PRODUCT AND BENEFIT RULES
OLD MUTUAL PROTECT FUNCTIONAL IMPAIRMENT INCOME COVER

CONTRACT NUMBER: 123456789

How to read these product and benefit rules

We/us/our means Old Mutual, which is the short form of our full name, Old Mutual Life Assurance Company (Namibia) Limited. Our registration number is 97/081. We are the insurer.

You/your/I means the owner – the person who took out the contract with us and who may give us instructions relating to it. The names of the owners are shown on Personal, product and benefit details.

In the rest of this pack, where we use insurance words that may be difficult to understand, look out for the definitions, examples and notes on the right hand side of the page:

- indicates a definition
- indicates an example
- indicates a note or more information.

Your completed application (including the accepted quote), other information (for example about the insured person's health) that has been provided to us in any form including in writing and verbally, these Product and benefit rules and the Personal, product and benefit details included in this pack, form the contract between you and us. The other documents in this pack do not form part of the contract but are provided to you to help you understand it better.

These Product and benefit rules have been written in the form of questions that you may want to ask us and our answers to them. If this pack does not fully answer your questions, you may contact us as described under "HOW DO I...?".

ABOUT YOU AND THE PRODUCT

What have I bought?

You have bought Old Mutual Protect Functional Impairment Income Cover. It pays the cover amount monthly if the insured person becomes functionally impaired or suffers a fracture. The name of the insured person is shown on the Personal, product and benefit details and the rules that apply are explained in these Product and benefit rules. In return for cover, you must pay its price, called premiums. You may have further customised the product to meet your needs by choosing other features and benefits.

What is a replacement owner?

A replacement owner is a person who will take over the ownership of the contract if it continues after your death. You must nominate him/her. Any nominated replacement owner's name will appear on Personal, product and benefit details. You may change the replacement owner at any time. We will not act on any replacement owner nomination that we receive after your death. If you have not named a replacement owner or the replacement owner you have named is no longer alive when you die, the executor of your estate must appoint the new owner in terms of your will or, if you do not have a will, the law of succession will apply.

The **executor** is the person who finalises your estate (what you owe and own) after your death. He/she may be appointed in your will or by a court.

What is a beneficiary?

A beneficiary is a person who will receive the cover amount when it becomes payable. Any beneficiary's name will appear on Personal, product and benefit details. If you are still alive at that time, you may choose whether we will pay the cover amount to you or the beneficiary.

If you are no longer alive at that time, we will pay the beneficiary who is alive at that time. If none of the beneficiaries are alive at the time, we will pay the cover amount to your estate.

If some of the beneficiaries are not alive at the time, we will divide the shares of the deceased beneficiaries between the beneficiaries that are still alive at the time in the same proportion as the remaining beneficiaries' shares.

We may allow you to name one or more beneficiaries or to change the beneficiary at any time. We will not act on any beneficiary nomination that we receive after your death. Unless you have indicated otherwise, all beneficiaries will receive equal shares of the cover amount.

Dividing deceased beneficiaries' shares between those that are alive when the cover amount becomes payable - Abel, Ben and Craig have been nominated to receive 50%, 25% and 25% of the cover amount respectively. Craig had passed away at the time that the cover amount becomes payable. His 25% share will be divided between Abel and Ben. Abel will receive 16.67% (two thirds of 25%) and Ben will receive 8.33% (one third of 25%) in addition to their original 50% and 25% shares.

What is cashback and who is the cashback beneficiary?

On each cashback anniversary, we will pay a percentage, as shown on Personal, product and benefit details of all the premiums that we have received for the contract since the previous cashback anniversary and while cashback existed on your contract, to the cashback beneficiary. The name of the cashback beneficiary is shown on Personal, product and benefit details. You may remove cashback from the contract at any time. Cashback will not be paid if the contract has been cancelled for any reason including where we pay a claim that results in the contract terminating.

Its premium is included in the premium for the product on Personal, product and benefit details. The cashback premium changes whenever the contract premium changes or at its review date. The next cashback review date is shown on Personal, product and benefit details.

A **cashback anniversary** is every fifth anniversary of the date on which the cashback was first added to the contract. If there is less than five years to the contract end date, cashback will be paid on the contract end date. The date of the next cashback anniversary is shown on Personal, product and benefit details.

When cashback is payable - if you added cashback to your contract on 1 July 2017, the first cashback anniversary will be on 1 July 2022. If you remove cashback from your contract on 30 June 2019, you will still receive cashback on 1 July 2022 if your contract has not been cancelled by this date, for the 2 years during which cashback existed on your contract (between 1 July 2017 and 30 June 2019).

Cancelled includes where we cancel the contract because you stopped paying premiums and where we cancel the contract on your instruction.

What and when do I pay?

Until the premium end date, you must pay all premiums on their due dates. The Personal, product and benefit details shows the starting premium, first premium due date, name of the premium payer, frequency of premiums and the premium end date.

You have 45 days (a grace period) from its premium due date to pay each premium. If we do not receive your first premium within 45 days from the first premium due date, your application will be cancelled. As the contract does not start until the first premium has been received, you may not apply to have it restarted. If a premium becomes due and we do not receive it within 45 days from the due date or another premium becomes due within the 45 days, we will cancel the contract. If we receive a claim and there is any premium outstanding, we will deduct it from the claim payment.

If we have cancelled the contract because you have not paid your premiums, you may, within six months from the date on which the contract was cancelled, apply to have it restarted. We may ask for further information before we agree to restart the contract. If we agree to restart the contract, it may be on different terms and you must restart your premiums. You will not have cover from when your contract was cancelled until we have agreed to restart it. If we have cancelled your contract again because you have not paid your premiums, you may only apply to have it restarted if we have received your premiums for at least six months from the time the contract was previously restarted.

When your premiums will/may change

Your premiums will/may change under any of the circumstances described below. If your premium changes, we will notify you of the new premium.

Compulsory yearly premium increases

Until the premium end date and for any compulsory yearly premium increase other than 0%, your premium will automatically increase every year on the compulsory yearly premium increase date as shown on Personal, product and benefit details. The compulsory yearly premium increase you have chosen is shown on Personal, product and benefit details and the different compulsory yearly premium increases are explained below.

Compulsory yearly premium increase	**How the premium will increase**
Fixed rate	Your premium will increase every year by the percentage you have chosen.
Age-linked	The yearly premium increase depends on the age of the insured person at his/her next birthday after the increase date: Age: Yearly premium increase Younger than 31: 0% 31 to 35: 4% 36 to 40: 6% 41 to 50: 8% 51 to 60: 9% Older than 60: 10%

This is necessary to keep the cover amount constant and the cover amount will not increase because of the compulsory yearly premium increase. You may change the compulsory yearly premium increase at any time.

Different terms could include the following examples:

- a premium increase,
- additional circumstances under which we will not pay,
- the insured person may no longer qualify for the existing benefit but may qualify for another benefit, or
- a cover decrease.

Compulsory yearly premium increases and scheduled yearly cover increases and their impact on the cover amount and premium – Joe has chosen a 10% compulsory yearly premium increase and chose a 10% scheduled yearly cover increase. His starting cover is N$100 000 and his starting premium is N$200. After 1 year, his new cover is N$110 000 (N$100 000 + N$10 000 (10% * N$100 000)). The premium increase for the additional cover is N$22. The premium increase because of the compulsory yearly premium increase is N$20 (10% * N$200). His new premium is N$242 (N$200 + N$22 + N$20). Every year, if no other changes are made, the cover amount will change because of scheduled yearly cover increases and his premium will change because of both scheduled yearly cover increases and compulsory yearly premium increases.

Review at the end of each guarantee term

Premiums are based on our expectations of future conditions and we expect them to be sufficient for the full term of the contract. However, future conditions are uncertain and may be different to our expectations. For this reason, we will review your premium or the cover amount at the end of each guarantee term. The first review date is shown on Personal, product and benefit details. At such a review, we may:

- keep the premium or the cover amount the same,
- increase the premium, or
- change the cover amount.

Different benefits may have different guarantee terms as shown in Personal, product and benefit details. If, at a review, the premium is increased while no premium is payable on the contract because the benefit is in payment, you must pay the increased premium if the contract continues after we have stopped making payments.

Changes to the cost of cover because of changes in law

We may change the premium at any time, even before the next review date, if the cost of providing cover changes significantly because of changes in tax or other laws.

Contract changes

Some contract changes (for example if you decide to increase or decrease the cover amount), may also change your premium.

Scheduled yearly cover increases

Your premium will also change every year if you have chosen a scheduled yearly cover increase other than 0% scheduled yearly cover increase, to pay for the increased cover amount. If you have chosen a compulsory yearly premium increase other than 0% and a scheduled yearly cover increase other than 0%, your premiums will increase by the compulsory yearly premium increase rate and by the cost of the increased cover amount bought by the scheduled yearly cover increase.

Are the premiums tax deductible and payments of the cover amount taxed?

Under current tax law, premiums for this benefit are tax deductible except where the payment of premiums benefits the spouse or child of the premium payer. If you meet all the requirements set out by law, you will be able to reduce your taxable income by the amount of premiums paid. The tax deduction is only available to those who have a taxable income against which this deduction can be claimed. When we pay the cover amount, you will be taxed accordingly. In each case, it is your responsibility to declare the amounts we pay on your tax return as income.

Can I miss premiums?

No, you must pay your premiums when they are due.

Why and how will the cover amount change?

The starting cover amount for each benefit is shown on Personal, product and benefit details.

When the cover amount will/may change

The cover amount will/may change under any of the circumstances described below. If the cover amount changes, we will notify you of the new cover amount.

Scheduled yearly cover increases

Until the premium end date, even if we are making monthly payments, the cover amount will automatically increase every year on the scheduled yearly cover increase date as shown on Personal, product and benefit details. The scheduled yearly cover increase you have chosen is shown on Personal, product and benefit details and the different scheduled yearly cover increases are explained below.

Scheduled yearly cover increase	**The cover amount will increase every year by:**
Fixed rate	the percentage you have chosen.
Inflation-linked	the inflation rate as set by us and as adjusted by a percentage you have chosen.

The impact of the scheduled yearly cover increase is explained under "What and when do I pay?".

If you do not want the cover amount to increase in a particular year, you need to inform us before the scheduled yearly cover increase date in that year. If you refuse the scheduled yearly cover increase three years in a row, we will change the scheduled yearly cover increase to a fixed rate 0% increase. You may later apply to change it again. We may ask for further information. We may or may not agree to the change.

Review at the end of each guarantee term

Premiums are based on our expectations of future conditions and we expect them to be sufficient for the full term of the contract. However, future conditions are uncertain and may be different to our expectations. For this reason, we will review your premium or the cover amount at the end of each guarantee term. The first review date is shown on Personal, product and benefit details. At such a review, we may:

- keep the premium or the cover amount the same,
- increase the premium, or
- change the cover amount.

Different benefits may have different guarantee terms as shown in Personal, product and benefit details. If, at a review, the premium is increased while no premium is payable on the contract because the benefit is in payment, you must pay the increased premium if the contract continues after we have stopped making payments.

Changes to the cost of cover because of changes in law

We may change the cover at any time, even before the date of the next cover review, if the cost of providing cover changes significantly because of changes in tax or other laws.

If you make any contract changes

Some contract changes you make (for example you decide to increase the cover amount), may also change the cover amount.

Why is it important that Old Mutual must always have up to date contact details for the persons who play a role in the contract?

We need your contact details to be up to date so that we can communicate with you about the contract. We need the beneficiaries' latest contact details so that we can pay the cover amount when it becomes payable. You must inform us if any contact details for any person who plays a role in the contract, changes.

Unclaimed benefits

We will try to find the persons who have the right to the cover amount or any other benefit under this contract when it becomes payable.

We will search our internal database, a database outside of Old Mutual like that of the Ministry of Home Affairs and Immigration or use a tracing agent.

If we use a tracing agent, we will deduct the cost of tracing from the cover amount or benefit before we pay it. The cost of tracing will change over time.

If we do not pay the benefit within 15 working days of all the requirements to confirm the validity and acceptance of the claim having been met, we will make up for the late payment by increasing the claim payment amount at our discretion.

Why must Old Mutual know about changes to the circumstances of the insured person?

You must tell us in writing about certain changes to the circumstances of the insured person as it may affect the contract and its terms. Please see "CHANGES TO THE CIRCUMSTANCES OF THE INSURED PERSON" at the end of this document for details.

Why is it important that I always provide honest and correct information to Old Mutual?

We use all the information you and the insured person provide to us and rely on it to make decisions about accepting your application, what cover we will provide and the premium you must pay. If the information we receive is untruthful, incorrect or incomplete, this may affect our decision-making.

If we find out that any information was untruthful, incomplete or withheld, we may make changes to your contract (such as the premium or the cover amount) or cancel it. If we cancel your contract, we will not refund your premiums.

We may investigate any claim. If you, the insured person or the claimant gave us incorrect, fraudulent or incomplete information at any time (including during application), we may refuse to pay the claim or cancel your contract. If we cancel your contract, we will not refund your premiums.

Why must I make sure that the cover amount is never more than the insured person's average monthly income?

It is your responsibility to make sure that the cover amount is never more than the insured person's average monthly income. If it is, we will reduce the cover amount and the payments. If we reduce the cover amount, we will not refund any premiums you have paid.

