ONEPLAN MEDICAL INSURANCE POLICY WORDING

The Oneplan Medical Plan is a unique combination of short-term insurance cover and non-insurance cover which have been combined to offer you, our valued client, the best of both worlds at an affordable monthly premium. It is important to take note of each section, its cover, limitations, waiting periods to ensure you fully understand the unique cover of each section.

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SECTION 1

1 DEFINITIONS, GENERAL CONDITIONS AND LIMITATIONS

1.1 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:

1.1.1 "Accident" means a sudden, unexpected, unusual, unintended and specific event which occurs at a specific time and place, excluding suicide or attempted suicide. The result of which incident requires medical attention.
1.1.2 "Admission" means a prolonged stay (overnight as an inpatient) in a facility that meets the definition of a hospital, this does not include casualty wards.
1.1.3 "Application Form" means the form that the Principal Insured completes, that shall be the basis for the selection of cover.
1.1.4 "South African Borders" means the land within the registered and published national boundaries of the Republic of South Africa.
1.1.5 "Children" means the Principal Insured's unmarried minor child who has not yet reached the age of 21. This age may be extended to 25 in respect of an unmarried child who is a full-time student and who is dependent on the principle Insured. There will be no age restriction for children who are either mentally or physically incapacitated from maintaining themselves, provided that the children are dependent on the principal Insured for support and maintenance.
1.1.6 "Day" means where an Insured person has been admitted before 24h00 as an inpatient in a medical facility and then follows to include a portion of the next consecutive 24 hr period.
1.1.7 "Disability" means an Insured person who has sustained an injury whereby they cannot perform ordinary tasks or occupations with the same ability as a person without such disability.
1.1.8 "Permanent Total Disability" means permanent and complete inability to complete tasks that may ordinarily have been achieved, prior to the event.
1.1.9 "Temporary Total Disability" means temporary and complete inability to complete tasks that may ordinarily have been achieved, prior to the event.
1.1.10 "Excess" means the amount of the claim that will not be payable by the Insurer on behalf of the Insured.
1.1.11 "Family" means a social unit who reside together or form a social grouping and consists of a Principle Insured who is older than 21, his/her spouse or life partner and their children as per the definition above.
1.1.12 "Inception Date" means the date on which the policy first became active, this will always fall on the 1st day of a calendar month.
1.1.13 "Injury" means physical injury, cut, abrasion, bruise, burn or disfigurement, bodily harm, sickness or disease caused to a person by an unforeseen accident.
1.1.14 "Insurer" means Absa Insurance Risk Management Services T/A AIRMS.
1.1.15 "Hospital" means an institution for health care providing patient treatment by specialized staff and equipment, for sick or injured persons where they are given surgical or medical treatment and providing for longer-term patient stays. Excluding places of recovery and or rehabilitation, drug or otherwise as well as mental institutions.
1.1.16 "Illness" means any unforeseen sickness, illness or disease originating, contracted, commencing or first manifesting itself during the Period of Insurance. Should the illness reoccur within a 6 month period it will be deemed to be part of the initial illness and associated claim.
1.1.17 "Insured Person" means a natural person who has applied and been accepted by the insurer and whose premium is paid and up to date.

1.1.18 "Principle Insured" means the natural person in who's name the agreement is entered into and whose name is reflected on the policy certificate,
1.1.19 "Medical Expenses" means the costs resulting from treatment for a disease or an accident by a medical doctor or other medical practitioner, in the form of medication or therapy, in hospital (including hospital stay), medical practice or at home (outpatient treatment).
1.1.20 "Onecard" means the transactional card.
1.1.21 "Pre-Existing Condition" means a medical condition that was in existence prior to this policy's inception date or that was newly diagnosed within the first three months from the inception date of the policy whether it was known or unknown to the Insured.
1.1.22 "Professional Sport" means the Insured's participation in a sporting activity, from which the majority of the Insured's income is earned.
1.1.23 "Schedule" means the document that lists the detail of the Insured amounts.
1.1.24 "Spouse" means a person whose relation to the Insured is seen to be that or similar to a husband and either under law or common law.
1.2.25 "Sum Insured" means the limit of cover the Insurer offers as stated in your schedule to which both parties have mutually agreed.
1.2.26 "Underwriter" means Onecard Management Service (PTY) Ltd.

1.2 GENERAL CONDITIONS

The policy wording, application form and the schedule shall be read together as one contract and any word or expression to which a specific meaning has been attached in any part of the policy or the cover explanation shall bear specific meaning wherever it may appear.

1.2.1 After premiums have been paid consecutively without interruption for a 12 month period, the restrictions applicable to pre-existing conditions shall no longer apply according to specific underwriting conditions that may apply.
1.2.2 The maximum entry age of the principal Insured cannot exceed 65 years if not specifically agreed otherwise.
1.2.3 Only one policy may be issued to any one Insured person.
1.2.4 The Insured person agrees to submit to medical examination at the expense of the insurers as often as shall be required in connection with any claim after a claim has been accepted. Further, the Insured agrees to present on request from the insurer, any documents or other information necessary to enroll the said Insured on the policy and to facilitate ongoing cover or claims processing.
1.2.5 It is the responsibility of the Insured to seek medical assistance immediately from when the Insured becomes aware of a medical condition that requires treatment. The Insurer will not be liable to indemnify the Insured as a result of misconduct in the treatment of medical requirements.
1.2.6 This policy is intended as a risk cover therefore if it becomes evident that the Insured entered into this policy with prior knowledge of a foreseeable or predicted medical event that would ordinarily be covered under this policy, then the insurer will not be liable to indemnify the client in terms of this schedule.
1.2.7 The Insured hereby gives the insurer the right to claim from the Insured any payment or compensation received by the Insured from any third party due to an event that is covered by this policy and that the insurer has paid to the client or on the clients behalf
1.2.8 Should a pre-existing condition exist that results in the injury or illness becoming more severe, the Insured shall only be due the amount deemed to have been incurred specifically as a result of the specific accident or illness.
1.2.9 In the event that the Insured receives payment or service within this policy during the grace period and the premium remains unpaid after this 15 day period expires the Insured undertakes to pay back to the insurer any and all cost incurred as a result of this claim being authorized including any collection or legal fees.
1.2.10 It is the duty of the Insured to ensure that no cover is requested or authorized while the Insured is inside the waiting periods specified. The Insured will have no claim against the insurer should there be an error in this regard, and no damages may be claimed financially or in any other form should the Insured incur costs or other damages as a result of misinterpretation hereof.
1.2.11 In certain instances the Insurer may elect to carry the cost of excess or additional amounts over and above the cover stipulated herein. It will be the responsibility of the Insured to repay any additional costs incurred over and above the cover stated back to the Insurer.
1.2.12 Any leniency offered in the processing of claims or extension of cover to the Insured is not deemed to be leniency on an ongoing basis and the terms of this policy remain in full force and effect.
1.2.13 It is the responsibility of the Insured to notify the Insurer or the Insurer's collection department should the premium fail to be deducted from the specified account.
1.2.14 Should premiums not be received or be returned for any reason, the cover of this policy will become suspended for a 15 day period within which period no cover will be payable to the Insured until receipt of the overdue premiums have been received. Should this premium not be received within the 15 day grace period, all cover will be immediately cancelled and this agreement shall be terminated.
1.2.15 It is the duty of the Insured to declare all medical and health information when applying for the policy. It is the responsibility of the Insured to supply and assist to get any medical history reports from any medical practitioner or facility if requested to do so to enable the underwriter to entertain any request or authorisation for any operation or procedure.
1.2.16 No Certificate of Insurance will be issued in the event that premiums are unpaid.
1.2.17 Proof of insurance will be issued on written request from the Insured to the Insurer. The policy must be active and a period of 30 days from the receipt of the first premium must have passed.

1.3 GENERAL EXCEPTIONS AND LIMITATIONS

Notwithstanding all exclusions, including pre-existing conditions applicable to the Insured, the Insurer shall not be liable for expenses, hospitalisation, injury, sickness or disease directly or indirectly caused by or related to the following if not specifically included elsewhere in this document:

1.3.1 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.
1.3.2 War, invasion, act of foreign enemy, hostilities or warlike operations (whether war be declared or not) or civil war.
1.3.3 Mutiny, military rising, military, martial law or state of siege, insurrection, rebellion or revolution.
1.3.4 Cost of operations, treatments and procedures for cosmetic or elective purposes.
1.3.5 Costs incurred for the treatment of obesity and health holidays.
1.3.6 The purchase of bandages, aids, patent foods, including baby foods, contraceptives and slimming preparations as advertised to the public and domestic and bio-chemical remedies.
1.3.7 Participation in civil commotion, labour disturbances, riot, strike or the activities of locked out workers.
1.3.8 Participation in any form of race or speed test other than on foot or in non-mechanically propelled watercraft
1.3.9 The cost of any treatment which is recoverable from another party.
1.3.10 Expenses incurred by the Insured or dependants of the Insured in the case of wilfully self-inflicted injuries or professional sport.
1.3.11 Cost of treatment for infertility
1.3.12 Any sexual transmitted diseases unless as a direct result of rape or crime.
1.3.13 Service rendered by persons not registered with the S A Medical and Dental Council the S A Nursing Council or the South African Health Service Professions Board
1.3.14 As a result of the influence of alcohol, drugs or narcotics upon such Insured Person unless administered by or prescribed by and taken in accordance with the instructions of a member of the medical profession other than himself.
1.3.15 A criminal act as defined by the laws governing the Republic of South Africa, this specifically includes driving under the influence of Alchohol or non prescription drugs.
1.3.16 Caused as a direct or indirect result of negligence to the Insured's medical needs or health.
1.3.17 All costs incurred during any waiting period and for conditions not disclosed.
1.3.18 All costs that exceed the stated and maximum allowed cover.
1.3.19 All costs incurred for permanently excluded conditions.
1.3.20 Costs incurred as a result of failure to carry out the instructions or advice of a medical doctor or dentist.
1.3.21 Mental illness, psychiatric disorders, symptoms and related treatment and hospitalisation.
1.3.22 All diagnostic procedures performed in order to diagnose a condition or illness.

