TOTAL AND TEMPORARY DISABILITY BENEFIT | FACT SHEET

The total and temporary disability benefit allows for an insured to continue to receive a monthly income for a fixed maximum payment period if they suffer a disability which leaves them totally and continuously unable to perform the duties of their own occupation with their own employer.

This is a free-standing, unapproved benefit.

The basic employee benefit

- The basic employee benefit is offered as a percentage of salary, paid to the insured as a monthly benefit for a fixed maximum payment period following the expiry of the waiting period.
- The basic employee benefit can either be on a scaled or a flat structure.

Scaled structure	Flat structure
Default scale applied to monthly salary as follows: 75% of the first R 8 000 65% of the next R 15 000 60% of the next R 9 000 55% of the next R 12 500 50% of the balance of salary This scale allows for the benefit to be calculated at a level not exceeding an employee's current taxable earnings, and which is considered appropriate based on their level of taxation. Other scaled options can be accommodated.	Default is 75% of salary. Other structures can be accommodated.

Ancillary benefits

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

- Employer benefit Covers a portion of the cost the employer incurs in maintaining a claimant's participation in a retirement fund and/or associated risk benefit fund when they become in receipt of a monthly disability benefit. This benefit is paid monthly to the employer along with the total and temporary disability benefit.	- Waiting period payback benefit Covers a portion of the cost the employer incurs should they continue paying the insured's salary during the waiting period. The amount payable equals the monthly basic employee benefit plus the employer benefit for the duration of the waiting period and is paid as a lump sum with the first total and temporary disability benefit payment.

- **Converting to an individual policy benefit** This benefit allows an insured who leaves the employer's employ or fund membership to convert the employee and employer 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.	- **Medical premium waiver benefit** Covers the cost the employer incurs in maintaining a claimant's participation in a medical aid scheme when they become in receipt of a monthly disability benefit. The claimant must have been the main member of the medical aid scheme for a minimum period of 3 months before their date of disability. The amount we pay includes the medical aid fund contributions for the claimant, their spouse and their children. This benefit is paid as long as the total and temporary disability benefit is paid and is paid to the employer to cover the cost of maintaining the claimant's medical scheme membership.

Benefit maximums

- The maximum employee benefit allowed is R230 000 per month.
- The maximum employer benefit allowed is R50 000 per month.
- The sum of the employer and employee benefit is limited to the insurable maximum which is 100% of the employee's net after-tax income at the date of disability.
- The payment period is selected by the policyholder and can be anything between 6 and 24 months. This period includes the waiting period.
- Aggregation applies. This means that an insured's benefit may be reduced if he receives a similar benefit from another source. This is done to ensure the insured is not financially enriched while in receipt of disability related income.
- The maximum medical premium waiver allowed is R10 000 per month.

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 employer and employee benefits 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 monthly benefit amount (i.e. the free cover limit amount) PLUS up to R15 000 accident cover per month. The total monthly 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 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	Totally and continuously incapable because of bodily injury or illness, disease, or surgery of performing with reasonable continuity the material and substantial duties of the insured's own occupation with his own employer.
Special conditions for licensed occupations and seamen	For any insured who is a seaman or in an occupation requiring a certification or license (for example pilots or drivers), the definition of disability for any occupation will apply from the date of disability. Having the license suspended, cancelled, or endorsed is not a reason for claiming the total and temporary disability benefit.
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 3 months, but policyholders can select a period between 1 and 3 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
Benefit escalations	If selected, the employee and employer benefit will increase yearly by the lesser of the rate selected and the Consumer Price Index over the preceding 12 months. The maximum escalation rate that can be selected is 10%.
Reduced benefit due to earnings	If a claimant continues to meet the definition of disability, but wishes to return to work, we will encourage their return to work by continuing to pay them a benefit equal to the difference in the salary received and the disability benefit due.
Recurrent disability	Cover is provided for an insured who becomes disabled again after previously receiving a total and temporary disability benefit under the policy. If the disability is from the same cause as the previous claim and the claim was not previously paid for the full maximum payment period, waiting periods will apply as follows: - Within 3 months of the date on which the previous total and temporary disability benefit stopped, the waiting period will not apply - After 3 months of the date on which the previous total and temporary disability benefit stopped, the waiting period will apply
Cessation of benefit	The benefit will stop if any of the following events occur: - The claimant is no longer considered disabled; - The claimant fails to submit the medical information as part of the subsequent assessments; - The claimant passes away; - The claimant reaches the maximum cover age; - The maximum payment period comes to an end; - The claimant no longer suffers from a loss of income due to their disability; - The claimant remains outside the Southern African region for longer than 3 months; or - The claimant refuses to undergo reasonable medical treatment.
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.