ambledown
FINANCIAL SERVICES (PTY) LTD

Naptosa

22 November 2020

Dear Sir/Madam

Introduction
Constantia Insurance Company Limited (the Insurer) has appointed Ambledown Financial Services (Pty) Ltd (Ambledown) to perform certain binder functions on behalf of the Insurer. These binder functions are regulated in terms of Section 48A of the Short-Term Insurance Act 53 of 1998 and are set out in a written binder agreement between the Insurer and Ambledown. The binder functions are listed below -

- Providing quotations and renewal pricings to potential and existing policyholders
- Accepting risk and performing all matters incidental to installing and renewing a scheme
- Assessing and paying claims up to specified limits

Ambledown is remunerated for performing the above binder functions by a binder fee as agreed with the Insurer.

The Insurer has also outsourced certain other supporting administration functions to Ambledown in terms of a written administration agreement between The Insurer and Ambledown. Ambledown is remunerated for performing these outsourced administration functions by an administration fee as agreed with the Insurer.

The fees payable to Ambledown are reflected in the premium breakdown provided in the policy schedule.

Cover
With reference to the above mentioned insurance policy, we have pleasure in confirming that this policy will be renewed with effect from 1 January 2021.

Your policy details are as follows:

RENEWAL OF NAPTOSA GAP SUPREME
MASTER POLICY NUMBER: AMBLG002162
PREVIOUS TOTAL MONTHLY PAYMENT DUE PER MEMBER: R 330.00
TOTAL MONTHLY PAYMENT DUE PER MEMBER FOR 2021: R 350.00
INSURER: CONSTANTIA INSURANCE COMPANY LIMITED (Reg. No. 1952/001514/06)

For your attention, attached please find the relevant documentation including the Master Policy Wording and Schedule of Insurance detailing your particular cover in terms of this policy. In compliance with the Code of Conduct in terms of the Financial and Advisory Intermediary Services Act a copy of the Disclosure Notice is also enclosed for your attention.

Please note that the attached wording replaces all wordings previously issued.

Premiums are collected via Debit Order in accordance with the payment date selected on your Application Form (or the previous business day should this day fall over a weekend/public holiday), in Arrears from your nominated bank account.

Please study the attached documentation whilst paying special attention to the Schedule of Insurance to ensure that all details contained therein are correct.

We trust that you will find the above to be in order and should any of your details change, or should you have a query or wish to submit a claim please contact your broker as indicated on the attached Schedule of Insurance

Yours Faithfully
AMBLEDOWN FINANCIAL SERVICES (PTY) LTD

NOTABLE CONDITIONS

It is important to note that the cover for your policy is subject to specific exclusions and terms and conditions which are set out in the policy document. As the policy holder, it is advisable to familiarise yourself with the terms and conditions both at the inception and during the operation of the policy.

Kindly take note of the following highlighted conditions that are material to your policy and might affect you when claiming. This information leaflet does not form part of your policy document; it is only for information purposes. All other important information is included in the policy document and it is advisable that you should read this leaflet as well as the policy document.

Dependants

Not all your dependants on your medical scheme are automatically covered.

You, your eligible spouse and your eligible children are covered.

> ***"Eligible Spouse"*** *means the spouse of the Principal Insured Person who is not already insured under this section or any other policy issued by a company providing similar cover. A spouse shall only be accepted for cover in terms of this policy if such spouse is covered by a registered medical aid scheme.*
>
> *For the purpose of the Policy "Eligible Spouse" shall include a party to any union acceptable according to South African Law.*
>
> *Where a person shares an abode with a Principal Insured Person and has done so for at least six (6) months and lives together in the manner of a legally married couple the person shall be regarded as a spouse.*
>
> *Should a Principal Insured Person have more than one spouse who could qualify as an Eligible Spouse then that Principal Insured Person must make an irrevocable nomination of one Eligible Spouse to whom the benefits provided by this policy are to apply.*
>
> *No benefits will be paid in respect of an Eligible Spouse if more than one person qualifies as such and no nomination has been made by the Principal Insured Person.*
>
> *"**Eligible Child"** means a child who is by way of natural/ biological child born of or stepchild or legally adopted child placed under the foster care of the Principal Insured Person and who has not attained the age of twenty one (21) and who is not already insured under this policy or any other insurance issued by a company providing similar cover.*
>
> *This age may be extended in respect of an unmarried child who is a dependant on the Principal Insured Person's Medical Scheme, who has not attained the age of twenty six (26).*
>
> *There will be no age restriction for children who are either mentally or physically incapacitated from maintaining themselves, always provided that the children are wholly dependent on the Principal Insured Person for support and maintenance. A child shall only be accepted for cover if such child is covered by a registered medical aid scheme.*

For mentally or physically incapacitated children over the age of 26, please provide us with documentation to approve the child as an eligible dependant.

Submission of Claims

You must submit a claim within 180 days (6 months) from the first day of treatment for an insured incident even if you do not have all the supporting documentation. Once the claim has been submitted, you have up to 12 months after the date of the incident to submit all your supporting documentation.

If you do not notify us of the claim within 180 days (6 months), the claim will be rejected.

For Example
You receive treatment on 1 January 2021. You should therefore submit a claim form by latest 30 June 2021. You will be allowed to submit supporting documentation up to 31 December 2021 to finalise your claim.

Outpatient Procedures

The policy is intended to cover in-hospital shortfalls. A list of out-patient procedures covered are listed in the policy. All other out-patient procedures are not covered by the policy. A limited benefit is provided for emergency treatment in a casualty unit.

Whether treatment is as a result of an emergency will be determined through diagnosis and not on the symptoms presented. The Medical Practitioner that treated you and / or the Casualty Unit that you have been treated in should use the correct codes and classification on the invoices they send to you and / or your medical aid.

If you are unsure, please contact us to confirm whether treatment will be covered by the policy.

Payment Arrangements with your Medical Scheme and Split Billing

If your policy offers co-payment benefits and / or sub-limitation benefits, the following co-payments are not covered by your policy:

- where you reach or sign an agreement with your Medical Scheme to pay a co-payment which is not listed in the rules of the Medical Scheme
- where you reach or sign an agreement with your Medical Scheme that they may impose a sub-limit which is not stated in the rules of your Medical Scheme

Where a doctor splits billing and do not send both accounts to the Medical Scheme, the accounts that have not been sent to the Medical Scheme will not be assessed. All accounts and line items on accounts should be linked to a recognised tariff code. Both the line items on the accounts and medical aid statement are used to assess and record your claim.

