Policy Document

Hollard Group Risk

All-In-One Master Policy

for clients of

TD Administrative Services (Pty) Ltd

(Version 3)

Voluntary Death Benefit

work.live.play.

don't worry - we've got you covered.

work with purpose • live with freedom • play with passion

Hollard.
group risk

Introducing your policy

We will pay the benefits set out in this policy for any *insured* who qualifies for the benefits on condition that:

- the policyholder pays the premiums set out in this policy, and
- the policyholder and *insured* comply with the terms and conditions of this policy.

Key words used in this policy

- 'We', 'us' and 'our' refer to Hollard Life Assurance Company Limited
- 'You' and 'your' refer to the policyholder named in the policy schedule
- *'Employer'* refers to the *employer* named in the policy schedule
- *'Employee'* refers to any person employed as a permanent and full-time *employee* by the *employer* named in the policy schedule
- *'Insured'* refers to an *employee* and/or *contractor* and/or *pensioner* who meets the conditions for eligibility to be covered by this policy
- 'He', 'him' and 'his' refers to a male or female
- *'Material information'* refers to information that affects our decision to insure the *insured* on the terms and conditions in this policy.
- *'Pensioner'* refers to an *employee* who has retired from service but who has not yet attained the age of 70 years.

The plural of these words is used where appropriate.

The headings in the policy are for reference only and will not affect the meaning of the terms and conditions to which they relate.

Words which refer to natural persons will also refer to legal persons.

Words defined in this policy appear in *italics*. For ease of reference, some definitions appear in the text in boxes. These terms have the same meaning throughout the policy. The glossary at the end of the document gives the full set of definitions.

ASISA jargon buster

The Association for Savings and Investment South Africa (ASISA) maintains a comprehensive jargon buster on its website, designed to make definitions and explanations contained in life insurance contracts and marketing material easier to understand. The jargon buster can be found in the Info centre section at www.asisa.org.za.

Plain language

You have the right to information in plain and understandable language as set out in the:

- Consumer Protection Act, 2008 (CPA); and
- General Code of Conduct for authorised Financial Services Providers and Representatives (Board Notice 80 as amended), to the Financial Advisory and Intermediary Services Act 37 of 2002 (FAIS)

This policy is written in plain English and special consideration was paid to:

- avoid uncertainty or confusion, and to not be misleading;
- clear and readable print size, spacing and format;
- context, comprehensiveness and consistency;
- organisation, form and style; and
- vocabulary, usage and sentence structure.

Summary of this policy

We will ensure that we:

- complete any assessment after receiving the medical information we ask for
- assess claims after receiving all the documents we ask for
- pay the benefits in terms of this policy

You must ensure that you:

- pay the premium in full and on time according to the *premium rate* set out in the policy schedule
- give us all information that materially affects our risk
- send us an electronic register of lives insured with relevant and updated information about the *insureds*.

Note: please read this policy for all conditions of your insurance with us and all responsibilities of the *parties*.

If you have any questions you can contact us during normal business hours on the numbers set out below:

Hollard Group Risk, a division of Hollard Life Assurance Company Limited
PO Box 87428
Houghton
2041

Tel: +27 (11) 351-5000
Fax: +27 (11) 351-8010
Email: hgrcompliance@hollard.co.za

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A. Conditions for cover

1. Conditions for eligibility

Any person to be insured under this policy must:

a. be an *employee* of the *employer,* or be a *contractor* for the *employer*; or

b. be a *pensioner*; and

c. be within the age limits set out in the policy schedule;

d. ordinarily reside in the *SADC region*, unless agreed to by us in writing;

e. be a citizen of the Republic of South Africa or have been given the necessary permission from the South African authorities to live and work in the Republic of South Africa, unless a *pensioner*; and

f. be listed on the register of lives insured **see: Section E - Your administrative responsibilities.**

It is voluntary for all *employees* and/or *contractors* who meet the conditions for eligibility to be insured for all the benefits under this policy.

Contractor	Any person who is not employed as a full time *employee* and who has entered into a contract of work with the *employer* for a contract period of at least six months.
Employee	Any person employed as a permanent and full-time staff member by the *employer*.
Employer	The *employer* named in the policy schedule.
Pensioner	An *employee* who has retired from service but who has not yet attained the age of 70 years.

2. Actively at work applies on certain dates

2.1 When cover starts

a. If an *employee* and/or *contractor* is *actively at work* on his *entry date*, his cover starts on his *entry date*, subject to our acceptance in writing.

b. If an *employee* and/or *contractor* is not *actively at work* on his *entry date*, his cover starts subject to our acceptance in writing, when:

- we receive satisfactory proof of his good health, or
- he completes two months of consecutive service with the *employer* without absence.

Actively at work	Attending to and capable of attending to the material and substantial duties of his job.
Entry date	The date an *employee* and/or a *contractor* and/or a *pensioner* meets the conditions for eligibility under this policy.

3. Temporary absence from work

3.1 Conditions for continuing cover while temporarily absent

We will continue to cover an *insured* who is temporarily absent from work, but only if all four of the following conditions are met:

a. **Intended temporary absence**. The *insured* and the *employer* intend the absence to be temporary (for example annual, sick, maternity or paternity leave);

b. **Shorter than 12 months**. The absence is not longer than 12 months. If the *insured* is temporarily absent more than once, the absences must be separated by at least three consecutive months. If not, the absences will be added together to determine whether the *insured* is absent for longer than the 12 month limit. We may agree to extend the 12 month limit if requested to do so in writing by the *employer*. If we do agree to extend the limit, we will inform you of our terms and conditions;

c. **Continuous salary**. During the temporary absence, the *employer* continues to pay the *insured's salary* (or a reduced *salary* according to the *employer's* policies) unless the *employer* grants unpaid leave in writing; and

d. **Continuous premium payments**. During the temporary absence, the *employer* continues to pay the premiums on behalf of the *insured*. If no salary is being paid during the temporary absence, the *insured* must pay the premiums directly via debit order.

