CRITICAL ILLNESS BENEFIT | FACT SHEET

The critical illness benefit provides a lump sum payment to insureds to fund lifestyle changes and unexpected expenses if they are diagnosed with a critical illness covered in the policy.

The benefit can be an acceleration of a linked unapproved death benefit or a free-standing benefit.

The basic benefit

- The basic benefit is offered as either a multiple of salary or as a flat benefit amount.
- The disclosure grid sets out the percentage of the benefit that is payable based on the level of severity of the critical illness condition. Where the benefits are not scaled according to severity level, 100% of the benefit will be payable if the criteria to qualify for the condition is met.
- The benefit is paid as a lump sum to the insured after expiry of the survival period of 14 days.

Ancillary benefits

The policyholder can choose to provide additional cover by including any of the following ancillary benefits:

- **Flexible critical illness benefit**
  This allows members to select the amount of cover they require, within the permitted minimum and maximum levels. Members who increase their level of cover will be required to pay an additional premium. There are terms and conditions related to when cover can be increased.
- **Converting to an individual policy benefit**
  This benefit allows an insured who leaves the employer's employ or fund membership to convert the basic and flexible critical illness benefit to an individual policy without undergoing medical underwriting. The insured must convert their cover within 60 days of their cover terminating under the group insurance arrangement. Individual cover will be limited to their previous level of cover. We will continue to cover an insured who is eligible to exercise the conversion, free of premiums, for 31 days under the group insurance policy after he leaves the employer's employ.
- **Continuing cover if disabled benefit**
  If disability income benefits are offered as part of the employee benefit programme, this benefit allows disability claimants to remain covered for the critical illness benefit whilst in receipt of disability income benefits.
  The salary on which a critical illness benefit will be calculated will be the salary at the insured's date of disability, increased each year by the income disability escalation rate, subject to a maximum of the Consumer Price Index.
- **Top-up benefit**
  If the top-up benefit has been selected, the insured's cover will be reinstated to the level of cover selected by the policyholder for any future critical illness events that are unrelated to the previous critical illness event claimed for.

Benefit maximums

- Our maximum critical illness benefit is currently R3 500 000 or 3 times annual salary. Please note however, that there may be different limits for the ancillary benefits and these maximums are subject to review from time to time.
- If the benefit is an acceleration of a linked death benefit, it can't be more than the death benefit.
- Aggregation does not apply.

Plan options

Critical Illness	Premier Plus	Premier	Standard
Heart attack (level A to D)	100%	Disclosure grid	Disclosure grid
Coronary artery bypass graft (level A to D)	100%	Disclosure grid	Disclosure grid
Stroke (level A to D)	100%	Disclosure grid	Disclosure grid
Cancer (level A to D)	100%	Disclosure grid	Disclosure grid
Kidney failure	100%	100%	100%
Major Organ transplant	100%	100%	100%
Loss of limbs	100%	100%	100%
Major burns	100%	100%	100%
Total blindness	100%	100%	100%
Coma	100%	100%	100%
Multiple sclerosis	100%	100%	100%
Alzheimer's Disease	100%	100%	N/A
Motor Neuron Disease	100%	100%	N/A
Parkinson's Disease	100%	100%	N/A
Benign Brain Tumour	100%	100%	N/A
Accidental HIV	100%	100%	N/A
Surgical repair for any structural defects of the heart	Disclosure Grid	Disclosure Grid	Disclosure Grid

Critical illness benefits disclosure grid

Five of the critical illness conditions are measured on a scale according to the level of severity of the condition, at the time of claim.

The scale for Heart Attack, Coronary Artery Bypass Graft, Stroke and Cancer is consistent with the requirements set out by the Association for Savings and Investment SA (ASISA) and the Standardised Critical Illness Definitions Project (SCIDEP) who set out to derive a set of standard industry definitions and criteria for these 4 main critical illness claims.

One other critical illness condition is assessed on a tiered basis depending on the severity of the condition, namely surgical repair for any defects of the heart.