Premium Payment

Whether you pay via debit order or direct deposit, the responsibility to pay your premium remains your responsibility. We will do our utmost to ensure that debit orders are collected, however we cannot ensure that premium are collected every month due to debit orders being returned by banks as unpaid.

When a debit order is rejected, either you and / or your broker will be notified. If two subsequent debit orders are rejected or if we are unable to collect premium due to a rejection reason, your policy will lapse.

Should any of your personal circumstances have changed that could affect your cover please contact your Broker/Financial Services Provider in order for them to assess whether your current policy is still appropriate and advise you accordingly.

2021 GAP COVER SERIES CHANGES AND ENHANCEMENTS

Specific Changes to Policy Wording:

*The following **DEFINITIONS** have been changed in the policy wording*

"Definitions" introduction	"Where an age is mentioned in the policy, it will be the age attained." *has been removed*
6. Eligible Child	"This age may be extended up to twenty six (26) in respect of an unmarried child who is a dependent on the Principle Insured Person's Medical Scheme." *has been replaced with* "This age may be extended in respect of an unmarried child who is a dependent on the Principle Insured Person's Medical Scheme, who has not attained the age of twenty six (26). "

*The following changes have been made under **DEFINED EVENTS***

3. The necessity for outpatient treatment for the following procedures:	"iii. Varicose veins in the rooms (if paid from scheme's risk)" *has been added*

*The following changes have been made under **GENERAL CONDITIONS***

Protection of Personal Information, Act, 2013 (POPIA)	a. "The Company or its authorised representatives shall process, disclose or transferring personal information only for the intended purpose of administering this contract or for any statutory purposes. b. An Insured Person has the right to - i. object to the processing of their personal information on reasonable grounds unless legislation allows for such processing, in the manner prescribed by POPIA; ii. request from the Company details of personal information the Company or its authorised representatives holds, and details of how personal information is processed. Requests should be addressed to – The Information Officer Ambledown Financial Services P.O Box 1862 Cramerview 2060 Tel: 0861 262 533 Email: compliance@ambledown.co.za iii. lodge a complaint with the Information Regulator, as per the contact details provided below. Chief Executive Officer Mr Marks Thibela P.O Box 31533 Braamfontein 2017 Tel: 010 023 5200 Email: complaints.IR@justice.gov.za c. The Company shall use its best endeavours to ensure personal information is reliable. The Principal Insured Person shall be responsible for advising the Underwriting Manager of any changes to the personal information of an Insured Person in a timely manner and such information is complete, correct and up to date." *has been added*

Claims	"The Complaints Officer Constantia Insurance Company Limited PO Box 3518 Cramerview 2060 Tel: 011 686 4200 Fax: 011 789 8828 Email: compliants@constantiagroup.co.za Or The Compliance Officer Adv Christiene Brummer Constantia Insurance Company Limited PO Box 3518 Cramerview 2060 Tel: 011 686 4200 Fax: 011 789 8828 Email: ChristieneB@constantiagroup.co.za" *has been changed*

The following changes have been made under ***TABLE OF BENEFITS***

g. Premium Waiver	"Following the death or the Total and Permanent Disability of the Principle Member of the Medical Scheme, a benefit equal to the total value of Medical Aid Scheme Contribution calculated for six (6) months on the Medical Aid Scheme Option of the Registered Medical Aid Scheme within the stated limitations. " *has been replaced with* "Following the death or the Total and Permanent Disability of the Principal Member of the Medical Scheme, a benefit equal to the total value of Registered Medical Aid Scheme Option Contribution and premium payable on this policy calculated for six (6) months within the stated limitations."

The following changes have been made under ***OVERALL LIMITATIONS***

Overall Limitation	"The following Policy Benefits are subject to an overall benefit limitation of R165,000 in the aggregate per Insured Person per annum:" *has been replaced with* "The following Policy Benefits are subject to an overall benefit limitation of R173,000 in the aggregate per Insured Person per annum:"

Should any of your personal circumstances have changed that could affect your cover please contact your Broker/Financial Services Provider in order for them to assess whether your current policy is still appropriate and advise you accordingly.

Security: Constantia Insurance Company Limited: 100%

This is not a medical scheme and the cover is not the same as that of a medical scheme. This policy is not a substitute for medical scheme membership.

NAPTOSA GAP SUPREME
MASTER POLICY WORDING

Master Policy Wording No.: CICL/SUPREME/2020

In consideration of and conditional upon the prior payment of the premium by or on behalf of the Insured and the acceptance thereof by or on behalf of Constantia Insurance Company Limited (*the Company)* before the inception date or renewal date (as the case may be) and subject to the Definitions, Defined Events, General Exceptions, General Conditions, Table of Benefits, Limitations and any Endorsements to the policy the Company agrees to pay the Principal Insured Person for an insured incident occurring during the period of insurance up to the limit of indemnity stated for the Insured Person and the benefit as stated in the Policy. The application form and declaration completed by the Insured Person and/or Principal Insured Person are the basis and form part of this policy as well as the policy schedule and any endorsement to the policy.

DEFINITIONS

In this policy all words and expressions signifying the singular shall include the plural and vice versa. Words and expressions implying the masculine gender shall include the feminine. The following words and expressions shall have the following meanings:

1. **"Accident"** means bodily injury caused by violent accidental and external physical means.

2. **"Biological Cancer Drug"** means a substance that is made from a living organism or its products and is used in the prevention, diagnosis, or treatment of cancer. For the purpose of this Policy Biological Drugs include antibodies, interleukins, and vaccines.

3. **"Cancer"** means a malignant tumour characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue. The term cancer includes leukaemia and Hodgkin's disease but the following are specifically excluded:

   a. All tumours, which are histologically described as pre-malignant, as non-invasive or as cancer in situ.
   b. All forms of lymphoma in the presence of any Human Immunodeficiency Virus.
   c. Kaposi's sarcoma in the presence of any Human Immunodeficiency Virus.
   d. Any skin cancer other than malignant melanoma.
   e. Cancerous cells that have not invaded the surrounding or underlying tissue.
   f. Early cancer of the prostate gland or breast. (Stage 1 described as T1a, N0, M0, G1)

4. **"Company"** means Constantia Insurance Company Limited, Reg No. 1952/001514/06, FSP No. 31111.