3.2 Where an insured is absent for longer than 12 months

Cover ends when an *insured* is absent from work for longer than the 12 month limit or any extended period agreed to by us in writing.

If the *insured* returns to work any time after the end of the 12 month limit or after any extended period agreed to by us in writing, we will treat him as a new *employee* and/or *contractor* and he must meet all conditions for eligibility and *actively at work* before we will cover him again.

3.3 Does not apply to a pensioner

This condition does not apply to a *pensioner*.

Insured	Means an *employee* and/or a *contractor* and/or a *pensioner* who meets the conditions for eligibility to be covered by this policy.
Salary	The *insured's salary*, wages or other remuneration set out on the *employer's* payroll (provided by you to us), used to determine the cover and/or premiums due under this policy. This is set out in the policy schedule.

4. Temporary absence from the SADC region

4.1 Conditions for continuing cover while temporarily absent

We will continue to cover an *insured* who temporarily leaves the *SADC region* for work or holiday, but only if all six of the following conditions are met:

a. **Intended temporary absence**. The *insured* and the *employer* intend the absence to be temporary (for example, a short business trip or holiday);

b. **Written approval for absence**. The *employer* gives written approval for the *insured* temporarily leaving the *SADC region*;

c. **Shorter than 12 months if on holiday**. The absence is not longer than 12 months if the *insured* is on holiday. If the *insured* is temporarily absent from the *SADC region* more than once, the absences must be separated by at least three consecutive months. If not, the absences will be added together to determine whether the *insured* is absent for longer than the 12 month limit. We may agree to extend the 12 month limit if requested to do so in writing by the *employer*. If we do agree to extend the period, we will inform you of our terms and conditions. Cover ends when an *insured* is absent from the *SADC region* for longer than the 12 month limit or any extended period agreed to by us in writing;

d. **No time limit if on business**. If the *insured* is temporarily absent from the *SADC region* for business reasons (for example on secondment), no time limitation will apply. At claim stage the *employer* must confirm in writing that the *insured's* absence from the *SADC region* was as a result of business and was approved by the *employer*.

e. **Continuous salary**. During the temporary absence, the *employer* continues to pay the *insured's salary,* unless the *employer* grants unpaid leave in writing. The *insured's salary*, as shown on the *employer's* payroll the day before the absence started, must remain the same throughout his absence, unless the increase in *salary* is as a result of the *employer's* annual *salary* review process and is in line with all other *employee salary* increases; and

f. **Continuous premium payments**. During the temporary absence, the *employer* continues to pay premiums on behalf of the *insured*. If no salary is being paid during the temporary absence, the *insured* must pay the premiums directly via debit order.

4.2 Where an insured is outside the SADC region on holiday for longer than 12 months

Cover ends when the *insured* is absent from the *SADC region* for longer than the 12 month limit or any extended period agreed to by us in writing when the *insured* is on holiday.

If the *insured* returns to the *SADC region* any time after the end of the 12 month limit or after any extended period agreed to by us in writing and is still employed by the *employer*, we will treat him as a new *employee* and/or *contractor* and he must meet all the conditions for eligibility and *actively at work* before we will cover him again.

4.3 Special conditions for a pensioner

Clauses 4.1 and 4.2 do not apply to a *pensioner*. We will continue to cover a *pensioner* who temporarily leaves the *SADC region* for any reason, or who resides outside the *SADC region*, but only if both of the following conditions are met:

a. **Shorter than 12 months**. The absence is not longer than 12 months. We may agree to extend the 12 month limit if requested to do so in writing by the *pensioner*. If we do agree to extend the period, we will inform the *pensioner* of our terms and conditions.

- Cover ends when a *pensioner* is absent from the *SADC region* for longer than the 12 month limit or any extended period agreed to by us in writing.
- If the *pensioner* resides outside of the *SADC region* on a permanent basis, the *pensioner* must tell us in writing of the country in which he has taken up permanent residence. We will not consider any claim unless we have been told and agreed to cover the *pensioner*.

b. **Continuous premium payments**. During the temporary absence, or whilst residing outside of the *SADC region*, the *pensioner* continues to pay premiums directly via debit order.

SADC region	The Southern African Development Community comprising Angola, Botswana, Democratic Republic of Congo, Lesotho, Madagascar, Malawi, Mauritius,

Mozambique, Namibia, Seychelles, the Republic of South Africa, Swaziland, Tanzania, Zambia and Zimbabwe.

B. Proof of good health

Each *employee* and/or *contractor* who applies for cover under this policy or whose cover increases must send us proof of good health.

The *maximum cover limit* is the level below which we give cover without the need for medical underwriting, but subject to a non-medical declaration of health. The *maximum cover limit* is revised each year. We will inform you in writing of any changes to the *maximum cover limit*.

If we reduce the *maximum cover limit*, we will not reduce the benefit previously granted to an *insured* under the higher *maximum cover limit.* If, after the date that we reduce the *maximum cover limit* the *insured's* benefit goes above the benefit previously granted, the *employer* must give us proof of the *insured's* good health.

Maximum cover limit	The level below which we give cover without the need for medical underwriting, but subject to a non-medical declaration of health. The maximum cover limit is set out in the policy schedule.

1. Cover below the maximum cover limit

1.1 At entry date

Each *employee* and/or *contractor* whose cover is less than the *maximum cover limit* as set out in the policy schedule, must complete a non-medical declaration of health at *entry date*.

We will decide whether or not to accept the *employee* and/or *contractor* for cover under this policy, or we may ask for additional information. If we ask for additional information we will tell the *employer* what information we need.

We will pay for any medical expenses the *employee* and/or *contractor* incurs in obtaining the information we need.

If we are satisfied with the *employee's* and/or *contractor's* health, we will accept him for cover under this policy.

