ambledown
FINANCIAL SERVICES (PTY) LTD

Naptosa

16 March 2018

Dear Fiona Drake

VAT Increase 1 April 2018

The Minister of Finance announced an increase in Value Added Tax (VAT) from 14% to 15% effective 1 April 2018.

We have calculated the new premium rate in accordance with the new VAT rate.

NAPTOSA GAP SUPREME
MASTER POLICY NUMBER: AMBLG002162
TOTAL MONTHLY PAYMENT DUE PER MEMBER: R 262.28
INSURER: CONSTANTIA INSURANCE COMPANY LIMITED (Reg. No. 1952/001514/06)

Please find attached your Policy and Schedule of Insurance detailing the VAT effective 1 April 2018.

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 financial advisor.

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 is financially dependent on 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 to twenty six (26) in respect of an unmarried child who is a dependant on the Principal Insured Person's Medical Scheme and is financially dependent on the Principal Insured Person.*
>
> *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 2018. You should therefore submit a claim form by latest 30 June 2018. You will be allowed to submit supporting documentation up to 31 December 2018 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 co-payment is due to the non-use of a hospital as a DSP.

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.

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FINANCIAL SERVICES (PTY) LTD

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/2018

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. Where an age is mentioned in the policy, it will be the age attained. 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 is financially dependent on 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 to twenty six (26) in respect of an unmarried child who is a dependant on the Principal Insured Person's Medical Scheme and is financially dependent on the Principal Insured Person.

    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 or a convalescent home.
    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
    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 which is a separately identifiable fee, in excess of the Medical Scheme Tariff and not considered refundable by a medical scheme.

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. Hernia repairs
            - Inguinal hernia
            - Femoral hernia
            - Umbilical hernia
            - Epigastric hernia
            - Spigelian hernia
        iii. Ischio-rectal abscess drainage
        iv. Closure of colostomy
        v. Surgical haemorrhoidectomy (excluding sclerotherapy or band ligation)
        vi. Lymph node biopsy
        vii. 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. Plasmatheresis

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

    XIII. Diagnostic radiology
        i. Myelogram
        ii. Bronchograhy
        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. Marsupilisation 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)

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. 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.

2. Investigations, treatment, surgery for obesity, its sequelae or cosmetic surgery or surgery directly or indirectly caused by or related to or in consequence of cosmetic surgery other than as a result of an insured event otherwise insured.

3. Cosmetic surgery shall include surgery for breast reduction or reconstruction unless necessitated as a result of treatment for cancer.

4. 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.

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

6. 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.

7. Drug addiction.

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

9. 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).

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

11. 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 traditional cancer treatment if such Designated Service Provider is Public Hospitals or Public Clinics.

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

13. Any procedure not covered or declined by the medical aid scheme.

14. 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.

15. 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.

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

17. Depression, insanity or mental stress or psychotic/ psychoneurotic disorders.

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

19. 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.

20. 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.

21. 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.

2. 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 Operational Officer
Constantia Insurance Company Limited
PO Box 3518
Cramerview
2060

Tel: 011 686 4200 Fax: 011 789 8828
Email: info@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. All benefits payable shall be paid to the Principal Insured Person or his legal representative whose receipt shall in every case be a full discharge to the Company.

f. No benefit payable shall carry interest.

3. 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 (40) day grace period from the premium payment date.

c. If the outstanding premium is not paid within the forty (40) day grace period, 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.

4. Termination of cover

a. This policy may be cancelled by the Insured Person at any time by giving thirty (30) 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 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.

5. 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.

6. 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.

7. 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 (30) days written notice.

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).

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 following an Emergency incurred in a hospital casualty unit of a Hospital 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 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.

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

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 R150,000 in the aggregate per Insured Person per annum:

a. Gap Cover

b. Co-payment Cover

c. Sub-limitation Cover

d. Private Care for Cancer Treatment Cover

e. Biological Cancer Drug Treatment Cover

f. Casualty Cover

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. @ 14% or 0% 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/2018
MASTER POLICY NUMBER:	AMBLG002162
PERIOD OF INSURANCE:	a. From 1 January 2018 to 31 December 2018 (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.
MONTHLY BROKER COMMISSION:	R 52.45
MONTHLY UMA FEE:	R 52.45
MONTHLY RISK PREMIUM:	R 157.38
GROSS PREMIUM:	**R 262.28**
VAT INCLUDED:	**R 34.21**
NOTE:	Please note that the abovementioned commissions are in accordance with legislation whereby, of Premium due, no more than 20% and 12.50% may be paid by way of commission for non-motor and motor risks respectively.
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 above mentioned broker within 180 (one hundred and eighty) days from the date of admission to hospital and/or treatment, whichever the first.