5. **"Co-Payment"** means a stated amount imposed as a co-payment or deductible by a medical scheme. A co-payment or deductible must be indicated in the rules of the medical scheme as approved by the Council for Medical Schemes.

6. **"Eligible Child"** means a child who is by way of natural/ biological child born of or stepchild or legally adopted child placed under the foster care of the Principal Insured Person and who has not attained the age of twenty one (21) and who is not already insured under this policy or any other insurance issued by a company providing similar cover.

   This age may be extended in respect of an unmarried child who is a dependant on the Principal Insured Person's Medical Scheme, who has not attained the age of twenty six (26).

   There will be no age restriction for children who are either mentally or physically incapacitated from maintaining themselves, always provided that the children are wholly dependent on the Principal Insured Person for support and maintenance. A child shall only be accepted for cover if such child is covered by a registered medical aid scheme.

7. **"Eligible Spouse"** means the spouse of the Principal Insured Person who is not already insured under this section or any other policy issued by a company providing similar cover. A spouse shall only be accepted for cover in terms of this policy if such spouse is covered by a registered medical aid scheme.

   For the purpose of the Policy "Eligible Spouse" shall include a party to any union acceptable according to South African Law.

   Where a person shares an abode with a Principal Insured Person and has done so for at least six (6) months and lives together in the manner of a legally married couple the person shall be regarded as a spouse.

Should a Principal Insured Person have more than one spouse who could qualify as an Eligible Spouse then that Principal Insured Person must make an irrevocable nomination of one Eligible Spouse to whom the benefits provided by this policy are to apply.

No benefits will be paid in respect of an Eligible Spouse if more than one person qualifies as such and no nomination has been made by the Principal Insured Person.

8. **"Emergency"** means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical treatment and/or an operation. If the treatment is not available, the emergency could result in weakened bodily functions, serious and lasting damage to organs, limbs or other body parts, or death.

   The determination of an Emergency will be done through diagnosis (through classification by the attending Medical Practitioner and/or the Casualty Unit) and not on symptoms presented.

9. **"Family"** means the Principal Insured Person, Eligible Spouse and Eligible Children (as defined) provided that the Eligible Spouse and Eligible Child are Insured Persons.

10. **"Hospital"** means any institution in the territory of the Republic of South Africa which in the opinion of the Company meets each of the following criteria:

    a. Has diagnostic and therapeutic facilities for surgical and medical diagnosis treatment and care of insured and sick persons by or under the supervision of a staff of medical practitioners.
    b. Provides nursing service supervised by registered nurses or nurses with equivalent qualifications.
    c. Is not other than incidentally either a mental institution, a convalescent home, rehabilitation or stepdown facility.
    d. Is not a place of rest for the aged or a place for drug addicts or alcoholics or a health hydro or natural cure clinic or similar establishment.
    e. Is not an institution providing long-term care for the blind, deaf, dumb or other handicapped persons.

11. **"Hospital Confinement"** means admission to a hospital ward.

12. **"Illness"** means any one somatic illness or disease which manifests itself during the period of insurance and includes premature senile degenerative changes, but not an illness which is of such a nature as to be incapable of diagnosis by objective evidence or which though capable of diagnosis by such evidence has not been so diagnosed.

13. **"Insured Incident"** means any one accident or illness which causes an Insured Person to be confined to hospital and to undergo certain medical or surgical procedures and/or operations.

14. **"Insured Person"** means

    a. A Principal Insured Person or an Eligible Spouse of a Principal Insured Person or an Eligible Child of a Principal Insured Person. Such persons must be covered by a registered medical aid scheme and who is not already insured under this section or any other policy issued by a company providing similar cover and
    b. Such other person as the Company may from time to time deem eligible.

15. **"Medical practitioner"** means a legally qualified medical practitioner registered by the Board of Health Care Funders (BHF).

16. "**Medical Aid Scheme Contribution**" means the amount paid by or in respect of a member or his registered dependants if any as membership fees of a Registered Medical Scheme.

17. **"Medical Aid Scheme Option"** means the Medical Aid Scheme Option of the Principal Insured Person immediately prior to the Defined Event.

18. "**Medical Scheme Option Reimbursement Rate"** means the multiple of the Medical Scheme Tariff as indicated by the rules of the Medical Scheme.

19. **"Medical Scheme Tariff"** means the rate equal to the Insured Person's Medical Scheme Rate.

20. **"Principal Insured Person"** means the Insured as detailed in the Schedule and accepted by the Company as eligible for participation in the insurance provided by this policy.

21. **"Schedule"** means the Schedule of Insurance attaching to and forming part of this Policy.

22. **"Split Billing"** means an amount charged by a Medical Practitioner or Hospital equal to the difference between the amount charged to the Medical Aid Scheme and the amount charged to the Insured Person.

23. **"Sub-Limitation"** means a sub-limitation indicated in the rules of the medical scheme as approved by the Council for Medical Schemes.

24. **"Treatment"** means any form of investigation or examination by or consultation with or treatment by a medical practitioner for the purpose of treating or monitoring an Insured Person's medical condition arising out of an insured incident.

25. **"Treatment Cycle"** means a period of twelve (12) months from the date of registration onto a treatment programme of your Medical Scheme.

26. **"Total and Permanent Disability"** means the state of totally and permanently disabled for one's own occupation, or similar occupation and/or any other occupation.

27. **"Underwriting Manager"** means Ambledown Financial Services (Pty) Ltd, Reg. No. 2004/006271/07, FSP No. 10287.

DEFINED EVENTS

In the event of an Insured Person suffering an insured incident (as defined) which necessitates the Insured Person:

1. Being confined to hospital and

2. Undergoing Medical and Surgical procedures and/or operations or Treatment (as defined) whilst in hospital, including:

   a. The necessity for chemotherapy or radiotherapy for the treatment of cancer on an out-patient basis,
   b. The necessity for kidney dialysis on an out-patient basis

3. The necessity for outpatient treatment for the following procedures:

   I. General Surgery
      i. Surgical biopsy of breast lump
      ii. Needle biopsy of breast lump
      iii. Hernia repairs
         - Inguinal hernia
         - Femoral hernia
         - Umbilical hernia
         - Epigastric hernia
         - Spigelian hernia
         - Varicose veins in the rooms (if paid from scheme's risk)

      iv. Ischio-rectal abscess drainage
      v. Closure of colostomy
      vi. Surgical haemorrhoidectomy (excluding sclerotherapy or band ligation)
      vii. Lymph node biopsy
      viii. Endoscopy