If you have chosen scheduled yearly cover increases other than fixed rate 0%, you need to take particular care that the cover amount is not more than the insured person's average monthly income.

The **average monthly income** is the income (for instance salary, fees, commission) less tax that the insured person earns from his/her occupation, profession or business as stated on Personal, product and benefit details. We only consider certain forms of income and we use certain assumptions to calculate the tax – this means that the income and tax that we calculate may differ from the insured person's actual income and tax. Also, sinace the income may vary from month to month, we calculate the average over a period of time. We average the income over a period of up to 12 months. We may average over a period of up to 36 months for insured persons with large fluctuations in income, for example, commission earners. In calculating the average, we may adjust the income by the inflation rate set by us.

Overinsurance - Peter's average monthly income was N$100 000 when he bought his Old Mutual Protect Disability Income Cover product. So he bought the Disability Income Cover benefit with cover for N$100 000 and he chose fixed rate 10% scheduled yearly cover increase to ensure that the cover amount increased each year. At his first scheduled yearly cover increase date, we automatically changed Peter's cover to N$110 000. However, Peter's average monthly income was only N$105 000 which means that if Peter were to become occupationally disabled, we would not pay more than N$105 000. This means that Peter is over insured and he should decrease his cover to N$105 000 to bring it in line with his average monthly income.

Will I get money from the contract if I or Old Mutual cancel it?

No, the contract does not have a cash value and because you enjoyed cover before it was cancelled, you cannot claim back the premiums you have paid.

Can I loan money from the contract?

Because the contract does not have a cash value, you cannot loan from it.

Can I transfer my rights to the contract?

We refer to the transferring of rights as cession.

You may transfer your rights by giving ownership to someone else (outright cession) and as security for a loan (security cession).

We will change our records to reflect the cessionary's name once all our requirements have been met including that you have informed us of the cession.

Cessions affect you, the replacement owner and beneficiaries

An outright cession transfers all your rights to the contract to the cessionary. He/she can make any contract changes including to change the beneficiaries or replacement owners.

A security cession limits your rights or ability to make contract changes. Until the security cession is cancelled, you may need the permission of the cessionary to make certain contract changes and your nominated beneficiaries will only receive any benefits after the cessionary has received what they are owed.

The **cessionary** is the person to whom rights to (in the case of a security cession) or the ownership of the contract (in the case of an outright cession), has been transferred. In the case of an outright cession, this person becomes the new owner.

What can I do if I have chosen term cover and that benefit reaches or nears its cover end date?

We may allow you to apply for a similar benefit within 90 days before or after the cover end date if:

- the premiums on this contract are up to date at the time,
- the insured persons on the new and this benefit are the same,
- the cover amount on the new benefit is not more than the cover amount on this benefit, and
- all our requirements at the time are met (for example completing an application).

WHAT ELSE DO I NEED TO KNOW?

Replacing an existing financial product

It may not be in your best interest to cancel or change existing financial products to take out other ones. For example: you may not be able to get cover for the same premium you previously paid and the new product may have more exclusions, restrictions or waiting periods.

Cooling-off period

You may ask us to cancel this contract within 31 days of receiving this pack. You may only cancel this contract if you have not claimed and we have not paid any benefits. After we have deducted the cost of the cover you have enjoyed, we will refund any premiums we have received before you instructed us to cancel the contract. You may also cancel any contract change within 31 days of giving us the instruction.

ABOUT THE BENEFITS

Information about the benefits, including the names of the insured person and the benefits, is shown on Personal, product and benefit details. The rules of each benefit are further described below.

ABOUT THE FUNCTIONAL IMPAIRMENT INCOME COVER BENEFIT

What is it?

This benefit pays up to 100% of the cover amount monthly if the insured person (whose name appears on Personal, product and benefit details) becomes:

- functionally impaired or
- suffers a fracture

after the cover started and if the waiting period is met.

Functionally impaired means that the insured person has suffered and meets the requirements of a qualifying functional impairment, despite following reasonable medical advice and adequate medical treatment. See the list of functional impairments that qualify at the end of this document.

Reasonable medical advice means the medical opinion provided by a health professional that the insured person can reasonably be expected to follow to improve or preserve his/her health. This may include investigations, recommendations, lifestyle adjustments and treatment options based on the best available information and appropriate to the condition, the health professional's knowledge and scope of practice.

Adequate medical treatment means the best possible treatment that a person can reasonably be expected to undergo and includes the use of simple external assistive devices for example hearing aids, glasses, contact lenses, a walking stick or a Zimmer frame but does not include the use of complex external assistive devices for example a wheelchair or leg prosthesis. The general meaning of the terms 'simple external assistive devices' and 'complex external assistive devices' is not limited by the specific examples provided.

A **fracture** means damage to the continuity of a bone. Not all fractures qualify for benefits under this product, for example hairline fractures or fractures of the toe. See the list of qualifying fractures and how many payments each fracture qualifies for depending on the waiting period chosen at the end of this document.

What is a waiting period?

A waiting period is the number of consecutive days or months for which the insured person's functional impairment must have continued or from the date of the fracture that must have passed before we will start the monthly payments. It starts on the date of the functional impairment or the fracture as confirmed by our medical officer. The waiting period you have chosen is shown on Personal, product and benefit details. You must continue to pay your premiums during the waiting period and while we decide if your claim is valid but can stop paying your premiums when we start the monthly payments. If your contract is cancelled before the waiting period ends, we will not start the monthly payments.

We may decide not to apply the waiting period if the insured person was functionally impaired for at least one month, recovers and then becomes functionally impaired from a related event within three months after his/her recovery.

If we decide not to apply the waiting period, we will start the monthly payments from the date of the functional impairment.

Waiting period end – Frank chose a 1-month waiting period. He suffers a fracture on 1 January 2016. The waiting period starts on 1 January and ends at midnight on 31 January 2016.

Cancelled may include because you have instructed us to cancel the contract or we have cancelled it (including because we have discovered that you or the insured person withheld information or deliberately disclosed inaccurate information and we have relied on this information in our decision to issue the contract).

Related event and the waiting period only applies once – Sally is diagnosed with chronic gastrointestinal disease and is functionally impaired. She chose a 1-month waiting period so she qualified for a monthly payment from month two. She recovers three months after her diagnosis and we stop making monthly payments. Two months later she is diagnosed with chronic liver disease and is again functionally impaired. Because we consider her chronic liver and gastrointestinal diseases to be related conditions and because her second condition happened within three months of her recovery from the first condition, we will not apply another 1-month waiting period and will start making monthly payments immediately.

Unrelated event and the waiting period is applied again - Sally is diagnosed with chronic gastrointestinal disease and is functionally impaired. She chose a 1-month waiting period so she qualified for a monthly payment from month two. She recovers three months after her diagnosis and we stop making monthly payments. Two months later she is diagnosed with hypertension and is again functionally impaired. Because we consider her chronic gastrointestinal disease to be unrelated to her hypertension and despite the short time between her recovery from the first condition and her diagnosis with the second, we will apply another 1-month waiting period and will start making monthly payments from month two.

Our medical officer, supported by published medical evidence, determines if events are **related**. Typically this means that they stem from the same incident (for example a certain car accident) or condition (for example cancer) or from complications or treatment following the same incident or condition.

What is a waiting period?

A waiting period is the number of consecutive days or months for which the insured person's functional impairment must have continued or from the date of the fracture that must have passed before we will start the monthly payments. It starts on the date of the functional impairment or the fracture as confirmed by our medical officer. The waiting period you have chosen is shown on Personal, product and benefit details. You must continue to pay your premiums during the waiting period and while we decide if your claim is valid but can stop paying your premiums when we start the monthly payments. If your contract is cancelled before the waiting period ends, we will not start the monthly payments.

We may decide not to apply the waiting period if the insured person qualified for at least one payment after he/she was functionally impaired, recovers and then becomes functionally impaired from a related event within the length of the chosen waiting period after his/her recovery.

If we decide not to apply the waiting period, we will start the monthly payments from the date of the functional impairment.

Waiting period end – Frank chose a 1-month waiting period. He suffers a fracture on 1 January 2016. The waiting period starts on 1 January and ends at midnight on 31 January 2016.

Cancelled may include because you have instructed us to cancel the contract or we have cancelled it (including because we have discovered that you or the insured person withheld information or deliberately disclosed inaccurate information and we have relied on this information in our decision to issue the contract).

Related event and the waiting period only applies once – Sally is diagnosed with chronic gastrointestinal disease and is functionally impaired. She chose a 12-month waiting period so she qualified for a monthly payment from month 13. She recovers 18 months after her diagnosis and we stop making monthly payments. Two months later she is diagnosed with chronic liver disease and is again functionally impaired. Because we consider her chronic liver and gastrointestinal diseases to be related conditions and because her second condition happened within three months of her recovery from the first condition, we will not apply another 12-month waiting period and will start making monthly payments immediately.

Unrelated event and the waiting period is applied again - Sally is diagnosed with chronic gastrointestinal disease and is functionally impaired. She chose a 12-month waiting period so she qualified for a monthly payment from month 13. She recovers 18 months after her diagnosis and we stop making monthly payments. Two months later she is diagnosed with hypertension and is again functionally impaired. Because we consider her chronic gastrointestinal disease to be unrelated to her hypertension and despite the short time between her recovery from the first condition and her diagnosis with the second, we will apply another 12-month waiting period and will start making monthly payments from month 13.

Our medical officer, supported by published medical evidence, determines if events are **related**. Typically this means that they stem from the same incident (for example a certain car accident) or condition (for example cancer) or from complications or treatment following the same incident or condition.

How much does Old Mutual pay?

The cover amount for the insured person can be claimed when he/she becomes functionally impaired or suffers a fracture. The starting cover amount is shown on Personal, product and benefit details. Each monthly payment is equal to a percentage of the cover amount that applies on the payment day.

For functional impairment, the percentage of the cover amount depends on:

- the severity of the functional impairment. The functional impairments, their requirements and the percentage of the cover amount payable in each case are shown at the end of this document,
- the average monthly income the insured person was earning from his/her occupation immediately before he/she became functionally impaired and
- the average monthly income the insured person receives from any other source while he/she is functionally impaired.

If the insured person is functionally impaired for part of a month when the monthly payment is payable, we will pay a proportion of the monthly payment that would have applied for that month.

The percentage of the cover amount that is paid for functional impairment may change over time as the insured person's condition worsens or improves.

If the insured person qualifies for more than one claim at the same time, we will pay the claim that results in the highest percentage of the cover amount.

If the insured person suffers a fracture, each monthly payment will be equal to 100% of the cover amount. We will not pay for a fracture if you have chosen a waiting period of longer than one month or if you suffer a fracture while we are already making monthly payments for functional impairment.

The cover amount will only be paid once our requirements have been met and if the claim is valid. We will pay the cover amount into a Namibian bank account.

Enhanced in payment scheduled yearly cover increases for qualifying occupations

If the insured person's occupation is one of our qualifying occupations, the scheduled yearly cover increase will be doubled while payments are being made under this contract. If double the scheduled yearly cover increase is more than the maximum enhanced in payment scheduled yearly cover increase we set, the cover amount will not increase by more than the set maximum. The enhanced in payment schedule yearly cover increase will stop and the scheduled yearly cover increase will continue if:

- we have already applied five enhanced in payment scheduled yearly cover increases or
- the insured person turns 35

whichever happens first.

Will there be any payment for the waiting period?

No, there will not be a payment for the waiting period.

When does cover start?

The cover starts on the cover start date for this benefit as shown on Personal, product and benefit details.

The **payment day** is the day of the month on which you have chosen to receive the monthly payments. When you claim, you can choose the payment day. If you did not choose a day of the month, the payment day will be the last day of the month. If any payment day is not a working day, we will make the monthly payment on the next working day.

Percentage of the cover amount payable on functional impairment – Jacob is an engineer and his monthly income was N$100 000 when he bought his Old Mutual Protect Functional Impairment Income Cover so he bought cover for N$100 000 and he chose fixed rate 10% scheduled yearly cover increase to ensure that the cover amount increased each year. At his first scheduled yearly increase date, we automatically changed Jacob's cover to N$110 000. Jacob then became functionally impaired and his monthly income was only N$105 000. We will never pay more than N$105 000. We will start paying N$105 000 per month.

Examples of **any other source** include income earned from:

- another occupation, and
- any income payments received from:
  - his/her employer,
  - any product provider.

Examples of a **product provider** include us and other insurers.

It does not include payments received from the road accident fund or for the specific purpose of covering continuing business expenses.

Functionally impaired for part of a month – John is the insured person with a cover amount of N$80 000. He chose a 1-month waiting period. On 1 May, he becomes functionally impaired and recovers on 15 June. The waiting period starts on 1 May and ends at midnight on 31 May. If John chose to receive his payments at the end of the month, on 30 June, we will make a monthly payment equal to N$40 000 (N$80 000 x 15 days / 30 days) for the part of the month 1 June until 15 June that John was functionally impaired.

You can request a list of the **qualifying occupations** from us.

When will the monthly payments start?

Once all our requirements have been met, the monthly payments for a valid claim will start after the end of the waiting period. When you claim, you may choose the payment day.

If all our requirements are met before the waiting period has passed, we will pay the first monthly payment on the payment day immediately after the end of the waiting period to cover the time after the end of the waiting period and up to the date of the first monthly payment.

