civil war, rebellion, revolution, military or usurped power, insurrection, civil commotion assuming the proportions of or amounting to an uprising; or

(ii) an act of terrorism; or

(iii) a riot; or

(iv) conduct during a strike (irrespective of whether the strike is lawful or unlawful) during which conduct lives are endangered, public or private property damaged, or an attempt or attempts are made to damage such property; or

(v) any other unlawful act or conduct of whatever nature during which lives are endangered, public or private property damaged, or an attempt or attempts are made to damage such property.

(b) is a direct or indirect consequence of –

(i) any radioactive contamination, including accidental radioactive contamination; or

(ii) the use of nuclear, biological or chemical weapons; or

(iii) attacks on or sabotage of facilities (including, but not limited to, nuclear power plants, reprocessing plants, final repository sites and research reactors) and storage depots, which lead to the release of radioactivity or nuclear, biological or chemical warfare agents,

irrespective whether any of the aforesaid is performed with the specific use of information technology.

13.8(2) The benefit described in this Schedule is not provided regarding an INSURED or a FAMILY MEMBER if the INSURED has the option of becoming a member of the FUND and, by so doing, becoming an INSURED and the INSURED or a FAMILY MEMBER dies before the INSURER receives full particulars regarding the INSURED.

13.8(3) The benefits described in this Schedule are not payable in regard to an INSURED and a FAMILY MEMBER of the INSURED if the INSURED has the option of becoming an INSURED but fails to become an INSURED within three MONTHS of becoming entitled to do so, unless the EMPLOYER and the INSURER agree in writing that the INSURED may become an INSURED from a later date. In such a case no benefits are payable if the INSURED or his/her FAMILY MEMBER dies as a result of natural causes within six MONTHS of the latest date on which the insurance described in this Schedule commences with the INSURER in respect of the particular person concerned.

13.8(4) If, in the opinion of the INSURER, an INSURED, as a result of a bodily injury or sickness, is incapable of performing his/her normal duties with the EMPLOYER on the latest date on which the insurance described in this Schedule or any increase in that insurance by virtue of an amendment to the Policy, commences with the INSURER regarding the INSURED, he/she will not qualify for the insurance or the increase, as the case may be, until –

(a) he/she, in the opinion of the INSURER, resumes his/her normal duties and the premiums for the insurance or the increase, as the case may be, are paid in respect of him/her as from the resumption of those duties; and

(b) he/she performs his/her normal duties for 60 consecutive BUSINESS DAYS.

13.9 Replacement of existing insurance

13.9(1) If, exclusively by virtue of sub-clause 13.8(4), the benefit in terms of this Schedule is not payable in regard to an INSURED or his/her FAMILY MEMBER who –

- immediately before the PARTICIPATION DATE was insured in terms of the insurance which was replaced by the insurance provided in terms of this Schedule; and
- since then has been insured for the benefit in terms of this Schedule without interruption,

but a benefit would have been paid in terms of the replaced insurance had it still applied to the INSURED or his /her FAMILY MEMBER, then the INSURER provides either –

(a) the benefit in terms of this Schedule; or

(b) an amount equal to the value, as determined by the INSURER, of the PREVIOUS FUNERAL BENEFIT,

whichever of the benefits referred to in paragraphs (a) and (b) is, in the opinion of the INSURER, the lesser in the case of the INSURED or his/her FAMILY MEMBER.

13.9(2) Notwithstanding any provision to the contrary, the benefit which the INSURER provides in terms of sub-clause 13.9(1) above, also applies to a person who on the PARTICIPATION DATE, as a result of ill-health or disability, receives an income disability benefit from a fund or insurance instituted by the EMPLOYER for its EMPLOYEES, provided that –

(a) the INSURER is notified of such a person in writing before the PARTICIPATION DATE; and

(b) the INSURER agrees in writing that such a person becomes an INSURED.

13.10 Maximum benefits

13.10(1) The total amount payable in terms of this Schedule at the death of any child together with any other amount which, to the knowledge of the INSURER or the EMPLOYER, is payable on the death of that child by any insurer or by a friendly society, may not exceed –

(a) R50 000, if the child is 6 years or older, but is under the age of 14 years; and

(b) R20 000, if the child is under 6 years of age or a still-born child.

13.10(2) The maximum amount payable in terms of this Schedule at the death of an INSURED or one of his/her FAMILY MEMBERS, other than a child referred to in sub-clause (1) above, is R70 000 or such other amount determined by the INSURER from time to time.

13.10(3) If a funeral benefit in respect of an INSURED or one of his/her FAMILY MEMBERS, other than a child referred to in sub-clause (1) above, becomes payable in terms of this Schedule and, by virtue of the INSURED's employment with other employers, other funeral benefits in respect of the INSURED or one of his/her FAMILY MEMBERS, as the case may be, also become payable, either in terms of this Policy or other group policies underwritten by the INSURER, the total amount of the particular funeral benefits payable by the INSURER in terms of the respective group policies, will be limited to the largest of the maximum amounts that the INSURER is prepared to pay in terms of each policy.

If the total amount of the funeral benefits payable by the INSURER must be reduced in terms of this sub-clause, the benefit payable in terms of each policy will be reduced proportionately according to the amount of the benefit.

13.11 Absence from service

Refer to Schedule 21 for the terms and conditions regarding the absence of the INSURED from the service of the EMPLOYER while insured in terms of this Schedule.

13.12 Territorial limitations

Refer to Schedule 22 for the terms and conditions regarding the absence of the INSURED from the Republic of South Africa while insured in terms of this Schedule.

13.13 Unclaimed benefits

Refer to Schedule 23 for the provisions regarding benefits that become payable and are not claimed.

13.14 Cancellation

13.14(1) If the insurance described in this Schedule is cancelled for a group of INSUREDS, the INSURER's liabilities in terms of this Schedule regarding each of those INSUREDS lapses, unless –

(a) an INSURED or a FAMILY MEMBER dies before the date of cancellation; and

(b) the claim for the benefit is submitted to the INSURER within six MONTHS after the date of cancellation; and

(c) the claim referred to is admitted by the INSURER.

13.14(2) For the purposes of this clause -

(a) the insurance described in this Schedule is also regarded as cancelled for a group of INSUREDS when –

(i) an EMPLOYER’s participation in the Policy or in the benefit provided in terms of this Schedule is terminated; or

(ii) the participation of a category of EMPLOYEES of an EMPLOYER in the Policy or in the benefit provided in terms of this Schedule is terminated; or

(iii) the benefit which is insured in terms of this Schedule is cancelled owing to an amendment to the Policy;

and

(b) an INSURED is deemed to be a member of a group if he/she was a member of the relevant group immediately prior to death of the INSURED or FAMILY MEMBER.

SCHEDULE 14 ACCIDENT BOOSTER BENEFIT

14.1 Definitions

In this Schedule -

AS A RESULT OF AN ACCIDENT means that -

(a) an unexpected bodily injury caused by physical contact with violent accidental tangible external means is the direct, effective, exclusive and proximate cause of the death or the disability concerned, as the case may be; and

(b) the accident must have taken place at a specific place and point in time and must have been unexpected and not contributed to by an illness or disease; and

(c) the death or the disability, as the case may be, is not attributable to the INSURED having negligently or willfully exposed himself/herself to danger, except in the interests of the law or to protect his/her or another's life or property; and

(d) the injury referred to occurs after the latest date on which the INSURED becomes entitled to the benefits in terms of this Schedule and while he/she is an EMPLOYEE; and

(e) the death or the disability, as the case may be, occurs within 6 MONTHS of the injury referred to in (a).

BENEFIT CESSATION DATE in regard to an INSURED means the earlier of his/her NORMAL RETIREMENT DATE and the last day of the MONTH in which he/she attains the age of –

- 65 years in the case of all INSUREDS other than PILOTS; and
- 60 years in the case of PILOTS.

BENEFIT ENTITLEMENT in regard to an INSURED means the benefit that would be provided by the INSURER in regard to him/her in terms of Schedules 4, 5, 6, 7, 8, or 9 but for the stipulations regarding proof of good health in each respective Schedule.

FREE COVER LIMIT means that part of the BENEFIT ENTITLEMENT regarding which proof of good health does not have to be submitted, as laid down from time to time by the INSURER and conveyed in writing to the EMPLOYER.

14.2 Benefit

14.2(1) If an INSURED dies or becomes disabled after the latest date on which the insurance described in this Schedule becomes applicable to him/her and before or on the BENEFIT CESSATION DATE, and a benefit becomes payable in respect of the INSURED in terms of Schedules 4, 5, 6, 7, 8, or 9(the benefit in terms of Schedules 7 and 8 includes the 'contribution waiver benefit' and the 'premium waiver benefit', if applicable), but the benefit that becomes payable is restricted to the FREE COVER LIMIT, that part of the benefit exceeding the FREE COVER LIMIT also becomes payable if the event giving rise to the claim is AS A RESULT OF AN ACCIDENT, provided that –

- the benefit provided in terms of this Schedule will not apply in the case of a claim in respect of an INSURED who effects individual insurance in terms of Schedules 18 or 19 and becomes an INSURED again within twelve MONTHS of the starting date of the individual insurance and the claim arises before the end of the period of twelve MONTHS referred to;
- in those cases where the death and/or disability benefits are provided in terms of Schedules 5 and 6 or 9, as the case may be, only that part of the 'core amount' exceeding the FREE COVER LIMIT also becomes payable as a death or a lump sum disability benefit, as the case may be;

- premiums must have been paid on the full BENEFIT ENTITLEMENT applicable to the INSURED, except where the death and/or disability benefits are provided in terms of Schedules 5 and 6 or 9, as the case may be, in which event premiums must have been paid on the full 'core amount' applicable to the INSURED in terms of Schedule 5;

- the benefit that becomes payable in terms of this Schedule will be paid in accordance with the payment stipulations as contained in Schedules 4, 5, 6, 7, 8 or 9, as the case may be;

- the BENEFIT ENTITLEMENT in respect of an INSURED may not exceed the maximum amounts determined by the INSURER from time to time.

14.3 Exclusions

14.3(1) No benefit is paid in terms of this Schedule for a claim arising in terms of Schedules 4, 5, 6, 7, 8 or 9 -

(a) in the first three MONTHS after the insurance in terms of the relevant Schedule becomes applicable to the INSURED; or

(b) in the first three MONTHS after an increase in the INSURED's BENEFIT ENTITLEMENT if the FREE COVER LIMIT is exceeded for the first time as a result of the increase.

