LUMP SUM DISABILITY BENEFIT | FACT SHEET

The lump sum disability benefit provides a lump sum payment to an insured who suffers a disability which leaves them totally and permanently unable to perform the duties of their own occupation or any occupation in the open labour market.

The benefit can be offered on an approved or unapproved basis and can be an acceleration of a linked 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 policyholder can select an optional taper period of 5 or 10 years. If a taper period is selected, the benefit will be reduced by 1.6666667% or 0.8333333% for each completed month in the 5 or 10 years respectively leading up to the insured maximum cover age.
- The benefit is paid as a lump sum following the expiry of the waiting period. For approved benefits, payment is made to the fund and then paid to the insured in line with relevant legislation. Unapproved benefits are paid directly to the insured.

Ancillary benefits

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

- Flexible disability benefit This allows insureds to select the amount of cover they require, within the permitted minimum and maximum levels. Insureds 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 benefit and the flexible lump sum disability 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.

Benefit maximums

- Our maximum lump sum benefit is currently R10 000 000 or 6 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.
- Aggregation may apply. This means that an insured's benefit may be reduced if he receives a similar benefit from another insurer for the same claim event.
- If the benefit is an acceleration of a linked death benefit, it can't be more than the death benefit.

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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 lump sum disability 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 500 000 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; - If the policyholder is a fund, when the insured's membership of the fund 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 a payout of the lump sum disability benefit; - 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

Definition of disability	Disability is the total and permanent inability to work because of illness or injury. This means that the insured is unable to perform the material and substantial duties of: - his own occupation; or - any occupation for which he is or could reasonably be expected to be educated, trained and experienced, for any employer
Date of disability	The date on which the insured meets the definition of disability. When determining the date of disability, the following will be considered: - The insured's medical records; - The insured's leave records; and - The record of the last day the insured was actively at work i.e. when he was last attending to and capable of attending to the material and substantial duties of his job.
Waiting period	The default waiting period is 6 months, but policyholders can select a period between 6 and 24 months.
Claim submission period	The claim must be notified, and all claim documentation must be submitted to us within 6 months of the date of disability.
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 - Copy of the insured's job description - Copy of the insured's sick leave records - 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
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, the fund is no longer registered (in the case of approved benefits) 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.