1.4 OTHER CONDITIONS

1.4.1 Premium payments

All premiums are payable monthly in advance. The period of grace allowed for non-payment of premiums is 15 days after the month in which the premium was due. If the premiums are not paid within the period of grace, the policy shall lapse. Should premiums, in whole or in part, be in arrears, then no claim shall be payable.

1.4.2 Claims

The Insurer shall pay claims to the Insured, their Estate or their Mandated Nominee or bank account.

1.4.2.1 following an Insured event the Insured shall at his own expense notify the Insurer as soon as is practicable.
1.4.2.2 supply in writing any such proof, medical evidence or other information as the Insurer may reasonably request.
1.4.2.3 no claim shall be payable if the Insurer is not notified of an Insured event within three months of its occurrence or within three months of the termination of this policy, whichever occurs first.
1.4.2.4 Claims submitted after three months will not be accepted. It is the responsibility of the Insured to ensure that the claim invoices have been received by the Insurer.
1.4.2.5 The Insurer reserves the right to increase premiums, with 30 days (one calendar month) notice in writing, if the Insured's risk profile changes or if the Insured's claims increases above the actuarial calculated rate that was used for the Insured's current premium.

1.4.3 The correctness of statements made to the Insurer

1.4.3.1 The Insurer relies on the truth, completeness and correctness of all statements submitted. If the cover granted, or reinstatement thereof has been obtained through any misrepresentation of concealment, this policy shall be void and monies paid in respect thereof shall be forfeited.
1.4.3.2 Should any cover have been paid out on the basis of the information provided by the Insured to the Insurer and such information proves to be incorrect in any respect, the Insurer shall have the right to take such steps as may be required to put it in the same position as it would have been in if the correct information had been provided in the first instance.

1.4.4 Liability of the Insurer

The liability of the Insurer, unless otherwise agreed with the Insured, shall be limited to the cover as stated in this policy wording and for which the correct premiums have been received.

1.4.5 Termination or alteration

Cover shall cease in the event of the following:

1.4.5.1 at 24H00 hours on the last day of the month in which premium/s have been paid. If a premium is not paid when due, or if a premium debit is dishonored, the Insured must prove to the satisfaction of the Insurer that this was an error by his paying agent.
1.4.5.2 in respect of minor children at the end of the calendar month in which he gets married, attains the age of twenty one years or twenty five years if full time student and financially depending on parents.
1.4.5.3 once the Insured (or his legal representative) has given written notice to terminate this policy, or once the Insurer has provided at least one month's written notice to the Insured of any such alteration or termination. Upon receipt of this notice, all the cover will be cancelled forthwith and all subsequent premiums paid will be refunded.
1.4.5.4 Cover and or policy wordings may be altered by the Insurer upon giving at least one month written notice of any possible changes to the policy, and once said notification has been issued the effective date of the new policy wordings shall replace any previous policy wordings.

1.4.6 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 Insurer it shall be made in the currency of the Republic of South Africa.

1.4.7 Acceptance of cover

1.4.7.1 The application form and or voice recording of the application will form the basis of this insurance cover.
1.4.7.2 The policy will only be active after the application and risk has been accepted by the Insurer or Administrator.
1.4.7.3 The Insurer and Administrator will calculate the final premium on the risk profile of each applicant and has the right to the increase the premium according to each applicants personal risk profile.

SECTION 2

2 ONEPLAN HEALTH COVER

The Insurers will pay to the Insured, on behalf of the Insured Person or his estate, the compensation stated in the Policy Schedule if during the Period of Insurance any Insured Person needs medical attention in the event of an unforeseen event as defined in this policy wording.

On all the risk cover under Section 2 the Underwriter will pay an additional R5-00 for a claims drop fee and R2-15 to cover point of sale fees. These covered amounts will be included in the risk underwriting cover amounts.

Section 2 is underwritten by Onecard Management Services (PTY) Ltd and the Insurer is ABSA Insurance Risk Management Services T/A AIRMS.

2.1 GENERAL PRACTIONER VISITS (POLICY CODE DV1)

2.1.1 Definition

The Insurer will compensate the Insured person the fixed lump sum amount of R230.00 (two hunderd and thirty rand) as a stated cover should the Insured visit a registered General Practitioner due to the occurrence of an unforeseen health event that requires treatment or consultation at a registered General Practitioner. The lump sum amount will be paid directly into your ONECARD, subject to the available annual limit. The policy holder will be responsible to pay the General Practitioner directly. You need to keep the General Practitioner's account on record as the Underwriter may ask for proof of payment in order to validate your claim. Cover is limited to the overall annual Insured amount.

2.1.2 Defined events

In the event that any of the Insured persons requires Medical Care due to a specific unforeseen health event inside the borders of South Africa the Insurer agrees to pay to the Insured Person or their Estate or Mandated Nominee the compensation stated under Cover payable per policy schedule.

2.1.3 Waiting periods

The Cover has a 30 day (One Calendar Month) waiting period from the inception date of the policy.

2.2 MEDICATION (POLICY CODE M1)

2.2.1 Definition

The Insurer will compensate the Insured person the amount as specified in the policy schedule on submission of a registered script for medication as prescribed by a registered General Practitioner, which is medically justifiable and necessary to cure or treat the unforeseen condition, as result of a claim contemplated in DV1.

Scripted Medication & Repeated Scripted Medication as prescribed by your General Practitioner as a result of a claim under DV1 above is covered according to the fixed stipulated amount as per the chosen policy. Cover is limited to the overall annual insured amount. The actual cost for medication up to the stated insured amount will be paid directly to your ONECARD and you will be responsible to pay your Pharmacy. The cost of medication above the stated limit per event and the annual limit applicable will be for the Insured's own account.

2.2.2 Defined events

In the event that the Insured has sought medical attention as per DV1 in the borders of South Africa which results in a General Practitioner prescribing medication for an unforeseen health event the Insurer agrees to compensate the Insured person or their Estate or Mandated Nominee the compensation stated amount in the policy schedule. Cover is limited to the overall annual Insured amount.

2.2.3 Waiting periods acute (scripted) medication

The Cover has a 30 day (One Calendar Months) waiting period from the inception date of the policy.

2.2.4 Waiting periods repeated scripted medication

The Cover has a 90 day (three calendar months) waiting period from the inception date of the policy.

2.2.5 Special conditions:

2.2.5.1 All conditions of a chronic nature on diagnosis are subject to underwriting and loading or exclusion as specified on the policy schedule.

2.2.5.2 Any pre-existing conditions where repeated scripted medication is diagnosed needs to be declared and is subject to a loading or exclusion or waiting period as specified in the policy schedule and will form part of the normal medication annual limits.

2.2.5.3 Newly diagnosed repeated script conditions needs to be reported and declared within 30 days after the date of diagnosis. In the event that the newly diagnosed chronic condition is not reported and declared, the Underwriter has the right to cancel the policy due to non-disclosure.

2.2.5.4 Any loading or exclusion of repeated scripted medication due to an unforeseen chronic condition will have no influence on the hospital cover section. This cover is to be read separately from the hospital cover.

2.2.5.5 All pre-existing chronic conditions and chronic conditions known or unknown, which are diagnosed and or vested within the first three months, if not otherwise stipulated, such scripted medication will be excluded and are not covered whatsoever.

2.3 PATHOLOGY (POLICY CODE P1)

2.3.1 Definition

In the event that a registered General Practitioner requests any blood tests, as a result of a claim contemplated in DV1 above, the Insured Cover are as shown on the policy schedule and in relation to the level of cover chosen will be paid directly in to your ONECARD and you will need to pay the pathologist directly. In the event of an accident or hospitalization, any related blood tests are covered under the Hospital cover if the cover is relevant to your chosen plan option.

The Insurer will compensate the Insured person the lump sum as stated in the policy schedule in the event that a Registered General Practitioner requests Pathology that is medically justifiable.

2.3.2 Defined events

In the event that the Insured Persons is in need of medical attention and a General Practitioner request's pathology tests, inside the borders of RSA the Insurer agrees to compensate the Principle Insured, their Estate or Mandated Nominee the compensation stated under cover payable in the Policy Schedule. Cover is limited to the overall annual insured amount.

2.3.3 Waiting period

The Cover has a 30 day (one calendar month) from the inception date of the policy.

2.4 RADIOLOGY (POLICY CODE R1)

2.4.1 Definition

In the event that a registered General Practitioner requests any x-rays, as a result of a claim contemplated in DV1 above, the insured lump sum will be paid directly in your ONECARD and you will need to pay the radiologist directly. In the event of an accident, any accident related X-rays and scans are covered under the Hospital cover section under Accident Cover.

The Insurer will compensate the insured person the lump sum as stated in the policy schedule in the event that a Registered General Practitioner request's radiology that is medically justifiable.

2.4.2 Defined events

In the event that the insured persons is in need of medical attention and a General Practitioner request's radiology to be done inside the borders of RSA the Insurer agrees to compensate the Principle Insured, their Estate or mandated nominee the compensation stated amount in the policy schedule. Cover is limited to the overall annual insured amount.

2.4.3 Waiting period

The Cover has a 30 day (one calendar month) waiting period from the inception date of the policy.

2.5 DENTISTRY (POLICY CODE D1)

2.5.1 Definition

The Insurer will compensate the Insured person the fixed lump sum amount as per the policy schedule, as a stated cover should the Insured visit a registered Dental Practitioner due the occurrence of an unforeseen dental event.

The stated cover as per the policy schedule will be paid directly into your ONECARD, subject to the available annual limit. The policy holder will be responsible to pay the Practitioner directly. You need to keep the Practitioner's account on record as the Underwriter may ask for proof of payment in order to validate your claim.

2.5.2 Defined events

In the event that any of the Insured persons requires Medical Care due to a specific unforeseen health event inside the borders of South Africa the Insurer agrees to pay to the Insured Person or their Estate or Mandated Nominee the compensation stated under Cover payable per policy schedule. Cover is limited to the overall annual Insured amount.