14.3(2) No benefit is paid in terms of this Schedule if the death or disability insured against in terms of the respective Schedules directly or indirectly arises from or is traceable to –

(a) a deliberate unlawful act committed by the INSURED that includes but is not limited to committing or attempting to commit the crime of murder, assault, housebreaking, theft, robbery, kidnapping or the INSURED committing a crime involving a sexual act or a crime of a similar nature to any of the aforesaid crimes;

(b) suicide or attempted suicide under any circumstances;

(c) intentional self-inflicted injury, self-inflicted injury while the INSURED is mentally disordered or deliberate failure to obtain the best medical assistance reasonably available;

(d) taking of medicaments by the INSURED, except in accordance with medical prescription;

(e) the driving of a mechanically driven vehicle by the INSURED while the alcohol content of his/her blood is more than the legal limit;

(f) cliff diving;

(g) free diving at depths greater than 25 meters;

(h) scuba diving at depths greater than 40 meters;

(i) unaccompanied scuba diving;

(j) cave diving, commercial diving or the exploration of underwater wrecks for financial gain;

(k) expedition style mountaineering;

(l) solo climbing mountaineering;

(m) expedition caving;

(n) hazardous aviation activities with a fixed-wing aeroplane and acrobatic flights, including such situations where the INSURED is a student pilot;

(o) microlight, helicopter or gyrocopter flying;

(p) recurrent hang-gliding, paragliding, sky-diving, parachuting or sky-surfing;

(q) buildings, aerials, spans, earth (BASE) jumping;

(r) motorized racing and speed contests;

(s) drag powerboat racing, competitive jet-skiing or competitive water skiing;

(t) professional boxing, professional kick-boxing, professional wrestling, martial arts or combat sports.

14.4 General

Depending on which benefit is being boosted by the benefit in terms of this Schedule, the provisions in Schedules 4, 5, 6, 7, 8, and 9 regarding the following:

- claims procedure;
- payment of benefit;
- general exclusions;
- absence from service;
- territorial limitations;
- deductions and unclaimed benefits;
- cancellation,

are mutatis mutandis applicable to the insurance offered in terms of this Schedule.

SCHEDULE 15 UNIVERSAL EDUCATION PROTECTOR BENEFIT

15.1 Application of Schedule

This Schedule do not apply to ABSA Life Limited.

Where this Schedule is applicable it applies only if an INSURED at the time that the insurance in terms of this Schedule becomes applicable to him/her, qualifies for death cover in terms of this Policy or in terms of a policy of the INSURER insuring the death benefits provided by the FUND for the benefit of the EMPLOYEES of the EMPLOYER, as the case may be.

15.2 Definitions

In this Schedule -

BOOK ALLOWANCE means the fees that are actually incurred for books prescribed by an EDUCATIONAL INSTITUTION in respect of an ELIGIBLE CHILD, subject to a maximum of 10% of the TUITION FEES paid or to be paid in respect of that ELIGIBLE CHILD in terms of this Schedule directly to the surviving parent or legal guardian nominated by the INSURED.

EDUCATIONAL INSTITUTION means

(a) a South African public or private school registered in terms of applicable legislation;

(b) an online home-school registered with the South African Comprehensive Assessment Institute (SACAI) and which provides the CAPS (public school) or IEB (private school) curriculums, or an international (GED – Grade 12 certificate) equivalent; and

(c) a South African university or university of technology (Technikon) or any institution of higher learning in respect of any National Qualification Framework (NQF) recognised tertiary level certificate or diploma, as well as a foreign university on the list of foreign universities approved by SANLAM. The list of foreign universities may be altered by SANLAM from time to time.

ELIGIBLE CHILD, in relation to an INSURED, means a child of the INSURED who is unmarried and who is -

(a) a biological child of the INSURED, including a biological child born after the date of the INSURED's death; or

(b) a legally adopted child of the INSURED, provided that the date of adoption or the date of application for adoption is before the date of death of the INSURED; or

(c) a stepchild of the INSURED, validated by a legal marriage or union in accordance with the Marriage Act, 1961, the Recognition of Customary Marriages Act, 1998, or the Civil Union Act, 2006, or the tenets of religion, of the INSURED,

provided that, an ELIGIBLE CHILD who is 18 years or older, apart from an ELIGIBLE CHILD who takes one year off in terms of clause 15.3(20), must at the INSURED's death already have made an application and be accepted as a student at the relevant EDUCATIONAL INSTITUTION.

MINIMUM ALLOWANCE means an amount which may be used for any school-related expenses, subject to a maximum amount of R1 100, 00 per annum, or such other maximum amount determined by SANLAM from time to time, to be paid in respect of an ELIGIBLE CHILD in terms of this Schedule directly to the surviving parent or legal guardian nominated by the INSURED.

PRE-SCHOOL means the education year immediately preceding Grade 1 and which is also commonly referred to as Grade 0 or Grade R.

TUITION FEES means the tuition fees that actually become payable to an EDUCATIONAL INSTITUTION in respect of an ELIGIBLE CHILD subject to any limitations provided for in this Schedule and subject to the maximum amounts set out in clause 15.3(3) here below.

UNIVERSITY RESIDENCE ALLOWANCE means the fees for an official university residence, including residence fees for a university of technology (Technikon), but excluding boarding fees for other boarding houses, schools, colleges or private accommodation, that actually become payable in respect of an ELIGIBLE CHILD, subject to a maximum of 30% of the TUITION FEES paid or to be paid in respect of that ELIGIBLE CHILD in terms of this Schedule.

15.3 Benefit

15.3(1) If an INSURED, while he/she is an EMPLOYEE, dies before or on the earliest of his/her NORMAL RETIREMENT DATE or the date he/she turns 65 and a death claim in terms of this Policy or in terms of a policy of the INSURER insuring the death benefits provided by the FUND for the benefit of its EMPLOYEES in respect of the INSURED has been admitted by SANLAM, or would have been admitted had the INSURED at the time of his/her death still enjoyed death cover in terms of such policy, then subject to any limitations provided for in this Schedule and the maximum amounts set out in clause 15.3(3) below, SANLAM becomes liable for payment of the following expenses, if and when such expenses actually are incurred following the death of the INSURED and in respect of each ELIGIBLE CHILD who has been recorded as such by SANLAM during the death claim process:

(a) TUITION FEES;

(b) BOOK ALLOWANCE;

(c) UNIVERSITY RESIDENCE ALLOWANCE.

15.3(2) In addition to the expenses referred to in clause 15.3(1) above, a MINIMUM ALLOWANCE subject to the provisions of clause 15.3(6) and clause 15.3(7) is paid. The MINIMUM ALLOWANCE if not claimed for a specific academic year is forfeited and cannot be carried over for future years of education.

15.3(3) Subject to the provisions of this Schedule, the above-mentioned benefit may be claimed for the maximum number of years of education stated in the table below. Where the ELIGIBLE CHILD has already commenced education at the time TUITION FEES becomes payable, the maximum number of years payable for the allowance is reduced by the completed number of years of education. The benefit for TUITION FEES, is limited to the maximum amounts stated below, or to such other maximum amounts SANLAM may determine from time to time.

EDUCATIONAL INSTITUTION	Maximum TUITION FEES per annum	Benefit Period
PRE-SCHOOL (Grade 0/ Grade R)	R47,000	1 year
Primary school (Grade 1 – Grade 7)	R91,000	7 years
Secondary school (Grade 8 – Grade 12)	R105,000	5 years
Tertiary education	South African EDUCATIONAL INSTITUTION: R69,000 Foreign EDUCATIONAL INSTITUTION: The Rand equivalent of $67,000	Duration of a first undergraduate degree or NQF recognised tertiary level first certificate, or first diploma granted by an EDUCATIONAL INSTITUTION
Transfer from a non-fee-paying school or fee exempt school to fee-paying school	R11,500	

15.3(4) If both parents of an ELIGIBLE CHILD are members of a group scheme(s) insured by SANLAM, and both die simultaneously or if one dies before the other, the total benefit available under the relevant scheme(s) in respect of the ELIGIBLE CHILD is limited to the maximum benefit that may be provided in respect of that ELIGIBLE CHILD in terms of clause 15.3(1) above.

15.3(5) When an ELIGIBLE CHILD graduates from a primary school to a secondary school the TUITION FEES payable by SANLAM for all the years of attending a secondary school will be limited to a 50% increase of the last year of primary school's TUITION FEES which were paid, or which would have been payable had SANLAM been liable for a benefit subject to the maximum for secondary school's TUITION FEES set out in clause above.

15.3(6) There are no limitations with regards to the type of expenses for which the MINIMUM ALLOWANCE may be utilised. The MINIMUM ALLOWANCE payable by SANLAM will be the maximum amount of the MINIMUM ALLOWANCE provided that -

(a) the MINIMUM ALLOWANCE will be reduced by any amount already paid by SANLAM in respect of the BOOK ALLOWANCE, or

(b) if the BOOK ALLOWANCE is only claimed after the MINIMUM ALLOWANCE has already been paid, the BOOK ALLOWANCE is reduced by the MINIMUM ALLOWANCE that was previously paid.

15.3(7) The MINIMUM ALLOWANCE will be payable for each academic year of the ELIGIBLE CHILD's school education, if:

(a) the ELIGIBLE CHILD attends a recognised EDUCATIONAL INSTITUITION for PRE-SCHOOL, primary or secondary school;

(b) the ELIGIBLE CHILD has not claimed a BOOK ALLOWANCE for the applicable academic year that exceeds the maximum amount of the MINIMUM ALLOWANCE.

15.3(8) On the death of the INSURED, SANLAM will pay the MINIMUM ALLOWANCE in respect of the academic year in which the INSURED died.

15.3(9) TUITION FEES levied by a private school, will be paid to the relevant private school provided that SANLAM is satisfied that, at the INSURED's death -

(a) the ELIGIBLE CHILD was attending a private school that is an EDUCATIONAL INSTITUTION. In this case any additional ELIGIBLE CHILD not yet of school going age at the INSURED'S date of death will also qualify for the private school TUITION FEES provided that he/she attends a private school upon reaching school going age ; or

(b) the ELIGIBLE CHILD who was then not yet of school-going age, was registered and accepted as a student at a private school that is an EDUCATIONAL INSTITUTION, provided he/she attends the private school upon reaching school going age.

15.3(10) Where an ELIGIBLE CHILD at the INSURED's death lived in a rural area the TUITION FEES levied by a rural public school that is an EDUCATIONAL INSTITUTION will be paid if the ELIGIBLE CHILD is attending such a rural school at the date of the INSURED'S death or when the ELIGIBLE CHILD attains school-going age.

15.3(11) However, the TUITION FEES of an urban public school will be paid provided SANLAM is satisfied that, at the INSURED's death -

(a) the ELIGIBLE CHILD was already attending an urban public school that is an EDUCATIONAL INSTITUTION. In this case any additional ELIGIBLE CHILD not yet of school going age as at the INSURED'S date of death will also qualify for the urban public school TUITION FEES provided, he/she attends an urban public school upon reaching school going age; or

(b) an ELIGIBLE CHILD who was then not yet of school-going age, was registered and accepted as a student at an urban public school that is an EDUCATIONAL

INSTITUTION provided, he/she attends the urban public school upon reaching school going age.

(c) SANLAM may request any information which SANLAM in its sole discretion deems relevant to satisfy itself of any of the aforementioned.

15.3(12) Benefits for an ELIGIBLE CHILD who is a special needs child will not be limited to the standard years of education for PRE-SCHOOL, primary school or secondary school set out in clause 15.3(3) above. The provisions in terms of clause 15.3(3) above will still apply which may result in the benefit payments ending before the ELIGIBLE CHILD completing his/her school education.

In this clause “Special Needs Child” means a child attending an EDUCATIONAL INSTITUITION providing education for children who are mentally or physically disabled.