If all our requirements are met after the waiting period has passed and:

- if there was at least one payment day between the end of the waiting period and the date our requirements are met, we will pay:
  - a single amount to cover the time after the end of the waiting period and up to the payment day immediately before or on the date our requirements are met and
  - the first monthly payment on the payment day immediately after the date our requirements are met to cover the time after the payment day immediately before or on the date our requirements are met and up to the date of the first monthly payment
- if there was no payment day between the end of the waiting period and the date our requirements are met, we will pay the first monthly payment on the payment day immediately after the date our requirements are met to cover the time after the end of the waiting period and up to the date of the first monthly payment.

We will not pay interest on any of these amounts. If your contract is cancelled before the waiting period ends, we will not start the monthly payments.

When will the monthly payments stop?

The monthly payments will stop:

- if the insured person dies,
- if we no longer recognise the insured person's functional impairment (as explained under "When will Old Mutual not recognise the insured person's ..." under the heading "When will Old Mutual not pay the cover amount?"),
- if the insured person fails to meet our requirements for following reasonable medical advice or adequate medical treatment,
- if the insured person fails to meet our requirements for regular evaluation of his/her functional impairment,
- when we have made the last monthly payment that the insured person qualifies for (as explained under "How many monthly payments will Old Mutual make?"),
- if the insured person no longer qualifies for the benefit because of changes to his/her circumstances (as explained under "CHANGES TO THE CIRCUMSTANCES OF THE INSURED PERSON"), or
- if your contract is cancelled,

whichever happens first.

If the insured person qualified for more than one claim at the same time, once we stop making payments for the claim that resulted in the highest percentage of the cover amount, we will continue to make monthly payments at a lower percentage of the cover amount if the insured person still qualifies for monthly payments under another claim.

If the monthly payments stop and cover continues, you must start paying your premiums again.

All our requirements are only met after the waiting period and at least one payment day has passed – Jolene is the insured person on the Functional Impairment Income Cover benefit with a cover amount of N$80 000 and a 1-month waiting period. She becomes functionally impaired on 1 May. The waiting period starts on 1 May and ends at midnight on 31 May. All our requirements are met on 15 July and she chose to receive the monthly payments at the end of the month. The first monthly payment of N$80 000 will be made on 31 July because she chose to receive monthly payments at the end of the month. We will make a single payment of N$80 000 (for June) because our requirements were only met after the waiting period has passed.

All our requirements are only met after the waiting period has passed but no payment day has passed – Jane is the insured person on the Functional Impairment Income Cover benefit with a cover amount of N$80 000 and a 1-month waiting period. She becomes functionally impaired on 1 May. The waiting period starts on 1 May and ends at midnight on 31 May. All our requirements are met on 21 June and she chose to receive the monthly payments at the end of the month. The first monthly payment of N$80 000 (for June) will be made on 30 June because she chose to receive monthly payments at the end of the month. No single payment will be made because there was no payment day between the end of the waiting period and the date our requirements were met.

We may need the insured person to prove that he/she still qualifies for payments by undergoing regular evaluation. When you claim, we will tell you how often the insured person must be evaluated.

When will the monthly payments stop?

The monthly payments will stop:

- if the insured person dies,
- on the cover end date shown on Personal, product and benefit details,
- if we no longer recognise the insured person's functional impairment (as explained under "When will Old Mutual not recognise the insured person's ..." under the heading "When will Old Mutual not pay the cover amount?"),
- if the insured person fails to meet our requirements for following reasonable medical advice or adequate medical treatment,
- if the insured person fails to meet our requirements for regular evaluation of his/her functional impairment,
- when we have made the last monthly payment that the insured person qualifies for (as explained under "How many monthly payments will Old Mutual make?"),
- if the insured person no longer qualifies for the benefit because of changes to his/her circumstances (as explained under "CHANGES TO THE CIRCUMSTANCES OF THE INSURED PERSON"), or
- if your contract is cancelled,

whichever happens first.

If the insured person qualified for more than one claim at the same time, once we stop making payments for the claim that resulted in the highest percentage of the cover amount, we will continue to make monthly payments at a lower percentage of the cover amount if the insured person still qualifies for monthly payments under another claim.

If the monthly payments stop and cover continues, you must start paying your premiums again.

How many monthly payments will Old Mutual make?

We will determine the number of monthly payments that we make, in line with the period of time the insured person continuously meets all the requirements of the functional impairment, as evidenced by sufficient specialist reports or test results from the treating doctor. Any supporting medical proof that we need will be at your own cost.

The number of monthly payments we make for fractures is specified in the table "FRACTURES THAT QUALIFY FOR PAYMENT UNDER THE FUNCTIONAL IMPAIRMENT INCOME COVER BENEFIT".

If the insured person suffers more than one fracture or suffers another fracture while we are making monthly payments for a previous one, we will pay the number of monthly payments that applies to the one with the highest number of payments.

When does cover stop?

The insured person's cover stops:

- if he/she dies,
- if he/she no longer qualifies for the benefit because of changes to his/her circumstances (as explained under "CHANGES TO THE CIRCUMSTANCES OF THE INSURED PERSON"),
- if the insured person refuses to follow reasonable medical advice or adequate medical treatment,
- if we do not receive your premiums and the grace period has passed, or
- if your contract is cancelled,

whichever happens first.

We may need the insured person to prove that he/she still qualifies for payments by undergoing regular evaluation. When you claim, we will tell you how often the insured person must be evaluated.

Insured person suffers a fracture while receiving monthly payments for another fracture – Mark has a 1-month waiting period on his Old Mutual Protect Functional Impairment Income Cover contract. He was in an accident and fractured his shoulder blade. Mark qualified for 1 monthly payment. Before receiving the payment, he falls and fractures the shaft of his thigh bone. This qualifies him for 2 monthly payments, but because we are still making monthly payments for his previous fracture, we will pay the number of monthly payments that applies to the fracture with the highest number of payments, which is the fracture to the shaft of the thigh bone. We will make 2 monthly payments in total.

When does cover stop?

The insured person's cover stops:

- if he/she dies,
- on the cover end date shown on Personal, product and benefit details,
- if he/she no longer qualifies for the benefit because of changes to his/her circumstances (as explained under "CHANGES TO THE CIRCUMSTANCES OF THE INSURED PERSON"),
- if the insured person refuses to follow reasonable medical advice or adequate medical treatment,
- if we do not receive your premiums and the grace period has passed, or
- if your contract is cancelled,

whichever happens first.

When will Old Mutual not pay the cover amount?

We will not pay the cover amount:

- if the insured person's functional impairment or fracture is before this benefit's cover start date,
- if we do not recognise the insured person's functional impairment or fracture (as explained below),
- if the insured person's functional impairment or fracture is because of an excluded event, activity or condition (as explained below), or
- if the waiting period is not met.

When will Old Mutual not recognise the insured person's ...

functional impairment?

We will not recognise the insured person's functional impairment if he/she suffers a functional impairment:

- that is not on the list of functional impairments,
- at the severity that the contract does not cover, or
- that does not meet all the requirements that the functional impairment must meet to qualify.

fracture?

We will not recognise the insured person's fracture if:

- he/she suffers a fracture that is not on the list of fractures that the contract covers or
- if you chose a waiting period longer than one month.

Excluded events, activities or conditions

We will not recognise the insured person's functional impairment or fracture if it is directly or indirectly caused by an event, activity or condition that is specifically or generally excluded.

Specific exclusions apply only to certain insured persons and not to others. Any specific exclusions that apply to the insured person on this benefit, are shown on Personal, product and benefit details.

General exclusions apply to all insured persons. We will not pay if:

- you fail to meet our requirement to tell us about changes to the circumstances of the insured person (as set out under "CHANGES TO THE CIRCUMSTANCES OF THE INSURED PERSON"),
- the insured person refuses to follow reasonable medical advice or adequate medical treatment,
- the insured person's functional impairment or fracture is caused by:
    - unrest, war or terrorist activity,
    - radioactivity or nuclear explosion,
    - him/her provoking, committing or attempting to commit a crime for example murder, assault, housebreaking, theft, robbery, the forceful detention of another person or any similar crime or
    - self-inflicted injury

Examples of **unrest** are riot, civil commotion, insurrection and rebellion.

ABOUT OTHER FEATURES AND BENEFITS

You have other features and benefits in your contract. Details are shown on Personal, product and benefit details where relevant and the rules are explained below.

ABOUT THE FAMILY SUPPORT BENEFIT

What is it?

It pays a benefit to help the insured person with his/her family responsibility. It includes:

- Spouse/partner and child support and
- Maternity/paternity support.

Its premium is included in the starting premium for the product on Personal, product and benefit details.

Spouse/partner and child support

It pays up to three monthly payments if the insured person's:

- spouse/partner dies or needs his/her care because of a severe illness
- child needs his/her care because of a severe illness.

How much does Old Mutual pay for Spouse/partner and child support?

The cover amount can be claimed when the insured person's spouse/partner or child suffers a severe illness or when the insured person's spouse/partner dies. The starting cover amount is shown on Personal, product and benefit details. We will pay 100% of the Functional Impairment Income Cover benefit's cover amount that is applicable on the date that we make the monthly payment. Each monthly payment is limited to N$100 000. A maximum of three claims can qualify for payments under Spouse/partner and child support – one claim for a spouse/partner and one per child for up to two children.

When does cover for Spouse/partner and child support start?

The cover starts on the cover start date for the Family Support Benefit as shown on Personal, product and benefit details.

A **spouse/partner** is the person to whom the insured person is married or with whom he/she is in a relationship similar to marriage that is intended to be permanent.

Severe illness means that the spouse/partner suffers and meets the requirements of a qualifying severe illness as confirmed by our medical officer. See the list of severe illnesses that qualify at the end of this document.

In addition, the Association for Savings and Investment South Africa (ASISA) has standardised critical illness definitions for:

- heart attack
- stroke
- cancer
- coronary artery bypass graft.

See the list of standardised critical illness definitions that qualify, at the end of this document.

This **child** must be the insured person's biological, step or legally adopted child.

To qualify for cover under this benefit, a **stepchild**'s biological or legally adoptive parent must, at any time after the birth of the stepchild, have been married to the insured person. For the purposes of this definition, **married** means a marriage (including a customary marriage) or union recognised under Namibia law.

Severe illness means that the child suffers and meets the requirements of a qualifying severe illness as confirmed by our medical officer. See the list of severe illnesses that qualify at the end of this document.

In addition, the Association for Savings and Investment South Africa (ASISA) has standardised critical illness definitions for:

- heart attack
- stroke
- cancer
- coronary artery bypass graft.

See the list of standardised critical illness definitions that qualify, at the end of this document.

Each payment limited to N$100 000 – Dilshaad's daughter, Asiyah, gets cancer and Dilshaad needs to pay for her treatment. At the time of the first monthly payment, the cover amount is N$90 000. After we have made the second monthly payment of N$90 000, the cover amount increases by 20% (to N$108 000) because she selected a scheduled yearly cover increase. The third monthly payment will be N$100 000 and not N$108 000 since each payment cannot be more than N$100 000.

When will the monthly payments start under Spouse/partner and child support?

Once all our requirements have been met, the monthly payments for valid claims will start on the payment day. We will pay a single amount to cover the time after the date of the severe illness or the spouse/partner's death and up to the start of the monthly payments. We will not pay interest on any of these amounts. While we make the monthly payments, you do not need to pay premiums.

When will the monthly payments stop under Spouse/partner and child support?

The monthly payments will stop:

- when we have made three monthly payments,
- if the insured person dies,
- if your contract is cancelled,
- on the insured person's 64th birthday, or
- if the Family Support Benefit is removed from your contract,

whichever happens earlier.

If the monthly payments stop and cover continues, you must start paying your premiums again.

When will the monthly payments stop under Spouse/partner and child support?

The monthly payments will stop:

- when we have made three monthly payments,
- if the insured person dies,
- on the Family Support Benefit's cover end date shown on Personal, product and benefit details,
- if your contract is cancelled,
- on the insured person's 64th birthday, or
- if the Family Support Benefit is removed from your contract,

whichever happens earlier.

If the monthly payments stop and cover continues, you must start paying your premiums again.

How many monthly payments will Old Mutual make for Spouse/partner and child support?

We will make up to three monthly payments for each valid claim.

When does cover under Spouse/partner and child support stop?

Cover under Spouse/partner and child support stops:

- if the insured person dies,
- if we do not receive your premiums and the grace period has passed,
- if your contract is cancelled,
- once we have paid three valid claims under Spouse/partner and child support,
- on the insured person's 64th birthday, or
- if the Family Support Benefit is removed from your contract,

whichever happens first.

When does cover under Spouse/partner and child support stop?

Cover under Spouse/partner and child support stops:

- if the insured person dies,
- on the Family Support Benefit's cover end date shown on Personal, product and benefit details,
- if we do not receive your premiums and the grace period has passed,
- if your contract is cancelled,
- once we have paid three valid claims under Spouse/partner and child support,
- on the insured person's 64th birthday, or
- if the Family Support Benefit is removed from your contract,

whichever happens first.

When does cover for a spouse/partner stop?

In addition to the reasons listed under "When does cover under Spouse/partner and child support stop?", cover for a spouse/partner stops at his/her 64th birthday.

When does cover for a child stop?

In addition to the reasons listed under "When does cover under Spouse/partner and child support stop?", cover for a child stops at his/her at his/her 18th birthday.

When will Old Mutual not pay under Spouse/partner and child support?

