POLICY TERMS AND CONDITIONS

SECTION A: BENEFITS

The benefits start when you have paid your first premium. It is important to keep paying your premiums to ensure that you are covered. In the event of unpaid premiums, cover will cease until such time as premiums are paid. Please note that waiting periods will re-start if your policy has lapsed, so please read the Policy Rules carefully. All benefits will be paid less any outstanding premiums.

HOSPITALISATION BENEFIT

Lump Sum Benefit: We will pay you, the Policy Owner, the Lump Sum Benefit amount for every hospital stay in excess of 3 days, subject to the limits and conditions outlined below.

Daily Benefit: We will pay you, the Policy Owner, the Daily Benefit amount for every day spent in hospital from day 11, subject to the limits and conditions outlined below.

What you are covered for:

Event	Benefit	Waiting Period*
Hospitalisation due to an Accident for more than 3 but less than 11 days	Lump Sum Benefit	No waiting period
Hospitalisation due to an Accidentfor more than 10 days	Lump Sum Benefit PLUS Daily Benefit	No waiting period
Hospitalisation due to a Specific Pre-Existing Medical Condition formore than 3 but less than 11 days	Lump Sum Benefit	12 months (minimum 12 paid Premiums)
Hospitalisation due to a Specific Pre-Existing Medical Condition formore than 10 days	Lump Sum Benefit PLUS Daily Benefit	12 months (minimum 12 paid Premiums)
Hospitalisation due to an Illness for more than 3 but less than 11 days	Lump Sum Benefit	3 months (minimum 3 paid Premiums)
Hospitalisation due to an Illness for more than 10 days	Lump Sum Benefit PLUS Daily Benefit	3 months (minimum 3 paid Premiums)
Hospitalisation due to Maternity related conditions for more than 1 day	Daily Benefit limited to 4 days or 7days if there are complications	12 months (minimum 12 paid Premiums

Limits of Cover:

- Total claims in terms of Hospitalisation Benefit Cover (Lump Sum and Daily Benefits) per calendar year are limited to the Total Annual Hospital Cover amount as it appears on your Personal Policy Schedule. This limitation applies to the Policy and not to each individual Insured Person.
- The Lump Sum Benefit is limited to R20 000 per Insured Person per calendar year. Once this limit has been reached, the Daily Benefit will be paid for each day of hospitalisation for subsequent hospital stays of longer than 3 days in the same calendar year.
- The Lump Sum benefit is not payable for the following conditions – instead 50% of the Daily Hospital Benefit will be payable subject to a limit of 3 days per calendar year:
- The treatment or control of chronic or acute pain.
- The treatment of any Gastro Intestinal Tract infections or diseases.
- The treatment of any Pelvic Inflammatory disease.
- Hospitalisation related to any Chronic Illness not listed above will be limited to a maximum of 15 days per policy per calendar year.

- For maternity related conditions the claim amount will be determined by the number of days that the Main Insured or Spouse stays in hospital, limited to 4 days or 7 days for complications. This is payable once per calendar year.
- The claim event date will determine the level of benefit for that claim.
- Benefits covered under this policy are subject to regulatory maximum limits.
- An Insured Person can be covered on a maximum of 1 Clientèle Health Event Life Plan

When will you not be covered?

- Hospitalisation that is not authorised by us or where we have not received reasonable notification.
- Hospitalisation or treatment received for an Excluded Condition (refer to the table in EXCLUSIONS Section).
- Hospitalisation not recommended by a Medical Specialist.
- Hospitalisation in a month where the Premium is not received.
- Hospitalisation for 3 days or less (other than for maternity claims).
- Hospitalisation due to Illness during a waiting period.
- Where the claim is fraudulent or exaggerated in any way.
- Hospitalisation in a facility that does not meet our definition of a Hospital.
- Hospitalisation related to any Illness where the length of stay exceeds the maximum recommended number ofdays for such conditions (refer to limits of cover and definitions

Conditions:

- You are required to notify us of all hospitalisation prior to admission, or no later than the next business dayfollowing admission, regardless of the duration of stay.
- Authorisation is required for certain conditions and for hospital stays exceeding 10 days.
- We reserve the right to refuse payment for claims where reasonable notification is not obtained.
- We reserve the right to refuse payment for claims resulting from hospitalisation at certain hospitals. A list ofapproved hospitals is available at www.clientele.co.za and can change from time-to-time.
- An Insured Person must be in hospital for at least 3 consecutive days (including the day of admission, not the day of discharge), and for at least 1 day for hospitalisation due to a maternity related condition.
- An Insured Person must be admitted to Hospital within 30 days of the Illness or Accident.
- If you are discharged from Hospital and have to be re-admitted within 10 days due to the same cause, it will be considered as the same claim event and the total number of days spent in Hospital due to this event will be used in determining the Benefit to be paid.
- This Policy is free from all restrictions on occupation or travel of an Insured Person.
- You must be a South African resident admitted into a registered South African Hospital.
- Hospitalisation for maternity related conditions is restricted to the Main Insured Person or Spouse only and does not apply to children covered on the policy.
- Benefits in respect of children covered under this policy may be subject to restrictions posed by present and future legislation and are defined as per your Personal Policy Schedule.

ACCIDENTAL DEATH BENEFIT

What you are covered for:

We will pay your Beneficiary the Accidental Death Benefit amount if you die in an Accident after the date thepolicy application was received and accepted by us and before the age of 70.

When will you not be covered?

- Death due to an Excluded Condition (refer to the table in the EXCLUSIONS Section).
- Death in a month where the premium is not received.
- Death after the age of 70.
- Where the claim is fraudulent or exaggerated in any way.
- Death due to an Accident where such Accident occurred before policy commencement or resale (whichever occurred last).

Conditions:

- The Accidental Death Benefit covers the Main Insured Person and their Spouse only.
- The Accidental Death Benefit and Premiums will cease on the earliest of the Main Insured Person or Spouse's 70th birthday.

ACCIDENTAL DISABILITY BENEFIT

What you are covered for:

We will pay you the Accidental Disability Benefit amount if you are disabled (Total and Permanent Disability) dueto an Accident before the age of 70.

When will you not be covered?

- Disability resulting from an Excluded Condition (refer to the table in EXCLUSIONS Section below).
- If the Accident occurs in a month where the premium is not received.
- If the Accident occurs after the age of 70.
- Where the claim is fraudulent or exaggerated in any way.
- If the Accident occurs before policy commencement or resale (whichever occurred last).

Conditions:

- The Accidental Disability Benefit covers the Main Insured Person and their Spouse only.
- The Accidental Disability Benefit and Premiums will cease on the earliest of the Main Insured Person or Spouse's 70th birthday.
- In order to claim on this Benefit, Disability must occur within 12 months of the Accident.
- Permanency of the Disability will be established 6 months after the claim.
- Payment of the Accidental Disability Benefit will result in the Benefit ceasing for that Insured Person. Thismeans that each Insured Person can only claim once on this Benefit.

DREAD DISEASE BENEFIT

What you are covered for:

We will pay you 100% of the Dread Disease Benefit amount if you are diagnosed with a Dread Disease before the age of 60 and 50% of the Dread Disease Benefit amount if you are diagnosed with a Dread Disease after the age of 60 but before the age of 70.

Event	A Most severe	B Moderate impairment	C Mild impairment	D Almost full recovery	Waiting Period
Stroke	100%	100%	100%	100%	6 months (minimum 6 paid Premiums)
Cancer	100%	100%	100%	100%	6 months (minimum 6 paid Premiums)
Renal Failure	100%	100%	100%	100%	6 months (minimum 6 paid Premiums)
Major Organ Transplant	100%	100%	100%	100%	6 months (minimum 6 paid Premiums)
Heart Attack	100%	100%	100%	0%	6 months (minimum 6 paid Premiums)
Coronary Artery Bypass Graft	0%	0%	0%	0%	N/A

This disclosure grid is based on ASISA's master Critical Illness Definition Document which is available on www.clientele.co.za.

This means that if you are diagnosed with any of these conditions, with the exception of Coronary Artery Bypass Graft, and the Illness meets the definition below, we will pay 100% of the Dread Disease Benefit Amount. Please refer to the Dread Disease Definitions section below to understand exactly what you are covered for.

When will you not be covered?

- Dread Disease resulting from an Excluded Condition (refer to the table in EXCLUSIONS Section below).
- If the Dread Disease is diagnosed in a month where the Premium is not received.
- If the Dread Disease is diagnosed after the age of 70.
- If the Dread Disease results in death within the Survival Period of 14 days following diagnosis.

Conditions:

- The Dread Disease Benefit covers the Main Insured Person only.
- The Dread Disease Benefit and Premiums will cease on the Main Insured Person's 70th birthday.
- Please read the Dread Disease Definitions in order to understand exactly what you are covered for.
- Payment of the Dread Disease Benefits will result in the Benefit ceasing. This means that you can only claim once on this Benefit.