15.3(13) If an ELIGIBLE CHILD, after the INSURED’s death, transfers from one EDUCATIONAL INSTITUTION to another EDUCATIONAL INSTITUTION, including the situation where the change in EDUCATIONAL INSTITUTION is occasioned by the ELIGIBLE CHILD emigrating from South Africa, the TUITION FEES payable will be limited to the TUITION FEES that would have been payable in terms of this Schedule had the ELIGIBLE CHILD remained at the previous EDUCATIONAL INSTITUTION.

15.3(14) Where an ELIGIBLE CHILD emigrates from South Africa after the INSURED’S death and after completing his/her secondary schooling so that the ELIGIBLE CHILD commences his/her tertiary education overseas, the TUITION FEES that will be payable to the foreign university is set out in clause 15.3(3) above.

15.3(15) Notwithstanding clause 15.3(13) above, where an ELIGIBLE CHILD transfers from a no-fee paying or fee exempt school to a fee-paying public school, the TUITION FEES payable will be subject to the maximum amount set out in clause 15.3(3) above. The TUITION FEES of the fee-paying public school will only be paid provided SANLAM is satisfied that the transfer took place -

(a) in the twelve months following the death of the INSURED; or

(b) when progressing from PRE-SCHOOL to primary school; or

(c) when progressing from primary school to secondary school.

15.3(16) An ELIGIBLE CHILD will be permitted to change his/her course of tertiary study for a first undergraduate degree or NQF recognised tertiary level first certificate or first diploma, provided that -

(a) The TUITION FEES paid will be limited to the fees that would have been payable for the remaining duration of the original degree, diploma or certificate; and

(b) the years of education will be limited to the remaining duration of the original degree, diploma or certificate.

15.3(17) If an ELIGIBLE CHILD repeats any particular grade of school education, TUITION FEES, BOOK ALLOWANCE and MINIMUM ALLOWANCE remain payable for him/her to repeat that grade subject to the maximum number of years of education set out in clause 15.3(3) above. In the event that the maximum number years of education is reached, no further benefits will be paid by SANLAM until the ELIGIBLE CHILD progresses to the next level of education.

15.3(18) If an ELIGIBLE CHILD fails to pass any year of tertiary education, no benefit is payable for him/her to repeat that year of tertiary education. Benefits will become payable again only if and when he/she progresses to the successive year of education. An ELIGIBLE CHILD will be deemed to have failed a year of tertiary education, if the ELIGIBLE CHILD fails more than two-thirds of the subjects taken, or if the child failed the academic year according to the policies of the tertiary EDUCATIONAL INSTITUITION.

15.3(19) Benefits in respect of an ELIGIBLE CHILD are not available in terms of this Schedule as long as he/she for any reason during his/her school education temporarily does not attend

an EDUCATIONAL INSTITUTION. Benefits may however become available again if SANLAM is satisfied that during such temporary period, he/she continued with his/her school education at a learning institution.

15.3(20) Years of education must run consecutively however an ELIGIBLE CHILD may take off one year between the completion of secondary school and the start of tertiary education. No benefits will be available in terms of this Schedule for that year.

15.3(21) Benefits may be claimed in respect of a year of education. In the case of tertiary education, the benefits for any year may be split into more than one payment, for example a payment per semester where one or more subjects run per semester.

15.3(22) SANLAM will only be in a position to properly evaluate a claim for benefits once SANLAM has been provided with all the relevant information and documentary proof which SANLAM in its sole discretion may request from time to time. Documentary proof will include proof of enrolment and acceptance by the EDUCATIONAL INSTITUTION at the start of the academic year, proof of the fees levied by the EDUCATIONAL INSTITUTION, proof of the books prescribed by the EDUCATIONAL INSTITUTION and quotations for the prices thereof, proof of the UNIVERSITY RESIDENCE ALLOWANCE and, if applicable, the previous year's education results.

15.3(23) If the EMPLOYER/parent/guardian has already made payment of fees levied by an EDUCATIONAL INSTITUTION, benefits will be paid only in respect of any outstanding TUITION FEES that has become payable after the date of death of the INSURED, subject to the provisions of this Schedule.

15.3(24) SANLAM will make payment of the benefits directly to the EDUCATIONAL INSTITUTION concerned. No payments will be made directly to the EMPLOYER /parent /guardian. However, if any legislation prevents the payment of the benefit from being made directly to the EDUCATIONAL INSTITUTION, the benefits concerned may be paid to ELIGIBLE CHILD or to their surviving parent or legal guardian at SANLAM'S sole discretion.

15.4 Notification of a claim

Benefits may be claimed in terms of this Schedule only if within six MONTHS after the death of the INSURED, the INSURER is notified in writing of the claim for the benefits.

15.5 Cessation of benefits

Benefits in terms of this Schedule in respect of an ELIGIBLE CHILD will automatically cease on the earlier of -

(a) his/her successful completion of the course for a first undergraduate degree or a NQF recognised tertiary level first certificate, or first diploma granted by an EDUCATIONAL INSTITUTION, subject to the provisions of clause 15.3(18);

(b) the end of the year in which he/she turns 23;

(c) his/her death;

(d) his/her education being interrupted except in the case referred to in clause 15.3(20).

15.6 General exclusions

15.6(1) Notwithstanding any provision to the contrary in the Policy, no benefit is paid in terms of this Schedule if the INSURED's death -

(a) is a direct or indirect consequence of active participation in

(i) war, invasion, acts of foreign enemies, hostilities, warlike operations (whether war be declared or not), civil war, rebellion, revolution, military or usurped power, insurrection, civil commotion assuming the proportions of or amounting to an uprising; or

(ii) an act of terrorism; or

(iii) a riot; or

(iv) conduct during a strike (irrespective of whether the strike is lawful or unlawful) during which conduct lives are endangered, public or private property damaged, or an attempt or attempts are made to damage such property; or

(v) any other unlawful act or conduct of whatever nature during which lives are endangered, public or private property damaged, or an attempt or attempts are made to damage such property.

(b) is a direct or indirect consequence of –

(i) any radioactive contamination, including accidental radioactive contamination; or

(ii) the use of nuclear, biological or chemical weapons; or

(iii) attacks on or sabotage of facilities (including, but not limited to, nuclear power plants, reprocessing plants, final repository sites and research reactors) and storage depots, which lead to the release of radioactivity or nuclear, biological or chemical warfare agents,

irrespective whether any of the aforesaid is performed with the specific use of information technology.

15.6(2) The benefit described in this Schedule is also not payable in respect of an INSURED if the INSURED dies within twelve MONTHS after the latest date on which the insurance of the benefit has commenced with the INSURER in respect of the INSURED and the death directly or indirectly arises from or is traceable to

- a bodily injury which occurred; or
- a condition of which the INSURED was conscious or experienced symptoms or for which medical treatment was received,

during the six MONTHS immediately before that date.

15.6(3) The benefit described in this Schedule is not provided regarding an INSURED if the INSURED has the option of becoming a member of the FUND and, by so doing, becoming an INSURED and dies before the INSURER receives his/her full particulars.

15.6(4) The benefit described in this Schedule, or any increase in it by virtue of an amendment to the Policy, is not provided regarding an INSURED if the INSURED, on the latest date on which the insurance described in this Schedule or the insurance of the increase, as the case may be, has commenced with the INSURER regarding the INSURED, in the opinion of the INSURER, is incapable of performing his/her normal duties with the EMPLOYER as a result of a bodily injury or sickness and dies before he/she, in the opinion of the INSURER, is capable of resuming his/her normal duties.

15.7 Absence from service

Refer to Schedule 21 for the terms and conditions regarding the absence of the INSURED from the service of the EMPLOYER while insured in terms of this Schedule.

15.8 Territorial limitations

Refer to Schedule 22 for the terms and conditions regarding the absence of the INSURED from the Republic of South Africa while insured in terms of this Schedule.

15.9 Deductions and unclaimed benefits

Refer to Schedule 23 for the provisions regarding the allowable deductions from benefits payable in terms of the Policy and for the provisions regarding benefits that become payable and are not claimed.

15.10 Cancellation

15.10(1) If the insurance described in this Schedule is cancelled for a group of INSUREDS, the INSURER's liabilities in terms of this Schedule regarding each of those INSUREDS lapses, unless -

(a) an INSURED dies before the date of cancellation; and

(b) the claim for the benefit is submitted to the INSURER within six MONTHS after the date of cancellation; and

(c) the claim referred to is admitted by the INSURER.

15.10(2) For the purposes of this clause –

(a) the insurance described in this Schedule is also regarded as cancelled for a group of INSUREDS when –

(i) an EMPLOYER's participation in the Policy or in the benefit provided in terms of this Schedule is terminated; or

(ii) the participation of a category of EMPLOYEES of an EMPLOYER in the Policy or in the benefit provided in terms of this Schedule is terminated; or

(iii) the benefit which is insured in terms of this Schedule is cancelled owing to an amendment to the Policy;

and

(b) an INSURED is deemed to be a member of a group if he/she was a member of the relevant group immediately prior to his/her death.

SCHEDULE 16 SALARY REFUND BENEFIT

16.1 Application of Schedule

This Schedule do not apply to ABSA Life Limited.

16.2 Definitions

In this Schedule –

WAITING PERIOD means the 'waiting period' as defined in Schedule 7.

16.3 Benefit

16.3(1) If the INSURER admits a claim for the payment of a disability income in respect of an INSURED in terms of Schedule 7, -

(a) the INSURER pays to the EMPLOYER the total amount of RISK SALARY that would be paid by the EMPLOYER to the INSURED during the WAITING PERIOD if the INSURED did not become disabled; or

(b) the INSURER pays to the EMPLOYER the total amount of RISK SALARY that would be paid by the EMPLOYER to the INSURED during the WAITING PERIOD if the INSURED did not become disabled, plus a percentage of such total amount of RISK SALARY,

as indicated in the CERTIFICATE OF PARTICIPATION.

16.3(2) The benefit in terms of this Schedule is payable when the first disability income payment is made in respect of the INSURED in terms of Schedule 7 and no benefit is payable in terms of this Schedule if the INSURED dies during the WAITING PERIOD.

16.4 Cancellation

16.4(1) If the insurance described in this Schedule is cancelled for a group of INSURED, the INSURER's liabilities in terms of this Schedule regarding each of those INSURED lapse, unless -

(e) a claim for the benefit in terms of this Schedule arises before the date of cancellation; and

(f) the claim referred to is submitted to the INSURER before or within six MONTHS of the date of cancellation; and

(g) the claim referred to is admitted by the INSURER; and

(h) the cost of the insurance described in this Schedule in respect of the INSURED is paid to the INSURER until the payment of the disability income in terms of Schedule 7 commences.

16.4(2) If the INSURER's liabilities do not lapse in terms of the preceding sub-clause, the INSURER must pay to the EMPLOYER the benefit that would be paid by the INSURER in terms of this Schedule if the insurance described in this Schedule is not cancelled.

16.4(3) For the purposes of this clause an INSURED is deemed to be a member of a group if he/she is a member of the group immediately prior to the commencement of disability in terms of Schedule 7

SCHEDULE 17 MEDICAL AID PREMIUM WAIVER BENEFIT

17.1 Application of Schedule

This Schedule do not apply to ABSA Life Limited.