We will not pay the cover amount:

- if the spouse/partner's death or the severe illness is before the Family Support Benefit's cover start date,
- if we do not recognise the severe illness (as explained below), or
- if the claim under Spouse/partner and child support is because of an excluded event, activity or condition (as explained below).

When will Old Mutual not recognise the severe illness?

We will not recognise the severe illness if the spouse/partner or child suffers a severe illness:

- that is not on the list of severe illnesses,
- at the severity that the contract does not cover, or
- that does not meet all the requirements that the severe illness must meet to qualify.

A **suicide** is a self-injury resulting in death, where, in our opinion, the insured person had the intention to take his/her own life. It includes so-called assisted suicide where another person helped him/her to take his/her own life.

Excluded events, activities or conditions

We will not pay the cover amount under Spouse/partner and child support if the claim is directly or indirectly caused by an event, activity or condition that is excluded.

We will not pay if:

- you fail to meet our requirement to tell us about changes to the circumstances of the insured person (as set out under "CHANGES TO THE CIRCUMSTANCES OF THE INSURED PERSON"),
- the claim is because of:
  - unrest, war or terrorist activity,
  - radioactivity or nuclear explosion,
  - the spouse/partner or child provoking, committing or attempting to commit a crime for example murder, assault, housebreaking, theft, robbery, the forceful detention of another person or any similar crime,
  - a self-inflicted injury
- the:
  - spouse/partner's death is because of anything other than an accident within six months of Family Support Benefit's benefit start date, or
  - severe illness is within six months of the Family Support Benefit's benefit start date,
- the spouse/partner's death is because of suicide in the first two years from Family Support Benefit's benefit start date,
- the claim is because of any conditions with which:
  - the spouse/partner or child was diagnosed before the Family Support Benefit's benefit start date,
  - the child was diagnosed before he/she became the insured person's legally adopted or stepchild,
  - the spouse/partner was diagnosed before he/she became the insured person's spouse/partner,
- the claim was directly or indirectly caused by the use of alcohol, poison, drugs or non-prescribed medication,
- the claim was as a result of a crime you committed against him/her, or
- in respect of a child – if the child does not live for at least 10 days from the date of the severe illness.

Maternity/paternity support

It pays a single amount when an insured event happens.

An **insured event** is when the:

- biological child of the insured person or his/her spouse is born or stillborn or
- insured person legally adopts a child younger than three.

The biological mother of the child must have been at least 26 weeks pregnant for the child to qualify as **stillborn**.

How much and when does Old Mutual pay for Maternity/paternity support?

The cover amount can be claimed when an insured event happens. We will pay the cover amount of four times the monthly premium that was applicable at insured event date, once our requirements have been met and if the claim is valid.

For claim events related to the death of an unborn or a child under the age of 14, we will never pay more than the legislative limits. The legislative limits are currently:

	Maximum cover amount
Children younger than 6 (including unborn children)	N$10 000
Children 6 and older but younger than 14	N$30 000

A maximum of two events qualify for payments under Maternity/paternity support. If two events occur at the same time, we will pay for both.

When does cover for Maternity/paternity support start?

The cover starts on the cover start date for the Family Support Benefit as shown on Personal, product and benefit details.

When does cover under Maternity/paternity support stop?

Cover under Maternity/paternity support stops:

- if the insured person dies,
- if we do not receive your premiums and the grace period has passed,
- if your contract is cancelled,
- once we have paid two valid claims under Maternity/paternity support, or
- if the Family Support Benefit is removed from your contract,

whichever happens first.

When does cover under Maternity/paternity support stop?

Cover under Maternity/paternity support stops:

- if the insured person dies,
- on the Family Support Benefit's cover end date shown on Personal, product and benefit details,
- if we do not receive your premiums and the grace period has passed,
- if your contract is cancelled,
- once we have paid two valid claims under Maternity/paternity support, or
- if the Family Support Benefit is removed from your contract,

whichever happens first.

When will Old Mutual not pay under Maternity/paternity support?

We will not pay the cover amount:

- if the insured event is before the Family Support Benefit's cover start date, or
- if the claim under Maternity/paternity support is because of an excluded event, activity or condition (as explained below).

Excluded events, activities or conditions

We will not pay the cover amount under Maternity/paternity support if the claim is directly or indirectly caused by an event, activity or condition that is excluded.

We will not pay if:

- you fail to meet our requirement to tell us about changes to the circumstances of the insured person (as set out under "CHANGES TO THE CIRCUMSTANCES OF THE INSURED PERSON"),
- the claim is because of:
    - unrest, war or terrorist activity,
    - radioactivity or nuclear explosion,
- the insured event happens within nine months from the Family Support Benefit's benefit start date as shown on Personal, product and benefit details,
- the insured event was as a result of a crime you, the insured person or his/her spouse/partner committed against the biological mother, or
- a stillbirth was caused by your, the insured person's or the biological mother's negligence or intentional harm.

HOW DO I...?

How do I contact Old Mutual?

Use any of these contact details to contact us

By phone	076 0535 TBC Monday – Friday between 7:30am and 5pm excluding public holidays
In person	Visit a branch during office hours.
By email	<include correct contact details of the relevant servicing email address once finalised >
By post	<include correct servicing postal address once finalised >
Our website	www.oldmutual.com.na

How do I complain?

If you disagree with us on any matter about your contract, you can use our internal dispute resolution process. We use this process to deal with complaints and to solve disagreements between you and us quickly, fairly and at no additional cost to you. For further information about the complaints handling process (including the times within which your complaint must be addressed), you may call 061 223 189 or visit a branch.

For complaints about your contract or Old Mutual

Contact us in any of the ways described under "How do I contact Old Mutual?". If, after you have contacted us, your complaint is not satisfactorily addressed, you can contact any of:

Who	Send a fax	Send an email	Write a letter
Old Mutual Namibia Client Services	(061) 299 3190	NAM-CSComplaints@oldmutual.com	PO Box 165 Windhoek Namibia
Head of Compliance	(061) 299 3520	MVollgraaff@oldmutual.com	PO Box 165 Windhoek Namibia

You can at any time contact:

Who	Send a fax	Send an email	Write a letter
Registrar for Long-term Insurance	(061) 290 5194	info@namfisa.com.na	PO Box 21250 Windhoek Namibia

For complaints about the advice you received or the adviser:

Who	Send a fax	Send an email	Write a letter
Registrar for Long-term Insurance	(061) 290 5194	info@namfisa.com.na	PO Box 21250 Windhoek Namibia

The courts

You can always refer your dispute to a Namibian court. In this case, you will need the help of an attorney and the process may take long and be expensive. For this reason, we encourage you to first follow our internal dispute resolution process in order to bring a speedy solution to your complaint.

How do I exercise my right to cool off?

You must give us an instruction in writing when you want to exercise your right to cool off. In writing means by email or sending us a letter.

How do I make a contract change or cancel my contract?

You must give us an instruction in writing when you want to make a contract change (for example to name or change a beneficiary) or cancel your contract. In writing means by email or sending us a letter. When we receive your email or letter, we will inform you which information and documents we require.

How do I claim?

The claimant must claim by completing the claim forms and providing us with the necessary information and documents through an adviser or at one of our branches. At the point of claim, we will inform the claimant which claim form he/she needs to complete and which information and documents we require.

We may also request other information or documents from any person (including directly from a doctor or clinic) to help us to decide if the claim is valid.

You must pay the costs related to satisfying our requirements for your Functional Impairment Income Cover benefit. This includes:

- the cost of obtaining expert evidence that must be submitted in Namibia or South Africa by persons or businesses that operate in Namibia or South Africa,
- if the insured person is not in Namibia or South Africa, the cost to travel to Namibia or South Africa to undergo evaluation to help us to decide whether the claim is valid, and
- the cost of reasonable medical advice or adequate medical treatment as determined by our medical officer.

Once all our claims requirements have been met, we will consider the claim and pay it if it is valid.

If your claim is fraudulent, we will cancel your contract and will not refund any premiums you have paid.

If all our requirements are not met, we cannot consider the claim and will not pay it until these requirements have been met.

CHANGES TO THE CIRCUMSTANCES OF THE INSURED PERSON ON THE FUNCTIONAL IMPAIRMENT INCOME COVER BENEFIT

The table below sets out what changes to the circumstances of the insured person you must tell us about. The actions we may or will take depends on whether you told us about the change or whether we found out about it and if we are making payments at the time of the change. Some changes in circumstances will only affect the payments being made or the contract itself, while other changes may affect both. Any change to the insured person's circumstances while we are not making payments will affect only the contract itself.

What changes about the insured person	**Actions we can take while we are making monthly payments**		**Actions we can take when we are not making monthly payments**	
	You tell us about the change	**You don't tell us about the change**	**You tell us about the change**	**You don't tell us about the change**
The insured person starts to regularly (more than on a once-off basis) participate in a risky activity or sport* that may expose him/her to a higher than average risk of accident or injury (for example motor racing, climbing, aviation, combat sports, water sports)	Impacts on the payments being made None Impacts on the contract itself We may: • change the premium or • offer different terms**	Same as under "You tell us about the change" on the left	We may: • change the premium, • offer different terms**, • remove the benefit*** or • recover benefit payments we had already made but that the insured person did not qualify for, from you	In addition to what is listed under "You tell us about the change" on the left, we may: • reject your claim***
The insured person's health/medical status changes (he/she recovers or his/her condition improves) while we are making payments	Impact on the payments being made We may: • change the benefit payments, • stop the benefit payments or • recover benefit payments we had already made but that the insured person did not qualify for, from you Impacts on the contract itself None	In addition to what is listed under "You tell us about the change" on the left, we may: • remove the benefit***	None	Same as under "You tell us about the change" on the left
The insured person dies	Impact on the payments being made We may: • stop the benefit payments or • recover benefit payments we made after the insured person's death, from you Impacts on the contract itself We will remove the benefit from your contract***	Same as under "You tell us about the change" on the left	We will remove the benefit from your contract***	Same as under "You tell us about the change" on the left

* Any details that you have provided to us, will appear on the Personal, product and benefit details. It is your responsibility to let us know if any of these details change.

** Different terms include the following examples:

- a premium increase,
- additional circumstances under which we will not pay,
- the insured person may no longer qualify for the existing benefit but may qualify for another benefit, or
- a cover decrease.

*** If we remove benefits from your contract or reject your claim, we will not pay back the premiums we have received. If a removed benefit was the last active benefit on the contract, the contract will be cancelled and you will no longer have any cover.

FUNCTIONAL IMPAIRMENTS THAT QUALIFY UNDER THE FUNCTIONAL IMPAIRMENT INCOME COVER BENEFIT

Body system	Functional impairment	Requirements that the functional impairment must meet to qualify	Percentage of the cover amount payable
Cardiovascular	Arrhythmia	The diagnosis of an arrhythmia by a medical specialist. With evidence of the following, despite adequate medical treatment: • Shortness of breath so severe that symptoms are present at rest (NYHA, Class IV), and • Symptoms of palpitations and syncope or dizziness correlating with ECG evidence of serious arrhythmia are present daily.	100%
		The diagnosis of an arrhythmia by a medical specialist. With evidence of the following, despite adequate medical treatment: • Marked limitation in activity due to symptoms, even during less-than-ordinary activity, e.g. walking short distances (NYHA Class III), and • Symptoms of palpitations and syncope or dizziness correlating with ECG evidence of serious arrhythmia are present frequently with at least 3 episodes per week.	50%
	Congestive Cardiac Failure	The diagnosis of Congestive cardiac failure by a specialist cardiologist or physician as a result of coronary artery disease or valvular heart disease or diseases of the aorta or pericardial disease. With evidence of the following: • Ejection fraction (EF) consistently less than 40% after adequate medical treatment, and shortness of breath so severe that symptoms are present during less than ordinary activity or at rest (NYHA Class III - IV), or • Awaiting cardiac transplantation.	100%
		The diagnosis of Congestive cardiac failure by a specialist cardiologist or physician as a result of coronary artery disease or valvular heart disease or diseases of the aorta or pericardial disease. With evidence of the following: • Ejection fraction (EF) consistently less than 45% after adequate medical treatment, and marked limitation in activity due to symptoms, even during ordinary or less than ordinary activity e.g. walking short distances (NYHA Class II - III).	50%

Cardiovascular (continued)	Hypertension	The diagnosis of uncontrolled hypertension confirmed by a medical specialist. With evidence of diastolic pressure greater than or equal to 110mmHg on adequate treatment and complicated by 2 or more of the following: • Stage 4 Kidney dysfunction • Cerebrovascular incident (excluding transient ischaemic attacks) confirmed by neuroimaging • Echocardiogram evidence of LVH (septal wall thickness to posterior LV wall thickness 1.3:1) • Grade IV retinopathy • Congestive Cardiac Failure with evidence of an ejection fraction (EF) consistently less than 45% after adequate medical treatment, and marked limitation in activity due to symptoms, even during ordinary or less than ordinary activity e.g. walking short distances (NYHA Class II - III).	100%
		The diagnosis of uncontrolled hypertension confirmed by a medical specialist. With evidence of diastolic pressure greater than 105mmHg on adequate treatment and complicated by 1 of the following: • Stage 3 Kidney dysfunction, or • Cerebrovascular incident (excluding transient ischaemic attacks) confirmed by neuroimaging, or • Grade III retinopathy.	50%
	Peripheral Arterial Disease	The diagnosis of peripheral arterial disease of the lower limbs by a vascular surgeon. With evidence of no recordable pulse on Doppler readings, and 1 of the following: • Severe Vascular Ulceration, or • Gangrene secondary to peripheral arterial disease.	100%
		The diagnosis of peripheral arterial disease of the lower limbs by a vascular surgeon. With evidence of the following: • Abnormal diminished pulse on Doppler readings, and • Ankle-brachial index (ABI) < 0.9 and • Pain on exercise as a result of peripheral arterial disease with claudication on walking less than 500m.	50%
	Peripheral Venous Disease	The diagnosis of veno-occlusive disease of the lower limbs by a vascular surgeon. With evidence of the following: • Severe deep and widespread vascular ulceration, and • Oedema of the lower limbs	50%