2.5.3 Waiting period

The cover has a 90 day (3 calendar months) waiting period from the inception date of the policy.

2.5.4 Special Conditions

2.5.4.1 Dental Procedures

The Insurer will only cover an unforeseen visit to a Dentist as a fixed amount as stated in the policy schedule per event. Policy code D1 does not cover any procedural cost outside of the stated maximum limit.

Dental Procedures are covered under a separate policy within the Oneplan Policy. Dental Procedures are supplied by Denis insurance Dental Policy. (Please refer to section 8 of this policy wording).

No specialist dentistry or operation is covered under this policy.

You are advised to read the Denis Policy wording together with the relevant stated cover in the policy schedule.

2.6 SPECIALIST COVER (POLICY CODE SP1)

2.6.1 Definition

In the event that a registered General Practitioner requires the Insured to consult a Specialist as a result of a claim contemplated in DV1, above the Insured cover amount as shown on the policy schedule, will be paid directly in to your ONECARD and you will need to pay the Specialist directly.

The Insurer will compensate the Insured person the lump sum as stated in the policy schedule in the event that a Registered General Practitioner requested the Insured to consult a Specialist for reasons that are medically justifiable.

2.6.2 Defined events

In the event that any of the Insured Persons requires Medical Care due to a specific unforeseen health event inside the borders of South Africa the Insurer agrees to pay to the Insured Person or their Estate or Mandated Nominee the compensation up to the stated limit under cover payable per policy schedule. Cover is limited to the overall annual insured amount.

2.6.3 Waiting period

The Cover has a 90 day (3 calendar months) waiting period from the inception date of the policy.

2.6.4 Special Conditions

2.6.4.1 A General Practitioner needs to refer the Insured for a medically justifiable reason to a registered Specialist.
2.6.4.2 An authorisation code needs to be requested and received from the Insurer.
2.6.4.3 Only policies that specifically include this cover enjoy Specialist cover as stated in the policy schedule.
2.6.4.4 A Specialist is for the purpose of this clause, regarded as a General Practitioner specialising in a field.
2.6.4.5 A specialist visit will only be approved if the health event cannot be treated by a General Practioner and is not covered under DV1.
2.6.4.6 Specialised dentistry, physio and optometry are not covered under this cover.
2.6.4.7 Psychiatric and related mental health events are not included and are not covered by this policy under any circumstances.

2.7 PRE-BIRTH COVER (POLICY CODE MG1)

2.7.1 Definition

In the event that a registered General Practitioner confirms a pregnancy, this cover activates after month 4 (four) of pregnancy. The stated cover as per the policy schedule will be paid directly into your ONECARD, subject to the available annual limit. Clients will need to pay the Practioner directly. The Cover includes the Gynaecologist consultation and all related procedures up to the maximum stated cover as per the policy schedule within the Cover rules.

The Insurer will compensate the insured person the lump sum as stated in the policy schedule in the event that a Registered General Practitioner requested the Insured to consult a Gynaecologist due to a positive pregnancy diagnosis.

2.7.2 Defined events

In the event that any of the Insured persons requires medical care due to a positive pregnancy diagnosis inside the borders of South Africa, the Insurer agrees to pay to the Insured Person or their Estate or Mandated Nominee the compensation up to the stated limit under Cover payable per policy schedule. Cover is limited to the overall annual Insured amount or individual claim.

2.7.3 Waiting period

The Cover has a 7 month (seven calendar months) waiting period from the inception date of the policy.

2.7.4 Special Conditions

2.7.4.1 A General Practitioner needs to refer the Insured after diagnosis to a registered Gynaecologist but only after the first four months of pregnancy.
2.7.4.3 An authorisation code needs to be requested and received from the Insurer.
2.7.4.3 Cover may only be activated 4 months from date of conception.
2.7.4.4 Cover extends to the principle policy holder, their spouse or partner only.
2.7.4.5 Only policies that specifically include the Cover enjoy Pre-birth Cover as stated in the policy schedule.

SECTION 3

3 ONEPLAN HOSPITAL RISK COVER

Section 3 is underwritten by Onecard Management Services (PTY) Ltd and the Insurer is ABSA Insurance Risk Management Services T/A AIRMS.

3.1 EMERGENCY ILLNESS (POLICY CODE EH1)

3.1.1 Definition

In the event that Insured persons require urgent medical attention in a situation that is deemed life threatening and authorised by the emergency call centre which cannot wait for a normal consultation at the Insured's doctor, the Insured may go to the nearest hospital casualty unit, where the Insurer will cover up to R 4 000 (four thousand rand) for the treatment received. Please be aware that the casualty unit will require a Certificate of Insurance and the Insured will need to contact the Emergency Call Centre for assistance.

For unforeseen emergency illness resulting in emergency medical care, the Insurer will compensate the Insured person medical expenses directly incurred due to the specific unforeseen health event up to a maximum amount of R4 000 (four thousand rand).

3.1.2 Defined events

In the event that Insured persons requires unforeseen Medical Care due to a health event, inside the borders of South Africa which results in Medical Expenses, the Insurer agrees to compensate the Principle Insured, their Estate or Mandated Nominee the compensation stated under Cover payable.

3.1.3 Excess

During the first 3 months of the policy, all claims will carry an excess of 15% of the total sum assured of R4000.00. Thereafter and excess of R200 (two hundred rand) will be payable for each and every claim.

3.1.4 Waiting period

The Cover is active from the inception date of the policy.

3.1.5 Special Conditions

3.1.5.1 The Cover will only be payable in the event that the emergency medical care needed is regarded as an emergency life-threatening event. Facilities include medical facilities, hospital casualty wards procedures and triage and medical centers that are registered as day clinics with or without overnight facilities. This Cover is not payable in conjunction with any other Cover. An emergency event is defined as an event in which failure to treat the injury or illness will result in permanent damage to the Insured.

3.1.5.2 In the event that the Underwriter and or Claims Manager at their discretion determine that the reason for visiting the emergency ward was not a life-threatening event, the maximum Cover contemplated in Section 2 of this policy wording will be applicable to the claim.

3.1.5.3 This Cover is not intended to replace Cover contemplated in Section 2 of this policy wording.

3.1.5.4 Pre-existing conditions are excluded.

3.2 ACCIDENT COVER (POLICY CODE ASB1)

3.2.1 Definition

In the event of an accident ALWAYS phone the Emergency Call Centre to report the accident. The Insured may not need an ambulance and may be able to go to the hospital unaided, but the event must be reported. The Emergency Call Centre will do an immediate pre-authorization and will send the needed Certificate of Insurance to the specific medical institution. The Cover is available immediately after inception date of the policy and no waiting period is applicable.

The Company will compensate the Insured person the lump sum amount for medical expenses in a medical facility that was directly incurred from the date of the unforeseen accident for up to six months after the date of the accident which is directly linked due to the specific Insured accident event up to the stated amounts per chosen policy and as stipulated on the policy schedule. Cover is limited as per the policy schedule.

3.2.2 Defined events

In the event that any of the Insured persons requires Medical Care and is admitted in a medical facility due to a specific unforeseen accident event inside the borders of South Africa the Insurer agrees to pay to the Insured Person or their Estate or Mandated Nominee the compensation stated under Cover payable per policy schedule. Cover is limited to the overall annual insured amount.

3.2.3 Excess

An amount of five hundred rand R500 (five hundred rand) excess is payable by the Insured person for each and every claim submitted under this Cover.

3.2.4 Waiting period

The Cover is active from the inception date of the policy.

3.2.5 Special conditions

The Insurer agrees to cover certain procedures after an accident that is directly linked to the specific health event. These procedures are to be approved by the Insurer or Administrator and medical evidence needs to be supplied by the client.

3.3 ILLNESS IN HOSPITAL (POLICY CODE IB1)

3.3.1 Definition

In the event that the Insured requires hospitalisation for illness or for an operation that is not a pre-existing or related condition, it is essential to contact the Emergency Call Centre to obtain your pre-authorisation. The Emergency Call Centre will send the required confirmations and Certificates of Insurance to the required medical facility.

The Insurer will compensate the insured person the lump sum amount for medical expenses in a medical facility that is directly incurred from the date of the unforeseen illness for up to six months after the date of the illness was diagnosed, which is directly linked to the specific diagnosed illness event, that result in the insured person being admitted in a medical facility or hospital. The Insurer will indemnify the Insured person up to the maximum Cover per chosen policy as stated in the policy schedule.

3.3.2 Defined events

In the event that the Insured person/s is admitted to a medical facility within the borders of South Africa due to an unforeseen illness or operation event, that is expressly not related to any pre-existing conditions whether known or unknown within fourteen days of the diagnoses of such illness the Insurer agrees to compensate the Insured person or their Estate or Mandated Nominee the compensation stated under Cover payable.

3.3.3 Excess

3.3.3.1 During months three to six of the policy, all claims will be subject to an excess amount of 15% of the claim amount, not exceeding the total sum assured.
3.3.3.3 Any claims submitted after 6 months of policy being in force will be subject to an excess of 5% of the claim amount, not exceeding the total sum assured.
3.3.3.4 The excess amount must be paid by the Insured to the Insurer before the claim will be settled.

3.3.4 Waiting period

There is a 90 day (three calendar months) waiting period from inception date of the policy before this Cover is active.