1.2 When the benefit increases

If an *insured's* benefit increases by more than 20% in any 12 month period, the *insured* must complete a new non-medical declaration of health and we will decide whether or not to accept the *insured* for cover under this policy, or we may ask for additional information. If we ask for additional information, we will tell the *employer* what information we need.

We will pay for any medical expenses the *insured* incurs in obtaining the information we need.

If you do not send us the information we ask for, we will limit the *insured's* benefits to the limit previously accepted.

We will send you a letter advising you of the level of cover at which we have accepted the *insured*.

- **Temporary accident cover during assessment**

  We will give temporary *accident* cover to an *insured* while we assess whether we will increase his cover. Please read the 'Temporary *accident* cover benefit' which is detailed in each benefit section of the policy.

- **If we accept the insured for the increased cover**

  If we are satisfied with the *insured's* health, we will accept him for the increased cover. However, there may be additional terms and conditions for the increased cover.

  We will send the *insured* an acceptance letter setting out the details of his accepted cover and any additional terms and conditions for the increased cover.

- **If we do not accept the insured for the increased cover**

  If we are not satisfied with the *insured's* health, we will not accept him above the limit previously accepted.

  We will send the *insured* a letter advising that we have declined the request for increased cover and confirm that the *insured* will only be covered up to the limit previously accepted.

2. Cover above the maximum cover limit

2.1 At entry date

Each *employee* and/or *contractor* whose cover at his *entry date* is more than the *maximum cover limit* as set out in the policy schedule, must give us proof of good health.

We will tell the *employer* what medical information we need to assess the *employee's* and/or *contractor*'s health. We will assess the medical information and decide whether or not to accept the employee for cover under this policy.

We will consider the previous insurer's underwriting decision if you send us the letter of acceptance, including:

- the date of acceptance;
- details of the accepted cover;
- forward underwriting terms; and
- details of any exclusions, loadings or special conditions.

We will pay for any medical expenses the *employee* and/or *contractor* incurs in obtaining the information we need.

If we are satisfied with the *employee* and/or *contractor* health, we will accept him for cover under this policy.

2.2 When the benefit increases

Within four months from the date on which an *insured's* benefits go above the *maximum cover limit* or the higher limit previously accepted, the *employer* must give us proof of the *insured's* good health.

We will tell the *employer* what medical information we need to assess the *insured's* health. We will assess the medical information and decide whether or not to accept the *insured* at a higher limit.

We will pay for any medical expenses the *insured* incurs in obtaining the information we need.

If you do not send us the information we ask for, we will limit the *insured's* benefits to the *maximum cover limit* or the higher limit previously accepted.

We will send you a letter advising you of the level of cover at which we have accepted the *insured*.

- **Temporary accident cover during assessment**

  We will give temporary *accident* cover to an *insured* while we assess whether we will increase his cover. Please read the 'Temporary *accident* cover benefit' which is detailed in each benefit section of the policy.

- **If we accept the insured at the higher limit**

  If we are satisfied with the *insured's* proof of good health, we will accept him at the higher limit. However, there may be additional terms and conditions for the increased cover.

  We will send the *insured* an acceptance letter setting out the details of his accepted cover and any additional terms and conditions for the increased cover. We will also set out the next higher limit at which we will accept the *insured* without further proof of good health.

- **If we do not accept the insured at the higher limit**

  If we are not satisfied with the *insured's* proof of good health, we will not accept him above the *maximum cover limit* or the higher limit previously accepted.

  We will send the *insured* a letter advising that we have declined the request for increased cover and confirm that the *insured* will only be covered up to the *maximum cover limit* or the higher limit previously accepted.

3. Review of decision

The *insured* may ask for a review of our decision to decline the increased cover. We will review our decision only if the *insured*:

- sends us further evidence and argument within 90 days of our decision; and
- covers all costs of the review. If we change our decision because of the review, we will reimburse the *insured* for the relevant and appropriate medical expenses that led us to change our decision.

4. If the policy ends

If the policy ends before we receive the medical information we have asked for, we will not assess an *insured's* health. This means that the *insured* will only be covered up to the *maximum cover limit* or the higher limit previously accepted.

C. Death benefit

1. Death benefit

1.1 Basic benefit

If an *insured* dies during the period of cover, we will pay the benefit as set out in the policy schedule, as a lump sum.

Conditions for the death benefit

a. This is a voluntary benefit and an *insured* must choose to be covered for the death benefit.

b. The *insured* must not be in receipt of a disability income benefit at the date he chooses to be covered for the death benefit.

c. You must give us proof of the *insured's* family status as at the *insured's* entry date and every time the *insured* wants to increase the death benefit.

The death benefit can only be selected at certain times

a. If this is a new policy, the *insured* must select the death benefit within three months of the *policy start date*.

b. If this is an existing policy, the *insured* may select the death benefit at any time.

c. Cover is subject to our acceptance in writing **see: Section B – Proof of good health.**

2. Temporary accident cover benefit

2.1 Basic benefit

The temporary *accident* cover benefit is available for a period of four months from the date that cover for an *insured* went above the *maximum cover limit* or the higher limit previously accepted. If an *insured* dies because of an *accident* during the four month period, we will pay the temporary *accident* cover benefit.

The temporary *accident* cover benefit is equal to the full potential death benefit, subject to the following limitation:

- the difference between the full potential death benefit and the *maximum cover limit* or the higher limit previously accepted is subject to the maximum temporary *accident* cover benefit set out in the policy schedule;
- provided we have not already completed our assessment and given you our decision in writing.

If we complete our assessment before the end of the four month period, the temporary *accident* cover benefit ends on the date we give you our decision in writing. The remaining terms and conditions of the policy will then apply.

Accident	An unfortunate incident the *insured* could not foresee that happens unexpectedly and unintentionally at an identifiable time and place and results in death or bodily injury.