Respiratory	Chronic Respiratory Failure	The diagnosis of a chronic respiratory failure by a pulmonologist. With persistent evidence of at least 1 of the following, despite adequate medical treatment: • Impaired airflow with FEV1 less than or equal to 40%, or • FVC less than or equal to 50%, or • DLCO of less than or equal to 40%.	100%
		The diagnosis of a chronic respiratory failure by a pulmonologist. With persistent evidence of at least 1 of the following, despite adequate medical treatment: • Impaired airflow with FEV1 less than or equal to 50%, or • FVC less than or equal to 60%, or • DLCO of less than or equal to 50%.	50%
	Pulmonary Arterial Hypertension	The diagnosis of pulmonary hypertension by a medical specialist. With evidence of a Systolic Pulmonary Artery Pressure greater than 70mmHg and complicated by at least 1 of the following: • Right sided heart failure, or • Shortness of breath so severe that symptoms are present at rest (NYHA Class IV).	100%
		The diagnosis of pulmonary hypertension by a medical specialist. With evidence of a Systolic Pulmonary Artery Pressure of 40-70 mmHg and complicated by at least 1 of the following: • Right sided heart failure, or • Marked limitation in activity due to symptoms, even during less-than-ordinary activity, e.g. walking short distances (NYHA Class III).	50%

Gastrointestinal	Ano-rectal impairment	Faecal incontinence • With evidence of complete faecal incontinence despite adequate medical and/or surgical treatment by a gastroenterologist or equivalent specialist.	100%
		A stoma in situ created by a gastroenterologist or equivalent specialist due to a gastrointestinal disorder.	50%
	Biliary Tract Disease	The diagnosis of a biliary tract disease by a liver specialist, gastroenterologist or equivalent medical specialist. With evidence of the following: • Persistent biliary tract obstruction with recurrent cholangitis, and • Persistent jaundice	75%
	Chronic Gastrointestinal Disease	The diagnosis of a chronic gastrointestinal disease by a gastroenterologist or equivalent specialist, as a result of a medical condition. With evidence of the following: • Medical findings confirming organic disease, and • Significant unintentional weight loss resulting in a BMI of less than 15 or 25% weight loss below the lower limit of the normal range for the individual, and • Symptoms uncontrolled by medical or surgical treatment. Psychiatric conditions are excluded.	100%
		The diagnosis of a chronic gastrointestinal disease by a gastroenterologist or equivalent specialist, as a result of a medical condition. With evidence of the following: • Medical findings confirming organic disease, and • Significant unintentional weight loss resulting in a BMI between 15 and 16.1 or 20% weight loss below the lower limit of the normal range for the individual, and • Symptoms uncontrolled by medical or surgical treatment. Psychiatric conditions are excluded.	75%
		The diagnosis of a chronic gastrointestinal disease by a gastroenterologist or equivalent specialist, as a result of a medical condition. With evidence of the following: • Medical findings confirming organic disease, and • Significant unintentional weight loss resulting in a BMI between 16.2 and 17 or 15% weight loss below the lower limit of the normal range for the individual, and • Symptoms uncontrolled by medical or surgical treatment. Psychiatric conditions are excluded.	50%
	Chronic Liver Failure	The diagnosis of chronic end-stage liver failure, with a Child Pugh Classification of class C, by a gastroenterologist or equivalent specialist.	100%
		The diagnosis of progressive chronic liver disease, with a Child Pugh Classification of class B, by a gastroenterologist or equivalent specialist.	50%
	Irreducible Hernia	The diagnosis of an irreducible hernia, following unsuccessful surgical repair of the hernia, by a gastroenterologist or equivalent specialist. With evidence of bowel dysfunction which impacts on activities of daily living, such that the insured person is unable to perform 2 of the Basic Activities of Daily Living and 2 of the Advanced Activities of Daily Living.	50%

Urogenital	Bladder Impairment	The diagnosis of a bladder impairment despite adequate surgical and medical treatment by a nephrologist or urologist. With evidence of 1 of the following: • No detectable reflex or voluntary urine control as a result of organic pathology, resulting in urinary incontinence, or • Total bladder resection, or • Chronic disorders of the bladder and its structures that require a permanent indwelling catheter.	100%
	Chronic Kidney Failure	The diagnosis of chronic renal failure despite adequate medical treatment by a nephrologist or urologist. With evidence of 1 of the following: • End-stage renal disease with an estimated GFR less than 24ml/min, or • Creatinine clearance of less than 28 ml per minute, or • Renal function deterioration that requires life-long peritoneal dialysis or lifelong haemodialysis.	100%
		The diagnosis of chronic renal failure despite adequate medical treatment by a nephrologist or urologist. With evidence of 1 of the following: • Chronic renal disease with an estimated GFR between 24-40ml/min, or • Creatinine clearance of 28 to 42 ml per minute.	50%

Central Nervous System	Impaired consciousness	The diagnosis of a coma of a specified severity by a neurologist or neurosurgeon. Medically induced comas are excluded. With evidence of the following for 14 days or more: • A decreased level of consciousness, with a Glasgow Coma Scale of less than 9, and • Requiring total medical support including intubation and assisted ventilation.	100%
		The diagnosis of a coma of a specified severity by a neurologist or neurosurgeon. Medically induced comas are excluded. With evidence of the following: • Decreased level of consciousness, with a Glasgow Coma Scale of less than 9, which is constant and present for greater than 96hrs.	50%
	Aphasia	The diagnosis of aphasia by a neurologist or neurosurgeon. With evidence of the following: • A total inability to express oneself or communicate (through speech, writing, or signs), or to comprehend spoken or written language, due to injury or disease of the brain, and • Deficits in the formal aspects of language such as naming, word choice, comprehension, spelling and syntax, and • Objective medical findings supporting the diagnosis of aphasia. Psychiatric conditions are excluded.	100%
	Cranial Nerve V (Trigeminal Neuralgia)	The diagnosis of severe unilateral or bilateral facial neuralgic pain by a neurologist due to an affliction of the Trigeminal Nerve. With evidence of the following: • Resistance to pharmacological treatment, and • Has resulted in decompression surgery.	50%
	Cranial Nerve VII	The diagnosis of facial nerve paralysis confirmed by a neurologist or neurosurgeon. With persistent evidence of the following: • Slight or no movement of the face, and • An inability to actively close the eyelids, and • Slight or no movement of the mouth.	100%
		The diagnosis of facial nerve paralysis confirmed by a neurologist or neurosurgeon. With persistent evidence of the following: • Slight or no movement of one half of the face with asymmetry at rest, and • An inability to actively close the eyelid on the affected side, and • Slight or no movement of the mouth.	50%
	Cranial Nerve VIII	The diagnosis of Vestibulocochlear nerve paralysis confirmed by a neurologist or neurosurgeon. With evidence of the following: • Nerve damage with severe imbalance resulting in limitation of activities of daily living such that the insured person is unable to perform 3 of the Basic Activities of Daily Living or 4 of the Advanced Activities of Daily Living.	100%
		The diagnosis of Vestibulocochlear nerve paralysis confirmed by a neurologist or neurosurgeon. With evidence of the following: • Nerve damage with moderately-severe imbalance resulting in limitation of activities of daily living such that the insured person is unable to perform 2 of the Basic Activities of Daily Living and 2 of the Advanced Activities of Daily Living.	50%

Central Nervous System (continued)	Cranial Nerves IX, X, XII	The diagnosis of Cranial Nerve IX, X, XII paralysis confirmed by a neurologist or neurosurgeon. With evidence of the following: • An inability to swallow or process oral secretions without choking, and • Need for external suctioning device, and • Medical findings confirming organic disease.	100%
		The diagnosis of Cranial Nerve IX, X, XII paralysis confirmed by a neurologist or neurosurgeon. With evidence of the following: • Severe dysarthria or dysphagia, and • Nasal regurgitation, and • Aspiration of liquids or semi-solid foods, and • Medical findings confirming organic disease.	50%
	Epilepsy	The diagnosis of epilepsy by a neurologist or neurosurgeon supported by objective medical findings and resistant to optimal therapy as confirmed by drug serum-level testing. With evidence of the following: • 3 or more generalised seizures per week for at least 3 consecutive months, and • An inability to perform 3 of the Basic Activities of Daily Living or 4 of the Advanced Activities of Daily Living.	100%
		The diagnosis of epilepsy by a neurologist or neurosurgeon supported by objective medical findings and resistant to optimal therapy as confirmed by drug serum-level testing. With evidence of the following: • 6 or more generalised seizures per month for at least 3 consecutive months, and • An inability to perform 2 of the Basic Activities of Daily Living and 2 of the Advanced Activities of Daily Living.	50%
	Gait disorders/ Poor motor coordination	The diagnosis of a cerebellar disorder by a neurologist or neurosurgeon correlating with objective medical findings. With evidence of the following: • Needs assistive devices or mechanical support for daily functions, or • An inability to perform 2 of the Basic Activities of Daily Living and 2 of the Advanced Activities of Daily Living, or • Documented previous falls and inability to stand, walk, stoop, squat, kneel, climb stairs, or • Inability to grasp and pincer grip and a complete loss of fine or gross motor coordination or grip strength.	50%
		The diagnosis of a cerebellar disorder by a neurologist or neurosurgeon. The diagnosis of a cerebellar disorder by a neurologist or neurosurgeon correlating with objective medical findings. With evidence of the following: • Difficulty with standing or maintaining a standing position, without assistive devices, and needs assistance with walking, or • Difficulty with fine or gross motor coordination or grip strength.	25%
	Hemiplegia	The total loss of the functioning of one side of the body due to an injury or disease of the brain as confirmed by a neurologist or neurosurgeon and correlating with objective medical findings.	100%

Central Nervous System (continued)	Dementia (incl. Alzheimer's Disease)	The diagnosis of dementia by a neurologist, physician or neurosurgeon With evidence of the following: • A diminished intellectual ability (may include personality changes and episodes of confusion), and • A score of 2 under the 5 point Clinical Dementia Rating scale, and • Needs constant supervision.	100%
		The diagnosis of dementia by a neurologist, physician or neurosurgeon With evidence of the following: • A diminished intellectual ability (may include a personality change and episodes of confusion), and • A score of 1 under the 5 point Clinical Dementia Rating scale, and • Needs some supervision with everyday duties.	50%
	Paraplegia / Diplegia	The total loss of the functioning of both legs or both arms due to an injury or disease of the brain or spinal cord. This must be confirmed by a neurologist or neurosurgeon and correlate with objective medical findings.	100%
	Quadriplegia	The total loss of the functioning of both legs and both arms due to an injury or disease of the brain or spinal cord. This must be confirmed by a neurologist or neurosurgeon and correlate with objective medical findings.	100%
Cancer	Cancer	The diagnosis of an advanced stage of cancer as confirmed by an oncologist with supporting documentation. With evidence of the following: • Diagnosis of at least a stage III cancer, and the insured person is unable to perform 2 of the Basic Activities of Daily Living or 3 of the Advanced Activities of Daily Living, or • Stage IV cancer or • Cancer which has resulted in organ failure will be assessed under the affected organ. Organ failure will only be assessed under the following definitions: Congestive Cardiac Failure or Chronic respiratory failure or Chronic liver failure or Chronic kidney failure or Organic Brain Disorders/ Dementia	100%

Senses	Loss of sight	Confirmed diagnosis of bilateral loss of sight by an ophthalmologist. The loss of sight cannot be improved through refractive correction or medication. With evidence of 1 of the following: • A reading of 6/60 or worse (or equivalent measure on a non-metric scale) in each eye after best correction, or • Severe proliferative diabetic retinopathy, or • Grade IV hypertensive retinopathy, or • Permanent Hemianopia in both eyes, or • A visual field loss to a 10˚ radius in the better eye. Loss of sight due to cataracts is excluded, unless there is evidence of failed cataract surgery or contraindications to cataract surgery.	100%
		Confirmed diagnosis of bilateral loss of sight by an ophthalmologist. The loss of sight cannot be improved through refractive correction or medication. With evidence of 1 of the following: • A reading of 6/36 or worse (or equivalent measure on a non-metric scale) in each eye after best correction, or • Severe non-proliferative diabetic retinopathy, or • Grade III hypertensive retinopathy, or • A visual field loss to a 20˚ radius in the better eye. Loss of sight due to cataracts is excluded, unless there is evidence of failed cataract surgery or contraindications to cataract surgery.	50%
		Confirmed diagnosis of loss of sight in one eye by an ophthalmologist. The loss of sight cannot be improved through refractive correction or medication. With evidence of the following: • A reading of 6/60 or worse (or equivalent measure on a non-metric scale) in one eye after best correction, or • The diagnosis of a hemianopia in one eye, or • A visual field loss to a 10˚ radius. Loss of sight due to cataracts is excluded, unless there is evidence of failed cataract surgery or contraindications to cataract surgery.	25%
	Loss of hearing	Total loss of hearing in both ears as confirmed by an ear, nose and throat surgeon. With evidence of the following: • Audiometry measurements, done with the use of hearing aids, with an average loss of greater than 87dB.	100%
		Total loss of hearing in both ears as confirmed by an ear, nose and throat surgeon. With evidence of the following: • Audiometry measurements, done with the use of hearing aids, averaging between 70-87dB.	50%
		Total loss of hearing in one ear as confirmed by an ear, nose and throat surgeon. With evidence of the following: • Audiometry measurements, done with the use of hearing aids, with an average loss of greater than 70dB.	25%