17.2 Definition

In this Schedule **MEDICAL AID PREMIUM** means the monthly medical aid premium, including the premium for the medical savings account, which is payable to the INSURED's medical aid scheme, where the INSURED is the principal member of that medical aid scheme. The premium for the medical aid savings account will be taken to be the monthly average of the medical aid savings account premium for the three months prior to the commencement of disability in terms of Schedule 7. The medical aid premium, including the premium for the medical aid savings account, is limited to the maximum amounts indicated in the table below, or to such other maximum amounts the INSURER determines from time to time.

Member of Medical Aid Scheme	**Maximum amount**
INSURED	• R4 000 per month
Spouse of INSURED	• R3 300 per month
Child of INSURED	• R1 800 per month per child

For purposes of this Policy, the MEDICAL AID PREMIUM in regard to an INSURED –

(a) does not include the medical aid premium for adult dependants of the INSURED, other than the spouse of the INSURED, which is payable to his/her medical aid scheme;

(b) includes the medical aid premium which eventually becomes payable in respect of an unborn child, provided that the pregnancy is in the second or third trimester at the time of diagnosis of disability for purposes of Schedule 7.

If an INSURED elects to upgrade health plans and his/her medical aid premium increases as a result thereof, the MEDICAL AID PREMIUM does not increase but remains based on his/her health plan immediately before the commencement of disability in terms of Schedule 7. However, the MEDICAL AID PREMIUM is increased in the same MONTH and at the same rate of increase that the medical aid scheme increases the premiums of its members, subject to a maximum increase of 20% per annum.

17.3 Benefit

17.3(1) During the period in which a disability income is paid in respect of an INSURED in terms of Schedule 7, the INSURER pays to the EMPLOYER the MEDICAL AID PREMIUM. The EMPLOYER will subsequently pay the MEDICAL AID PREMIUM to the INSURED's medical aid scheme. The MEDICAL AID PREMIUM in respect of the INSURED will be paid for a maximum period of 24 MONTHS less the WAITING PERIOD.

17.3(2) If a disability income commences in terms of Schedule 7 within twelve MONTHS of the date on which the MEDICAL AID PREMIUM in question is increased and the INSURED's disability directly or indirectly arises from or is traceable to -

- a bodily injury which occurred; or
- a condition of which the INSURED was conscious or experienced symptoms or for which medical treatment was received

during the six MONTHS immediately before the increase, the MEDICAL AID PREMIUM is determined as if the increase is not applicable to the INSURED.

17.4 Cancellation

17.4(1) If the insurance described in this Schedule is cancelled for a group of INSURED, the INSURED's liabilities in terms of this Schedule regarding each of those INSURED lapse, unless -

(a) a claim for the benefit in terms of this Schedule arises before the date of cancellation; and

(b) the claim referred to is submitted to the INSURER before or within six MONTHS of the date of cancellation; and

(c) the claim referred to is admitted by the INSURER; and

(d) the cost of the insurance described in this Schedule in respect of the INSURED is paid to the INSURER until the payment of the MEDICAL AID PREMIUM commences.

17.4(2) If the INSURER’s liabilities do not lapse in terms of the preceding sub-clause, the INSURER must apply the MEDICAL AID PREMIUM, that would be paid by the INSURER to the EMPLOYER in terms of this Schedule if the insurance described in this Schedule is not cancelled, on a basis on which the INSURER decides in consultation with the EMPLOYER.

SCHEDULE 18 OPTION TO APPLY FOR INDIVIDUAL DEATH AND LUMP SUM DISABILITY INSURANCE ON OWN LIFE

18.1 Definitions

In this Schedule -

ACCIDENT means a bodily injury which –

(a) is caused by physical contact with violent, accidental, tangible and external means; and

(b) is the direct, effective, exclusive and proximate cause of the death or disability concerned, as the case may be; and

(c) is not attributable to the INSURED having negligently or willfully exposed himself/herself to danger, except in the interests of the law or to protect his/her or another's life or property.

DATE OF WITHDRAWAL in regard to an INSURED means –

(a) the date on which he/she ceases to be an EMPLOYEE; or

(b) his/her NORMAL RETIREMENT DATE if he/she continues his/her service with the EMPLOYER after his/her NORMAL RETIREMENT DATE and no death benefit in terms of Schedules 4 or 5 is applicable to him/her after his/her NORMAL RETIREMENT DATE; or

(c) the last day of the MONTH in which he/she reaches the age indicated in the CERTIFICATE OF PARTICIPATION if he/she continues his/her service with the EMPLOYER after that date, and a death benefit in terms of Schedules 4 or 5 remains applicable to him/her after his/her NORMAL RETIREMENT DATE,

whichever event occurs first.

18.2 Option to apply for individual life insurance

An INSURED has an option to apply for individual life insurance on the INSURED'S life with the INSURER to commence not later than sixty days after the applicable DATE OF WITHDRAWAL defined above.

This option may only be exercised if -

(a) the death benefit in terms of SCHEDULE 4chedules 4 or 5 is applicable to the INSURED immediately before the DATE OF WITHDRAWAL; and

(b) the application for the insurance is submitted to an office of the INSURER within sixty days after the DATE OF WITHDRAWAL; and

(c) the INSURED is a South African citizen, or if the INSURED is not a South African citizen, he/she complies with the conditions under which a person who is not a South African citizen can obtain individual life insurance from the INSURER; and

(d) premiums are paid up to the DATE OF WITHDRAWAL.

For this option an INSURED whose life is still insured in terms of the Policy is regarded as not ceasing to be an EMPLOYEE until that insurance lapses.

18.3 Option to apply for individual disability insurance

An INSURED has an option to apply for individual disability insurance on the INSURED's life with the INSURER to commence not later than sixty days after the applicable DATE OF WITHDRAWAL defined above. The individual disability insurance must comprise lump sum disability benefits.

The option may only be exercised if -

(a) the insurance of the lump sum disability benefits in terms of Schedules 6 or 9 is applicable to the INSURED in terms of the Policy immediately prior to the DATE OF WITHDRAWAL;

(b) the application for the insurance is submitted to an office of the INSURER within sixty days after the DATE OF WITHDRAWAL;

(c) the INSURED is younger than 60 years and has not reached his/her NORMAL RETIREMENT DATE;

(d) the INSURED is a South African citizen, or if the INSURED is not a South African citizen, he/she complies with the conditions under which a person who is not a South African citizen can obtain individual disability insurance from the INSURER; and

(e) premiums are paid up to the DATE OF WITHDRAWAL.

18.4 Waiting period

18.4(1) If this option is included with the death or death and lump sum disability benefits set out in the CERTIFICATE OF PARTICIPATION on the EMPLOYER's PARTICIPATION DATE, the following applies:

(a) Every EMPLOYEE who qualifies as an INSURED on the PARTICIPATION DATE may exercise the option to apply for individual insurance as from the PARTICIPATION DATE, provided that premiums for the option have been paid to the INSURER in respect of the INSURED as from the PARTICIPATION DATE; and

(b) Every EMPLOYEE who qualifies as an INSURED after the PARTICIPATION DATE may only exercise the option to apply for individual insurance after he/she has been an INSURED for twelve consecutive MONTHS, and premiums for the option have been paid to the INSURER in respect of the INSURED for those twelve consecutive MONTHS.

18.4(2) If this option is added to the death or death and lump sum disability benefits set out in the CERTIFICATE OF PARTICIPATION after the EMPLOYER's PARTICIPATION DATE, the following applies:

Every EMPLOYEE who qualifies as an INSURED before, on or after the date that the option is added to the benefits may only exercise the option after he/she has been an INSURED for twelve consecutive MONTHS after the date that the option is added to the benefits, and premiums for the option have been paid to the INSURER in respect of the INSURED for those twelve consecutive MONTHS.

18.5 Maximum death and disability sums insured

18.5(1) The death sum insured of the individual insurance may not exceed the death benefit applicable to the INSURED in terms of Schedules 4 or 5, as the case may be, excluding the 'accident booster benefit' in terms of Schedule 14, immediately before the DATE OF WITHDRAWAL. Any increase in the death benefit by virtue of an amendment to the Policy which becomes effective in the twelve MONTHS immediately preceding the DATE OF WITHDRAWAL is, however, not taken into account in determining the said maximum death sum insured.

18.5(2) The disability sum insured of the individual insurance may not exceed the least of -

(a) the lump sum disability benefit applicable to the INSURED in terms of Schedules 6 or 9, as the case may be, excluding the 'accident booster benefit' in terms of Schedule 14, immediately before the DATE OF WITHDRAWAL;

(b) the amount to which the INSURER, on the date on which the option is exercised, normally restricts similar individual disability insurance with regard to the INSURED'S income;

(c) the amount of the death sum insured of the individual policy.

Any increase in the lump sum disability benefit by virtue of an amendment to the Policy which becomes effective in the twelve MONTHS immediately preceding the DATE OF WITHDRAWAL is, however, not taken into account in determining the said maximum disability sum insured.

18.5(3) If an INSURED in respect of whom individual insurance has been effected in terms of the option in this Schedule, again becomes an EMPLOYEE, the maximum sum insured that may be obtained in terms of this option will be reduced by the sum insured in terms of the previous option on its inception date and by the sums insured in terms of other options similar to the option in this Schedule effected with the INSURER.

18.5(4) Notwithstanding the preceding provisions, the maximum sum insured that may be obtained in terms of this option may not exceed the maximum benefit normally applicable to similar insurance with the INSURER.

18.6 Proof of good health

No proof of good health is required other than the INSURER's requirements in respect of Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and Cotinine tests.

18.7 Premium rates and other provisions of individual insurance

From the inception date of the individual insurance, the premium rates, occupational risk (if any) and other provisions that were applicable to the INSURED in terms of this Policy, will no longer apply to the insurance. The individual insurance effected by the INSURED will be subject to the provisions that normally apply to individual insurance with the INSURER. However, if on medical grounds, any special premium rates and other provisions were applicable to the INSURED in terms of this Policy, adjustments to the same extent may be made to the rates and provisions applicable to the individual insurance.

18.8 Death within the option period

18.8(1) If an INSURED who qualifies for this option, dies within sixty days after the DATE OF WITHDRAWAL, an amount equal to the maximum death sum insured that could have been obtained without proof of good health in terms of this option, is paid. Such amount will not be payable if the INSURED effects any individual insurance in terms of this option which takes effect before the death of the INSURED.

18.8(2) The provisions of Schedules 4 or 5, as the case may be, are applicable mutatis mutandis in respect of the payment of a benefit in terms of this clause.

18.9 Disability within the option period

If an INSURED, who may obtain individual disability insurance, becomes disabled within sixty days after the DATE OF WITHDRAWAL, the INSURER pays a disability benefit to the INSURED. But this disability benefit is only paid if the INSURED becomes disabled to the extent required for the lump sum disability benefit in terms of Schedules 6 or 9, as the case may be, to become payable. The disability benefit will not be payable if the INSURED effects any individual insurance in terms of this option which takes effect before the commencement of the disability. The disability benefit will be equal in value to the maximum disability insurance which could have been obtained by the INSURED in terms of this option.

18.10 Reappointment

If an INSURED in respect of whom individual insurance has been effected in terms of the option in this Schedule, again becomes an INSURED within twelve MONTHS of the starting date of the individual insurance, his/her death benefit and disability benefit in terms of Schedules 4 or 5 and 6 or 9, as the case may be, will be reduced by the sum insured under the individual insurance on its starting date. This reduction will not apply in the event of a claim within the twelve MONTHS referred to if the event giving rise to the

claim is as a result of an ACCIDENT and not due to natural causes. This reduction will also not apply as from the day after the period of twelve MONTHS referred to has passed or as from the day the INSURED, at the INSURER's expense, submits proof of good health to the satisfaction of the INSURER after becoming an INSURED again, whichever is the earlier.