3.3.5 Special conditions

3.3.5.1 The time periods stated above and compensation payable will terminate immediately upon the Insured persons discharge from the hospital.
3.3.5.2 Pre-existing conditions (known or not known) and related and associated conditions caused by the pre-existing conditions are excluded for the period contained in the policy schedule. If not disclosed or known such conditions will be regarded as a pre-existing conditions and will be excluded for at least 12 months from the inception date.
3.3.5.3 The section above is not related to dreaded diseases, and no compensation will be payable to the Insured for the diagnoses of or hospitalization due to a dreaded disease, please see the Dreaded Disease Cover section..
3.3.5.4 Should the person be re admitted within 6 (six) months of being discharged for the same illness it will be deemed under this section to form part of the same illness event and compensation will carry on as if the stay were uninterrupted.
3.3.5.5 Tonsillectomies and gromits are not covered during the first 12 months from the inception date of the policy.
3.3.5.6 Hernias are excluded for the first 12 months from the inception date of the policy.
3.3.5.7 It is specifically recorded that no dental (any type of dental conditions including specialized dentistry) operations or procedures in any type of hospital will be covered under this Cover.
3.3.5.8 This Cover will not be paid together with any other Cover in this policy.
3.3.5.9 A minimum turnaround time of 48hrs is required for authorisation under this Cover.
3.3.5.10 Pregnancy is expressly included in this section subject to a 12 month waiting period from date of inception until date of birth.
3.3.5.11 The new born baby will enjoy the full cover as a normal child should have, from actual birth subject to the baby being registered and accepted as an Insured child within 30 days of the date of birth.
3.3.5.12 In the event that the next month's debit order is returned, will the Insurer have the right to claim back any cover paid towards the new born baby.
3.3.5.13 In the event that the birth of the child is within the first 12 months from the inception of the policy, the Insurer not cover the birth nor any complications related to the birth nor will the new born be covered until the new born baby has left the hospital with a clean bill of health.
3.3.5.14 Immunisation is not covered by this policy unless it falls within the medication and medical practioner limits provided under the Health Cover section.
3.3.5.15 Hysterectomies are excluded for a period of 12 months from the date of inception.

3.4 DREADED DISEASE COVER (POLICY CODE DD1)

3.4.1 Definition

In the event that you need assistance due to a Dreaded Disease that was not pre-existing, you need to phone the Emergency Call Center to get claim authorisation. The Emergency Call Center will send the required confirmations and Certificates of Insurance to the required medical institution.

The Insurer will compensate the Insured person the lump sum amount for medical expenses in an approved medical facility and that is directly incurred from the date of the unforeseen dread disease is diagnosed for up to twelve months after the date of the of diagnoses which is directly linked due to the specific Insured Dread Disease illness up to an amount as per each specific plan as stipulated in the policy schedule. The Insured can only claim again for a new event for the same disease after a 6 month recovery period from the end of the previous incident.

3.4.2 Defined events

In the event that any of the Insured person/s are in need of Medical Care and is admitted to a medical facility for medical care inside the borders of South Africa due to a specific Insured dreaded disease that was not diagnosed within the first three months of the policy or that was not a pre-existing condition (known or unknown with inception), the Insurer agrees to pay to the Insured person or their Estate or Mandated Nominee the compensation stated under Cover payable. The Insurer will compensate the Injured person/s for the following dread disease events:

3.4.2.1 Heart Attack: Myocardial infarction (MI) or acute myocardial infarction (AMI), commonly known as a heart attack, is the interruption of blood supply to part of the heart, causing heart cells to die. This is most commonly due to occlusion (blockage) of a coronary artery following the rupture of a vulnerable atherosclerotic plaque, which is an unstable collection of lipids (fatty acids) and white blood cells (especially macrophages) in the wall of an artery. The resulting ischemia (restriction in blood supply) and oxygen shortage. Diagnosis will be based on a history of typical chest pain, new electrocardiographic changes and the elevation of cardiac enzymes.

3.4.2.2 Chronic Coronary Heart Disease: Coronary disease (or coronary heart disease) refers to the failure of coronary circulation to supply adequate circulation to cardiac muscle and surrounding tissue.

3.4.2.3 Stroke: A stroke (sometimes called a cerebrovascular accident (CVA)) is the rapidly developing loss of brain function(s) due to disturbance in the blood supply to the brain. This can be due to ischemia (lack of blood flow) caused by blockage (thrombosis, arterial embolism), or a haemorrhage (leakage of blood). As a result, the affected area of the brain is unable to function, leading to inability to move one or more limbs on one side of the body, inability to understand or formulate speech, or inability to see one side of the visual field

3.4.2.4 Cancer: (medical term: malignant neoplasm) is a class of diseases in which a group of cells display uncontrolled growth (division beyond the normal limits), invasion (intrusion on and destruction of adjacent tissues), and sometimes metastasis (spread to other locations in the body via lymph or blood). These three malignant properties of cancers differentiate them from benign tumors, which are self-limited, and do not invade or metastasize. Hodgkin's disease and leukemia are considered diseases. All skin cancers except invasive malignant melanomas is excluded. Most cancers form a tumor but some, like leukemia does not.

3.4.2.5 Kidney Failure: Renal failure or kidney failure (formerly called renal insufficiency or chronic renal insufficiency) describes a medical condition in which the kidneys fail to adequately filter toxins and waste products from the blood. Cover is for acute (acute kidney injury) and malfunction where dialysis treatment is needed.

3.4.2.6 Major Organ Transplant: Organ transplantation is the moving of an organ from one body to another, or from a donor site including bone marrow on the patient's own body, for the purpose of replacing the recipient's damaged or absent organ. Transplant of parts of organs and other tissue are excluded. .

3.4.2.7 Brain Tumours: A brain tumor is an intracranial solid neoplasm, a tumor (defined as an abnormal growth of cells) within the brain or the central spinal canal.

3.4.2.8 Paraplegia: Paraplegia is an impairment in motor or sensory function of the lower extremities. It is usually the result of spinal cord injury or a congenital condition such as spina bifida which affects the neural elements of the spinal canal. The area of the spinal canal which is affected in paraplegia is either the thoracic, lumbar, or sacral regions.

3.4.2.9 Blindness: Total blindness is the complete lack of form and visual light perception and is clinically recorded as NLP, an abbreviation for "no light perception." Blindness is frequently used to describe severe visual impairment with residual vision. Those described as having only light perception have no more sight than the ability to tell light from dark and the general direction of a light source. Blindness is the condition of lacking visual perception due to physiological or neurological factors.

3.4.3 Waiting period

The cover has a 90 day (three calendar months) waiting period from date of inception.

3.4.4 Special conditions

3.4.4.1 Pre-existing conditions and newly diagnosed within first 3 months are excluded if not specifically included in writing and that newly diagnosed conditions in the first three month will be regarded as a pre-existing condition.

3.4.4.2 Newly diagnosed Dread Diseases within the first 3 months will be regarded as a pre-existing condition. Where a Dread Disease occurs (newly diagnosed) during months 3 to 6 of the policy, the condition will be subject to a full medical report and medical history confirming that it is not a pre-existing condition whether it was known or unknown to the policyholder on the date of signing up or joining of the plan. Pre-existing Dread Disease conditions will not be covered if not specifically agreed in writing.

3.4.4.3 As a general rule all pre-existing conditions that existed in the period of 12 months prior to inception and diagnosed within the first three months of the policy, will have a minimum of 12-month general exclusion if not accepted specifically on a reduced period.

3.4.4.4 In the event that the Insured person is discharged and has successfully been treated and a minimum period of 6 (six) months have passed from the end of the previous event, the Insured will be covered for any newly diagnosed disease including the same kind of disease.

3.4.4.5 The Insurer will not pay the Cover under any other Cover together with this section.

3.4.4.6 The Insurer agrees to cover certain procedures that are directly linked to the specific health (dread disease) event. This procedures are to be approved by the Insurer or Administrator and medical evidence needs to be supplied by the client.

SECTION 4

4 ONEPLAN DISABILITY COVER

Section 4 is underwritten by Onecard Management Services (PTY) Ltd and the Insurer is ABSA Insurance Risk Management Services T/A AIRMS.

4.1 ACCIDENT PERMANENT DISABILITY COVER (POLICY CODE APD1)

4.1.1 Definition

In the event that the Insured person sustains a bodily injury, that results in partial or full disability within the borders of South Africa due to an unforeseen accident, the Insurer will make compensation stated under Cover payable, in terms of the policy wording.

The Insurer will compensate the Insured person such percentage of the amount as specified in the policy schedule and as specified in the percentage of permanent disablement table of Cover.

4.1.2 Defined events

In the event that the Principle Insured sustains a bodily injury due to an accident in the borders of South Africa which results within 12 (twelve) calendar months from the date of the accident, in permanent disability or loss of the use of limbs the Insurer agrees to compensate the Insured person or their Estate or mandated nominee the compensation stated in the Percentage of permanent disablement table of Cover (see below).

Injury		Percentage of permanent disablement
Loss of two Limbs		100%
Loss of both hands, or of all fingers and both thumbs		100%
Total loss of sight		100%
Total paralysis		100%
Injuries resulting in employee being permanent bedridden		100%
Any other injury causing permanent total disablement		100%
Loss of arm at shoulder		65%
Loss of arm between elbow and shoulder		65%
Loss of arm at elbow		55%
Loss of arm between wrist and elbow		55%
Loss of hand at wrist		50%
Loss of four fingers and thumb of one hand		50%
Loss of four fingers		40%
Loss of thumb	Both phalanges	25%
	One phalanx	15%
Loss of index finger	Three phalanges	10%
	Two phalanges	8%
	One phalanx	5%
Loss of middle finger	Three phalanges	8%
	Two phalanges	6%
	One phalanx	4%
Loss of ring finger	Three phalanges	6%
	Two phalanges	5%
	One phalanx	3%
Loss of little finger	Three phalanges	4%
	Two phalanges	3%
	One phalanx	2%
Loss of metacarpals	First, second and third (additional)	4%
	Fourth or fith (additional)	2%
Loss of leg	At hip	70%
	Between knee and hip	70%
	Below knee	45%
Loss of toes	All	15%
	Big, both phalanges	7%

4.1.3		Big, one phalanx	3%
		Toes other than big toes	
		Four toes	7%
		Three toes	5%
		Two toes	3%
		One toe	1%
	Loss of eye	Whole eye	100%
		Sight	100%
		Sight except perception of light	100%
	Loss of hearing	Both ears	100%
		One ear	100%

Waiting period

The Cover is active from the inception date of the policy.

4.1.4 Special conditions

The Insurer's liability is limited should compensation become duefor multiple Cover under this policy. The compensation will be limited to a maximum of 100% of the stated Cover. This is applicable to a specific insurable accident event.