The disclosure grid sets out the benefit which is payable based on the level of severity of the critical illness condition. Where the benefits are not scaled according to severity level, 100% of the benefit will be payable if the criteria to qualify for the condition is met.

	Level A Most Severe	Level B Moderate impairment	Level C Mild impairment	Level D Almost full Recovery
Heart attack	100%	75%	50%	25%
Coronary artery bypass graft	100%	75%	50%	25%
Stroke	100%	75%	50%	25%
Cancer	100%	75%	50%	25%
Surgical repair for any structural defects of the heart	100%	75%	N/A	25%

Cover conditions

Eligibility	- Minimum entry age is 18 - Maximum entry age is 1 year prior to the selected maximum cover age - Maximum cover age is 65 **An insured must:** - be an employee or, if permitted, a contractor of the employer and be a member of the fund, if the policyholder is a retirement fund - live in the Southern African region and must either 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 - be listed on the register of lives insured
When cover for an insured starts	- On the insured's entry date, if the insured is actively at work; or - If the insured is not actively at work, when we receive satisfactory proof of his good health, or the insured completes two consecutive months of service with the employer without absence.
Underwriting requirements	A free cover limit is determined for each policy. The free cover limit is the level below which we give cover without the need for medical underwriting. The basic benefit and flexible death benefit will be added together to determine if an insured's cover is above the free cover limit. Proof of good health is required for cover above the free cover limit or previously accepted cover. We will cover the cost of the medical evidence requested. Proof of good health must be provided within 4 months of the insured's cover going above the free cover limit or previously accepted cover. We provide temporary accident cover for up to 4 months, while we assess whether we will increase the provided cover to the full potential cover. Accident cover is the insured's restricted benefit amount (i.e. the free cover limit amount) PLUS up to R1 000 000 accident cover. The total benefit payable will be limited to the insured's full potential benefit. Accident cover ends after the 4-month period comes to an end or we complete our underwriting assessment and provide a decision in writing.
Actively at work	Required
Temporary absence from work	An insured who is temporarily absent from work can continue to enjoy cover provided: the absence is intended to be temporary; it is shorter than 6 months; premiums continue being paid; and the insured continues receiving a salary.

	If the insured is temporarily absent from work more than once, the absences must be separated by at least 3 consecutive months. If they are not, they will be added together to determine whether he is absent for longer than the 6-month limit.
Temporary absence from Southern Africa	An insured who is temporarily absent from Southern Africa can continue to enjoy cover provided: the absence is intended to be temporary; it is shorter than 3 months; premiums continue being paid; and the insured continues receiving a salary. If the insured is temporarily absent from work more than once, the absences must be separated by at least 3 consecutive months. If they are not, they will be added together to determine whether he is absent for longer than the 3-month limit. Southern Africa includes Angola, Botswana, Eswatini, Lesotho, Malawi, Mauritius, Mozambique, Namibia, South Africa and Zambia.
When cover for an insured ends	Cover ends when any of the following occur: - The insured's employment with the employer ends; - Any conditions for eligibility are no longer met; - Premiums are not paid; - The insured passes away; - The insured reaches the maximum cover age; - The insured receives 100% of the critical illness benefit, unless the top-up benefit was selected; - The insured is temporarily absent from work for more than 6 months (or any extended period agreed to by us writing); or - The insured remains outside the Southern African region for more 3 months (or any extended period agreed to by us in writing)

Claim conditions

Date of event	The date of event is the date on which, in our opinion and based on all objective evidence on record, the insured meets the criteria of a critical illness definition or a severity level in the relevant critical illness definition. Where the critical illness is defined as the undergoing of a surgical or medical procedure, the date of event is the date the surgery or medical procedure takes place. We will determine this date taking into account the insured's medical records and the definition of the critical illness.
Survival period	14 days
Restoring the death benefit	If we pay a critical illness benefit and there is a linked death benefit, we will then reduce the death benefit by the amount paid for the critical illness. If the insured survives the period set out in the policy schedule, we will restore their death benefit back to the amount it was before the critical illness benefit was paid. This period is selected by the employer and can be 30, 60, 90 or 120 days.
Claim submission period	The claim must be notified, and all claim documentation must be submitted to us within 6 months of the date of event.
Claim documents required	We typically need the documents listed below. If we need any additional evidence, we will tell you what we need: - A signed claim form from the insured, the employer and the medical attendant