   II. Urology
      i. Vasectomy
      ii. Cystoscopy
      iii. Orchidopexy
      iv. Prostate biopsy

   III. Opthalmology
      i. Cataract removal
      ii. Pterygium removal
      iii. Trabeculectomy

   IV. ENT surgery
      i. Direct laryngoscopy
      ii. Tonsillectomy
      iii. Laser ENT Surgery
      iv. Conventional ENT Surgery
      v. Nasal surgery (Turbinectomy and Septoplasty)
      vi. Sinus surgery (FESS)
      vii. Myringotomy
      viii. Grommets

   V. Orthopaedic
      i. Arthroscopy
      ii. Carpal Tunnel Release
      iii. Ganglion surgery
      iv. Bunionectomy

   VI. Paediatric surgery
      i. Orchidopexy

   VII. Hepatobiliary surgery
      i. Needle biopsy of the liver

   VIII. Cardiothoracic surgery
      i. Bronchoscopy

IX. General medical cardiology
    i. Coronary angioplasty
    ii. Coronary angiogram

X. Neurology
    i. 48-hour halter EEG

XI. Immunology
    i. Plasmapheresis

XII. Gastroenterology
    i. Oesophagoscopy
    ii. Gastroscopy
    iii. Colonoscopy
    iv. ERCP

XIII. Diagnostic radiology
    i. Myelogram
    ii. Bronchography
    iii. Angiograms
        - Carotid
        - Cerebral
        - Coronary
        - Peripheral

XIV. Obstetrics & gynaecology
    i. Tubal ligation
    ii. Childbirth in a non-hospital setting
    iii. Incision and drainage of Bartholin's cyst
    iv. Marsupialisation of Bartholin's cyst
    v. Cervical laser ablation
    vi. Hysteroscopy
    vii. Phototherapy
    viii. Dilation and curettage

XV. Hyperbaric oxygen treatment for:
    i. Radionecrosis
    ii. Malunion of major fractures
    iii. Avascular leg ulcers
    iv. Decompression sickness
    v. Chronic osteitis
    vi. Serious anaerobic infections

4. The necessity for outpatient diagnostic radiology limited to:

    a. Magnetic Resonance Imaging (MRI)
    b. Computed Tomography Scans (CT Scans)
    c. Positron Emission Tomography (PET Scans)

5. The treatment received in a casualty unit of a Hospital provided that such treatment is not for routine physical treatment or any other medical examination or treatment other than emergency medical treatment.

6. The death of the Principal Member of the Registered Medical Aid Scheme or the event that an accident or illness resulted in the Total Permanent Disability of the Principal Member of the Registered Medical Aid Scheme.

7. A severe illness benefit in the event of the initial detection of a cancerous growth, and/or the first accurate diagnosis of cancer (as defined), provided that such diagnosis affects a person's lifestyle in such a way that the person's ability to function normally is altered.

The Company will pay to the Principal Insured Person an amount in accordance with the table of benefits subject to the limitations.

GENERAL EXCEPTIONS

The Company shall not be liable for hospitalisation, bodily injury, sickness or disease directly or indirectly caused by related to or in consequence of

1. No benefits shall be payable for an insured incident for which the Insured Person received treatment or advice twelve (12) months prior to becoming an Insured Person. This exclusion only applies to the first twelve (12) months of an Insured Person's cover.

2. Nuclear weapons or nuclear material or by ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel. For the purpose of this exception combustion shall include any self-sustaining process of nuclear fission.

3. Investigations, treatment, surgery for obesity or any medical treatment directly or indirectly caused by or related to any condition that is a consequence of obesity.

4. Cosmetic surgery or surgery directly or indirectly caused by or related to or in consequence of cosmetic surgery.

5. Routine physical or any procedure of a purely diagnostic nature or any other examination where there is no objective indication of impairment in normal health and laboratory diagnostic or X-ray examinations except in the course of a disability established by prior call or attendance of a physician.

6. Suicide, attempted suicide or intentional self-injury.

7. The taking of any drug or narcotic unless prescribed by and taken in accordance with the instructions of a registered medical practitioner (other than the Insured Person) or any illness caused by the use of alcohol.

8. Drug addiction.

9. An event directly attributable to the Insured Person where the alcohol content in the blood exceeds the legal level permitted by law.

10. Participation in

    a. Active military duty, police duty, police reservist duty, civil commotion, labour disturbances, riot, strike or the activities of locked out workers.
    b. Aviation other than as a passenger.
    c. Any form of race or speed test (other than on foot or involving any non-mechanically propelled vehicle vessel craft or aircraft).

11. No benefits are payable which should be provided by the medical aid scheme such as Prescribed Minimum Benefits.

12. No benefits shall be payable due to the Insured person's failure to comply with the Medical Scheme rules regarding the failure to make use of a Hospital that is a Designated Service Provider, Preferred Service Provider, Associated Hospital or Network Hospital. This exclusion does not apply to:

    a. Traditional cancer treatment if such Designated Service Provider is Public Hospitals or Public Clinics; or
    b. A once-off benefit per family per annum applicable to a penalty imposed by the medical scheme for the use of a non-network hospital.

13. No benefits shall be payable for Computed Tomography Scans (CT Scans) where the scan is used for guidance during a procedure to administer pain relief, draining of bodily fluids, biopsies or any other medical procedure.

14. No benefits are payable for ward fees, theatre fees, medicines, material expenses / costs and any other hospital expenses.

15. Any medical / surgical procedure not covered or declined by the medical aid scheme.

16. No benefit shall be payable for the severe illness benefit if the Insured Person was diagnosed with Cancer (as defined) prior to the inception of this Policy.

17. Investigations, treatment or surgery for artificial insemination or hormone treatment for infertility.

18. Depression, insanity, mental or mental stress, psychotic / psychoneurotic disorders, behavioural and neurodevelopmental disorders.

19. No benefits shall be payable in the event of fraudulent submission by the claimant.

20. Sub-Limitations imposed by a medical scheme as a result of an agreement between a member and a medical scheme will not qualify for benefits in terms of this policy.

21. A co-payment or deductible as a result of an agreement between a member and a medical scheme will not qualify for benefits in terms of this policy.