2.2 Conditions for the temporary accident cover benefit

Only applies while we assess your cover

This benefit applies only to a death caused by an *accident* while we are assessing whether to cover the *insured* above the limit previously accepted.

Benefit does not apply to death caused by illness

If an *insured* dies because of illness while we are assessing whether to cover him above the limit previously accepted, we will pay the death benefit for the *insured* up to the limit previously accepted only.

We must have been able to complete the previous assessment

The temporary *accident* cover benefit will not be available on subsequent occasions when the *insured's* death benefit exceeds the limit previously accepted, if we were not able to complete the previous assessment because we were not sent the information we asked for.

3. Continuing cover for death benefit if disabled

3.1 Basic benefit

We will continue to cover an *insured* for the death benefit if the *insured* receives disability income benefits under any disability income policy taken out by his *employer*.

Disabled on or after the insured's entry date

If an *insured* suffers a disability on or after his *entry date*, we will continue to cover him for the death benefit based on the *salary* as reflected on the register of lives insured. This *salary* may not exceed the *salary* applicable on the day before the *insured* suffered the disability.

Entry date	The date an *employee* and/or a *contractor* and/or a *pensioner* meets the conditions for eligibility under this policy.

Disabled before the insured's entry date

We will not cover an *insured* for the death benefit if an *insured* suffered a disability before his *entry date.*

3.2 Conditions for benefit

a. The *insured* must be 65 or younger.

b. The *insured* must be in receipt of a disability income benefit and the payment of the disability income benefit must not have been suspended or terminated by the insurer.

c. You must continue to pay the premiums for the *insured*.

3.3 Increases in the death benefit

We will allow a disability income claimant's *salary* in respect of the death benefit to increase yearly, if the disability income claimant remains covered for the death benefit.

The *salary* will increase at the benefit increase rate and on the increase date at which the disability income claimant receives his increase under the policy for disability income benefits.

After the increase in *salary* we will tell you what the new premium is for the death benefit.

3.4 When cover for an insured ends

Cover for an *insured* who is a disability income claimant and remains covered for the death benefit, ends when any of the following occurs:

- the *insured's* disability income benefit ends;
- premiums are not paid; or

- the *insured* reaches the termination age under the policy for his disability income benefit and returns to work. The *insured* will not be eligible for any cover under this policy.

4. Continuing cover for death benefit if a pensioner

4.1 Basic benefit

We will continue to cover an *insured* for the death benefit until age 70 if the *insured* retires from service and chooses to remain covered for the death benefit.

We will also continue to cover an *insured* for the death benefit, for one month after the date of retirement regardless of whether he chooses to remain covered or not.

4.2 Conditions for the benefit

a. The *insured* must be 70 or younger.

b. The *insured* must have retired for reasons other than ill-health.

c. The *insured* must apply for this benefit in writing within one month of the date of retirement.

d. The *insured* must continue to pay premiums via debit order at the *premium rate* as set out in the policy schedule, by the last day of each month.

4.3 Increases in the death benefit

We will not allow a *pensioner's* death benefit to increase. The death benefit will be subject to a maximum of the accepted death benefit immediately prior to the date of retirement.

5. Exclusions – when we will not pay the benefit

5.1 Failing to disclose all material information about the insured

We will not pay a death benefit claim if you were required to give *material information* about the *insured* but did not do so.

Material information	Information that affects our decision to insure the *insured* on the terms and conditions in this policy.

5.2 Pre-existing conditions

We will not pay a death benefit claim within the first 24 months of cover for a death that was caused by an illness or injury that existed at any time before the *insured's entry date*, where the *insured's entry date* is on or after 1 November 2009.

If, within the first 24 months of any increase in the death benefit, a claim is made for a death that was caused by an illness or injury that existed at any time before the increase, we will not pay the amount of the increased cover. This means we will only pay the benefit amount that would have been paid before the date of the increased cover.

An increase in the death benefit includes:

- a *salary* increase that leads to an increase in the death benefit; or
- a change in the family status that leads to an increase in the death benefit.

Pre-existing condition	Refers to a medical condition or disability which existed at any time before an *insured's entry date*.

Entry date	The date an *employee* and/or a *contractor* and/or a *pensioner* meets the conditions for eligibility under this policy.

5.3 Insured's actions cause death

We will not pay a death benefit claim if the *insured's* death is directly or indirectly caused by any of the following:

Warlike activities

a. Nuclear, biological and chemical warfare or sabotage.

b. The *insured* actively taking part in:

- any war, invasion, rebellion, revolution, uprising, riot, civil commotion, strike, *labour disturbance*, and the seizing of power; or
- overthrowing or influencing any government by force or *terrorism*.

Labour disturbance	Refers to a disturbance, including a riot, commotion or other form of public disorder in the work place which results in physical damage to property or injury or death.
Terrorism	Refers to an act which involves the use of violence, threats or intimidation to disrupt, coerce or influence a government or people as set out in the Protection of Constitutional Democracy against Terrorist and Related Activities Act (Act 33 of 2004) as amended.

Self-inflicted death

The *insured*:

- deliberately or negligently exposing himself to the risks and events that led to the claim, except where the *insured* attempts to save a human life;
- attempting suicide or deliberately inflicting injury on himself within 24 months of the *insured's entry date*, or the date of any increase in the death benefit;
- refusing to seek or follow reasonable medical advice or treatment;
- driving when over the legal alcohol limit;
- taking drugs or poison; or
- taking medication unless a qualified medical practitioner prescribes them.