	- Medical reports - Clinical evidence - A copy of the insured's identity document - A copy of the insured's payslip for the last completed month of employment - Proof of banking details
Medical evidence costs	The insured or policyholder must pay for the initial medical evidence to support the claim. Hollard Group Risk will pay for medical evidence required over and above that required to support the claim.

Exclusions	- If the insured fails to disclose all material information (information that affects our decision to insure them on the terms and conditions in the policy) about himself
	- Criminal activity – if the disability is directly or indirectly caused by the insured committing a crime
	- Warlike activities
	  ○ Nuclear, biological and chemical warfare or sabotage.
	  ○ The insured actively taking part in:
	  ▪ any war, invasion, rebellion, revolution, uprising, riot, civil commotion, strike (including a protected strike), labour disturbance, and the seizing of power
	  ▪ overthrowing or influencing any government by force or terrorism
	- If the insured
	  ○ deliberately or negligently exposes himself to risks and events that led to the claim, except where he attempts to save a human life;
	  ○ attempts suicide or deliberately inflicts injury on himself;
	  ○ refuses to seek or follow reasonable medical advice or treatment;
	  ○ drives when over the legal alcohol limit;
	  ○ takes drugs or poison; or
	  ○ takes medication unless a qualified medical practitioner prescribes them.

Pre-existing conditions	- If the insured suffers a disability which occurs within the first 12 months of cover or 12 months from an increase in the benefit and the medical condition or disability existed in the 6 months before their entry date or increase in cover. - This condition may be waived if an insured is actively in the service of the employer and has previously satisfied the conditions for cover under a policy issued by any other insurer who offered the same benefits immediately prior to the policy start date.
Multiple claims	- If the top-up benefit has been selected, the insured's cover will be reinstated to the level of cover selected by the policyholder for any future critical illness events that are unrelated to the previous critical illness event claimed for. - If the top-up benefit has not been selected, the total critical illness benefit payable under the policy will not exceed 100% of the benefit. This means that once 100% of the benefit has been paid, the insured's cover stops. No further cover is possible for any future critical illness events. - If the insured has received a benefit of less than 100% for a tiered critical illness event, and their condition later worsens to the extent that they meet the criteria for a higher severity level, they will receive the remainder of the benefit. - If the insured has received a benefit of less than 100% for a tiered critical illness event and is then later diagnosed with a related condition that has a higher payment level, the difference between the two benefits will be paid.

Disputes	If a dispute arises, a request can be made for us to review our decision. This must be a written request received within 90 days of the date that our rejection letter is received. Alternatively, a complaint can be lodged with the National Financial Ombudsman.

Administration information

Register of lives inured	An updated register of lives insured is required monthly.
Premium frequency	Premiums are payable monthly. We allow a 31-day grace period for premiums after the first premium.
Changes in premium	Premiums may change at the yearly premium review or when there are material changes to the employer's business or lives insured.
Notice period for changes in policy terms and conditions	31 days
Termination of the policy	The policy ends when premiums are not paid, the employer stops being in business, or the notice period for cancelling the policy comes to an end. Hollard may cancel the policy by giving 60 days' written notice. The policyholder may cancel the policy immediately if it's within the first month of the policy start date, or by giving 31 days written notice thereafter.

Important

This fact sheet is in terms of our standard policy terms and conditions as well as our standard benefits offered and does not include any of our special offers, endorsements or bespoke policies.

For the complete terms and conditions, please refer to our policy document, a copy of which can be requested from Hollard. To contact Hollard for our policy documents, please contact HGRAdmin@hollard.co.za. In the event of any dispute or any discrepancy between this document and the provisions of the policy, the policy will prevail.

For more information about this product or any of our other Group Insurance products, please contact your Hollard consultant.