SECTION 5

5 ONEPLAN DEATH COVER

Section 2 is underwritten by Onecard Management Services (PTY) Ltd and the Insurer is ABSA Insurance Risk Management Services T/A AIRMS.

5.1 NATURAL DEATH COVER (POLICY CODE NDB1), ACCIDENTAL DEATH COVER (POLICY CODE ADB1) AND FAMILY DEATH COVER (POLICY WORD DDB1)

5.1.1 Description

In the event that the insured person dies , the Insurer will make compensation stated under Cover payable, in terms of the policy Cover schedule.

In the event that any Insured person under this policy dies due to an unforseen event, the policy will pay the Principle Insured or his Estate or nominated account the death cover per deceased insured person as stated in the policy schedule as a stated lump sum amount.

5.1.2 Waiting period

5.1.2.1 Death of any insured due to an accident is covered from the inception date of the policy.
5.1.2.2 Death of any insured due to natural unforeseen causes is covered only after 3 months (three calendar months) from the inception date of the policy.

5.1.3 Death Cover Claims procedure

5.1.3.1 Upon the death of any person, the Insurer or Underwriter needs to be informed as soon as possible and the necessary supporting documentation must be sent to the Underwriter.
5.1.3.2 Claim documentation need to be submitted within 6 (six) months of the date of death.
5.1.3.3 No claim where documentation is submitted after 6 (six) months of the date of death will be paid.

5.1.3 Claim documentation

5.1.4.1 A claim notification document duly completed and signed by the Insured or the beneficiary.
5.1.4.2 The duly certified final death certificate signed, stamped and dated by a Commissioner of Oaths.
5.1.4.3 A fully completed BI1663 Form
5.1.4.4 A Certified copy of the Principal Insured person's Identity Document.
5.1.4.5 A Certified copy of the deceased's identity document
5.1.4.6 Proof of relationship and/or validity of cover where applicable.
5.1.4.7 The Underwriter and or Claims Manager reserves the right to request further documentation from the claimant in order to properly assess a claim and such documentation must be submitted within 6 (six) months after the date of death.

5.1.4 Payment of Cover

It is hereby expressly stated that the Underwriter will accept the claimant in the event of the death of the Principle Insured, as the legitimate claimant if not specifically instructed otherwise.

SECTION 6

6 ONEPLAN PROTECTOR PLAN COVER (POLICY CODE PR01)

Section 2 is underwritten by Onecard Management Services (PTY) Ltd and the Insurer is ABSA Insurance Risk Management Services T/A AIRMS.

6.1 Definition

6.1.1 Work related accident or illness cover

The Insurer will compensate the Principle Insured a stated lump sum to the amount of actual earnings up to a maximum of R2 250 (two thousand two hundred and fifty rand) per week for a maximum period of 52 weeks or until the Insured person can re commence working activities for work related accident and illness.

6.1.2 Work related accidental death cover

The Insurer will compensate the Insured person the amount of R130 000 (One hundred and thirty thousand rand) in the event that the Principle Insured dies due to a specific work related accident inside the borders of South Africa.

6.2 Defined events

6.2.1 Work related accident or illness cover

In the event that the Insured person sustain a bodily injury or an illness inside the borders of South Africa in working hours and specifically as a result of work related activities, which leads to that Insured person being temporarily or partially unable to perform the whole of his/her work, as employed prior to the incident. The Insurer agrees to compensate the Insured person or Estate or its Mandated Nominee the compensation stated under Cover payable. Cover is limited to the overall annual Insured amount.

6.2.2 Work related accidental death cover

In the event that any Insured person sustains bodily injury which was specifically and directly related to the Insured's employment within the borders of South Africa and which directly and independently of all other causes results within 12 months (twelve calendar months) of the accident in the death of the Insured person the Insurer agrees to compensate the Nominated Beneficiary, on behalf of any Insured Person or their Estate the compensation stated in the Insuring Section.

6.3 Waiting period

6.3.1 Work related accident or illness cover

90 day waiting period applies from date of inception of your Oneplan policy.

6.3.2 Work related accidental death

No waiting period applies. Cover is applicable from the inception date of the policy.

6.4.1 Special conditions

6.4.1.1 The Insurer will only compensate the Insured person from the second week of temporary disablement in the event of an accident that was specifically work related and that happened inside working hours.
6.4.1.2 The Insurer will only compensate the Insured person from the third week of temporary disablement in the event of an illness that was specifically work related and that happened inside working hours.
6.4.1.3 The Insurer will calculate the days of a week on the basis that each week has seven days.
6.4.1.4 Commuting to and from work is expressly excluded from this section.
6.4.1.5 This Cover is optional and has to be chosen on the application for this insurance.

SECTION 7

7 ONEPLAN OPTOMETRY COVER (POLICY CODE OB1)

The Optometry Program is supplied through the Eyenet Group and it is a non-insurance benefit.

7.1 Definition

The Optometry benefit is a Non-Insurance Cover supplied to insured persons through the Eyenet Optometrist Network

7.2 Waiting period

The waiting period on this benefit is 12 months from the commencement date of the Oneplan policy.

7.3 Cover cycle

The optometry benefit is available to clients of Oneplan and can be used once every 24-month cycle starting 12 months after the inception date of the Oneplan Policy.

7.4 Authorisation Procedures Eyenet Optometry Cover

7.4.1 Contact Eyenet call Centre on 0861 39 36 38.
7.4.2 Call centre will confirm cover and advise which Eyenet Optometrist is the nearest to them. Alternatively the client can confirm the Eyenet Optometrist address on the Oneplan website and when making an appointment request the optometrist to contact Eyenet to confirm cover.
7.4.3 Only procedures (visit, eye test and spectacles) will be covered in the rooms of a Eyenet Optometrist.

7.5 Description of cover package

7.5.1 Optical frame

7.5.1.1 A selection of at least 20 different fashion frames to be available in the practice.
7.5.1.2 Frames to have flexi temples.
7.5.1.3 Frames to be guaranteed for at least one year against manufacturing defects.
7.5.1.4 Retail value of frame up to R250-00.

7.5.2 Lenses

7.5.2.1 SV clear CR39 OR BF Flat Top Clear CR39 Lenses cut and fitted to chosen frame.

7.5.3 Optometric Examination

7.5.3.1 Comprehensive eye test and consultation, including at least visual evaluation, binocular optical correction and pathology screening of the eye.
Diagnosis of the above and responsibility of the diagnosis taken.
Written referral to opthalmologist, where needed. Opthalmologist procedures not covered under this Cover.
Dispensing of spectacles.
Adjustment of frame, where required.

7.6 QUALIFYING NORMS

7.6.1 Spectacles are granted if the following norms are met:

7.6.1.1 An unaided visual acuity of at least 6/12 or worse on the Snellen Scale for distance and near vision.
7.6.1.2 A refraction requirement of at least 0.75 dioptre sphere and/or 0.75 dioptre cylinder on distance vision for both eyes or
7.6.1.3 A refraction requirement of at least 1.25 dioptre sphere on near vision for both eyes.

7.6.2 For the granting of bifocals, insured persons have to comply both the distance and near vision qualifying norms. However, in borderline cases, the functionality will be taken into account. Motivation for such cases must be submitted in writing to Eyenet, either by fax or e-mail.
7.6.3 Multifocal lenses will only allowed to Oneplan Elite Policy holders.
7.6.4 PLEASE NOTE: Low Prescription lenses are not covered.
7.6.5 Where insured persons wish to upgrade to more expensive frames, a credit of R200-00 is to be given in lieu of the standard frame not being used. The balance is for the insured person's own account.

7.7 EXCLUDED

7.7.1 Contact lenses
7.7.2 Multi-Focal lenses
7.7.3 Sunglasses
7.7.4 Extras and/or any frames outside the Cover package.
7.7.5 No operation for illness related issues is covered under this section.

SECTION 8

8 ONEPLAN DENTAL COVER

8.1 Administrator

Denis Insurance Administrators (Pty) Ltd ("DIA"), FSP26/10/36026

8.2 Your intermediary

Denis Insurance Administrators (Pty) Ltd ("DIA"), FSP26/10/36026

8.3 Type of policy

8.3.1 Short Term Insurance Stated Cover

8.3.2 Denis Dental Plan is not a medical aid and the cover is not equivalent to that of a medical scheme. It is an insurance policy offering financial benefits for every day dental problems, at an affordable premium.

8.4 Operative clause

8.4.1 In return for the timeous payment of the required monthly premium and subject to the terms and conditions of this policy, Denis will pay specific amounts on the occurrence of specific conditions or events involving dental health.
8.4.2 Rules apply to each insured condition or events which are described in this document.
8.4.3 Claims are valid once a diagnosis has been made by a registered dental practitioner and as such the claim may be submitted to the administrator.
8.4.4 Active cover will be as stipulated on the Policy schedule according to your specific chosen plan.