18.11 Lapse of option

18.11(1) This option is not available in respect of an INSURED when he/she ceases to be an INSURED as a result of -

- an amendment to the Policy;
- termination of the EMPLOYER'S participation in the Policy;
- termination of the EMPLOYER'S business;
- a retrenchment exercise where the EMPLOYER retrenches the greater of three EMPLOYEES and 2% or more of the total number of EMPLOYEES; or
- the business of the EMPLOYER being transferred to or amalgamated with any other business, company or organisation.

18.11(2) The relative option lapses in respect of an INSURED if and as soon as the insurance in terms of Schedules 4 or 5 and 6 or 9, as the case may be, is cancelled with regard to the group of INSURED to which he/she belongs.

SCHEDULE 19 OPTION TO APPLY FOR INDIVIDUAL INCOME DISABILITY INSURANCE ON OWN LIFE

19.1 Definitions

In this Schedule –

ACCIDENT means a bodily injury which -

(a) is caused by physical contact with violent, accidental, tangible and external means; and

(b) is the direct, effective, exclusive and proximate cause of the disability concerned; and

(c) is not attributable to the INSURED having negligently or willfully exposed himself/herself to danger, except in the interests of the law or to protect his/her or another's life or property.

19.2 Option to apply for individual income disability insurance

19.2(1) An INSURED who is insured for income disability insurance in terms of Schedule 7 and whose service with the EMPLOYER is terminated for reasons other than occupational disability has an option to apply for individual income disability insurance on the INSURED's life with the INSURER, to commence not later than sixty days after the date of termination of service.

19.2(2) The individual income disability insurance that may be effected by the INSURED excludes any insurance of the 'CONTRIBUTION WAIVER BENEFIT' and the 'PREMIUM WAIVER BENEFIT' as defined in Schedule 7.

19.2(3) This option may only be exercised if -

(a) the INSURED is under the age of 60 years on the date of termination of service and has not reached his/her NORMAL RETIREMENT DATE;

(b) the application for the insurance is submitted to an office of the INSURER within sixty days after the date of termination of service;

(c) the INSURED engages in an occupation for which the INSURER normally offers such insurance;

(d) the INSURED is a South African citizen, or if the INSURED is not a South African citizen, he/she complies with the conditions under which a person who is not a South African citizen can obtain individual income disability insurance from the INSURER; and

(e) premiums are paid up to the date of termination of service.

19.2(4) For this option an INSURED whose life is still insured in terms of this Policy is regarded as not terminating service until the insurance lapses.

19.3 Waiting period

19.3(1) If this option is included with the income disability benefit set out in the CERTIFICATE OF PARTICIPATION on the EMPLOYER's PARTICIPATION DATE, the following applies:

(a) Every EMPLOYEE who qualifies as an INSURED on the PARTICIPATION DATE may exercise the option to apply for individual income disability insurance as from the PARTICIPATION DATE, provided that premiums for the option have been paid to the INSURER in respect of the INSURED as from the PARTICIPATION DATE; and

(b) Every EMPLOYEE who qualifies as an INSURED after the PARTICIPATION DATE may only exercise the option to apply for individual income disability insurance after he/she has been an INSURED for twelve consecutive MONTHS, and premiums for

the option have been paid to the INSURER in respect of the INSURED for those twelve consecutive MONTHS.

19.3(2) If this option is added to the income disability benefit set out in the CERTIFICATE OF PARTICIPATION after the EMPLOYER's PARTICIPATION DATE, the following applies:

Every EMPLOYEE who qualifies as an INSURED before, on or after the date that this option is added to the benefit may only exercise the option after he/she has been an INSURED for twelve consecutive MONTHS after the date that the option is added to the benefit, and premiums for the option have been paid to the INSURER by or on behalf of the INSURED for those twelve consecutive MONTHS.

19.4 Maximum level of benefits

The maximum level of benefits, including the income disability benefit, the waiting period and the benefit period, that may be effected in terms of clause 19.2, may not exceed the limits of the benefits for which the INSURED was insured in terms of Schedule 7, excluding the 'accident booster benefit' in terms of Schedule 14, immediately before the date of termination of service. Any increase in the benefits by virtue of an amendment to the Policy which becomes effective in the twelve MONTHS immediately preceding the date of termination of service is, however, not taken into account in determining the said maximum level of benefits.

If an INSURED in respect of whom individual insurance has been effected in terms of the option in this Schedule, again becomes an EMPLOYEE, the maximum level of benefits that may be obtained in terms of this option will be reduced by the level of benefits in terms of the previous option on its inception date and by the levels of benefits in terms of other options similar to the option in this Schedule effected with the INSURER.

Notwithstanding the preceding provisions, the maximum level of benefits that may be obtained in terms of this option may not exceed the maximum benefit normally applicable to similar insurance with the INSURER.

19.5 Proof of good health

No proof of good health is required other than the INSURER's requirements in respect of Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and Cotinine tests.

19.6 Premium rates and other provisions of individual insurance

From the inception date of the individual insurance, the premium rates, occupational risk (if any) and other provisions that were applicable to the INSURED in terms of this Policy, will no longer apply to the insurance. The individual insurance effected by the INSURED will be subject to the provisions that normally apply to individual insurance with the INSURER. However if, on medical grounds, any special premium rates and other provisions were applicable to the INSURED in terms of this Policy, adjustments to the same extent may be made to the rates and provisions applicable to the individual insurance.

19.7 Disability within the option period

If an INSURED who qualifies for this option, becomes disabled within sixty days after the date of termination of service, the INSURER pays a disability benefit to the INSURED. But this disability benefit is only paid if the INSURED becomes disabled to the extent required for the income disability benefit in terms of Schedule 7 to become payable. The disability benefit will not be payable if the INSURED effects any individual insurance in terms of this option which takes effect before the commencement of the disability. The disability benefit will be equal in value to the maximum disability insurance which could have been obtained by the INSURED in terms of this option.

19.8 Reappointment

If an INSURED in respect of whom individual income disability insurance has been effected in terms of the option in this Schedule, again becomes an INSURED within twelve

MONTHS of the starting date of the individual insurance, his/her income disability benefit in terms of Schedule 7 will be reduced by the amount insured under the individual insurance on its starting date. This reduction will not apply in the event of a claim within the twelve MONTHS referred to if the event giving rise to the claim is as a result of an ACCIDENT and not due to natural causes. This reduction will also not apply as from the day after the period of twelve MONTHS referred to has passed or as from the day the INSURED, at the INSURER's expense, submits proof of good health to the satisfaction of the INSURER after becoming an INSURED again, whichever is the earlier.

19.9 Lapse of option

19.9(1) This option is not available in respect of an INSURED when he/she ceases to be an INSURED as a result of -

- an amendment to the Policy;
- termination of the EMPLOYER's participation in the Policy;
- termination of the EMPLOYER's business;
- a retrenchment exercise, where the EMPLOYER retrenches the greater of three EMPLOYEES and 2% or more of the total number of EMPLOYEES; or
- the business of the EMPLOYER being transferred to or amalgamated with any other business, company or organisation.

19.9(2) The option in terms of this Schedule lapses in respect of an INSURED if and as soon as the insurance in terms of Schedule 7 is cancelled with regard to the group of INSURED to which he/she belongs.

SCHEDULE 20 OPTION TO APPLY FOR INDIVIDUAL INSURANCE ON QUALIFYING SPOUSE'S LIFE

20.1 Definition

In this Schedule –

ACCIDENT means a bodily injury which –

(a) is caused by physical contact with violent, accidental, tangible and external means; and

(b) is the direct, effective, exclusive and proximate cause of the death of the QUALIFYING SPOUSE; and

(c) is not attributable to the QUALIFYING SPOUSE having negligently or willfully exposed himself/herself to danger, except in the interests of the law or to protect his/her or another's life or property.

DATE OF WITHDRAWAL in regard to an INSURED means -

(a) the date on which his/her service with the EMPLOYER is terminated; or

(b) the date on which the MARRIAGE of the INSURED and his/her QUALIFYING SPOUSE is legally dissolved, or dissolved according to any law or custom, as the case may be; or

(c) the INSURED's NORMAL RETIREMENT DATE if he/she continues his/her service with the EMPLOYER after the NORMAL RETIREMENT DATE and no death benefit is applicable to the QUALIFYING SPOUSE in terms of Schedule 10 after the NORMAL RETIREMENT DATE; or

(d) the last day of the MONTH in which he/she reaches the age indicated in the CERTIFICATE OF PARTICIPATION, subject to a maximum age of 70 years, if he/she continues his/her service with the EMPLOYER after the NORMAL RETIREMENT DATE and the death benefit in respect of the QUALIFYING SPOUSE remains applicable to him/her in terms of Schedule 10 after the NORMAL RETIREMENT DATE; or

(e) the last day of the MONTH in which the QUALIFYING SPOUSE reaches the age of 70 years if the INSURED continues his/her service with the EMPLOYER thereafter,

whichever event occurs first.

MARRIAGE in regard to an INSURED means his/her 'marriage' in terms of Schedule 10**.**

QUALIFYING SPOUSE in regard to an INSURED means his/her 'qualifying spouse' in terms of Schedule 10**.**

20.2 Option to apply for individual life insurance

20.2(1) An INSURED or his/her QUALIFYING SPOUSE, may apply for individual life insurance on the QUALIFYING SPOUSE's life with the INSURER to commence not later than sixty days after the applicable DATE OF WITHDRAWAL defined above.

This option may only be exercised if -

(a) the death benefit in terms of Schedule 10 is applicable to the QUALIFYING SPOUSE immediately before the DATE OF WITHDRAWAL;

(b) the application for the insurance is submitted to an office of the INSURER within sixty days after the DATE OF WITHDRAWAL;

(c) the QUALIFYING SPOUSE is a South African citizen, or if the QUALIFYING SPOUSE is not a South African citizen, he/she complies with the conditions under which a person who is not a South African citizen can obtain individual life insurance from the INSURER; and

(d) premiums are paid up to the DATE OF WITHDRAWAL.

20.2(2) For this option it is deemed that an INSURED to whom a lump sum disability benefit on his/her own life has been granted in terms of the Policy, ceases being an INSURED on the date on which the lump sum disability benefit becomes payable.

20.3 Waiting period

20.3(1) If this option is included with the QUALIFYING SPOUSE's death benefit set out in the CERTIFICATE OF PARTICIPATION on the EMPLOYER's PARTICIPATION DATE, the following applies:

(a) Every EMPLOYEE who qualifies as an INSURED on the PARTICIPATION DATE, or his/her QUALIFYING SPOUSE, may exercise the option to apply for individual life insurance as from the PARTICIPATION DATE, provided that premiums for the option have been paid to the INSURER in respect of the INSURED as from the PARTICIPATION DATE; and

(b) Every EMPLOYEE who qualifies as an INSURED after the PARTICIPATION DATE, or his/her QUALIFYING SPOUSE, may only exercise the option to apply for individual life insurance after the INSURED has been an INSURED for twelve consecutive MONTHS, and premiums for the option have been paid to the INSURER in respect of the INSURED for those twelve consecutive MONTHS.