Senses (continued)	Loss of speech	The total loss of the ability to produce intelligible and audible speech due to injury or disease, as confirmed by an ear, nose and throat surgeon, neurologist or neurosurgeon. • Objective medical evidence of an ear, nose and throat disorder causing the impairment must be provided. Loss of speech due to psychiatric causes are excluded.	100%
		The loss of 50% of speech, as confirmed by an ear, nose and throat surgeon, neurologist or neurosurgeon. Objective medical evidence of an ear, nose and throat disorder causing the impairment must be provided, with clinical evidence of 2 of the following requirements: • Audibility: while whisper may be present, there is no audible voice. • Intelligibility: while single words may be recognisable, most words are unintelligible. • Function: speech is impractically slow and laboured. Loss of speech due to psychiatric causes are excluded.	50%
Endocrine	Endocrine Disorders	The diagnosis of an endocrine disorder, which despite adequate medical and surgical treatment, has resulted in organ failure, as confirmed by a medical specialist. • Organ failure will only be assessed under the following definitions: Congestive Cardiac Failure or Chronic respiratory failure or Chronic liver failure or Chronic kidney failure or Organic Brain Disorders/ Dementia	100%
Psychiatric	Psychiatric Disorder	The diagnosis of a psychiatric disorder, as confirmed by a specialist psychiatrist. Resulting in continuous institutionalisation and with evidence of the following: • persistent GAF score of 40 or less certified under the DSM IV classification, or • persistent WHODAS average domain score of 4 certified under the DSM 5 classification	100%
		The diagnosis of a psychiatric disorder, as confirmed by a specialist psychiatrist. Requires constant supervision and with evidence of the following: • persistent GAF score of 40 or less certified under the DSM IV classification, or • persistent WHODAS average domain score of 4 certified under the DSM 5 classification	75%

Trauma	Facial Disorders or Disfigurement	Total facial disfigurement as confirmed by a maxillofacial specialist or related specialist. There should be destruction or loss of skin, bone, or muscles that requires reconstructive surgery.	100%
	Major Burns	The diagnosis of third degree burns (full thickness burns) by a plastic surgeon or trauma specialist. With evidence of at least: • 30% of total body surface affected as measured on the Lund and Browder Chart or equivalent scale, or • more than 50% of the combined surface area of the bilateral upper limbs affected including involvement of at least 60% of combined surface area of the palms of both hands; and restriction of joint mobility of at least two of the following: 3 fingers, wrist or elbow.	100%
		The diagnosis of third degree burns (full thickness burns) by a plastic surgeon or trauma specialist. With evidence of: • at least 20% of total body surface affected as measured on the Lund and Browder Chart or equivalent scale, or • more than 50% of the combined surface area of the bilateral lower limbs including involvement of at least 60% of the combined surface area of the soles of both feet; or • more than 50% of the combined surface area of an upper and lower limb including involvement of at least 60% of the combined surface area of the sole of one foot and the palm of one hand.	50%
	Inhalational Burn	Inhalational burns resulting in a tracheostomy.	50%

Haematology	Clotting Disorders	The diagnosis of a clotting disorder, which despite adequate medical and surgical treatment, has resulted in organ failure, as confirmed by a medical specialist. • Organ failure will only be assessed under the following definitions: Congestive Cardiac Failure or Chronic respiratory failure or Chronic liver failure or Chronic kidney failure or Organic Brain Disorders/ Dementia	100%
	Red Blood Cell Disorders	The diagnosis of severe chronic anaemia by a physician or haematologist. With evidence of the following: • Hb persistently less than 8g/dL, and • Requiring 2-3U of blood every 2 weeks.	100%
		The diagnosis of severe chronic anaemia by a physician or haematologist. With evidence of the following: • Hb persistently less than 8g/dL, and • Requiring 2-3U of blood every 4-6 weeks.	50%
	White Blood Cell Disorders	The diagnosis of a severe white blood cell disorder by a physician or haematologist. With evidence of 1 of the following: • An absolute neutrophil count of less than 250, resulting in at least 3 hospitalisations per year for acute bacterial infections, or • Lymphoma or Leukaemia requiring at least 3 chemotherapy regimens per year.	100%
		The diagnosis of a severe white blood cell disorder by a physician or haematologist. With evidence of 1 of the following: • An absolute neutrophil count of between 250 and 500 , resulting in at least 2 hospitalisations per year for acute bacterial infections, or • Lymphoma or Leukaemia requiring at least 1 chemotherapy regimen per year.	50%

Musculoskeletal	Chronic Spinal Column Conditions	• A history of chronic pain syndrome due to a chronic spinal condition for a duration of at least two years. It must be treated by a multidisciplinary pain management team with at least three of the four requirements listed below, which must be confirmed by an orthopaedic or neurosurgeon. All these criteria must be present in the same region, as defined below, for a valid claim to be paid. Or • Confirmed diagnosis of Cauda equina syndrome resulting in bowel or bladder dysfunction. Spinal Regions: The neck and lower back are part of the spine. The spinal regions are: • Cervical region (C1-C7). • Thoracic region (T1-T12) and • Lumbosacral region (L1-S1). The C7 to T1 joint will be classified in the cervical region, and the T12 to L1 joint in the thoracolumbar region. List of four requirements: 1. 50% or more compression of a vertebral body or multiple level compression fractures giving rise to kyphotic deformity. 2. Clinically significant radiculopathy (motor and sensory deficit or muscle atrophy and clinical signs of nerve tension and radiological evidence at the same site as clinically found. NB – We will not accept radiological signs of nerve compression without clinical evidence of neurological involvement as proof of functional impairment. 3. Alteration of motion segment integrity confirming instability with neurological deficit. 4. Multiple back or cervical operations (i.e. two or more on separate occasions within a period of 5 years) comprising laminectomy, discectomy or fusion, or a combination thereof.	100%
		• A history of chronic pain syndrome due to a chronic spinal condition for a duration of at least two years. It must be treated by a multidisciplinary pain management team with at least two of the four requirements listed below, which must be confirmed by an orthopaedic or neurosurgeon. All these criteria must be present in the same region, as defined below, for a valid claim to be paid. Spinal Regions: The neck and lower back are part of the spine. The spinal regions are: • Cervical region (C1-C7). • Thoracic region (T1-T12) and • Lumbosacral region (L1-S1). The C7 to T1 joint will be classified in the cervical region, and the T12 to L1 joint in the thoracolumbar region. List of four requirements: 1. 1. 50% or more compression of a vertebral body or multiple level compression fractures giving rise to kyphotic deformity. 2. Clinically significant radiculopathy (motor and sensory deficit or muscle atrophy and clinical signs of nerve tension and radiological evidence at the same site as clinically found. NB – We will not accept radiological signs of nerve compression without clinical evidence of neurological involvement as proof of functional impairment. 3. Alteration of motion segment integrity confirming instability with neurological deficit. 4. Multiple back or cervical operations (i.e. two or more on separate occasions within a period of 5 years) comprising laminectomy, discectomy or fusion, or a combination thereof.	50%

Musculoskeletal (continued)	Chronic Spinal Column Conditions	• A history of chronic pain syndrome due to a chronic spinal condition for a duration of at least two years. It must be treated by a multidisciplinary pain management team with at least one of the four requirements listed below, which must be confirmed by an orthopaedic or neurosurgeon. All these criteria must be present in the same region, as defined below, for a valid claim to be paid. Spinal Regions: The neck and lower back are part of the spine. The spinal regions are: • Cervical region (C1-C7). • Thoracic region (T1-T12) and • Lumbosacral region (L1-S1). The C7 to T1 joint will be classified in the cervical region, and the T12 to L1 joint in the thoracolumbar region. List of four requirements: 1. 50% or more compression of a vertebral body or multiple level compression fractures giving rise to kyphotic deformity. 2. Clinically significant radiculopathy (motor and sensory deficit or muscle atrophy and clinical signs of nerve tension and radiological evidence at the same site as clinically found. NB – We will not accept radiological signs of nerve compression without clinical evidence of neurological involvement as proof of functional impairment. 3. Alteration of motion segment integrity confirming instability with neurological deficit. 4. Multiple back or cervical operations (i.e. two or more on separate occasions within a period of 5 years) comprising laminectomy, discectomy or fusion, or a combination thereof.	25%
	Combination of loss of use of an upper and lower limb	The total loss of use of an upper and a lower limb appendage as defined below: • a foot at the transverse tarsal joint (Chopart's joint), • a leg at or above the ankle joint up to the hip joint, • a hand (at the metacarpophalangeal joint), • an arm at or above the wrist joint up to the shoulder joint, as confirmed by an orthopaedic or neurosurgeon.	100%
	Loss of use of both hands or arms	The total loss of use of: • both hands at the metacarpophalangeal joints, or • both arms at or above the wrist joint up to the shoulder joint, or • one hand at the metacarpophalangeal joint and one arm at or above the wrist joint up to the shoulder joint, as confirmed by an orthopaedic or neurosurgeon.	100%
	Loss of use of both feet or legs	The total loss of use of: • both legs at or above the ankle joint up to the hip joint, or • both feet at the transverse tarsal joint (Chopart's joint), or • one foot at the transverse tarsal joint (Chopart's joint) and one leg at or above the ankle joint up to the hip joint, as confirmed by an orthopaedic or neurosurgeon.	100%
	Loss of use of one arm	The total loss of use of one arm at or above the wrist joint up to the shoulder joint, as confirmed by an orthopaedic or neurosurgeon.	75%
	Loss of use of one hand	The total loss of use of one hand at the metacarpophalangeal joint involving more than 3 fingers, one of which includes either the thumb or the index finger, as confirmed by an orthopaedic or neurosurgeon.	50%
	Loss of use of one thumb	The total loss of use of one thumb, as confirmed by an orthopaedic or neurosurgeon.	25%
	Loss of use of one leg	The total loss of use of one leg, at or above the ankle joint up to the hip joint, as confirmed by an orthopaedic or neurosurgeon.	75%
	Loss of use of one foot	The total loss of use of one foot at the transverse tarsal joint (Chopart's joint), as confirmed by an orthopaedic or neurosurgeon.	50%

HIV/AIDS	AIDS	The clinical manifestation of AIDS/Stage 4 HIV infection, as confirmed by a medical specialist.
		
		With evidence of the following:
		
		• Positive HIV antibody test (or other recognised test for the presence of AIDS, acceptable to Old Mutual), and CD4 cell count of less than 200 despite compliance with anti-retroviral treatment as per latest National Guidelines, and either:
		  • The presence of 3 or more of the following 5 conditions:
		1. Weight loss of more than 10% body weight in less than 6 months
		2. Shingles
		3. Oral thrush
		4. Chronic diarrhoea
		5. Active tuberculosis
		
		Or:
		
		  • The diagnosis of one or more of the following 8 diseases:
		1. Kaposi's sarcoma,
		2. Candidiasis of oesophagus, trachea,
		3. bronchi or lungs,
		4. Oral hairy leukoplakia,
		5. Pneumocystis carinii pneumonia,
		6. Extra pulmonary Cryptococcus,
		7. Cytomegalo virus infection of an internal organ other than the liver,
		8. Disseminated atypical mycobacteriosis,
		9. Visceral leischmaniasis
			100%

Activities of Daily Living	Activities of Daily Living	Any illness, condition or event that results in the insured person being unable to perform certain Basic Activities of Daily Living and / or Advanced Activities of Daily Living, as specified below. • An inability to perform 3 of the Basic Activities of Daily Living or 4 of the Advanced Activities of Daily Living. Old Mutual's Medical Officer must confirm that: • The insured person has undergone adequate medical treatment and has reached an adequate level of functioning that can reasonably be expected of a person suffering from the illness, condition or event, and • The insured person does not qualify, as a result of suffering from an illness, condition or event, for the payment of the cover amount for any other listed Functional Impairment under this benefit. Where applicable, the activities listed below must be performed with simple external assistive devices (e.g. walking stick, Zimmer frame), but without complex external assistive devices (e.g. wheelchair, leg prosthesis). • The general meaning of the terms 'simple external assistive devices' and 'complex external assistive devices' is not limited by the specific examples quoted or the class or type of the examples quoted.	100%
		Any illness, condition or event that results in the insured person being unable to perform certain Basic Activities of Daily Living and / or Advanced Activities of Daily Living, as specified below. • An inability to perform 2 of the Basic Activities of Daily Living and 2 of the Advanced Activities of Daily Living. Old Mutual's Medical Officer must confirm that: • The insured person has undergone adequate medical treatment and has reached an adequate level of functioning that can reasonably be expected of a person suffering from the illness, condition or event, and • The insured person does not qualify, as a result of suffering from an illness, condition or event, for the payment of the cover amount for any other listed Functional Impairment under this benefit. Where applicable, the activities listed below must be performed with simple external assistive devices (e.g. walking stick, Zimmer frame), but without complex external assistive devices (e.g. wheelchair, leg prosthesis). The general meaning of the terms 'simple external assistive devices' and 'complex external assistive devices' is not limited by the specific examples quoted or the class or type of the examples quoted.	50%

ACTIVITIES OF DAILY LIVING UNDER THE FUNCTIONAL IMPAIRMENT INCOME COVER BENEFIT

Basic activities of daily living:	
Activity	**Description**
Bathing	The ability to wash/bathe oneself independently
Transferring	The ability to move oneself from a bed to a chair or from a bed to a toilet independently
Dressing	The ability to take off and put on one's clothes independently
Eating	The ability to feed oneself independently. This does not include the making of food
Toileting	The ability to use a toilet and cleanse oneself thereafter, independently
Locomotion on a level surface	The ability to walk on a flat surface, independently

Advanced activities of daily living:	
Activity	**Description**
Driving a car	The ability to open a car door, change gears or use a steering wheel
Medical care	The ability to prepare and take the correct medication
Money management	The ability to do one's own banking and to make rational financial decisions
Communicative activities	The ability to communicate either verbally or written
Shopping	The ability to choose and lift groceries from shelves as well as carry them in bags
Food preparation	The ability to prepare food for cooking as well as using kitchen utensils
Housework	The ability to clean a house or iron clothing
Community ambulation with or without assistive device, but not requiring a mobility device	The ability to walk around in public places using only a walking stick if necessary

FRACTURES THAT QUALIFY UNDER THE FUNCTIONAL IMPAIRMENT INCOME COVER BENEFIT

For fractures, the amount we pay depends on the waiting period that you chose.