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

Please read carefully
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:

1.1. Name, address and contact details
1.2. Financial Services Provider License number
1.3. Legal status
1.4. Whether the services rendered are under supervision
1.5. Whether the broker holds more than 10% of the Insurer's shares and/or
1.6. Whether the broker received more than 30% of the total remuneration from the Insurer in the past year
1.7. Whether the broker holds any form of professional indemnity insurance
1.8. Details of complaints policy and procedures
1.9. Details of compliance arrangements
1.10. The Rand amount of fees, commissions or any valuable consideration payable
1.11. Contractual arrangements with the Insurer including any restrictions or conditions

2. YOUR UNDERWRITING MANAGER

Name:	Ambledown Financial Services (Pty) Ltd	Financial Services Provider License No:	10287
Postal Address:	P.O. Box 1862 Cramerview 2060	Physical Address:	Ambledown House Eton Office Park East c/o Sloane & Harrison Streets Bryanston
Telephone No:	(086) 126 2533	Facsimile No:	(011) 463 1600

Ambledown has received more than 30% of the total remuneration from the Constantia Group in the past year.

3. YOUR INSURER (THE RISK CARRIER WITH WHOM YOUR POLICY IS PLACED)

Name:	Constantia Insurance Company Limited	Financial Services Provider License No:	31111
Postal Address:	P.O. Box 3518 Cramerview 2060	Physical Address:	Unit 3 Tulbagh 360 Oak Avenue Randburg 2191
Telephone No:	(011) 686 4200	Facsimile No:	(011) 789 8828

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: Adv Christiene Brummer
E-mail: 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
Physical Address	:	Ambledown House, Eton Office Park East, c/o Sloane & Harrison Streets, Bryanston
Postal Address	:	P.O. Box 1862, Cramerview, 2060
Telephone	:	(086) 126 2533
E-mail	:	compliance@ambledown.co.za

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	:	Mrs Astrid Baynes
Physical Address	:	Unit 2 Tulbagh, 360 Oak Avenue, Randburg
Postal Address	:	P.O. Box 3158, Cramerview, 2060
Telephone	:	(011) 686 4200
E-mail	:	complaints@constantiagroup.co.za

7. CONFLICT OF INTEREST REQUIREMENTS

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

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

7.3. 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

Compliance Officer	:	Mr Paul Makwea
Physical Address	:	Ambledown House, Eton Office Park East, c/o Sloane & Harrison Streets, Bryanston
Postal Address	:	P.O. Box 1862, Cramerview, 2060
Telephone	:	(086) 126 2533
E-mail	:	compliance@ambledown.co.za

9. PARTICULARS OF THE SHORT-TERM INSURANCE OMBUDSMAN

Postal Address	:	P.O. Box 32334 Braamfontein 2017
Telephone Number	:	(011) 726 8900
Sharecall Number	:	(086) 072 6890
Facsimile Number	:	(011) 726 5501
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 OMBUD FOR FINANCIAL SERVICE PROVIDERS (FAIS OMBUD)

Postal Address	:	P.O. Box 74571 Lynnwood Ridge 0040
Telephone Number	:	(012) 470 9080; (012) 762 5000
Facsimile Number	:	(012) 348 3447; (086) 764 1422
E-mail	:	info@faisombud.co.za

Should you not receive satisfaction in respect of a complaint lodged with the insurer (other than regarding the settlement of a claim), you may contact the FAIS Ombud.

11. PARTICULARS OF THE REGISTRAR OF SHORT – TERM INSURANCE

Postal Address	:	P.O. Box 35655 Menlo Park 0102
Telephone Number	:	(012) 428 8000
Facsimile Number	:	(012) 347 0221
E-mail	:	info@fsb.co.za

Disputes regarding contractual terms may be referred to the Registrar.

12. OTHER MATTERS OF IMPORTANCE

12.1. 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.

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

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

12.4. Your insurance may only be cancelled on 30 days prior notice which may be provided either directly to you or to your broker.

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

12.6. 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)

12.7. 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.

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

12.9. A polygraph or any lie detector test may be required in the event of a claim. The failure of such test may not be the sole reason for repudiating a claim.

13. USE OF YOUR PERSONAL INFORMATION

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

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

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

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

14.4. Complete all forms in ink.

14.5. Keep all documents handed to you.

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

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

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