6. Claims

6.1 How to claim

When you want to claim the death benefit for an *insured* you must:

a. **tell us of the death in writing within nine months** from the date of death. We will tell you what evidence and other documents we need to process the claim; and

b. **send us the evidence and other documents we need within three months** of telling us of the death. We typically need the following documents (but these may not be all):

- an original signed claim form
- an original certified copy of the *insured's* identity document
- an original certified copy of the *insured's* South African death certificate (if the *insured* was a South African citizen)

- an original certified copy of the *insured's* death certificate or other similar document issued by the relevant authority in the foreign country (if the *insured* was a *pensioner* and died outside of the *SADC region* and was not a South African citizen)
- a copy of the *insured's* last payslip
- proof of banking details
- proof of the *insured's* employment status (*employee* or *contractor*)
- if applicable, a copy of the relevant Police report

If we ask for an original certified copy of a document we will not accept a certified copy of a previously certified copy.

C. **send us any additional information we may ask for within three months** from the day that we ask for the information.

6.2 If the claim process is not followed

If the steps above are not followed, and/or you do not send us the information we ask for within the time periods given above, it will cause a delay in the assessment of your claim.

6.3 If we do not accept the claim

If we do not accept the claim, you may ask us to review our decision **see: Section G – Dispute resolution**. We will review our decision only if you:

- send us further evidence and argument within 90 days of the date that you receive our rejection letter; and
- cover all costs of the review.

7. Payment of the benefit

7.1 Beneficiary nomination

The *insured* must nominate a beneficiary to receive the death benefit in the event of the death of the *insured*. The *insured* may nominate more than one beneficiary.

The *insured* may withdraw the nomination at any time. The change or withdrawal of the nomination shall not be binding on us unless the *insured* has told us in writing.

7.2 Who we will pay

We will pay the *insured's* death benefit as a lump sum to the nominated beneficiary.

If the nominated beneficiary is under the age of 18, we will pay the *insured's* death benefit to the legal guardian or the trust.

If the *insured* dies without nominating a beneficiary or the nominated beneficiary cannot be located within 12 months of the date of death, the *insured's* death benefit will be paid to the *insured's* estate.

Nominations in a will or any other testamentary instrument that the *insured* agreed to, shall not affect or invalidate any existing beneficiary nomination that we have recorded.

7.3 When we will pay

We will pay as soon as we have accepted the claim.

7.4 How we calculate interest

a. The benefit will not attract any interest for the first six months from the date that we accepted the claim.

b. An unclaimed benefit **see**: **Section C, nr. 7.5 – If we cannot make payment**, will attract interest as set out below:

After six months from the date that we accepted the claim, we will calculate interest on a monthly basis at a rate of:

- The Standard Bank of South Africa money market interest rate that is applicable during the period that the benefit remains unclaimed;
- less our administration fee.

7.5 If we cannot make payment

In terms of the ASISA Standard on Unclaimed Assets (as amended), it is your responsibility to ensure that the contact details of the policyholder, the *insured* or the *insured's* beneficiary (as applicable) are correct.

If anything prevents us from making payment within six months from the date that we accepted a claim, the benefit is referred to as an unclaimed benefit.

We will keep the claim open until we have obtained the outstanding information that will enable us to pay the claim.

a. If the policyholder instructed us to make payment to the *insured* or the *insured's* beneficiary (as applicable), and we cannot make payment within six months from the date that we accepted the claim, we will pay the benefit to the policyholder.

b. If anything prevents us from making payment to the policyholder, we will take the following steps to trace the policyholder, the *insured* or the *insured's* beneficiary (as applicable):

- We will attempt to contact the policyholder, the *insured* or the *insured's* beneficiary (as applicable) to tell them of the available benefit.
- If we cannot reach the policyholder, the *insured* or the *insured's* beneficiary (as applicable), we will compare our internal database with an external database, and/or make use of an external tracing company.
- We will repeat the tracing process after three years from the date that we accepted the claim, and again after ten years from the date that we accepted the claim.
- If after ten years from the date that we accepted the claim we are still unable to trace the policyholder, the *insured* or the *insured's* beneficiary (as applicable), we will not repeat the tracing process.
- We will deduct administrative, tracing and management fees that we incur as a result of tracing, from the value of the claim.
- We will not trace the policyholder, the *insured* or the *insured's* beneficiary (as applicable) where the value of the claim is less than R1,000.00.

8. Converting to an individual policy benefit

8.1 Basic benefit

We will allow an *insured* who leaves the *employer*'s employ to convert the death benefit to an individual policy. We will also continue to cover an *insured* for the death benefit, for one month after he leaves the *employer*'s employ.

8.2 Conditions for the converting to an individual policy benefit

a. The *insured* must be 65 or younger.

b. The *insured* must have left the *employer's* employ for reasons other than retirement.

c. Immediately before converting his death benefit to an individual policy, the *insured* must have been covered under this policy or any previous policy taken out by the *employer* for a similar benefit for at least twelve consecutive months.

d. The *insured* may apply for this benefit only once. This means an *insured* who returns to the employ of the *employer* may not apply for this benefit again, unless agreed to by us in writing.

e. The *insured* must apply for this benefit within one month of leaving the *employer's* employ.

f. The *insured* must undergo tests for HIV/AIDS and any other tests we may require.

8.3 The new policy

If we agree to issue an individual policy to an *insured* who applies for this benefit, the *insured* understands that:

- the new policy may have additional or different *premium rates*, terms, conditions and exclusions than those of this policy;
- the individual benefit will be subject a maximum of the lesser of R1,000,000 and the accepted death benefit under this policy; and
- he may not ask for a later *maximum cover age* than applies to this policy.

8.4 When this benefit is not available

This benefit is not available to an *insured* who:

- retires from service;
- stops working because of disability; or
- is a *pensioner* whose cover continues in terms of this policy.

9. When cover for an insured ends

Cover for an *insured* ends when any of the following occurs:

- the last day of the month in which the *insured* notifies us in writing that his cover should end;
- any conditions for eligibility are no longer met;
- premiums are not paid;
- the *insured* reaches the *maximum cover age;*
- the *insured* other than a *pensioner,* is temporarily absent from work for more than 12 months (or any extended period agreed to by us writing); or
- the *insured other than a pensioner,* remains outside the *SADC region* on holiday for more than 12 months (or any extended period agreed to by us in writing).
- the *pensioner* remains outside the *SADC region* for more than 12 months (or any extended period agreed to by us in writing), unless the *pensioner resides outside of the SADC region* on a permanent basis and told us in writing.