Fracture	1-month waiting period	Other waiting periods
Collar bone (Clavicle)	No income	No income
Facial bones – Le Forte II	No income	No income
Forearm (Radius or ulna or both)	No income	No income
Bones of the hand (includes wrist and fingers) requiring plaster/fibreglass cast or surgery	No income	No income
Hind foot or ankle	No income	No income
Skull	No income	No income
Compression fracture of a vertebral body <10%	No income	No income
Two or less ribs	No income	No income
Three or more ribs	1 month's income	No income
Knee cap (patella)	1 month's income	No income
Leg - between the knee and foot (Tibia or fibula or both)	1 month's income	No income
Shoulder blade (scapula)	1 month's income	No income
Humerus	1 month's income	No income
Spinous processes or transverse processes of the spine	1 month's income	No income
Facial bones – Le Forte III	2 months' income	No income
Pelvis	2 months' income	No income
Compression fracture of a vertebral body ≥10%	2 months' income	No income
Dislocation fracture of the spine requiring surgery	2 months' income	No income
Depressed fracture of the skull requiring surgery	2 months' income	No income
Neck of femur (thigh bone)	2 months' income	No income
Shaft of femur (thigh bone)	2 months' income	No income

SEVERE ILLNESSES THAT YOUR SPOUSE/PARTNER QUALIFIES FOR UNDER THE FAMILY SUPPORT BENEFIT

Body system	Severe illness	Requirements that the severe illness must meet to qualify	Percentage of the cover amount payable

Cancer	Cancer	Confirmation of a malignant tumour diagnosed and characterised by the uncontrolled growth of malignant cells and invasion beyond the layer of cells in which it originated inta deeper layer of tissue. The term malignant tumour includes leukaemia, sarcoma and lymphoma.
		
		All cancers classified as Stage II by the American Joint Committee for Cancer are covered, where the following cancers are only covered as specified:
		
		• Prostate cancer is covered from Stage III
		• Malignant melanoma is covered from Stage II
		• WHGrade II brain tumours are covered if neurological deficit is present
		• Blood cancers are covered at the stages specified below
		  • Chronic Lymphocytic Leukemia, from Stage II on the Rai classification
		  • Chronic Myeloid Leukemia
		  • Hodgkin's/Non Hodgkin's lymphoma from Stage II on the Ann Arbor classification
		  • Multiple Myeloma Stage from Stage I on the Durie-Salmon Scale
		
		Exclusions
		
		• All cancers which are histologically classified as any of the following:
		  • pre-malignant
		  • non-invasive
		  • cancer in situ
		  • having borderline malignancy
		  • tumours with low malignant potential
		
		• All prostate cancers, unless conforming tthe specifications above
		• All skin cancers, except malignant melanoma as specified above
		• All blood cancers, unless as specified above
			100%

	Hematopoietic Stem Cell (Bone Marrow) Transplant	One of the following: • Undergoing a hematopoietic stem cell (bone marrow) transplant • Inclusion on a bone marrow transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure Requirements for a claim to be considered: • Confirmation by the treating specialist with supportive evidence	100%

Cardiovascular	Heart Attack	Confirmed diagnosis of a heart attack by the treating cardiologist characterised by death of heart muscle, due to inadequate blood supply.
		
		Requirements for a claim to be considered
		
		• Raised cardiac biomarkers with at least one reading above the upper reference level
		• Two of the following must be present:
		  • compatible clinical symptoms
		  • new characteristic electrocardiography (ECG) changes indicative of myocardial ischaemia or myocardial infarction
		  • angiography showing critical occlusion of a coronary artery indicative of myocardial ischaemia or myocardial infarction
		  • evidence of hypokinesis on ECHO confirming the death of heart muscle tissue
		
		Exclusions
		
		• Other acute coronary syndromes (including but not limited to angina and unstable angina)
		• Coronary spasms
		• Elevations of troponin in the absence of overt ischemic heart diseases (e.g. myocarditis, apical ballooning, cardiac contusion, pulmonary embolism, drug toxicity)
			100%

	Coronary Artery Bypass Graft	The undergoing of surgery to correct the narrowing of, or blockage to, one or more coronary arteries by means of a bypass graft.	100%
	Aortic Surgery	The repair of a narrowing, obstruction, dissection or aneurysm of either the main thoracic or abdominal aorta, by means of any minimally invasive surgical technique. This includes keyhole or catheter techniques, or a mini-thoracoscopic/ laparoscopic surgical procedure. Requirements for a claim to be considered: • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	100%
	Cardiomyopathy	Confirmed diagnosis of cardiomyopathy by the treating cardiologist. Requirements for a claim to be considered • The cardiomyopathy results in permanent and irreversible cardiac impairment, evidenced by echocardiogram findings showing left ventricular ejection fraction (LVEF) of less than 50%, measured twice at least 3 months apart.	100%
	Heart Surgery	The correction of any structural abnormality of the heart, through surgically opening the chest cavity (thoracotomy or sternotomy). Requirements for a claim to be considered: • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis Exclusions: • Any investigative procedure NOTE: Coronary artery bypass graft is covered as a separate severe illness	100%
	Heart Transplant	One of the following: • Undergoing a heart transplant • Inclusion on a heart transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure Requirements for a claim to be considered: • Confirmation by the treating specialist with supportive evidence	100%

Central Nervous System	Acquired Intellectual or Cognitive Impairment	Confirmed diagnosis of a permanent acquired intellectual or cognitive impairment caused by an organic disease or injury. Requirements for a claim to be considered: • Confirmation by the treating neurologist or psychiatrist • Objective tests such as brain imaging demonstrating appropriate pathology • IQ must be less than 60 as measured by at least two independent psychiatrists using the appropriate Wechsler Intelligence Scale and at least one other internationally recognized equivalent neuropsychological test Exclusions: • All other mental, psychological and psychiatric conditions	100%
	Brain surgery	Any condition for which the insured person has undergone open brain surgery. This must involve a craniotomy (where there is surgical removal of part of the bone from the skull to expose the brain). This includes depressed skull fracture requiring removal of bone or reconstruction of the skull. Requirements for a claim to be considered: • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis Exclusions: • Stereotactic or radiosurgery • Burr hole surgery • Any minimally invasive surgery such as keyhole or endovascular surgery	100%
	Coma	Confirmed diagnosis of a coma by the treating neurologist or neurosurgeon. Requirements for a claim to be considered • Decreased level of consciousness, with a Glasgow Coma Scale of 8 or less • The coma is constant and present for longer than 14 days Exclusions: • Medically induced comas • Comas due to the consumption of alcohol, drugs or medication not used as prescribed	100%
	Paralysis	The total and permanent loss of use of: • A hand or hands at the level of the wrist joint and above, or • A foot or feet at the level of the ankle and above Requirements for a claim to be considered: • Permanence must be confirmed by the treating specialist • Supportive special investigations	100%

Central Nervous System (continued)	Stroke	Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in neurological deficit, confirmed by neuroimaging investigation and appropriate clinical findings by a specialist neurologist. Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months.
		
		Stroke as a result of traumatic injury to brain tissue or blood vessels is included.
		
		Requirements for a claim to be considered
		
		• One of the following must be present:
		  • The inability to do 3 or more Advanced Activities of Daily Living, as defined below.
		  • A Whole Person Impairment (WPI) of 11%- 20%. WPI figures are calculated as per the latest version of the American Medical Association Guides to the Evaluation of Permanent Impairment
		
		Exclusions
		
		• Transient ischaemic attack
		• Vascular disease affecting the eye or optic nerve
		• Migraine and vestibular disorders
			100%

	Motor Neurone Disease	Confirmed diagnosis of motor neurone disease by the treating neurologist. Requirements for a claim to be considered: • There must be appropriate evidence, which could include nerve conduction studies (NCS) and electromyography (EMG)	100%
	Dementia (incl. Alzheimer's Disease)	Confirmed diagnosis of Alzheimer's disease or any other type of dementia by the treating neurologist. Requirements for a claim to be considered: • The diagnosis meets the criteria of the latest Diagnostic and Statistical Manual of Mental Disorders (DSM) • Supportive imaging and neurological reports	100%
	Parkinson's disease	Confirmed diagnosis of primary idiopathic Parkinson's disease by the treating neurologist. Requirements for a claim to be considered: The diagnosis must be confirmed by the presence of at least 2 cardinal symptoms of Parkinson's disease, which are: • Bradykinesia • Resting tremor • Muscle rigidity • Postural instability Exclusions: • Parkinsonian syndromes including but not limited to those caused by the consumption of alcohol, drugs or medication not used as prescribed • Secondary Parkinsonism • Essential tremor	100%

Autoimmune and Connective Tissue	Advanced Rheumatoid arthritis	Confirmed diagnosis and treatment of rheumatoid arthritis by the treating rheumatologist. Requirements for a claim to be considered: • Serological markers to be positive • Despite adequate treatment for at least 6 months with disease modifying drugs including biologics, the disease remains unresponsive or poorly responsive • The insured person undergoes joint replacement, joint reconstruction or joint fixation Exclusions: • Reactive arthritis • Psoriatic arthritis	100%
Urogenital	Chronic kidney failure	Confirmed diagnosis of chronic renal failure by the treating nephrologist or urologist. Requirements for a claim to be considered One of the following must be present, despite adequate medical treatment: • End-stage renal disease with an estimated Glomerular Filtration Rate (GFR) less than 24ml/min • Renal function deterioration for which either peritoneal dialysis or haemodialysis has been instituted	100%
	Kidney transplant	One of the following: • Undergoing a kidney transplant • Inclusion on a kidney transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure Requirements for a claim to be considered: • Confirmation by the treating specialist with supportive evidence	100%
Gastrointestinal	Chronic liver failure	Confirmed diagnosis of chronic end-stage liver disease by the treating gastroenterologist or equivalent specialist. Requirements for a claim to be considered: • Supportive clinical, laboratory and histological evidence • The liver failure must be classified as at least Child-Pugh class C Exclusions: • Liver disease caused by the consumption of alcohol, drugs or medication not used as prescribed	100%
	Liver transplant	One of the following: • Undergoing a liver transplant • Inclusion on a liver transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure Requirements for a claim to be considered: • Confirmation by the treating specialist with supportive evidence	100%
	Pancreatectomy or Pancreas transplant	One of the following: • Undergoing a complete pancreatectomy • Undergoing a complete pancreas transplant • Inclusion on a pancreas transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure Requirements for a claim to be considered: • Confirmation by the treating specialist with supportive evidence	100%

HIV/AIDS	AIDS	Confirmed diagnosis of AIDS or Stage 4 HIV infection by the treating specialist. Requirements for a claim to be considered: • Positive HIV antibody test (or other recognised test for the presence of HIV, acceptable to Old Mutual) • CD4 count of persistently less than 200 cells/mm3 must be present, despite compliance with anti-retroviral treatment as per latest National Guidelines • At least one of the AIDS-defining conditions listed in the current World Health Organization's (WHO) clinical staging of HIV/AIDS	100%
Respiratory	Chronic Respiratory Failure	Confirmed diagnosis of a chronic respiratory disorder by the treating pulmonologist. Requirements for a claim to be considered: Any one of the below measurements taken on at least 3 occasions, at least 1 month apart • Impaired airflow with FEV1 (forced expiratory volume in the first second) of ≤40% predicted • FVC (forced vital capacity) of ≤40% predicted • DLCO (diffusing capacity of the lungs for carbon monoxide) of ≤40% predicted	100%
	Prolonged mechanical ventilation	A severe physical injury or organic disease that results in an extended period of assisted mechanical ventilation. Requirements for a claim to be considered: One of the following must be present: • A severe physical injury that results in ICU admission for more than 14 full days, with assisted mechanical ventilation for more than 7 full days • Any organic disease that results in assisted mechanical ventilation of more than 30 consecutive days NOTE: • A day is 24 hours • The life covered does not qualify for a payment for any other listed severe illness under this benefit • The survival period applies from the date the claim definition has been met	100%
	Lung Transplant	One of the following: • Undergoing a lung transplant (this includes the whole lung or a lobe of the lung) • Inclusion on a lung transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure Requirements for a claim to be considered: • Confirmation by the treating specialist with supportive evidence	100%