8.5 Benefit rules

8.5 An x-ray or diagnostic photograph of the damaged tooth may be requested by the administrator
8.5 A written report of describing the accident must be supplied with the claim

8.6 Claims process

8.6.1 A claim may only be submitted AFTER a diagnosis by a registered dental health care provider has been completed. The policyholder should notify the dental claims administrator within 14 days from the date the accident occurred. All cover in respect of valid claims will be paid to the policyholder provided that the insured is in good standing.
8.6.2 The claimant must submit a valid diagnostic report or treatment invoice from a registered dental practitioner.
8.6.3 A medical certificate indicating the nature of the external blow is required where claiming for accidental trauma cover.
8.6.4 The dental claims administrator may request clinical documentation and/or evidence to support the claim.
8.6.5 A claim may be made telephonically by calling 0860 104940 you will need your policy number and the dental invoice or treatment plan available for the operator.
8.6.6 The dental invoice may be submitted directly by mail to Denis, PO Box 114, Century City, Canal Walk, 7446 or faxed to 021 528 5861
8.6.7 No claims will be processed if the policy is in arrears

8.7 Benefit Definitions

8.7.1 Accident: In terms of this policy the word accident relates only to an event where the force which fractures the tooth is from an external source. For example: a fall where forceful contact is made between the teeth and a hard surface, or where a hard object (such as a cricket ball) strikes the teeth resulting in the fracture. Deciduous teeth are excluded.
8.7.2 Dental Abscess: This is defined as a periapical (tip of the root) or other radicular (root) infection that results from a tooth related pathology (decay or fracture)
8.7.3. Emergency: An event where the insured has dental pain or infection and needs immediate treatment for the relief thereof. Routine visits are expressly excluded from this policy. Cover are paid per event
8.7.4 Gingivitis: is an inflammatory condition that may affect the gums if plaque (germs) is not removed by manual brushing, this is also known as scale and polishing
8.7.4 Impacted: Teeth are termed "impacted" where eruption into the oral cavity is impeded by the position of another tooth or the bone of the mandible. Cover is granted only when there is pathology associated with the impacted tooth. Pathology is defined for the purposes of impaction as cysts, tooth resorbtion, recurrent pericoronitis (an intermittent infection of the gum surrounding a tooth which is in the process of eruption) in the case of partially impacted teeth (infection must have occurred at least two times over a 6 month period), or osteomyelitis (a severe infection of the bone) resulting from the impaction
8.7.5 Missing tooth: This benefit is limited to teeth lost either due to an accidental blow or surgical procedure after the inception date of the policy and where the missing tooth must be replaced for reasons of occlusal stability by means for a bridge. This benefit specifically excludes pre-existing conditions.
8.7.6 Prognosis: The "prognosis" of a condition is the likely chance of successful treatment. For example a poor prognosis of restoring a tooth means that the dentist feels that a tooth is affected too badly by decay or fracture and that there is no point in trying to restore the tooth and rather extract it
8.7.7 Rehabilitation: means the successful rebuilding of a damaged tooth
8.7.8 Severely decayed or damaged: This indicates that at least two thirds of the visible tooth structure has been lost to decay or trauma regardless of the nature of the trauma
8.7.9 Tooth decay: Also known as "caries" is the bacterial process that results in demineralisation of the tooth structure and subsequent cavitation (creation of a hole). For insurance purposes the tooth is considered decayed once there is either clinical or radiological evidence of cavitation. Marginal leakage which is the visible staining of the margin between an existing filling and the tooth without demonstrated cavitation is not covered in terms of this insurance policy.

8.8 Benefit definitions, rules and claims procedure

8.8.1 Gingivitis

8.8.1.1 Once diagnosed and the claim settled, the gingivitis condition is considered properly treated and therefore un-claimable per insured life for a period of 12 months.
8.8.1.2 A waiting period of 3 months is required, before this benefit can be claimed.

8.8.2 Tooth decay

8.8.2.1 Enamel fracture due to mastication (chewing) or bruxism (tooth grinding) attracts the same cover as tooth decay.
8.8.2.2 Tooth decay is measured on the prognosis of rehabilitation.
8.8.2.3 Once diagnosed and the claim settled, the tooth decay with a poor prognosis of rehabilitation is considered properly treated and therefore un-claimable on the policy per individual tooth.
8.8.2.4 Once diagnosed and the claim settled, the tooth is considered properly treated and therefore un-claimable per individual tooth for a period of 3 years.
8.8.2.5 Tooth decay with a good prognosis of rehabilitation will attract a different cover amount than tooth decay with a poor prognosis of rehabilitation.
8.8.2.6 No claim is payable on the same tooth, if a previous claim for pathology associated with impaction has been filed.
8.8.2.7 Changing existing fillings for reasons including headache, fatigue or other conditions not directly related to the tooth structure is not covered.
8.8.2.8 Changing of existing fillings for cosmetic reasons is not covered.
8.8.2.9 A maximum of 10 teeth may be claimed for tooth decay with good prognosis of rehabilitation in any 12 months.
8.8.2.10 A waiting period of 3 months is required, before this benefit can be claimed.

8.8.3 Dental abscess

8.8.3.1 Dental abscess is measured on the prognosis for rehabilitation.
8.8.3.2 A dental abscess with a poor prognosis of rehabilitation attracts the same cover amount as tooth decay with a poor prognosis of rehabilitation.
8.8.3.3 Once diagnosed and the claim settled, the tooth is considered properly treated and therefore un-claimable on the policy per individual tooth.
8.8.3.4 Once diagnosed and the claim settled, the dental abscess with a good prognosis of rehabilitation is considered properly treated and therefore un-claimable per individual tooth for a period of 5 years.
8.8.3.5 A tooth decay claim cannot be made at the same time for the same tooth.
8.8.3.6 The benefit is payable once per tooth regardless of the number of roots on the tooth or number of abscesses associated with the tooth.
8.8.3.7 A maximum of 5 teeth may be claimed for a dental abscess in any 12 months.
8.8.3.8 Deciduous teeth (milk teeth) are excluded.
8.8.3.9 A waiting period of 3 months applies to the condition.

8.8.4 Impacted tooth

8.8.4.1 Teeth that are in the process of eruption, but are not impacted, are excluded.
8.8.4.2 Once diagnosed and the claim settled, the individual impacted tooth is considered properly treated. Therefore no further claims will be paid for this tooth.
8.8.4.3 A waiting period of 3 months applies.

8.8.5 Severely decayed or damaged tooth

8.8.5.1 A maximum of two teeth are covered in a period of 12 months.
8.8.5.2 The administrator will require a diagnostic x-ray (such x-ray should be taken before any treatment is attempted) to substantiate claim.
8.8.5.3 Once diagnosed and the claim settled, the tooth is considered properly treated and therefore un-claimable per individual tooth for a period of 5 years.
8.8.5.4 The replacement of existing crowns is not covered.
8.8.5.5 Deciduous teeth (milk teeth) are excluded.
8.8.5.6 A three month waiting period applies to this benefit.

8.9 Exclusions

No claims will be processed when policy is in arrears.

8.10. Claims documentation

8.10.1 A diagnostic report is defined as follows: A report that indicates the existence of the condition and which has been written by a registered dental practitioner. Such report may contain an x-ray analysis or the x-ray itself or an intra-oral photograph, which clearly shows the condition.
8.10.2 The minimum diagnostic reporting should contain the diagnostic description code (ICD-10) and, for cover which involves a tooth, the relevant FDI tooth number.

8.10.3 A treatment invoice is defined as follows: A treatment invoice indicates that a procedure has been done in order to treat an existing condition. Such invoices usually contain procedure descriptions or diagnostic descriptions.
8.10.4 If the treatment that has been rendered is a treatment that is appropriate for both insured and non-insured conditions, then diagnostic evidence of the original condition is always required to support the claim.

8.11 Premium payment

8.11.1 The premium is payable monthly and is subject to review.
8.11.2 The premium will be debited monthly together with the Oneplan Medical Insurance premium through Oneplan's appointed agent and will be paid to Denis Insurance Administrator's account by the appointed Agent.
8.11.3 The premium is due monthly in advance.
8.11.4 The Commencement Date of the policy will be the first of the month after which the first premium was deducted and received as stated on the Oneplan Policy Schedule
8.11.5 If it is not received by the Administrator by the due date, this insurance shall be deemed to have been cancelled at midnight on the last day of the last month for which a premium has been received.
8.11.6 The Administrator shall not be obliged to accept any premium tendered to it after the Commencement Date provided that premiums due with effect from the second month of the currency of this Policy will be accepted if paid within 15 days of the due date.

8.12 Waiting periods

8.12.1 The waiting periods as specified in the policy schedule and per herein will apply from the later of:
a. the policy Commencement Date, which is reflected on the policy schedule; and
b. the effective date of the inclusion of an insured life.

8.13 Policy termination

8.13.1 Cover under this Policy shall cease on the day that:
8.13.1.1 the premiums that are due are unpaid (and as provided for in the above Premium Payment clause);
8.13.1.2 the Policyholder dies;
8.13.1.3 the Insurer provides 30 (thirty) days written notice of cancellation to the policyholder at the latter's last known address;
8.13.1.4 the Policyholder provides 30 (thirty) days written notice for cancellation to the Administrator
8.13.1.5 the Policyholder's child dependent(s) reaches the maximum expiry age of 21 (twenty one);or
8.13.1.6 the Policyholder or Spouse reaches the maximum expiry age of 65 (sixty five), whichever of the aforementioned events first occur.

8.14 Repudiation of Claims

Where the Insured/claimant disputes Denis rejection of the claim, the Insured/claimant has 180 (one hundred and eighty) days from the date of the rejection letter to make representations to Denis in respect of this decision. If the dispute is not resolved at the end of this period then the Insured/claimant must within a further 180 (one hundred and eighty) days institute legal action by way of the service of summons against Denis failing which the Insured/claimant will forfeit her claim and no liability can arise in terms of such claim.

8.15 Misrepresentation

This Policy shall be voidable in the event of misrepresentation, misdescription or non-disclosure by or on behalf of the Insured of any material particular, to Denis, in which event, any and all premiums so paid or payable shall be forfeited to Denis.

8.16 No surrenders or cessions

This Policy may not be surrendered, assigned or transferred.

8.17 Condition precedent

Strict compliance by the Principal Insured and by the Administrator with all the provisions, conditions and terms of this Policy shall be a condition precedent to liability on the part of Denis hereunder.

8.18 Policy amendments

Denis may amend the terms and conditions of this Policy upon giving the Administrator written notice of such intention at least one (1) month before any premium rate adjustment, and 1 (one) months before any other Policy amendment. The Administrator must inform the Principal Insured of any material amendment of the terms and conditions.

8.19 VAT (Value added tax)

It is hereby agreed that all sums insured, amounts and limits reflected in this Policy are inclusive of VAT.

8.20 Fraud

If any claim under this Policy is in any respect fraudulent, or if any fraudulent means or devices are used by the Insured or anyone acting on their behalf to obtain any cover under this Policy, all benefit under this Policy in respect of such claims shall be forfeited.