Cover for an *insured* other than a *pensioner* who leaves the *employer's* employ will end on the earlier of:

- one month after the *insured's* employment with the *employer* ends;
- the date the *insured* converts his cover under this policy to an individual policy; or
- the date the *insured* is employed by a new employer who offers death benefits for at least 50 % of the death benefit covered by this policy.

Maximum cover age	The last day of the month in which the *insured* turns the age set out in the policy schedule. The maximum cover age is the age at which cover for an *insured* ends. This age is selected by the policyholder and is generally the age at which the *insured* would attain normal retirement age.

D. Premiums

1. Your monthly premium

What you must pay

You must pay the premium on behalf of the *employee* and/or the *contractor* at the *premium rate* as set out in the policy schedule, by the last day of each month.

A *pensioner* must pay the premium via debit order at *the premium rate* as set out in the policy schedule, by the last day of each month.

When we calculate the *premium rate* that applies to your policy, we consider:

a. the nature of the *employer's* business and the occupations of the *employees* and/or the *contractors*;

b. the geographical region in which the *employer* undertakes business;

c. the ages, genders and *salaries* of all *insureds;* and

d. any previous claim experience.

Premium rate	The rate we use to calculate your premium. This is set out in the policy schedule.

Overdue premiums

a. If any premium is not paid in time, we will allow a one month grace period for you to pay it except for the first premium which must be paid on time.

b. If you do not pay the outstanding premium within the grace period, cover will end on the last day of the month for which a premium was received. This policy will then automatically end, unless you agree in writing to any terms of reinstatement we may offer. We are not obliged to offer terms for reinstatement or to reinstate your policy.

c. We will not consider any claim that arises during the grace period unless we receive the full outstanding premium before the end of the grace period.

Premiums for new insureds

If an *insured's entry date* is not on the first day of the month, you only need to pay a pro-rata premium for the number of days that the *insured* was covered for in the first month.

If you are unable to calculate and pay the pro-rata premiums then the fifteen-day rule must be applied. This means that if an *insured's entry date* is on or after the 16th of the month, then we will waive the premiums due from the *entry date* to the end of the same month.

Premiums in month of claim

If an *insured's* date of claim is not on the first day of the month, you only need to pay a pro-rata premium for the number days that the *insured* was covered for in the last month.

If you are unable to calculate and pay the pro-rata premiums then the fifteen-day rule must be applied. This means that if an *insured's* date of claim is on or before the 15th of the month, then we will waive the premium due from the beginning of the month to the date of claim.

2. Premium rate guarantee

Your *premium rate* is guaranteed for the period shown in the policy schedule.

2.1 Only applies when information is complete and correct

The *premium rate* guarantee does not apply if we have received incorrect or incomplete information that materially affects our risk.

We base our decision to insure the *insured* on the information you give to us, either directly or through your *intermediary*. If any of this information is incomplete or incorrect, our decision will have been based on incomplete or incorrect information and, if we had known the complete and correct information when you applied for the policy, we may not have agreed to cover the *insured* for the amount set out in the policy schedule.

It is your responsibility to ensure that all *material information* we receive is complete and correct. We may, therefore, recalculate your *premium rate* if any *material information* is incorrect or incomplete.

We will recalculate the *premium rate* according to the correct information. The revised *premium rate* applies retrospectively to your *policy start date* or *policy review date*.

If the revised premium is more than your current premium, you must pay the difference to us immediately. We will only consider claims when all outstanding premiums are paid in full.

If the revised premium is less than your current premium, we will refund the difference to you.

Material information	Information that affects our decision to insure the *insured* on the terms and conditions in this policy.
Intermediary	The person or entity you appoint to carry out any of your duties under this policy on your behalf. The person or entity is set out in the policy schedule.

3. When premiums may change

3.1 Yearly premium review

We will review your premium every year on the *policy review date* set out in the policy schedule. You must pay the revised premium from the effective date of the policy review.

If you do not agree with the revised *premium rate*, you may ask us to review our decision. We will review our decision only if you:

- send us a written request to review our decision within three months of the effective date of the policy review;
- continue to pay the premium at the revised *premium rate*; and
- send us an updated electronic register of lives insured.

Policy review date	The date on which we will review your *premium rate* every year. The date is set out in the policy schedule.

3.2 When there are changes to the business and insureds

We may change your *premium rate* on three months' written notice if:

a. the number of *insureds* changes by more than 20%;

b. the total benefits and/or *salary* for all *insureds* changes by more than 20%;

c. the benefit weighted average age of *insureds* changes by more than two years;

d. the majority occupation split of *insureds* changes, for example if the occupation split changes from 80% administrative to 50% administrative;

e. the geographical spread in which the *employer* undertakes business changes materially;

f. the male-to-female ratio of *insureds* changes by more than 20%; and/or

g. the nature of the *employer's* business changes materially.

E. Your administrative responsibilities

1. Electronic register of lives insured

You must ensure that an up-to-date electronic register of lives insured is sent to us.

The register of lives insured must show, for each *insured*:

- full name;
- identity number;
- employee or membership number;
- date of birth;
- gender;
- yearly *salary*;
- date of retirement (if a *pensioner*);
- current death benefit;
- premium amount; and
- all other *material information*.

1.1 Information must be correct

It is your responsibility to ensure the information on the register of lives insured is correct for each *insured*.

You must send us an up-to-date electronic register of lives insured:

- on the *policy start date*; and
- every month, by the last day of the month.