20.3(2) If this option is added to the QUALIFYING SPOUSE's death benefit set out in the CERTIFICATE OF PARTICIPATION after the EMPLOYER's PARTICIPATION DATE, the following applies:

Every EMPLOYEE who qualifies as an INSURED before, on or after the date that this option is added to the benefit, or his/her QUALIFYING SPOUSE, may only exercise the option after the INSURED has been an INSURED for twelve consecutive MONTHS after the date that the option is added to the benefit, and premiums for the option have been paid to the INSURER in respect of the INSURED for those twelve consecutive MONTHS.

20.4 Maximum sum insured

20.4(1) The death sum insured of the individual insurance may not exceed the death benefit applicable to the QUALIFYING SPOUSE in terms of Schedule 10 immediately before the DATE OF WITHDRAWAL. Any increase in the death benefit by virtue of an amendment to the Policy which becomes effective in the twelve MONTHS immediately preceding the DATE OF WITHDRAWAL is, however, not taken into account in determining the said maximum death sum insured.

20.4(2) If an INSURED in respect of whose QUALIFYING SPOUSE individual insurance has been effected in terms of the option in this Schedule, again becomes an INSURED, the maximum sum insured that may be obtained in terms of this option will be reduced by the sum insured in terms of the previous option on its inception date and by the sums insured in terms of other options similar to the option in this Schedule effected with the INSURER.

20.4(3) Notwithstanding the preceding provisions, the maximum sum insured that may be obtained in terms of this option may not exceed the maximum benefit normally applicable to similar insurance with the INSURER.

20.5 Proof of good health

No proof of good health of the QUALIFYING SPOUSE is required other than the INSURER's requirements in respect of Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and Cotinine tests.

20.6 Premium rates and other provisions of individual insurance

From the inception date of the individual life insurance, the premium rates, occupational risk (if any) and other provisions that were applicable to the INSURED in terms of this Policy, will no longer apply to the insurance. The individual insurance effected by the INSURED or his/her QUALIFYING SPOUSE, will be subject to the provisions that normally apply to individual insurance with the INSURER. However if, on medical grounds, any special premium rates and other provisions were applicable to the QUALIFYING SPOUSE in terms of this Policy, adjustments to the same extent may be made to the rates and provisions applicable to the individual insurance.

20.7 Death within the option period

If a QUALIFYING SPOUSE who qualifies for this option, dies within sixty days after the DATE OF WITHDRAWAL, an amount equal to the maximum death sum insured that could have been obtained without proof of good health in terms of this option, is paid to the INSURED, or in the event of his/her death, to his/her estate. Such amount will not be payable if the INSURED or his/her QUALIFYING SPOUSE effects any individual insurance in terms of this option which takes effect before the death of the QUALIFYING SPOUSE.

20.8 Reappointment

If an INSURED who ceases to be an INSURED and in respect of whose QUALIFYING SPOUSE individual insurance has been effected in terms of the option in this Schedule, again becomes an INSURED within twelve MONTHS of the starting date of the individual insurance, the death benefit insurance provided in terms of Schedule 10 on his/her QUALIFYING SPOUSE's life will be reduced by the sum insured under the individual insurance on its starting date. This reduction will not apply in the event of a claim within the twelve MONTHS referred to if the event giving rise to the claim is as a result of an ACCIDENT and not due to natural causes. This reduction will also not apply as from the day after the period of twelve MONTHS referred to has passed or as from the day the QUALIFYING SPOUSE, at the INSURER’s expense, submits proof of good health to the satisfaction of the INSURER after the INSURED becomes an INSURED again, whichever is the earlier.

20.9 Lapse of option

20.9(1) This option is not available in respect of the INSURED or his/her QUALIFYING SPOUSE when the INSURED ceases to be an INSURED as a result of -

- an amendment to the Policy;
- termination of the EMPLOYER's participation in the Policy;
- termination of the EMPLOYER's business;
- a retrenchment exercise, where the EMPLOYER retrenches the greater of three EMPLOYEES and 2% or more of the total number of EMPLOYEES; or
- the business of the EMPLOYER being transferred to or amalgamated with any other business, company or organisation.

20.9(2) The option in terms of this Schedule lapses in respect of an INSURED if and as soon as the insurance in terms of Schedule 10 is cancelled with regard to the group of INSURED of whom he/she is a member.

SCHEDULE 21 ABSENCE FROM SERVICE

21.1 Definitions

In this Schedule -

LABOUR RELATIONS ACT means the Labour Relations Act (Act No.66 of 1995), as amended, and the regulations made in terms of it, or any substituting statutory measures.

21.2 Absence with the EMPLOYER'S consent

21.2(1) If an INSURED is absent from the service of the EMPLOYER with the EMPLOYER's consent, he/she remains an INSURED as if he/she remains an EMPLOYEE, subject to the following:

(a) During the period of absence the INSURED's RISK SALARY is deemed to be equal to the RISK SALARY he/she received immediately before the commencement of absence.

(b) The benefits in terms of the Policy remain applicable to the INSURED during the period of absence but not for longer than two years. Periods of absence that are interrupted by periods of service of less than three MONTHS, are added together to determine whether the period of two years has elapsed or not.

(c) Premiums for the benefits that remain applicable to the INSURED remain payable to the INSURER in terms of the Policy.

An INSURED will be deemed to be absent with the EMPLOYER'S consent while he/she is engaged in a strike that is protected in terms of the LABOUR RELATIONS ACT, subject to the provisions of sub-clauses 4.7(1), 5.10(1), 6.10(2), 7.9(2), 8.8(2), 9.10(2), 11.7(1), 12.6(1), 13.8(1) and 15.6(1).

21.2(2) If an INSURED is absent from the service of the EMPLOYER with the EMPLOYER'S consent, but the premiums in respect of him/her are not continued during any period of his/her absence, his/her benefits in terms of the Policy will lapse and will only be reinstated upon his/her return to work, provided that –

(a) the payment of the premiums in respect of the INSURED must be resumed; and

(b) the INSURED must –

(i) in the opinion of the INSURER, resume his/her normal duties for 60 consecutive BUSINESS DAYS; or

(ii) submit proof of good health to the satisfaction of the INSURER in accordance with the provisions of the relevant Schedule or, where applicable, the UNDERLYING INSURANCE,

whichever is the earlier.

The option in sub-paragraph (ii) above does not apply in the case of funeral insurance in terms of Schedule 13.

21.3 Absence without the EMPLOYER'S consent

An INSURED ceases to be an INSURED and the INSURED'S service with the EMPLOYER is regarded as terminated for purposes of the Policy if and as soon as he/she is absent from the EMPLOYER'S service without the EMPLOYER'S consent. The EMPLOYER must immediately inform the INSURER of the INSURED's absence and of the date when it commenced.

21.4 INSURED in receipt of an income continuation benefit

21.4(1) While an INSURED receives income in accordance with income disability insurance (not comprising a lump sum disability benefit) effected by the EMPLOYER for the benefit of its

EMPLOYEES, he/she is deemed to be an EMPLOYEE who is not absent from service and continues to be insured for the benefits that are applicable to him/her according to his/her EMPLOYER's CERTIFICATE OF PARTICIPATION until the earlier of -

(a) his/her NORMAL RETIREMENT DATE; and

(b) the date on which payment of the income disability benefit ceases; and

(c) the date he/she turns 65; and

(d) with regard to any benefit in terms of the Policy for which he/she is insured, the date on which the insurance of that benefit is cancelled or lapses for the group of EMPLOYEES of the EMPLOYER to which he/she belonged immediately before the commencement of his/her disability.

21.4(2) While the INSURED receives such an income disability benefit the following applies in respect of the benefits that remain applicable to him/her in terms of the Policy:

(a) The applicable benefits will change in accordance with any changes in terms of the Policy to the same benefits of the group of EMPLOYEES of the EMPLOYER to which he/she belonged immediately before the commencement of his/her disability, provided that, subject to paragraph (c) below, the INSURED will not be allowed –

- any increases to the flexible amount of his/her death benefits, if applicable;
- any new disability benefits in terms of the Policy; or
- any increases to existing lump sum disability benefits for which he/she is insured in terms of the Policy, unless the commencement of disablement in terms of clauses 6.5 or 9.5, as the case may be, is a later date than the commencement of the income disability benefit in terms of sub-clause 21.4(3) below.

(b) The critical illness benefit in terms of Schedule 11 will remain applicable to an INSURED, provided that his/her disability is as a result of an event other than one of the critical illness events as defined in clause 11.1.

(c) The Universal Education Protector benefit that remains applicable to him/her is the benefit that is applicable in terms of the Policy and is calculated on the basis of the Policy provisions that apply at the date that the INSURER becomes liable for payment of such a benefit.

(d) The INSURED'S RISK SALARY is deemed to be equal to the RISK SALARY he/she received immediately before the commencement of his/her disability.

(e) If so indicated in the CERTIFICATE OF PARTICIPATION, the applicable benefits that are based on the INSURED's RISK SALARY are determined as if the INSURED's RISK SALARY increases every year on a date determined by the INSURER, at a rate of the lesser of –

(i) 10% per annum, compounded annually; and

(ii) the increase in the CONSUMER PRICE INDEX for the year ending three MONTHS prior to the increase date; and

(iii) the rate at which the income disability benefit is increased.

(f) Premiums for the applicable benefits must be paid to the INSURER in terms of the Policy.

21.4(3) In the preceding sub-clauses the commencement of the INSURED's disability is taken to be the start of any waiting period that is to elapse before the income disability benefit becomes payable.

21.5 Existing income disability benefit claims

Notwithstanding any provision to the contrary, the provisions of this Schedule do not apply to an INSURED who on the PARTICIPATION DATE, as a result of ill-health or disability, receives an income disability benefit from a fund or insurance instituted by the EMPLOYER for its EMPLOYEES.

SCHEDULE 22 TERRITORIAL LIMITATIONS

22.1 Definitions

In this Schedule –

QUALIFYING SPOUSE in regard to an INSURED means his/her 'qualifying spouse' in terms of Schedule 10**.**

22.2 Territorial limitations

The insurance provided in terms of the Policy in respect of an INSURED is applicable while he/she is physically present in the Republic of South Africa. If the INSURED is physically outside the Republic of South Africa and premiums continue to be paid in respect of the INSURED, the insurance of the INSURED remains applicable for a maximum period of six MONTHS. It is not necessary to inform the INSURER if the INSURED is physically outside the Republic of South Africa for an uninterrupted period of six MONTHS or less.

22.3 Extension of period

Before the end of the period of six MONTHS referred to in the previous clause and before the end of each period of twelve MONTHS thereafter, the EMPLOYER may request the INSURER in writing to extend the period of insurance. The INSURER will inform the EMPLOYER in writing of its decision in this regard and if any additional conditions will apply in respect of the INSURED, provided that the EMPLOYER continues to pay the premiums in respect of the INSURED. The EMPLOYER must provide the INSURER with the following in respect of the INSURED:

(a) The country in which the INSURED is physically present.

(b) The expected period of stay in the relevant country.

(c) The nature of the INSURED's work responsibilities.