PREMIUM PAY BACK BENEFIT (*Only Applicable to the Ultimate H.E.L.P Plan*)

What you are covered for:

After 6 months and 6 paid premiums, on the death of an Insured Person and approval of a valid death claim, we will pay back all premiums received for the specific Insured Person (see Personal Policy Schedule for relevant premium split). This benefit only applies to the Main Insured Person and Spouse, in other words this benefit does not apply to any Children covered on the policy. After the death of the Main Insured Person or Spouse (where applicable) the premium going forward will be halved.

A Main Insured Person that was younger than 50 years of age on the date of commencement can elect for us to pay back 50% of all premiums paid to age 65, on or after the Main Insured Person's 65th birthday. On the subsequent death of the Main Insured Person we will pay back all premiums paid for the Main Insured Person less the amount already paid back.

If your Spouse is covered on the policy, for purposes of determining the Premium Pay Back Benefit amount, the Main Policy Premium is considered to be 50% in respect of the Main Insured Person and 50% in respect of the Spouse. In other words, if a valid Premium Pay Back Benefit claim is received for your Spouse, 50% of the received Main Policy Premium and Other Benefit Premium will be paid.

When will you not be covered?

- Death before we have received 6 premiums in at least 6 months.
- Death due to riot, terrorism, war or similar event.
- Death due to a violation of an act of law.
- Where the claim is fraudulent in any way.

Conditions:

- Should a premium not be received in the month preceding the death of the Insured Person, only the premiums received from the Date of Commencement or resale (whichever occurred last) up to that point will be paid after the completion of the applicable waiting period.
- Premiums paid back will exclude additional benefit premiums.
- Premiums paid prior to resale are forfeited from the Premium Pay Back Benefit.
- Where a Spouse is covered, the premiums paid back will be 50% of the total premium in the event of the death of either the Main Insured Person or Spouse.

AIRTIME BENEFIT

On notification of a claim for any Insured Person we will load the airtime benefit to a non-contract cell phone number of the Main Insured Person's choosing. This benefit is payable once per valid claim event.

SECTION C: POLICY RULES

- You have a 31-day cooling off period to cancel the policy. This means, from the time we send your policy documents, as long as there has been no claim or you have not received any benefit under the policy, if the policy is cancelled within these 31 days, we will refund the premiums you have paid.

- We reserve the right to submit a debit instruction to your bank at any time during the month and to debit your account using any reasonable collection methods. To do this, we may also track and debit your account up to 10 working days earlier than the debit date. Should the total premium be adjusted by us or yourself as general increase / decrease, the adjusted premium will be deducted from your bank in the same manner. This instruction will remain in force unless otherwise notified by us or cancelled by you, the Policy Owner.
- You must make sure that there are sufficient funds in your bank account to pay your premium on the agreed date. If any debit order is not paid, you will be responsible for the related bank charges.
- If we do not receive your premium on the agreed date, you have a grace period of 15 days to pay it.
- If you are on a monthly premium frequency your policy will lapse if we do not receive your premium for three consecutive months. If you are on an annual premium frequency your policy will lapse if we do not receive your annual premium when due.
- If you are on a monthly premium frequency, we reserve the right to lapse your policy after two consecutive disputes.
- You have the right to cancel this policy by giving us 31 days' notice. Premiums paid during this notice period will not be refunded.
- We reserve the right to change the terms and conditions of this policy at any time. Written notice of changes will be sent to the Policy Owner's latest contact details we have on record one month in advance and will be binding on you, the Policy Owner and us.
- If a policy is resold, the waiting periods will start again from the date of resale. We may choose to apply special terms and conditions when reselling your lapsed or cancelled policy.
- We reserve the right to cancel your policy with immediate effect if a claim is found to be fraudulent in any respect. This means that you will no longer be covered and all premiums paid will be forfeited.
- If a date of birth of an Insured Person has been recorded incorrectly, we may amend the benefits at the date of a claim, taking into account the correct age of the Insured Person. It is important to notify us if this information is incorrect on your Personal Policy Schedule.
- The annual premiums and benefits will be reviewed by 1 December each year. We will let you know each year what the new benefits and premiums are for the next calendar year. If you do not receive this communication, please contact us to confirm the updated premiums and benefits applicable.
- Clientèle reserves the right to cancel all policies in this product line on 31 December each year, by giving one month's notice.
- Additional Insured Dependents may only be added within six months of a life event, i.e. marriage, birth or legal adoption. Cover will start from the 1st premium (whether varied or not) paid after the Additional Insured Dependents have been added. A maximum of 4 children may be covered on your Family Plan.
- The Policy Owner may change the Beneficiary (ies) nominated at any time prior to a claim event, by notifying us. Please ensure that you are always in possession of a Personal Policy Schedule that reflects your latest nomination. Where a minor Child is a Beneficiary, payment will be made into a trust fund and will only be paid out when the minor Child attains the age of majority.
- Any question of law arising shall be decided according to the laws of the Republic of South Africa.
- This policy has been issued on the basis that the information provided during the application process was true and correct.
- **IMPORTANT NOTE:** This Policy is classified as a Health Insurance Product. This is not a medical scheme and the cover is not the same as that of a medical scheme. This policy is not a substitute for medical scheme membership. This document is issued in accordance with the Policyholder Protection Rules as set out in the Rules published in terms of Sections 48 and 62 of the Long Term Insurance Act of 1998.
- Annual premium increases are subject to the Consumer Price Index (CPI) annual inflation rate published by Statistics South Africa.
- The Accidental Disability, Accidental Death and Dread Disease Benefits are only payable once if claims arise out of the same event. In order to claim on more than 1 Benefit, the claim event must be different.