8.21 Jurisdiction

Only the courts of the Republic of South Africa shall have jurisdiction to entertain any claims arising out of or in respect of this Policy and the law of the Republic of South Africa shall apply to this Policy. The parties hereby consent to the jurisdiction of the Witwatersrand Local Division of the High Court in respect of all claims and causes of action between them, whether now or in the future, arising out of or in respect of this Policy.

8.22 Payments

All payments are to be made in the currency of the Republic of South Africa and where payment is to be made to or by Denis it shall be made at Denis's Head Office unless Denis allows otherwise.

SECTION 9

9 LIFESENSE P3 PERSONAL PROTECTION PROGRAM

The Personal Protection Program is supplied by the Lifesense Group and it is a non-insurance Cover.

9.1 Defined events

9.1.1 Trauma Assistance

In the event of major crime related incidents such as rape, attended rape, hijacking, armed robbery, murder, mugging, domestic violence, suicide, major car accidents and natural disasters such as death in the family, Lifesense will arrange face to face counselling with a professional trauma councillor free of charged.

9.1.2 Shelter Facilities

Lifesense offer Oneplan Insured members the Cover of a 72-hour safe house in the event of domestic violence.

9.1.3 Preventative HIV Treatment

In the event of accidental contact with possible HIV infected blood through accidental sexual transmissions i.e. sexual assault and rape, blood transfusions or needlestick, contact with bodily fluids e.g. sporting injuries or vehicle accidents, occupational exsposure, covered insured persons will receive under this program access to anti-retrovirals or prophylactic therapy and access to STD preventative medication. This includes 2 blood tests and the 31 day preventative HIV/AIDS programme.

9.2 Claims

Insured persons need to contact the Lifesense 24-hour contact number for assistance.

SECTION 10

10 FMS SUPPORT: HIV/AIDS DISEASE MANAGEMENT, FUNERAL AND REPATRIATION PROGRAM

10.1 HIV/AIDS Disease Management

10.1.1. Introduction

The primary goal is to render a 24-hour, cost effective disease management programme for HIV positive members whereby we educate and support members to seek early, preventative care in order to prevent HIV transmission as well as educating and supporting HIV positive members on the clinical advantages in staying compliant to prescribed medication regimes. Our highly trained and dedicated HIV Case Managers emphasise the simple and confidential process of receiving ARV medication, staying compliant to treatment and discussing psycho-social issues in order to facilitate transparency and comfort with the member in the cost effective management of his / her own disease.

10.1.2. Territory

Cover will only be provided within the borders of South Africa.

10.2 Product benefits

10.2.1 HIV Screening (VCTs)

Individuals have a need and a right to know their HIV infection status to assist in protecting themselves and others and to plan for the future. We assist our clients in conducting onsite Voluntary Counselling and Testing as an on-going intervention strategy to enable people to cope with the stress and anxiety related to HIV and preventing new infections by:

- Identifying people that are HIV negative in order to reinforce change in risk behaviour, thereby reducing the risk of acquiring HIV
- Identifying those that are HIV positive also to modify risk behaviour and thereby reducing transmission of HIV
- Providing access to preventative treatment
- Providing HIV positive members with the option of early access to medical care and on-going emotional and social support.

As part of our offering, we can assist our clients to initiate and execute onsite HIV screenings. The VCT procedure used has been designed in accordance with World Health Organisation standards. To ensure validity of VCT testing, we not only ensure the appropriate use of the tests, but also ensure that all testers are trained adequately, that there is adequate quality control of testing and that test kits are not expired when used. Other important procedures that are used encourage any individual who tests negatively and has been involved in risk behaviour to be tested again in three months' time. Both the process and tests used in conducting VCT drives meet international standards and hence any individual participating in a VCT drive can have the confidence that the results will be accurate and that they will be treated appropriately according to worldwide practice.

10.2.2 HIV / AIDS Disease Management

The HIV / AIDS comprehensive Disease Management Programme consists of the following:

10.2.2.1 Patient Case Management with Monitoring & Education

- The patient monitoring component entails telephonic interaction between Case Manager and patient on a regular basis. The initial call has the purpose of establishing baseline information regarding lifestyle patterns, counselling needs, access to a doctor or healthcare facility and to establish a medication delivery need and process.
- Subsequent to this telephone call, the relevant documentation is faxed to the treating doctor, lab results are followed up and documented and referral for psychological counselling where needed is initiated.
- Follow up calls are scheduled on a monthly basis, unless there is a need for more frequent calls and / or follow up. These include patients who are on treatment as well as those not ready to participate in a treatment program.

10.2.2.2 Patient Medication Compliance Monitoring

- The primary care provider (General Practitioner) faxes all the relevant documentation and our in-house doctor evaluates the script in conjunction with the pathology laboratory results and clinical conditions. Treatment is approved and sent to the courier service for dispensing. The patient is educated and prepared for the prescribed treatment.
- The delivery address of ARV medication is checked with every telephone call. Quality assurance measures exist to monitor delivery and acceptance of medication.

10.2.2.3 Clinical Management & Support to General Practitioners

- Patients' treating doctors have access to our in-house doctor to assist in education and prescription protocols. Patient non-compliance and specific idiosyncrasies regarding patient-doctor relationships are dealt with the patients' Case Manager.

10.2.2.4 Medical Management of HIV Positive Members

- All HIV positive members are managed from the Call Centre, ensuring optimal utilisation of benefits. Those on pre-HAART supplements are monitored and relevant education given. Those HIV positive members who are registered on HAART treatment regimens are actively managed by the medical advisor in the call centre and the team of expert Case Managers.
- Behaviour modification is measured at every call by the Case Managers and the member is supported and encouraged to stay enrolled on the treatment programme. Our in-house Medical HIV specialist oversees the treatment regimens prescribed by the uninsured member's preferred medical doctor or at the clinic. All scripts are authorised by him and liaison with the treating doctors will also occur if necessary.
- Anti-retroviral medication and treatment is prescribed according to stage of illness, and in accordance with international guidelines. This ensures that the medication prescribed is the optimal treatment in respect of the member's stage of illness, and with the medical advisor being an expert in Resistance therapy, treatment is optimised according to the most recent research findings.
- The call centre Case Managers have regular contact with the patient and doctor to effectively support and monitor compliance to treatment. Monitoring visits to the doctor are made 3-6 monthly according to the individual's stage of illness.

10.2.2.5 Clinical Management

- Adherence to clinical management components such as regular doctor visits and pathology tests are managed by the Case Manager in the call centre.

10.2.3 Included per registered case per month

10.2.3.1Pre-HAART

- Administration and reporting
- Individualised Case Management
- Script Review
- Initial consultation at medical practitioner
- Follow up medical consultations
- Baseline path lab tests
- Follow up path lab tests
- Supplements delivered at address of choice
- Prophylaxis to opportunistic infections

10.2.3.2.HAART

- Administration and reporting
- Individualised Case Management
- Script Review
- Initial consultation at medical practitioner
- Follow up medical consultations
- Baseline path lab tests
- Follow up path lab tests
- ARV Medication delivered at address of choice
- Supplements delivered at address of choice
- Prophylaxis towards opportunistic diseases

10.3 Funeral Support Services

10.3.1 Definitions

"Funeral Support Services" shall mean the Services ,that FMS will provide to an Eligible Person in respect of a Life Assured, and which in summary depending on the requirements and on the circumstances of the Eligible Person will include the following:

1. Repatriation as contemplated in 1.2 below;
2. Transportation arrangements for a single relative to accompany the mortal remains to the nearest funeral home of choice closest to the place of burial;
3. Accommodation for a maximum of one night, if required, for a single relative accompanying the mortal remains to place of burial;
4. Legal assistance regarding the funeral procedures e.g. death certificate, removal of body, etc;
5. Assistance in the arrangement of a funeral or cremation, it being recorded that any costs shall not be for the account of FMS.
6. Assistance in obtaining a death Certificate.
7. Referral to pathologists if required;
8. Referral to a psychologist or psychiatrist if required;
9. Referral for special counselling particularly relating to the loss of a child if required;

"Territory" shall mean the Republic of South Africa, Namibia, Zimbabwe, Botswana, Swaziland, Lesotho and Mozambique (south of the 22° parallel).

"Repatriation" shall mean the repatriation of mortal remains of a Life Assured to the funeral home of the Eligible Person's choice, closest to the place of burial. The place of death must fall within the Territory and the place of burial must fall within the Republic of South Africa;

10.3.2 Service

FMS shall in the event of the death of any Life Assured; provide all or some of the funeral support services in respect of the Life Assured, depending on the requirements of the Eligible Person.

10.3.3 Procedure for provision of services

10.3.3.1 In the case of the death of any Life Assured the Eligible Person shall be entitled (if the Services offered by FMS are required), to contact FMS as soon as practicable and to furnish FMS with the following information:
10.3.3.2 The name and identity number of the deceased, address where death occurred and the employees number.
10.3.3.3 The name, address and telephone number where FMS can reach the Eligible Person.
10.3.3.4 FMS warrants that:

- It maintains and operates a telephone call centre 24 hours a day, 365 days a year. All calls are voice logged for future reference should a Party require that a call be retrieved.
- It has the necessary trained personnel to provide the Services.
- It will cause the services to be rendered in a prompt, efficient and courteous manner taking into account the Eligible Person's personal circumstances.

10.3.3.5 In the event of the Eligible Person's representatives making their own arrangements and incurring repatriation costs without referral to FMS, FMS will not be held responsible for these costs, although FMS may still give the Eligible Person other assistance.

SECTION 11

11 COMPLAINTS POLICY

11.1 Complaint has to be in writing

In order for a complaint to receive the attention that it deserves, we request that your complaint is submitted to us in writing. Please ensure, that where the complaint is delivered by hand or by any other means, that you retain proof of delivery.

11.2 Complaint has to be relevant

The financial services environment is complex. We will endeavour to address all reasonable requests from our clients, but may also refer you to a more appropriate facility. Where the complaint pertains to any aspect of our service, or any disclosures that ought to be made by us, we will endeavour to address those complaints in writing, within 5 working days.

In instances where the complaint pertains to something not within our control, such as product information or investment performance we will forward the complaint to the product provider concerned.