22. Split Billing.

GENERAL CONDITIONS

1. Cooling-Off Period

A Principal Insured Person may:

a. in any case where no benefit has yet been paid or claimed or an insured incident has not yet occurred; and

b. within a period of thirty (30) days of receipt of the policy by the Principal Insured, or from a reasonable date on which it can be deemed that the policyholder received the policy referred to above, cancel the policy by written notice sent to the Underwriting Manager.

c. All premiums or moneys paid by the policyholder to the insurer up to the date of receipt of the cancellation notice or received at any date thereafter in respect of the cancelled or varied policy, shall be refunded to the policyholder less the cost of any risk cover actually enjoyed.

2. Protection of Personal Information Act, 2013 (POPIA)

a. The Company or its authorised representatives shall process, disclose or transferring personal information only for the intended purpose of administering this contract or for any statutory purposes.

b. An Insured Person has the right to -
   i. object to the processing of their personal information on reasonable grounds unless legislation allows for such processing, in the manner prescribed by POPIA;
   ii. request from the Company details of personal information the Company or its authorised representatives holds, and details of how personal information is processed. Requests should be addressed to –

   The Information Officer
   Ambledown Financial Services
   P.O Box 1862
   Cramerview
   2060

   Tel: 0861 262 533
   Email: compliance@ambledown.co.za

   iii. lodge a complaint with the Information Regulator, as per the contact details provided below.

   Chief Executive Officer
   Mr Marks Thibela
   P.O Box 31533
   Braamfontein
   2017

   Tel: 010 023 5200
   Email: complaints.IR@justice.gov.za

c. The Company shall use it best endeavors to ensure personal information is reliable. The Principal Insured Person shall be responsible for advising the Underwriting Manager of any changes to the personal information of an Insured Person in a timely manner and such information is complete, correct and up to date.

3. Claims

a. Following an insured event the Principal Insured Person shall at his own expense:

   i. As soon as possible notify the Underwriting Manager of any claim in writing but not later than one hundred and eighty (180) days from the first day of treatment for such insured incident.
   ii. Supply in writing any such proof or other information as the Company may reasonably request.
   iii. As often as required, provide authority for the Company to inspect all current and/or past medical or other information including the results of any blood tests and submit to medical examination on behalf of and at the expense of the Company.
   iv. Where the Insured Person is not a Principal Insured Person the Principal Insured Person shall provide or obtain the necessary permission or consent to comply with this condition failing which all benefits in respect of any claims subject to this condition shall be avoidable.

b. Any claim in terms of this policy will prescribe after twelve (12) calendar months from the date of occurrence of the insured incident if the claim is outstanding and not a subject of a then pending court case.

c. Where the Company rejects or disputes a claim or the quantum of a claim, or voids the policy, the Principal Insured has ninety (90) days (the "representation period") from receipt of the Company's written notification to dispute the decision of the Company. This must be done in writing to the Company:

   The Complaints Officer
   Constantia Insurance Company Limited
   PO Box 3518
   Cramerview
   2060

   Tel: 011 686 4200 Fax: 011 789 8828
   Email: complaints@constantiagroup.co.za

   Or

The Compliance Officer
Adv Christiene Brummer
Constantia Insurance Company Limited
PO Box 3518
Cramerview
2060

Tel: 011 686 4200 Fax: 011 789 8828
Email: ChristieneB@constantiagroup.co.za

Alternatively, the Principal Insured may contact:

The Ombudsman for Short-Term Insurance
PO Box 32334
Braamfontein
2017

Tel: 011 726 8900 Fax: 011 726 5501
Info@osti.co.za www.osti.co.za

If the dispute is not satisfactorily resolved in this manner, the Principal Insured has a further one hundred and eighty (180) days after the expiry of the representation period for the service of summons on the Company.

d. Any benefit payable in respect of hospital confinement shall only become due at the end of a period of such confinement. However payments on account can be made to the Principal Insured Person at the end of a thirty (30) day period of hospital confinement at the discretion of the Company.

e. The Company will negotiate with and request the Insured Person's Medical Scheme to re-assess any claim, negotiate any discount with the relevant Service Providers and pay the benefit payable in terms of this policy directly to the Service Provider, should a discount be negotiated.

f. All benefits payable shall be paid to the Principal Insured Person, his legal representative or the medical practitioner whose receipt shall in every case be a full discharge to the Company.

g. No benefit payable shall carry interest.

4. Premiums

a. The premium is due by the first (1st) day of the month that the premium relates to. The premium must be paid by the premium payment date as set out in the policy schedule.

b. If the premium is not paid by the premium payment date, the Company will allow a forty five (45) day grace period (fifteen (15) day grace period for arrear policies) from the premium payment date.

c. If the outstanding premium is not paid within the forty five (45) day grace period (fifteen (15) day grace period for arrear policies), then this policy shall be deemed to have been cancelled at midnight on the last day of the month for which the last premium was received.

d. The Company may offer terms of reinstatement, but is not obliged to do so or to reinstate the Insured Person's policy.

e. The Company is not obliged to accept premium tendered to it after the grace period or after the period of insurance detailed in the schedule.

f. The Company will not consider any claim that arises during the grace period unless the Company receives the full outstanding premium before the end of the grace period.

g. A full month's premium is due in respect of any Insured Person whose cover commences or ceases during a calendar month if such person enjoyed cover for fifteen (15) days or more in that particular month.

5. Termination of cover

a. This policy may be cancelled by the Insured Person at any time by giving thirty one (31) days' notice in writing.

b. An insured incident will only qualify for benefits if the hospitalisation caused by such insured incident commences before the date of cancellation in which case all outstanding claims must be submitted to the Company within three (3) months after the date of cancellation.

c. Cover terminates on the death of the Principal Insured Person. However, on the death of the Principal Insured Person the cover of the Eligible Spouse under this policy may be continued should such spouse elect to do so within sixty (60) days of the death of the Principal Insured Person.

d. No Premium refund shall be due in the case of cancellation by the Insured Person.

6. Medical examination

Payment of any benefit is conditional on

a. The Insured Person supplying such medical evidence as is required; and

b. If requested by the Company, an Insured Person undergoing any medical examination at the Company's expense.

7. Jurisdiction

The policy shall be subject to the laws of the Republic of South Africa whose courts shall have sole jurisdiction to the exclusion of the courts of any other country.

Where payment is to be made to or by the Company it shall be made in the currency of the Republic of South Africa at the Company's head office unless the Company allows otherwise.

8. Commencement of cover

Cover in terms of this policy commences on the first (1st) day of the calendar month for which the premium has been paid by or for the Insured Person.