If we do not receive the updated register of lives insured during any month, we will use the information contained in the last register of lives insured we received. Only those *insureds* listed in the last received register of lives insured will be covered under this policy.

a. Whenever a change happens

You must ensure that you send us details of any changes **see: Section E, nr.1 – Electronic register of lives insured,** which may affect any *insured's* benefits. These changes must be sent to us whenever they happen during the year.

If we do not receive the details of these changes, we will use the information contained on the last register of lives insured we received. This means potential *insureds* will not be covered and existing *insureds* may not be covered for any amount over the limit previously accepted.

If the policy ends before we receive the last month's register of lives insured, we will not ask for medical information to assess an *insured's* health where the *insured's* benefit goes above the *maximum cover limit* or higher limit previously accepted **see: Section B – Proof of good health.**

F. Ending this policy

1. When this policy ends

The policy ends when:

a. you do not pay the premiums due under this policy;

b. the *employer* stops being in business and the contractual employment comes to an end; and/or

c. the notice period for cancelling this policy comes to an end.

2. Cancelling this policy

2.1 When we may cancel

We may cancel this policy by giving you two months' written notice.

2.2 When you may cancel

You may cancel this policy by giving us:

- immediate notice, in writing, if it is within the first month from the *policy start date*
- two months' written notice after the end of the first month from the *policy start date*.

At the end of the notice period, the policy will automatically end. If you wish to reinstate the policy, you must agree in writing to any terms of reinstatement we may offer. We are not obliged to offer terms for reinstatement or to reinstate the policy.

2.3 Premiums paid after cancellation

If you pay us any premium for any period of insurance after the date that this policy ends, we will refund the premiums to you.

Policy start date	The date cover under this policy begins. The date is set out in the policy schedule.

2.4 Cooling off period

In the case where no benefit has been paid or no insured event has yet occurred, you may within one month of receiving either the policy wording or a summary of the policy wording, request us in writing to cancel this policy and we will refund any premiums paid, less the deduction of the costs for any cover provided for risk benefits.

G. Dispute resolution

If we do not accept a claim made in terms of this policy, void this policy or if you dispute the amount of the claim you may request us to review our decision. We will only review our decision if you send us a written request to review within 90 days (the "representation period") of the date that you receive our rejection letter.

You must send the written request to:

Hollard Group Risk Compliance

A division of Hollard Life Assurance Company Limited

PO Box 87428

Houghton

2041

Tel: +27 (11) 351-5000

Fax: +27 (11) 351-3221

Email: hgrcompliance@hollard.co.za

Alternatively, you may contact:

The Ombudsman for Long-term Insurance

Private Bag X45

Claremont

7735

Tel: +27 (21) 657-5000

Fax: +27 (21) 674-0951

Email: info@ombud.co.za

If the dispute is not satisfactorily resolved in this manner, you may institute legal action against us for the enforcement of the claim, by way of the service of summons against us. Summons must be served on us within 180 days of the expiry of the representation period. If this is not done, your claim against us will be forfeited and will become time barred and we will no longer be liable for the claim.

H. General conditions

1. Good faith

You and us will always act in good faith in our mutual dealings.

Any administration error made by us will not invalidate the cover validly in force or continue cover which is not validly in force.

Conditions precedent

All benefit payments are subject to the verification of the validity of any claim.

Our liability in terms of this policy is conditional on you, the *insured* or anyone acting on your or the *insured's* behalf, complying with all the terms, conditions and warranties of this policy.

2. Whole contract

This policy, the policy schedule and any endorsements, as well as any forms, declarations and communication relating to this policy, make up the whole contract between you and us. We are not bound by any changes unless we have agreed to them in writing and have incorporated them into this policy by means of an endorsement and/or a policy schedule.

3. Changes to policy conditions

If any statutory authority introduces measures which affect this policy or if legislation changes, we will make the necessary changes to this policy, after notifying you about the reason for the changes.

If you consider any change to be prejudicial to you, you may end this policy, subject to the relevant provisions contained in the policy.

4. No waiver

If we agree to change the terms and conditions of this policy, the changes will not be valid unless they are made in writing and signed by us.

If we agree to change any deadlines or requirements on an ad hoc basis, it does not mean that we have agreed generally or in all cases to change the deadlines or requirements.

5. Our liability does not exceed the benefit

Our payment of any benefit is a full discharge of our obligations under this policy in respect of an admitted claim and once we have paid it, we will not be liable for anything else. Our liability does not exceed the benefit for which you have paid premiums and no interest will be payable on any benefit.

6. Fraud

We do not tolerate any misrepresentation or fraud.

We will not accept any liability under this policy because you or the *insured* (or any person acting for you or the *insured*) misrepresent/s any information about the *insured* or make/s a fraudulent claim. If we are prejudiced or suffer a loss because of misrepresentation or fraud, then we will be entitled to:

- not pay any further benefit for the *insured*;
- recover any benefit paid;
- end the policy;
- retain premiums paid; and/or

- take legal action.

7. No transfer and exercise of rights

You may not transfer (including cede, assign or dispose of) this policy or any of the benefits payable under this policy to any other person.

Only you can exercise any rights against us in terms of this policy unless the provisions of a particular benefit state otherwise.

8. Communicating with each other

The *parties* must communicate with each other in writing. The *parties* may use registered post, e-mail or fax.

For any formal notices or processes of law, the *parties* must use the addresses set out in the policy schedule, which are the addresses at which the *parties* agree to be served any notices or processes (*domicilium citandi et executandi*). The *parties* must tell each other, in writing, within seven days of any change in these addresses.

We will communicate with you, the *administrator,* the *employer*, the *intermediary* or the *insured* and such communications will be treated as if we had communicated directly with you.

9. Currency

Premiums and benefits payable under this policy must be paid in South African Rands and into a South African and/or Namibian bank account only.

10. Law

The policy shall be governed by and interpreted in accordance with South African Law in the courts of the Republic of South Africa.