11.3 Procedures

The following is a step-by-step guideline of how a complaint will be dealt with, once received by us:

1. The complaint will be lodged in our central complaints register on the same day that it is made and confirmation of receipt forwarded to you.
2. The complaint is immediately brought to the attention of the Key Individual of this provider for allocation to a trained and skilled person who specialises in that type of complaint.
3. The complaint will be investigated and we will revert to you with our findings within 5 working days.
4. In the event that you are not satisfied with our solution, you may refer the complaint to the Managing Director of our business. The Managing director may amend the solution or confirm it. Please be informed that certain decisions may have to be approved by the Board or Management committee of the organisation. In such a case, we will communicate that fact to you, as well as the date on which a decision will be taken.
5. If, after having referred the complaint to the Managing Director, you are still not satisfied with the outcome, we will regard the complaint as being unsatisfactorily resolved. In such a case, you may approach the office of the Ombud for Financial Services Providers or take such other steps as may be advised by your legal representatives. The referral to the office of the Ombud must be done in accordance with the provisions of section 21 of the FAIS Act and the rules promulgated in terms of that section. In instances where we have not been able to arrive at a resolution within six weeks after you have lodged your complaint, the matter may automatically be referred to the Ombud.
6. You must, if you wish to refer a matter to the Ombud, do so within a period of six months. The Ombud will not adjudicate in matters exceeding a value of R800 000.00.
7. The Ombud –may be contacted at his offices in Pretoria, at the following address:

   Noluntu Bam
   The FAIS Ombud, Celtis House
   Eastwood Office Park
   Lynnwood, Pretoria
   Telephone No: 0860 FAISOM (0860 324 766)
   E-mail: info@faisombud.co.za

In the event of us not reverting to you within the time periods indicated above, kindly contact Lilian Mohr for an explanation as to why we have not yet communicated with you. Please do not accept any communication from any person until it has been confirmed in writing.

Compliance Manager: Lilian Mohr
Email address: lilian.m@oneplan.co.za
083 777 1425

STATUTORY DISCLOSURES - INTRODUCTORY LETTER AND SECTION 13 CERTIFICATION

DISCLOSURES REQUIRED IN TERMS OF THE FINANCIAL ADVISORY AND INTERMEDIARY SERVICES ACT 37 OF 2002

1. Status of Financial Services Provider in terms of the FAIS Act	
Outsourced FAIS Solutions cc is an authorised Financial Service Provider, Company Registration number 2007/008602/23, FAIS License number 31724. Dawn Julyan (ID 6909230072080) and Bernard van Rooyen are key individuals approved by the Financial Services Board. Oneplan is appointed as a representative of the FSP by virtue of a written mandate.	
2. Representative Personal Contact Particulars:	3. Remuneration
Cell No: 083 777 1425 Telephone No: 010 001 0141 Facsimile No: 086 697 6870 E-mail: lilian.m@oneplan.co.za	Oneplan is a representative in terms of a written mandate of the FSP, and receives incentive remuneration from product providers as per the maximum commission permissible in addition to any fees contracted directly with any client and agreed to in writing. No incentives are provided by the FSP to its representatives.
4. FSP Representative Office Contact Particulars	
Physical Address: 54 Maxwell Drive, Woodmead North Office Park, Ground Floor, Woodmead, Gauteng, South Africa Postal Address: PO Box 652075, Benmore 2010, Gauteng	Telephone No: 010 001 Facsimile No: 086 610 3918 E-mail: info@oneplan.co.za
5.Responsible Key Individual Contact Particulars	
Physical work address: 481 Barry Hertzog street, Waterkloof Glen 0181 Facsimile No: 086 636 5217	Telephone No: 012-998 7938 E-mail address: dawn@legal1.co.za
6. Qualifications and Memberships	
Total Experience in the Financial Services Industry: 8	Inception: 2009
7. Independent Status of (FSP) and Professional Indemnity Insurance	
FSP has agreements with most of the major product providers being: ABSA Insurance Risk Management Services T/A AIRMS, Lifesense Group, Netcare 911, and our representatives are authorised to place business with any of them. In the past 12 months this business did not earn more than 30% of its income from any product provider. FSP has no financial interest in any product supplier. We do carry professional indemnity insurance and our representatives are required to have this in place."	
8. Authorisation	
The FSP accepts responsibility for the actions of the above mentioned representatives acting within the mandates listed below. The representative is authorised to give advice and render intermediary services on the following product categories:	
Long term insurance category A, B and C, Short term commercial and personal lines	
The financial services provider will not be held liable in terms of any prejudice in respect of services or advice provided by any representative which falls outside the scope of this authorisation, and any complaint in respect of any product which falls outside the definition of financial product of the FAIS Act, can not be forwarded to the FAIS Ombud	
9. Complaints Procedures and conflict of interest	
If you have a complaint, please contact the FSP Key Individual. He/She will assist you to address the concerns you have. Please note that in terms of the FAIS act, all complaints must be addressed to us in writing. Should we not be able to address the concerns to your satisfaction, you may wish to lodge a complaint with any of the Ombudsmen whose detail appear below, but in particular with the FAIS Ombud. If you wish to learn more about our complaints policy and procedure, please contact our complaints officer Ms Julyan at the office number above or consult our website www.fais2.com. FSP 31724 subscribes to the highest ethical code and we require all our representatives to adopt this in their dealings. A copy of our conflict of interest policy can be found on our website .	
10. FSP Compliance Officer's Details	
Madhu Patel Compliance practice number 177	Telephone No: (031) 3096363
11. FAIS Ombud Details for all FAIS advice related complaints	
The Customer Contact Division The FAIS Ombud Celtis House Eastwood Office Park Lynnwood, Pretoria	PO Box 74571 Lynnwood Ridge 0040 Telephone No: 0860 FAISOM (0860 324 766) E-mail: info@faisombud.co.za
12. Long term Ombud details for all Long term insurance complaints	
3rd Floor Sanclare Building 21 Dreyer Street Claremont 7700	Telephone No: (021) 657 5000 Facsimile No: (021) 674 0951 E-mail: info@ombud.co.za Private Bag X 45, Claremont, 7735

STATUTORY DISCLOSURE FOR DENIS INSURANCE ADMINISTRATORS (PTY) LTD

Contact and other details of the Administrator:

a. The Administrator, Denis Insurance Administrators (Pty) Ltd, is an Authorised Financial Services Provider in terms of the Financial Advisory and Intermediary Services Act (FSP number 36026)
b. Physical Address: Block D, The Forum, Northbank Lane, Century City, 7441
c. Postal Address: PO Box 114, Century City, Canal Walk 7446
d. Telephone Number: 0860104940
e. Fax Number: 021 528-5861
f. Compliance Officer: Providus Compliance Consulting: (021) 979 5201
g. The Administrator is a company incorporated in terms of South African company legislation. It performs services as an intermediary under the Short Term Insurance Act and Financial Advisory and Intermediary Services Act, entering into short-term policies. It has an agreement with Guardrisk, a cell captive insurer, and has the necessary mandates to act on behalf of Guardrisk
h. Professional indemnity insurance is in force

Contact and other details of Guardrisk:

a. Guardrisk Insurance Company Ltd is an Authorised Financial Services Provider in terms of the Financial Advisory and Intermediary Services Act (FSP number 75). Guardrisk is a registered short-term insurer in terms of the provisions of the Short-term Insurance Act,1998
b. Physical Address: 4th Floor, Alexander Forbes Place, 90 Rivonia Road, Sandton, 2196
c. Postal Address: P.O. Box 786015, Sandton, 2146
d. Telephone Numbers: 011 669 1000 / 021 401 9929
e. Fax Numbers: 011 669 1931 / 021 415 4741
f. Compliance Officer: available on above numbers.

OTHER MATTERS OF IMPORTANCE

You, the Insured, must be informed of any material changes in the detail provided above about the Administrator and Guardrisk;
If the information about the Administrator and Guardrisk was given orally, it must be confirmed in writing within 30 (thirty) days;
If any complaint to the Administrator and / or Guardrisk is not resolved to your satisfaction, you may submit the complaint to the Registrar of Short term Insurance;
A polygraph or any lie detector test is not obligatory in the event of a claim and the failure thereof may not be the sole reason for repudiating a claim;
If the premium is paid by debit order: it may only be in favour of one person and may not be transferred without your approval; and
Guardrisk must inform you at least 30 (thirty) days before the cancellation thereof, in writing of its intention to cancel such debit order;
Guardrisk and not the Administrator must give reasons for repudiating your claim;
Guardrisk may not cancel your insurance merely by informing the Administrator. There is an obligation to make sure the cancellation notice has been sent to you;
You are entitled to a copy of this Policy document free of charge; and
You have read and understood the contents of this Policy.

WARNINGS TO INSURED

Do not sign any blank or partially completed forms;
Complete all forms in ink;
Keep all documents handed to you;
Make a note as to what is said to you;
Do not be pressurized to buy the product; and
Incorrect or non-disclosure by you of relevant facts may influence the Insurer / Administrator regarding any claims made.

COMPLAINTS PROCEDURE

If any insurance complaint to the Administrator or Insurer is not resolved to your satisfaction, you may submit the complaint to the following regulators:

The Short Term Insurance Ombudsman – in the event of claims problems not satisfactorily resolved
P O Box 32334, Braamfontein, 2017
Tel: 011 726 8900, Share call: 0860 726 890, Fax: 011 726 5501
E-mail: info@osti.co.za Website: www.osti.co.za

The FAIS Ombud – in respect of complaints about the Administrator
P O Box 74571, Lynwood Ridge, 0040
Tel: 012 470 9080 Share call: 0860 324 766 / 0860 FAISOM Fax: 012 348 3447
E-mail: info@faisombud.co.za Website: www.faisombud.co.za

The Registrar of Short Term Insurance (Financial Services Board) if any complaint to the Administrator or Insurer is not resolved to your satisfaction
P O Box 35655, Menlo Park, 0102
Tel: 012 428 8000, Fax: 012 347 0221