8. Amendments

The company reserves the right to amend this policy wording by way of endorsement as well as to adjust the premiums by giving thirty one (31) days written notice prior to the effective date of the change.

9. Cover

a. Cover shall only be in force provided that the Insured Person is registered with a medical aid scheme.

b. No benefit shall be payable in respect of any medical or surgical treatment unless such treatment occurred during the period of hospital confinement as an in-patient or during chemotherapy or radiotherapy as an out-patient for the treatment of cancer or during treatment as an out-patient for the necessity of kidney dialysis.

c. The minimum entry age for the Principal Insured Person is age 18 (eighteen) and the maximum entry age is age 65 (sixty-five).

TABLE OF BENEFITS

a. Gap Cover - A benefit equal to actual cost limited to five (5) times the Medical Scheme Tariff less the higher of the Medical Scheme Tariff or Medical Scheme Option Reimbursement Rate for treatment received whilst as an in-patient and/or outpatient (as stated in the Defined Event).

b. Co-payment Cover - A benefit equal to the charges in the form of a co-payment or deductable applied for treatment received whilst as an in-patient and/or outpatient (as stated in the Defined Event).

This benefit shall include any costs incurred from the penalty imposed by the medical scheme for the use of a non-network hospital or a hospital that is not listed as a designated service provider. This benefit for such penalties is only payable once per family per annum.

c. Sub-limitation Cover - A benefit equal to charges above any sub-limitation imposed by the Medical Scheme for treatment received whilst as an in-patient and/or outpatient (as stated in the Defined Event).

d. Private Care for Cancer Treatment Cover: The benefits provided over the sub-limitation and/or the co-payment imposed by the medical scheme for treatment in a private facility for cancer. Treatment includes in-hospital expenses, chemicals, medication and outpatient radiotherapy or chemotherapy.

For the purpose of this Policy outpatient treatment excludes specialist's consultations.

e. Biological Cancer Drug Treatment Cover - The sub-limitation imposed by the Medical Scheme for biological cancer drugs, limited to Herceptin, Mylotarg, Nexavar, Gleevec, Sprycel, Faslodex, Velcade, Tarceva, Alimta, Zevalin, Avastin, Erbitux, Sunitinib, Sutent, Fludara, Mabthera, Votrient, Gemzar, Cisplatin, Everolimus with specific oncological condition and/or specific sub-groups of cancers limited to subgroups of the following categories.

i. HER 2-positive Breast Cancer
ii. Acute myeloid leukaemia
iii. Advanced hepatocellular carcinoma
iv. Acute lymphoblastic leukemia
v. Chronic myeloid leukemia
vi. Chronic lymphocytic leukemia
vii. Hairy cell leukaemia

viii. Myelodysplasia
ix. HER 2-negative breast cancer
x. Gastrointestinal stromal tumour
xi. Multiple myeloma
xii. Non small cell lung cancer
xiii. Non-hodgkins lymphoma
xiv. Metastatic colorectal cancer
xv. Advanced renal cell carcinoma
xvi. Head and neck cancer

f. The cost of a medical or a surgical procedure performed in a casualty ward of a Hospital following an emergency and where such costs were not met by the Medical scheme.

g. Following the death or the Total and Permanent Disability of the Principal Member of the Medical Scheme, a benefit equal to the total value of Registered Medical Aid Scheme Option Contribution and premium payable on this policy calculated for six (6) months within the stated limitations.

The company shall pay the Registered Medical Aid Scheme the Medical Aid Scheme Contribution for six (6) months commencing on the first (1st) day of the following month from the date the incident occurred.

Where:
A Registered Medical Aid Scheme:
i. discontinues the selected Medical Scheme Option or
ii. is liquidated or
iii. is amalgamated with another registered medical aid scheme or
iv. The Principal Member discontinues participation with the Registered Medical Aid Scheme or the original Medical Aid Scheme Option.

The Company will pay out a lump sum benefit equal to six (6) months for Medical Aid Scheme Contributions on the selected Medical Aid Scheme Option less any benefit provided to the member or on behalf of the member.

Where the total value of one month's current Medical Aid Scheme Contribution is greater than the total value of previous monthly Medical Aid Scheme Contributions representing earlier benefits then the difference in the value of the Medical Aid Scheme Contributions will be deducted from the lump sum benefit.

The member may request that a lump sum benefit equal to the total Medical Aid Scheme Contributions for the selected Medical Aid Scheme Option for the six (6) months be paid from the inception of the benefit subject to limitations as specified.

h. The Severe Illness Benefit provides a once-off lump sum payment to an Insured Person of R50,000 following the first accurate diagnosis of Cancer (as defined).

SPECIFIC CONDITION

The Stated Benefit and Premium Waiver Benefit terminate at the earlier of the member reaching the benefit expiry age, or age 65 (sixty-five). This means that claims submitted before the benefit expiry age will be assessed and paid, but claims after the benefit expiry age will not be accepted.

The benefit expiry age will be the age at which the Insured Person would attain normal retirement age. The age selected is 65 for all Insured Persons.

SPECIFIC EXCESS

d. Cancer treatment in a private hospital is subject to an excess of R200,000 per Treatment Cycle, provided such treatment was received in a private institution.

e. Biological Cancer Drug Treatment Cover is subject to an excess of R200,000 for the treatment of cancer in a private institution per Treatment Cycle unless a R200,000 excess has been deducted as per paragraph (d) in the Specific Excess for the private treatment of cancer.

SPECIFIC LIMITATIONS

b. The maximum benefit payable for cost incurred from the penalty imposed by the medical scheme for the use of a non-network hospital or a hospital that is not listed as a designated service provider is R10,000 per family per annum.

f. Treatment in a casualty unit of a Hospital shall be limited to R10,000 in the aggregate per Insured Person per annum.

h. The Severe Illness Benefit is payable once in a lifetime per Insured Person.

OVERALL LIMITATIONS

The following Policy Benefits are subject to an overall benefit limitation of R173,000 in the aggregate per Insured Person per annum:

a. Gap Cover

b. Co-payment Cover

b. Non-DSP Penalty Cover

c. Sub-limitation Cover

d. Private Care for Cancer Treatment Cover

e. Biological Cancer Drug Treatment Cover

f. Casualty Cover

EMERGENCY MEDICAL CARE ER24
084 124

ER24 Virtual App

As part of the 2021 benefits, Ambledown has extended its agreement with ER24 and will be providing all members and direct dependants with access to the ER24 Virtual app (on Apple App store and Google Play store).

app store | google play

The services will be customised and some of the exciting benefits include:

- ER24 "Emergency Button" for escalation to the 24/7 support line including the dispatch of an ambulance if medical assistance is required.