11. Consent to disclosure of private information

Each *insured*, by virtue of being insured under this policy, authorises us to access any information about him and to obtain any such information, which we may reasonably need to:

- assess his cover above the *maximum cover limit* **see: Section B - Proof of good health;**
- assess the validity of a claim; and/or
- trace him in the event of an unclaimed benefit **see: Section C, nr. 7.5 – If we cannot make payment;**

and authorise any person and/or institution from whom we may request such access and information to grant access and provide the information.

Each *insured*, by virtue of being insured under this policy, also authorises us to share and provide any information which we obtain about him, with other insurers.

This right of access extends to claims made by any dependants or beneficiaries of the *insured* or any other party claiming benefits.

The information which we are authorised to access and obtain includes, but is not limited, to information about the *insured's* health, even if we have not asked for proof of good health. Any medical information required will only relate to that of the *insured* and no other person.

You must advise each *insured* of the contents of this clause. Unless we receive written notice to the contrary, we will assume that each *insured* has accepted the contents of this clause and we will be entitled to act accordingly.

I. Glossary of defined terms

Accident	An unfortunate incident the *insured* could not foresee that happens unexpectedly and unintentionally at an identifiable time and place and results in death or bodily injury.
Actively at work	Attending to and capable of attending to the material and substantial duties of his job.
Administrator	TD Administrative Services (Pty) Ltd, (registration number 201/090534/07), a company duly registered in accordance with the company laws of South Africa and a licensed financial services provider (FSP number 7379). This is the entity we appointed to carry out any administrative duties under this policy on our behalf.
Contractor	Any person who is not employed as a full time *employee* and who has entered into a contract of work with the *employer* for a contract period of at least six months.
Employee	Any person employed as a permanent and full-time staff member by the *employer*.
Employer	The *employer* named in the policy schedule.
Entry date	The date an *employee* and/or a *contractor* and/or a *pensioner* meets the conditions for eligibility under this policy.
Insured	An *employee* and/or a *contractor* and/or a *pensioner* who meets the conditions for eligibility to be covered by this policy.
Insurer	Hollard Life Assurance Company Limited (registration number 1993/001405/06), a company duly registered in accordance with the company laws of South Africa and a licensed financial services provides (FSP number 17697)
Intermediary	The person or entity you appoint to carry out any of your duties under this policy on your behalf. The person or entity is set out in the policy schedule.
Labour disturbance	Refers to a disturbance, including a riot, commotion or other form of public disorder in the work place which results in physical damage to property or injury or death.
Material information	Information that affects our decision to insure the *insured* on the terms and conditions in this policy.
Maximum cover age	The last day of the month in which the *insured* turns the age set out in the policy schedule. The maximum cover age is the age at which cover for an *insured* ends. This age is selected by the *policyholder* and generally the age at which the *insured* would attain normal retirement age.

Maximum cover limit	The level below which we give cover without the need for medical underwriting, but subject to a non-medical declaration of health.
Parties	Collectively refers to *the insurer*, the *administrator*, the *policyholder* and/or the *employer,* the *employee* and/or the *insured.*
Pensioner	An *employee* who has retired from service but who has not yet attained the age of 70 years.
Policy review date	The date on which we will review your *premium rate* every year. The date is set out in the policy schedule.
Policy start date	The date cover under this policy begins. The date is set out in the policy schedule.
Pre-existing condition	Refers to a medical condition or disability which existed in at any time before an *insured's entry date*.
Premium rate	The rate we use to calculate your premium. This is set out in the policy schedule.
SADC region	The Southern African Development Community comprising Angola, Botswana, Democratic Republic of Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, the Republic of South Africa, Swaziland, Tanzania, Zambia and Zimbabwe.
Salary	The *insured's* salary, wages or other remuneration set out on the *employer's* payroll (provided by you to us), used to determine the cover and/or premiums due under this policy. This is set out in the policy schedule.
Terrorism	Refers to an act which involves the use of violence, threats or intimidation to disrupt, coerce or influence a government or people as set out in the Protection of Constitutional Democracy against Terrorist and Related Activities Act (Act 33 of 2004) as amended.

Additional information

This section does not form part of the policy and is provided for information purposes only.

All material facts must be accurately, fully and properly disclosed by you. All information provided by you or on your behalf is your own responsibility. You need to be satisfied with the accuracy of any transaction submitted by anyone on your behalf.

You must not sign any incomplete or blank documents. No person may request or insist that you do so.

We have appointed TD Administrative Services (Pty) Ltd (TDAS) to handle claims and policy administration. TDAS's FSP reference number is 7379. TDAS has Professional Indemnity cover in force.

For all claims and administration matters, please contact:

Postal address
TD Administrative Services (Pty) Ltd
PO Box 1468
Bromhof
2154

Physical address
TD Administrative Services (Pty) Ltd
3 Hamerkop Road
Randpark Ridge Ext 5
Randburg

Tel: +27 (86) 111-2348
Fax: +27 (86) 540-5694
Email: claims@tdas.co.za

If you have a complaint about this policy

First try and resolve it with Hollard Group Risk, by writing to:

Hollard Group Risk Compliance
A division of Hollard Life Assurance Company Limited
PO Box 87428
Houghton
2041

Tel: +27 (11) 351-5000
Fax: +27 (11) 351-3221
Email: hgrcompliance@hollard.co.za

If you feel that the policy or the manner in which the policy was sold does not meet legal requirements, or if you are not happy about the advice received, please write to:

The Compliance Officer
Hollard Life Assurance Company Limited
PO Box 87428
Houghton
2041

Tel: +27 (11) 351-5000
Fax: +27 (11) 351-5001
Email: compliance@hollard.co.za

If the matter is not resolved to your satisfaction by Hollard, you may submit the complaint to:

The Ombudsman for Long-term Insurance
Private Bag X45
Claremont
7735

Tel: +27 (21) 657-5000
Fax: +27 (21) 674-0951
Email: info@ombud.co.za