22.4 Reinstatement of insurance

If the insurance in respect of an INSURED does not continue during any period of his/her absence from the Republic of South Africa, the INSURER may reinstate the insurance upon his/her return to the Republic of South Africa, provided that –

(a) the payment of the premiums in respect of the INSURED must be resumed; and

(b) the INSURED must –

(i) in the opinion of the INSURER, resume his/her normal duties for 60 consecutive BUSINESS DAYS; or

(ii) submit proof of good health to the satisfaction of the INSURER in accordance with the provisions of the relevant Schedule or, where applicable, the UNDERLYING INSURANCE,

whichever is the earlier.

The option in sub-paragraph (ii) above does not apply in the case of funeral insurance in terms of Schedule 13.

22.5 Periods of absence added together

Absences from the Republic of South Africa that are separated by intervals of less than 6 consecutive weeks will be added together to determine whether or not the above-mentioned period of 6 MONTHS, or such longer period as may be permitted in terms of the previous provisions of this Schedule, has elapsed.

22.6 Claims procedure

If a claim should arise while an INSURED is outside the Republic of South Africa, the normal claims procedure in terms of the relevant Schedule will apply, provided that the insurance in respect of the INSURED continues while he/she is outside the Republic of South Africa.

22.7 Territorial limitations in respect of a QUALIFYING SPOUSE

The provisions of this Schedule apply mutatis mutandis if an INSURED's QUALIFYING SPOUSE is at any stage absent from the Republic of South Africa. Consequently paragraphs 22.3(c) and 22.4(b) do not apply in the case of a QUALIFYING SPOUSE who is absent from the Republic of South Africa.

SCHEDULE 23 DEDUCTIONS AND UNCLAIMED BENEFITS

23.1 Definitions

In this Schedule -

UNCLAIMED BENEFIT means a benefit payable by the INSURER in respect of a claim admitted by the INSURER in terms of this Policy, but in respect of which the BENEFICIARY cannot be traced.

23.2 Deductions from benefits

Notwithstanding any provision to the contrary in the Policy, expenses incurred by the EMPLOYER in respect of the following may be deducted from the benefits payable in terms of this Policy, and paid to the EMPLOYER –

(a) payments in respect of the funeral costs of the INSURED or a family member of the INSURED; and

(b) any expenses paid to a third party on behalf of the INSURED or a family member of the INSURED; and

(c) any monies advanced to the INSURED or a family member of the INSURED.

For the purposes of this clause a 'family member' is any person whom the EMPLOYER has confirmed to the INSURER in writing is a family member of the INSURED.

23.3 UNCLAIMED BENEFITS

23.3(1) Once a claim in terms of this Policy has been admitted, the rights of a BENEFICIARY in respect of payment of an UNCLAIMED BENEFIT remain intact indefinitely.

23.3(2) The INSURER must take reasonable steps to trace BENEFICIARIES as set out in the ASISA Standard On Unclaimed Assets, or in any standard or code replacing the aforesaid code.

23.3(3) The EMPLOYER must provide the INSURER with all reasonable assistance in tracing BENEFICIARIES.

23.3(4) The INSURER must pay interest on an UNCLAIMED BENEFIT from the date that all information needed for the evaluation and payment of the relevant claim has been received, at the rate as determined by the INSURER taking into account prevailing after administration charge money market interest rates and any other factors that the INSURER may deem relevant.

23.3(5) An UNCLAIMED BENEFIT may be reduced by the amount of any reasonable costs incurred by the INSURER in identifying and tracing the relevant BENEFICIARY.

23.3(6) An UNCLAIMED BENEFIT may be reduced by all fees levied by the INSURER in respect of the administration of the UNCLAIMED BENEFIT, on the understanding that, in the event where no fees in respect of administration have been deducted by the INSURER from an UNCLAIMED BENEFIT, a fee may be charged by the INSURER for payment of the UNCLAIMED BENEFIT to the relevant BENEFICIARY.

23.3(7) Fees in respect of the administration and payment of UNCLAIMED BENEFITS will be as laid down by the INSURER from time to time and must be communicated by the INSURER to the EMPLOYER.

23.3(8) If the amount of an UNCLAIMED BENEFIT is less than R1 000, or an UNCLAIMED BENEFIT decrease to less than R1 000, and the cost of tracing the relevant BENEFICIARY will exceed the amount of the UNCLAIMED BENEFIT, no steps, or alternatively no further steps, will be taken by the INSURER to trace the BENEFICIARY.

23.3(9) In the event of an UNCLAIMED BENEFIT decreasing to nil, the INSURER's liability regarding the payment of the UNCLAIMED BENEFIT automatically terminates, and the

BENEFICIARY will have no further claim against the INSURER in respect of the UNCLAIMED BENEFIT.

SCHEDULE 24 PREMIUMS

24.1 Definitions

In this Schedule –

REVIEW DATE means 1 April of each year.

24.2 Monthly premiums

24.2(1) In consideration for the INSURER's obligation in terms of the Policy, the EMPLOYER is liable for a monthly premium to the INSURER in respect of every INSURED. The premiums are laid down by the INSURER from time to time.

24.2(2) Premiums payable for any particular MONTH must be paid by the EMPLOYER to the INSURER through one channel and in one amount and are payable on the last day of that MONTH.

24.2(3) Fifteen days of grace are allowed for the payment of premiums.

24.2(4) If an INSURED's insurance in terms of the Policy does not commence on the first day of a MONTH no premium is payable for the MONTH in which he/she becomes an INSURED.

24.2(5) If a benefit is -

(a) no longer applicable to an INSURED with effect from the fifteenth or a later day of a MONTH, a premium is payable for the MONTH concerned as if the benefit was applicable to the INSURED during that whole MONTH; or

(b) no longer applicable to an INSURED with effect from the fourteenth or an earlier day of a MONTH, no premium is payable for the MONTH concerned as if the benefit was not applicable to the INSURED during that whole MONTH.

24.3 Alternative arrangements

The provisions of this Schedule are subject to the condition that the INSURER may effect alternative arrangements with the EMPLOYER for the payment of premiums or any part thereof to the INSURER.

24.4 Late payment of premiums

If any premium in regard to an INSURED is not paid promptly in terms of the Policy, the INSURER's liability to make any payment or to provide any benefit regarding that INSURED lapse. The INSURER may reinstate its liability regarding the INSURED prior to such lapse on the conditions which it may lay down.

24.5 Premium rates

24.5(1) The INSURER determines the premium rates in respect of the INSUREDS who are EMPLOYEES of a particular EMPLOYER. The premium rates are applicable from the PARTICIPATION DATE of the EMPLOYER and are guaranteed for 12 MONTHS.

24.5(2) Thereafter, taking into account the risk profile of those INSUREDS, the INSURER may revise the premium rates and conditions at each subsequent REVIEW DATE, subject to thirty-one days written notice to the EMPLOYER. These revised premium rates are applicable from the REVIEW DATE and are also guaranteed for 12 MONTHS.

24.5(3) Notwithstanding sub-clauses (1) and (2) above, the INSURER may revise the premium rates and conditions at any time if there is a material change in the risk profile of those INSUREDS which affects the risks under this Policy, subject to thirty-one days written notice to the EMPLOYER.

24.5(4) The EMPLOYER must, before the expiry of the thirty-one days period of notice referred to in sub-clauses (2) and (3) above, inform the INSURER in writing that it accepts or rejects the revised premium rate.

If the EMPLOYER –

(a) accepts the revised premium rate or, does not inform the INSURER in writing of the EMPLOYER's acceptance or rejection of the revised premium rate, the revised premium rate will take effect as from the expiry of the thirty-one days period of notice referred to; or

(b) rejects the revised premium rate, the INSURER may by notice to the EMPLOYER terminate those INSUREDS' participation in the Policy as from the expiry of the thirty-one days period of notice referred to.

24.5(5) If the data, which is supplied by the EMPLOYER to the INSURER in terms of clause 26.3 for a review of the premium rate, is incomplete or contains a material error or discrepancy and it has a material effect on the assessment of the premium rate, the INSURER is entitled to change the premium rate with retrospective effect to the date of the relevant review of the premium rate.

24.6 Agreed maximum rate

If the premiums on this Policy should at any time increase to more than a percentage agreed to between the INSURER and the EMPLOYER of an INSURED's RISK SALARY, then the benefits in terms of the Policy decrease in proportion to the excess, unless the EMPLOYER and the INSURER agree otherwise in writing.

SCHEDULE 25 CANCELLATION OF EMPLOYER'S PARTICIPATION

25.1 Cooling-off rights

25.1(1) An EMPLOYER may cancel it's participation in the Policy as from the PARTICIPATION DATE, provided that –

(a) as from the PARTICIPATION DATE no benefit is paid or claimed or an event insured against does not occur in respect of an INSURED who is an EMPLOYEE of the EMPLOYER; and

(b) the EMPLOYER notifies the INSURER in writing of the cancellation within the 'cooling-off' period provided for in the Policyholder Protection Rules published in terms of the Long-term Insurance Act, 1998.

25.1(2) The INSURER must refund all the premiums paid in respect of the relevant INSUREDS since the PARTICIPATION DATE after deducting the cost of any risk cover actually enjoyed by the INSUREDS.

25.2 Cancellation

25.2(1) The INSURER or an EMPLOYER may cancel the EMPLOYER's participation in the Policy or in a particular benefit in terms of the Policy at any time by giving the other thirty-one days written notice.

25.2(2) An EMPLOYER may also cancel the participation in the Policy or in a particular benefit in terms of the Policy of a category of its EMPLOYEES at any time by giving the INSURER thirty-one days written notice.

25.2(3) An EMPLOYER's participation in the Policy will be deemed to be cancelled with effect from the date on which –

- the EMPLOYER ceases to do business; or
- for other reasons, the participation in the Policy of the EMPLOYER is terminated.

25.2(4) If any obligation to the INSURER in terms of the Policy is not met by an EMPLOYER, the INSURER may cancel the EMPLOYER's participation in the Policy or in a particular benefit in terms of the Policy by giving the EMPLOYER thirty-one days written notice.

25.2(5) The INSURER may cancel an EMPLOYER's participation in the Policy with immediate effect if it is determined by the INSURER that -

(a) the EMPLOYER's participation in the Policy or the premium value was concluded as a result of fraud or other criminal activity, or as a result of material misrepresentation or non-disclosure by the EMPLOYER; or

(b) the EMPLOYER fails to meet any of its obligations in terms of the Financial Intelligence Centre Act, 2001 (Act No. 38 of 2001).

25.3 Liability of parties

If the EMPLOYER's participation in the Policy is cancelled in full, or is cancelled only with regard to a particular benefit or a particular category of its EMPLOYEES, the following applies:

(a) the INSURER's liability to the EMPLOYER is limited to the benefits payable in terms of the provisions of the various Schedules in the Policy regarding cancellation; and

(b) the EMPLOYER must pay to the INSURER the premiums payable in respect of the period before cancellation, as well as those premiums which, in terms of the provisions of the various Schedules in the Policy regarding cancellation, are payable to the INSURER after cancellation.

SCHEDULE 26 MISCELLANEOUS PROVISIONS

26.1 The contract between the INSURER and the EMPLOYER

26.1(1) The Policy, any endorsements to the Policy, the CERTIFICATE OF PARTICIPATION and any amendments to the CERTIFICATE OF PARTICIPATION constitute the contract between the INSURER and the EMPLOYER.