Emergency | 24/7 support line

- As COVID-19 is expected to be with us into 2021, the ER24 Virtual app includes a self-assessment screening capability with escalation to the 24/7 support line if medically required.

COVID-19 | Self Assessment Screening | 24/7 support line

COVID-19 has had a profound impact on the mental well-being of many South Africans. The ER24 Virtual app includes depression and anxiety self-assessment screening with escalation to the 24/7 support line if medically required. Further self-assessment screening and escalation options will be made available during 2021 e.g. cardiovascular, diabetes, etc.

Members will be notified of relevant and useful content via the ER24 Virtual Care app if their notification settings are activated. ER24 will be producing and uploading monthly educational videos for members, which will include what to do when a baby is choking, procedures in the event of a heart attack or when someone goes into anaphylactic shock.

IvyOnline Support Learning for high school learners

INTRODUCTION

Ambledown and Constantia have partnered with Boston Connect to provide learners with online support for learners in their high school studies. The online platform (IvyOnline) is an engaging CAPS curriculum.

The COVID-19 virus has had a significant impact on schooling. The platform provides just the type of support that will assist your children and gives them an extra advantage. The services are provided through the platform that includes video lessons, e-books and assessments, developed by qualified educators. The platform is available through a laptop, desktop or a mobile cellular phone.

ACCESS TO THE ONLINE PLATFORM

- Register your dependants for this exciting benefit, as many times as needed via the **Registration page** to generate a unique coupon code.
- Use the unique coupon code to access the platform on **www.ivyonline.education** .

Now your dependants have the additional support needed to learn and develop while at home. Let's start learning!

Disclaimer: Constantia is the Insurer and Ambledown is the Administrator

ambledown
FINANCIAL SERVICES (PTY) LTD

Ambledown is an Authorised Financial Services Provider, No. 10287

CONSTANTIA
Insurance made personal

Constantia Insurance Company Limited, an authorised FSP 31111

SCHEDULE OF INSURANCE

This Schedule serves as a contract of insurance between the Insured Person and the Company and forms part of the Company's Policy Wording (detailed below) under which benefits are provided as stated therein and must be read in conjunction with same.

All Premiums and Fees are inclusive of V.A.T. @ 15.00% as applicable and this Schedule becomes a Tax Invoice once Premium and Fees have been accepted by the Company, Broker and Administrator respectively.

PRODUCT:	NAPTOSA GAP SUPREME
INSURER (the Company):	CONSTANTIA INSURANCE COMPANY LIMITED, FSP No. 31111, VAT No. 4920108935
UNDERWRITING MANAGER:	AMBLEDOWN FINANCIAL SERVICES (PTY) LTD, FSP No. 10287, VAT No. 4340215856
BROKER:	MEMP FINANCIAL SERVICES (PROPRIETARY) LIMITED, FSP No. 13833, VAT No. 4500190790
THE INSURED:	Naptosa
MASTER POLICY WORDING:	CICL/SUPREME/2021
MASTER POLICY NUMBER:	AMBLG002162
PERIOD OF INSURANCE:	a. From 1 January 2021 to 31 December 2021 (both days inclusive). b. Plus any subsequent period for which the company agrees to accept a renewal premium.
ORIGINAL INCEPTION DATE:	1 March 2016
TERRITORIAL LIMITS:	SADC territories
WAITING PERIOD:	Unless due to an Accident (as defined), no benefits shall be payable for the first 3 months from the date of inception.
VALUE ADDED PRODUCT:	R 0.70
MONTHLY BROKER COMMISSION:	R 67.50
MONTHLY UMA FEE:	R 70.00
MONTHLY RISK PREMIUM:	R 211.80
GROSS PREMIUM:	**R 350.00**
VAT INCLUDED:	**R 45.65**
NOTE:	Please note that the abovementioned commissions are in accordance with the Demarcation Regulations.
PREMIUM COLLECTION METHOD:	Via Debit Order
PAYMENT DATE:	1st of every month
PAYMENT OBLIGATION:	You have an obligation to pay your premium in accordance with the Master Policy wording.
CLAIMS PROCEDURE:	Claims must be reported in writing to the Underwriting Manager within 180 (one hundred and eighty) days from the date of admission to hospital and/or treatment, whichever the first.

ambledown
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DISCLOSURE NOTICE

IN TERMS OF SECTION 4 TO 7 OF THE GENERAL CODE OF CONDUCT OF THE FINANCIAL ADVISORY AND INTERMEDIARY SERVICES (FAIS) ACT, NO 37 OF 2002

This notice **does not** form part of the Insurance Contract or any other document. It does however contain information which is in your interest. This notice is provided at the inception of each policy.

1. Your intermediary

You have the right to the following information regarding the Broker, as indicated in your Policy's Schedule of Insurance, who must hold a valid license to operate under specific categories of business:

a. Name, address and contact details
b. Financial Services Provider License number
c. Legal status
d. Whether the services rendered are under supervision
e. Whether the broker holds more than 10% of the Insurer's shares and/or
f. Whether the broker received more than 30% of the total remuneration from the Insurer in the past year
g. Whether the broker holds any form of professional indemnity insurance
h. Details of complaints policy and procedures
i. Details of compliance arrangements
j. The Rand amount of fees, commissions or any valuable consideration payable
k. Contractual arrangements with the Insurer including any restrictions or conditions

2. Your underwriting manager

NAME:	Ambledown Financial Services (Propriety) Limited	FINANCIAL SERVICES PROVIDER LICENSE NO:	10287
TELEPHONE NO:	(086) 126 2533	FACSIMILE NO:	(011) 463 1600
POSTAL ADDRESS:	PO Box 1862 Cramerview 2060	PHYSICAL ADDRESS:	Ambledown House Eton Office Park East c/o Sloane & Harrison Streets Bryanston

3. Your insurer (the risk carrier with whom your policy is placed)

NAME:	Constantia Insurance Company Limited	FINANCIAL SERVICES PROVIDER LICENSE NO:	31111
TELEPHONE NO:	(011) 686 4200	FACSIMILE NO:	(011) 789 8828
POSTAL ADDRESS:	PO Box 3518 Cramerview 2060	PHYSICAL ADDRESS:	Building B and Portion of Building A Nicol Main Office Park 2 Bruton Road Bryanston 2191
FSP LICENCE CATEGORY:	Category 1 Short-Term, Personal and Commercial Lines and Participatory interests in Collective Investment Schemes. Licensed to offer both Intermediary Services and Advice.	COMPLIANCE OFFICER: E-MAIL:	Adv Christiene Brummer christieneb@constantiagroup.co.za

4. Your policy, premiums and fees

Refer to your Policy Schedule for your Policy, Premiums and Fees

5. Claims procedure

Full details of the specific claims procedure that you should follow are stated in the insurance policy wording.