SECTION E: EXCLUSIONS

The Insurer will not be liable in respect of any claim for Hospitalisation, Accidental Death, Accidental Disability or Dread Disease which is directly or indirectly caused by, arising from, contributed to by, aggravated by, connected with or resulting from any of the following

Specific Exclusions:

Activities contrary to the law	Includes any act contrary to the laws of the Republic of South Africa, including driving a motor vehicle while the blood alcohol level is higher than that permitted by law, irrespective of whether such act is a cause of the claim event.
Addiction	Including treatment or where, in our opinion, the cause of admission arose from any underlying drug or alcohol dependence syndrome.
Cosmetic	Cosmetic or plastic surgery, except in the case of bodily reconstruction due to an accident will not be covered.
Cystic Fibrosis	Including treatment for any of its manifestations.
Dangerous Activity	Engaging in or training for underwater activities for which artificial breathing apparatus is required, climbing or mountaineering, potholing, parachuting, hang-gliding, winter sports, professional sports and racing other than on foot; Flying, other than as a fare-paying passenger in a fixed-wing aircraft or helicopter, provided and operated by an airline or air charter company which is duly licensed for the regular transportation of fare-paying passengers, and only between established commercial airports and/or licenced commercial heliports.
Dental	Including dental conditions or treatment that is related to any other Illnesses.
Elective or treatments for Obesity	Operations, treatments and examinations for obesity or of the Insured Person's own choosing which has no connection with any Illness.
Infertility	Including Artificial Insemination as defined in the Human Tissues Act No 65 of 1983 (as amended).
Intentional or Self-inflicted	Including attempted suicide independent of the Insured Person's state of mind.
Psychological or Psychiatric Disease	Any event traceable to psychiatric trauma, or your state of mental or physical health, prior to or after the event that gives rise to a claim. Including, but not limited to, diseases or disorders such as Depression and Post Traumatic Stress Disorder or any psychiatric trauma.
Quarantine	Includes where quarantine occurs in a registered Hospital
War	Including, but not limited to, riot, terrorism, war or similar events.

General Exclusion:

No objective impairment in health	Where, in our opinion, based on the medical information provided, the cause of admission did not require admission into hospital or equivalent treatment could have been provided as an out-patient.

Rehabilitation	Includes admissions into a registered Hospital, where the primary treatment is rehabilitative. Including admissions into rehabilitation centres, nature, cure clinics, or hydros.
Not recommended by a Medical Specialist	Including taking any drug, unless it is proved that the drug was taken in accordance with proper medical prescription (unrelated to any addiction). Only claims from patients referred to Hospital by a qualified Medical Specialist will be accepted.
Non-compliance to treatment	Where, in our opinion, based on the medical information provided, the cause of admission resulted from or is exaggerated by the non-compliance of prescribed treatment.
Investigations, Routine physical or any other examinations	Includes investigation of pain or pain-related conditions where a diagnosis cannot be confirmed by supporting test results, regardless of treatment received.

Additional Exclusions applicable to the Death, Accidental Disability and Dread Disease Benefits

Pre-Existing Medical Conditions	Any medical condition for which medical advice, Diagnosis, care or treatment was recommended or received prior to the date of commencement or resale (whichever occurred last).
Contamination	The use of nuclear, biological or chemical weapons or any radioactive contamination.