26.1(2) Any reference in this Policy to 'the Policy' or 'this Policy' includes the CERTIFICATE OF PARTICIPATION.

26.1(3) If there is any difference or discrepancy between this Policy and a CERTIFICATE OF PARTICIPATION the Policy will prevail unless there is a provision in the CERTIFICATE OF PARTICIPATION clearly stating that, notwithstanding a contrary provision in the Policy, the relevant provision(s) in the CERTIFICATE OF PARTICIPATION will prevail in a particular situation.

26.2 Currency and law

26.2(1) All amounts payable to or by the parties in terms of the Policy, are payable in the Republic of South Africa in the currency of the Republic of South Africa.

26.2(2) Any question arising under this Policy will be decided according to the laws of the Republic of South Africa.

26.3 Provision of data

26.3(1) The EMPLOYER must provide, in the manner determined by the INSURER, all the data that the INSURER may require in relation to the Policy.

26.3(2) The INSURER may act upon the data without further enquiry and is not responsible to anybody for any mis-statements, errors or omissions that may be contained in the data.

26.3(3) If it transpires that any such data is incorrect or incomplete, the INSURER may, in consultation with the EMPLOYER, effect adjustments in the insurance which the INSURER provides in terms of the Policy and to the basis for the calculation of the premium for the insurance. These adjustments may only be made to the extent which, in the INSURER's opinion, is necessitated by the incorrect or incomplete data.

26.3(4) The INSURER may share such data with any other party that is involved in the insurance in terms of this Policy.

26.4 The INSURER's liability regarding payment

26.4(1) Payment of any benefit by the INSURER in respect of an INSURED in terms of this Policy releases the INSURER from any further liability in relation to that benefit. Neither the EMPLOYER nor the INSURED, the INSURED's estate or any other person will have any claim against the INSURER once the INSURER has paid the particular benefit in accordance with the provisions of this Policy.

26.4(2) The INSURER's liability in this regard will not exceed the lesser of -

(a) the amount of the benefit for which premiums have been paid and received; and

(b) where applicable, the amount of the cover in regard to the benefit for which the INSURED has been accepted by the INSURER.

26.5 Alterations to the Policy

26.5(1) Subject to any contrary provision in the Policy, the INSURER may at any time amend any provision of the Policy, provided that the INSURER notifies the EMPLOYER in writing of the amendment contemplated at least thirty-one days before the amendment becomes effective. In this Policy the amendment that the INSURER issues, is also referred to as an endorsement.

26.5(2) The EMPLOYER must, before the expiry of the thirty-one days period of notice, inform the INSURER in writing that it accepts or rejects the amendment.

If the EMPLOYER -

(a) accepts the amendment or, does not inform the INSURER in writing of the EMPLOYER's acceptance or rejection of the amendment, the amendment will take effect as from the expiry of the thirty-one days period of notice; or

(b) rejects the amendment, the INSURER may by notice to the EMPLOYER terminate the EMPLOYER's participation in the Policy or the participation of a particular group of EMPLOYEES of the EMPLOYER in the Policy, as the case may be, as from the expiry of the thirty-one days period of notice referred to.

26.5(3) If the Policy is amended with regard to the benefits payable in terms of the Policy, the amendment will, unless specifically stated otherwise, not apply to –

(a) the benefits in respect of INSURED who are no longer EMPLOYEES on the amendment date; and

(b) benefits regarding claims which arise before the amendment date.

26.6 Changes by the authorities

In the event of any changes in legislation or in the legally binding rulings of the regulatory authority that may have an impact on the INSURER's position in terms of the Policy, the INSURER, notwithstanding any provision to the contrary, may adjust, the provisions of the Policy that relate to the changes with effect from the date on which the relevant changes become effective.

26.7 Indemnity

26.7(1) The INSURER indemnifies the EMPLOYER against any losses or damages that may result from the negligence, dishonesty or fraud of any of the INSURER's directors, employees or agents.

26.7(2) The EMPLOYER also indemnifies the INSURER against any losses or damages that may result from the negligence, dishonesty or fraud of any of the EMPLOYER's directors, employees or agents.

26.8 Address

26.8(1) The INSURER and the EMPLOYER must provide each other with their chosen addresses for purposes of normal communication in writing and their email addresses.

26.8(2) The INSURER or the EMPLOYER may change any of their addresses by giving written notice of the new address to the other party.

26.9 Communication

26.9(1) All communication and notices to be given, sent or made under this Policy must be in writing.

26.9(2) For the purposes of the Policy, “in writing” includes e-mail.

26.9(3) Any notice or communication addressed to the EMPLOYER and not sent via email, must be delivered or sent by post to the EMPLOYER at the chosen address last notified in writing to the INSURER.

26.9(4) If the EMPLOYER deals with the INSURER through an intermediary, any notice or communication in connection with the Policy that is addressed to the intermediary will be deemed to be addressed to and received by the EMPLOYER. Any notice or communication received by the INSURER from that intermediary will be deemed to have been sent by the EMPLOYER.

26.10 Cession

Neither the Policy nor any rights in terms of the Policy or any certificate issued by the INSURER in relation to the Policy, may be ceded, pledged or assigned in any way.

26.11 Fraud or dishonesty

26.11(1) The INSURER reserves the right to reject any claim if such claim is found by the INSURER to be based on fraud or dishonesty, including; corruption, cyber-crime, misrepresentation, or providing any deliberate non-disclosure or false information or any attempt to perpetrate any dishonest conduct to claim a benefit by the EMPLOYER, INSURED or any other party who stands to or may benefit from the insurance in terms of the Policy, if it materially affects the INSURER’s assessment of a claim submitted for any benefit.

26.11(2) The INSURER shall be entitled to institute an investigation in any circumstances where it suspects fraudulent or dishonest behaviour in relation to a claim. Such investigation may include applying legally compliant techniques, to approach the EMPLOYER, INSURED, family members or relatives of the INSURED and/or any person(s) who may assist in the verification/investigation of a claim and/or have in their possession any information or documentation on the relevant claim.

26.11(3) Depending on the outcome of the investigation, the INSURER reserves the right to:

(a) terminate, suspend or adjust the INSURED’s benefit as appropriate in accordance with the relevant provisions of the Policy;

(b) declare all premiums paid by the EMPLOYER in respect of the relevant INSURED forfeited; and/or

(c) report all suspected criminal conduct to the law enforcement authorities for criminal prosecution or other appropriate legal action.

26.11(4) If, after the INSURER paid any claim, it finds that the claim was based on false, dishonest or incomplete information, which materially affects the INSURER’s assessment of the claim, all claim payments must be refunded to the INSURER.

26.11(5) Notice of the INSURER’s determination of the outcome of the investigation will be communicated to the EMPLOYER.

26.12 Personal Information

26.12(1) The EMPLOYER is a joint RESPONSIBLE PARTY in relation to any PERSONAL INFORMATION it provides to SANLAM as a joint RESPONSIBLE PARTY in terms of the Policy. The PERSONAL INFORMATION of a DATA SUBJECT is collected and shared by the EMPLOYER or service provider

appointed by the EMPLOYER in compliance with the APPLICABLE LAWS and/or DATA PRIVACY LAWS.

26.12(2) SANLAM and the EMPLOYER agree that, in relation to a DATA SUBJECT, the PERSONAL INFORMATION relating to the DATA SUBJECT will be processed in accordance with the provisions of DATA PRIVACY LAWS.

26.12(3) SANLAM may use PERSONAL INFORMATION or obtain PERSONAL INFORMATION for the following purposes:

(a) underwriting and providing accurate and effective insurance cover and related value-added services;

(b) member communication;

(c) market research and statistical analysis;

(d) verification of the personal information provided;

(e) to comply with all legal and regulatory requirements, including applicable codes of conduct;

(f) to protect SANLAM's interests; and

(g) any purposes related to the above.

26.12(4) SANLAM may share the EMPLOYER's or the DATA SUBJECT's PERSONAL INFORMATION within the Sanlam Group and/or with other service providers appointed by SANLAM and industry bodies or other insurers where required for any of the purposes listed above, or with third parties where SANLAM is lawfully required to do so.

26.12(5) SANLAM may send the EMPLOYER's or the DATA SUBJECT's PERSONAL INFORMATION to service providers outside the Republic of South Africa for storage or further processing on SANLAM's behalf. SANLAM will not send the PERSONAL INFORMATION to a country that does not have information protection legislation similar to that of the Republic of South Africa, unless SANLAM has a binding agreement with the service provider which ensures that it effectively adheres to the principles for processing of PERSONAL INFORMATION in compliance with the APPLICABLE LAWS or DATA PRIVACY LAWS.

26.12(6) The EMPLOYER or the DATA SUBJECT may request to access, change or correct PERSONAL INFORMATION relating the EMPLOYER or the DATA SUBJECT from SANLAM's records. If legislation allows, SANLAM may charge an administrative fee subject to prior notice to the EMPLOYER or the DATA SUBJECT of any such cost before executing the request.

26.12(7) All enquiries from the DATA SUBJECT and the Authority concerning the processing of the PERSONAL INFORMATION provided to SANLAM will be responded to by the EMPLOYER within a reasonable time unless SANLAM and the EMPLOYER have agreed otherwise.

26.12(8) SANLAM has implemented appropriate technical and organisational information security measures to keep the PERSONAL INFORMATION secure, accurate, current, and complete. However, SANLAM cannot guarantee the security or accuracy of any information transmitted to SANLAM.

26.12(9) PERSONAL INFORMATION will be held and used for as long as permitted for legal, regulatory, fraud prevention and legitimate business purposes.

26.12(10) SANLAM may contact the EMPLOYER and/or the DATA SUBJECT regarding events, seminars, products, services and content that may be of interest, or invite the EMPLOYER and/or the DATA SUBJECT to participate in research with the aim of improving SANLAM's products and services.

26.13 Breach notification

26.13(1) In respect of any PERSONAL INFORMATION BREACH, the EMPLOYER shall:

(a) notify SANLAM of the PERSONAL INFORMATION BREACH without undue delay (but in no event later than 72 hours after becoming aware of the PERSONAL INFORMATION BREACH); and

(b) provide SANLAM without undue delay (wherever possible, no later than 72 hours after becoming aware of the PERSONAL INFORMATION BREACH) with such details as SANLAM require regarding:

(i) the nature of the PERSONAL INFORMATION BREACH including the categories and approximate number of DATA SUBJECTS and protected PERSONAL INFORMATION concerned;

(ii) any investigations into such PERSONAL INFORMATION BREACH;

(iii) the likely consequences of the PERSONAL INFORMATION BREACH; and

(iv) any measures taken, or that the EMPLOYER recommends, to address the PERSONAL INFORMATION BREACH, including to mitigate its possible adverse effects, provided that, (without prejudice to the above obligations) if the EMPLOYER cannot provide all these details within the timeframes set out in this sub-clause (b), it shall (before the end of such timeframes) provide SANLAM with reasons for the delay and when it expects to be able to provide the relevant details (which may be phased), and give SANLAM regular updates on these matters.

26.13(2) The EMPLOYER shall promptly (and in any event within 3 Business Days) inform SANLAM if it receives a COMPLAINT and provide SANLAM with full details of such COMPLAINT.