On the occurrence of any event, which may result in a claim or possible claim under the policy, please notify Ambledown Financial Services (Pty) Ltd in writing or telephonically within 180 days of the Insured Event occurring. (Late notification could result in rejection of the claim.)

6. Lodging a complaint

In the case of dissatisfaction with services received, you have the right to lodge a complaint through:

COMPLAINTS OFFICER:	Paul Makwea	E-MAIL:	compliance@ambledown.co.za
TELEPHONE NO:	(086) 126 2533		
POSTAL ADDRESS:	PO Box 1862 Cramerview 2060	PHYSICAL ADDRESS:	Ambledown House Eton Office Park East c/o Sloane & Harrison Streets Bryanston

A full Complaints Resolution Policy may be requested from the Compliance Officer as per details below.

In the case of dissatisfaction with services received, you have the right to lodge a complaint with Constantia Insurance Company Limited through:

COMPLAINTS OFFICER:	The Complaints Officer	E-MAIL:	complaints@constantiagroup.co.za
TELEPHONE NO:	(021) 424 8040		
POSTAL ADDRESS:	P.O. Box 2215 Cape Town 8000	PHYSICAL ADDRESS:	Building B and Portion of Building A Nicol Main Office Park 2 Bruton Road Bryanston 2191

7. Conflict of interest requirements

a. Ambledown Financial Services (Pty) Ltd has established a Conflict of Interest Management Policy which is available on request from our Compliance Officer.

b. In order to meet regulatory requirements, financial or immaterial expenditure by and to our staff are monitored.

c. Where potential Conflicts of Interest have been identified which do not have a direct impact on you, the insured, internal structures are in place to manage and control such circumstances.

8. Ambledown's compliance officer

In the case of dissatisfaction with services received, you have the right to lodge a complaint through:

COMPLAINTS OFFICER:	Paul Makwea	E-MAIL:	compliance@ambledown.co.za
TELEPHONE NO:	(086) 126 2533		
POSTAL ADDRESS:	PO Box 1862 Cramerview 2060	PHYSICAL ADDRESS:	Ambledown House Eton Office Park East c/o Sloane & Harrison Streets Bryanston

9. Particulars of the Short-Term Insurance Ombudsman

POSTAL	PO Box 32334	SHARECALL NO:	(086) 072 6890

ADDRESS:	Braamfontein 2017	FACSIMILE NO:	(011) 726 5501
TELEPHONE NO:	(011) 726 8900	E-MAIL:	info@osti.co.za

The Ombudsman is available to advise you in the event of claims problems which are not satisfactorily resolved by the Insurer.

10. Particulars of the Ombud for financial service providers (FAIS Ombud)

POSTAL ADDRESS:	PO Box 74571 Lynnwood Ridge 0040	TELEPHONE NO:	(012) 470 9080 (012) 762 5000
E-MAIL:	info@faisombud.co.za	FACSIMILE NO:	(012) 348 3447 (086) 764 1422

Should a complaint which pertains to advice or intermediary services (other than the settlement of a claim) provided, not be resolved within 6 weeks, or you are not satisfied with the resolution decision, you have 6 months in which to refer the matter to the FAIS Ombud.

11. Particulars of the Registrar of Short-Term Insurance

POSTAL ADDRESS:	P.O. Box 35655 Menlo Park 0102	FACSIMILE NO:	(012) 346 6941
		TELEPHONE NO:	(012) 428 8000
		E-MAIL:	info@fsca.co.za

Disputes regarding contractual terms may be referred to the Registrar.

12. Other matters of importance

a. No person may request or induce you to waive your rights as set out in this disclosure notice or any other rights confirmed by the Short Term Insurance Act and/or the Financial Advisory and Intermediary Services Act.

b. Failure to provide all correct and full material information may influence an insurer in respect of any claim arising under your contract of insurance.

c. You will be informed of any material changes to the information referred to in paragraph 1 and 2.

d. Your insurance may only be cancelled on 31 days' prior notice which may be provided either directly to you or to your broker.

e. You are entitled to request a copy of the master policy free of charge.

f. You are entitled to a 15-day period of grace after the due date for the payment of your premium. (this period of grace applies from the second month on monthly policies only)

g. By entering into this Insurance contract you acknowledge that the sharing of credit, claims and underwriting information by Insurers is essential to enable the insurance industry to assess the risk fairly and to reduce the incidence of fraudulent claims as this is in the public interest and is aimed at limiting premiums.

h. The application, certificate of insurance and the policy wording must be read as one document.

13. Use of your personal information

The premium is due by the first (1st) day of the month that the premium relates to. The premium must be paid by the premium payment date as set out in the policy schedule. When you enter into this policy, you will be giving us your personal information that may be protected by data protection legislation, including but not only, the Protection of Personal Information Act, 2013 (POPI). We will take all reasonable steps to protect your personal information.

You authorise us to:

a. Process your personal information to:

i. Communicate information to you that you ask us for.

ii. Provide you with insurance services.

iii. Verify the information you have given us against any source of database.

iv. Compile non-personal statistical information about you.

b. Transmit your personal information to any affiliate, subsidiary or re-insurer so that we can provide insurance services to you and to enable us to further our legitimate interests including statistical analysis, re-insurance and credit control.

c. Transmit your personal information to any third party service provider that we may appoint to perform functions relating to your policy on our behalf.

You acknowledge that this consent clause will remain in force even if your policy is cancelled or lapsed.

14. Warning

a. You, the client, must disclose all material facts accurately, fully, truthfully and properly.

b. The underlying policy has no cooling off rights. Your premium must be paid for cover to take effect.

c. Do not sign any blank or partially completed application form.

d. Complete all forms in ink.

e. Keep all documents handed to you.

f. Make note as to what is said to you.

g. Don't be pressurised to buy the product.

h. Misrepresentation, incorrect or non-disclosure by you of relevant facts may impact on any claims arising from your contract of insurance.