Senses	Loss of hearing	Confirmed diagnosis of loss of hearing in both ears by the treating ENT specialist. Requirements for a claim to be considered: • Average auditory threshold, measured at 500, 1000, 2000 and 3000 Hertz in the better ear using a pure tone audiogram, of between 90 or more decibels • This must be confirmed by audiometry conducted with hearing aids	100%
	Loss of sight	Confirmed diagnosis of loss of sight by the treating ophthalmologist. The loss of sight can't be improved through refractive correction or medication. Requirements for a claim to be considered One of the following must be present: • A reading of 6/60 or worse (or equivalent measure on a non-metric scale) in each eye , after best correction • A visual field loss to a 10° radius, after best correction • Severe proliferative diabetic retinopathy • Grade IV hypertensive retinopathy • Permanent hemianopia in both eyes Exclusions: • Loss of sight due to cataracts, unless there is evidence of failed cataract surgery or contraindications to cataract surgery	100%
	Loss of speech	Total permanent and irreversible loss of the ability to speak as a result of physical injury or disease as diagnosed by the treating ENT specialist, neurologist or neurosurgeon. Requirements for a claim to be considered: • The loss of speech has to be present for a continuous period of at least 6 months Exclusions: Loss of speech due to psychiatric causes	100%
Terminal Illness	Terminal Illness	Confirmed diagnosis of a medical condition that is or has become incurable by a treating specialist. In the opinion of the treating specialist and as confirmed by our medical officer, the condition is likely to result in death within 12 months after the diagnosis.	100%

Trauma	Accidental brain injury	Death of brain tissue due to traumatic injury as a result of an accident resulting in neurological deficit, confirmed by neuroimaging investigation and appropriate clinical findings by a specialist neurologist. Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months. Requirements for a claim to be considered One of the following must be present: • The inability to do 3 or more Advanced Activities of Daily Living, as defined below. • A Whole Person Impairment (WPI) of 11%20%. WPI figures are calculated as per the latest version of the American Medical Association Guides to the Evaluation of Permanent Impairment NOTE: • An accident is an unexpected and visible event of external origin that causes traumatic bodily injury and is not traceable, even indirectly, to the spouse/partner's state of mental or physical health before the event.	100%
	Major Burns	Confirmed diagnosis of external third degree burns (full thickness burns) by the treating plastic surgeon or trauma specialist. Requirements for a claim to be considered One of the following must be present: • At least 20% of total body surface affected, as measured on the Lund and Browder Chart or equivalent • 30% of the surface area of the face affected, which for the purposes of this definition includes the forehead and ears Exclusions: • Sunburn or sun exposure	100%
Musculoskeletal	Amputation of limb	Any organic disease or severe physical injury that results in the medically necessary, complete physical severance of: • A hand or hands at the level of the wrist joint or above, or • A foot or feet at the level of the ankle and above Requirements for a claim to be considered: • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	100%

SEVERE ILLNESSES THAT YOUR CHILD QUALIFIES FOR UNDER THE FAMILY SUPPORT BENEFIT

Body system	Severe illness	Requirements that the severe illness must meet to qualify	Percentage of the cover amount payable

Cancer	Cancer	Confirmation of a malignant tumour diagnosed and characterised by the uncontrolled growth of malignant cells and invasion beyond the layer of cells in which it originated into a deeper layer of tissue. The term malignant tumour includes leukaemia, sarcoma and lymphoma.
		
		All cancers classified as Stage II by the American Joint Committee for Cancer are covered, where the following cancers are only covered as specified:
		• Prostate cancer is covered from Stage III
		• Malignant melanoma is covered from Stage II
		• WHO Grade II brain tumours are covered if neurological deficit is present
		• Blood cancers are covered at the stages specified below
		  • Chronic Lymphocytic Leukemia, from Stage II on the Rai classification
		  • Chronic Myeloid Leukemia
		  • Hodgkin's/Non Hodgkin's lymphoma from Stage II on the Ann Arbor classification
		  • Multiple Myeloma Stage from Stage I on the Durie-Salmon Scale
		
		Exclusions
		• All cancers which are histologically classified as any of the following:
		  • pre-malignant
		  • non-invasive
		  • cancer in situ
		  • having borderline malignancy
		  • tumours with low malignant potential
		• All prostate cancers, unless conforming tthe specifications above
		• All skin cancers, except malignant melanoma as specified above
		• All blood cancers, unless as specified above
			100%

	Hematopoietic Stem Cell (Bone Marrow) Transplant	One of the following: • Undergoing a hematopoietic stem cell (bone marrow) transplant • Inclusion on a bone marrow transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure Requirements for a claim to be considered: • Confirmation by the treating specialist with supportive evidence	100%

Cardiovascular	Heart Attack	Confirmed diagnosis of a heart attack by the treating cardiologist characterised by death of heart muscle, due to inadequate blood supply.
		
		Requirements for a claim to be considered:
		
		• Raised cardiac biomarkers with at least one reading above the upper reference level
		• Two of the following must be present:
		  • compatible clinical symptoms
		  • new characteristic electrocardiography (ECG) changes indicative of myocardial ischaemia or myocardial infarction
		  • angiography showing critical occlusion of a coronary artery indicative of myocardial ischaemia or myocardial infarction
		  • evidence of hypokinesis on ECHO confirming the death of heart muscle tissue
		
		Exclusions
		
		• Other acute coronary syndromes (including but not limited to angina and unstable angina)
		• Coronary spasms
		• Elevations of troponin in the absence of overt ischemic heart diseases (e.g. myocarditis, apical ballooning, cardiac contusion, pulmonary embolism, drug toxicity)
			100%

	Coronary Artery Bypass Graft	The undergoing of surgery to correct the narrowing of, or blockage to, one or more coronary arteries by means of a bypass graft.	100%
	Aortic Surgery	The repair of a narrowing, obstruction, dissection or aneurysm of either the main thoracic or abdominal aorta, by means of any minimally invasive surgical technique. This includes keyhole or catheter techniques, or a mini-thoracoscopic/ laparoscopic surgical procedure. Requirements for a claim to be considered: • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	100%
	Cardiomyopathy	Confirmed diagnosis of cardiomyopathy by the treating cardiologist. Requirements for a claim to be considered: • The cardiomyopathy results in permanent and irreversible cardiac impairment, evidenced by echocardiogram findings showing left ventricular ejection fraction (LVEF) of less than 50%, measured twice at least 3 months apart.	100%
	Heart Surgery	The correction of any structural abnormality of the heart, through surgically opening the chest cavity (thoracotomy or sternotomy). Requirements for a claim to be considered: • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis Exclusions: • Any investigative procedure NOTE: Coronary artery bypass graft is covered as a separate severe illness	100%
	Heart Transplant	One of the following: • Undergoing a heart transplant • Inclusion on a heart transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure Requirements for a claim to be considered: • Confirmation by the treating specialist with supportive evidence	100%

Central Nervous System	Acquired Intellectual or Cognitive Impairment	Confirmed diagnosis of a permanent acquired intellectual or cognitive impairment caused by an organic disease or injury. Requirements for a claim to be considered: • Confirmation by the treating neurologist or psychiatrist • Objective tests such as brain imaging demonstrating appropriate pathology • IQ must be less than 60 as measured by at least two independent psychiatrists using the appropriate Wechsler Intelligence Scale and at least one other internationally recognized equivalent neuropsychological test Exclusions: • All other mental, psychological and psychiatric conditions	100%
	Brain surgery	Any condition for which the insured person has undergone open brain surgery. This must involve a craniotomy (where there is surgical removal of part of the bone from the skull to expose the brain). This includes depressed skull fracture requiring removal of bone or reconstruction of the skull. Requirements for a claim to be considered: • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis Exclusions: • Stereotactic or radiosurgery • Burr hole surgery • Any minimally invasive surgery such as keyhole or endovascular surgery	100%
	Coma	Confirmed diagnosis of a coma by the treating neurologist or neurosurgeon. Requirements for a claim to be considered: • Decreased level of consciousness, with a Glasgow Coma Scale of 8 or less • The coma is constant and present for longer than 14 days Exclusions: • Medically induced comas • Comas due to the consumption of alcohol, drugs or medication not used as prescribed	100%
	Paralysis	The total and permanent loss of use of: • A hand or hands at the level of the wrist joint and above, or • A foot or feet at the level of the ankle and above Requirements for a claim to be considered: • Permanence must be confirmed by the treating specialist • Supportive special investigations	100%

Central Nervous System (continued)	Stroke	Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in neurological deficit, confirmed by neuroimaging investigation and appropriate clinical findings by a specialist neurologist. Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months. Stroke as a result of traumatic injury to brain tissue or blood vessels is included. Requirements for a claim to be considered: • A Whole Person Impairment (WPI) of 11%20%. WPI figures are calculated as per the latest version of the American Medical Association Guides to the Evaluation of Permanent Impairment Exclusions • Transient ischaemic attack • Vascular disease affecting the eye or optic nerve • Migraine and vestibular disorders	100%
	Motor Neurone Disease	Confirmed diagnosis of motor neurone disease by the treating neurologist. Requirements for a claim to be considered: • There must be appropriate evidence, which could include nerve conduction studies (NCS) and electromyography (EMG)	100%
	Muscular Dystrophy	Confirmed diagnosis of muscular dystrophy by the treating neurologist. Requirements for a claim to be considered: • There must be appropriate evidence, which could include characteristic electromyography (EMG) and muscle biopsy findings	100%
Autoimmune and Connective Tissue	Juvenile Idiopathic Arthritis	Confirmed diagnosis of juvenile idiopathic arthritis by the treating rheumatologist. Requirements for a claim to be considered: • Age at onset must be less than 16 years • Signs and symptoms must have been present for at least 3 months • Active juvenile idiopathic arthritis in at least two major joints (e.g. fingers, hands, wrists, knees, hips, elbows, shoulders) as evidenced by clinical signs and x-rays	100%
Urogenital	Chronic kidney failure	Confirmed diagnosis of chronic renal failure by the treating nephrologist or urologist. Requirements for a claim to be considered One of the following must be present, despite adequate medical treatment: • End-stage renal disease with an estimated Glomerular Filtration Rate (GFR) less than 24ml/min • Renal function deterioration for which either peritoneal dialysis or haemodialysis has been instituted	100%
	Kidney transplant	One of the following: • Undergoing a kidney transplant • Inclusion on a kidney transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure Requirements for a claim to be considered: • Confirmation by the treating specialist with supportive evidence	100%

Gastrointestinal	Chronic liver failure	Confirmed diagnosis of chronic end-stage liver disease by the treating gastroenterologist or equivalent specialist. Requirements for a claim to be considered: • Supportive clinical, laboratory and histological evidence • The liver failure must be classified as at least Child-Pugh class C Exclusions: • Liver disease caused by the consumption of alcohol, drugs or medication not used as prescribed	100%
	Liver transplant	One of the following: • Undergoing a liver transplant • Inclusion on a liver transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure Requirements for a claim to be considered: • Confirmation by the treating specialist with supportive evidence	100%
	Pancreatectomy or Pancreas transplant	One of the following: • Undergoing a complete pancreatectomy • Undergoing a complete pancreas transplant • Inclusion on a pancreas transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure Requirements for a claim to be considered: • Confirmation by the treating specialist with supportive evidence	100%
HIV/AIDS	AIDS	Confirmed diagnosis of AIDS or Stage 4 HIV infection by the treating specialist. Requirements for a claim to be considered: • Positive HIV antibody test (or other recognised test for the presence of HIV, acceptable to Old Mutual) • CD4 count of persistently less than 200 cells/mm3 must be present, despite compliance with anti-retroviral treatment as per latest National Guidelines • At least one of the AIDS-defining conditions listed in the current World Health Organization's (WHO) clinical staging of HIV/AIDS	100%

Respiratory	Chronic Respiratory Failure	Confirmed diagnosis of a chronic respiratory disorder by the treating pulmonologist. Requirements for a claim to be considered: Any one of the below measurements taken on at least 3 occasions, at least 1 month apart • Impaired airflow with FEV1 (forced expiratory volume in the first second) of ≤40% predicted • FVC (forced vital capacity) of ≤40% predicted • DLCO (diffusing capacity of the lungs for carbon monoxide) of ≤40% predicted	100%
	Prolonged mechanical ventilation	A severe physical injury or organic disease that results in an extended period of assisted mechanical ventilation. Requirements for a claim to be considered: One of the following must be present: • A severe physical injury that results in ICU admission for more than 14 full days, with assisted mechanical ventilation for more than 7 full days • Any organic disease that results in assisted mechanical ventilation of more than 30 consecutive days NOTE: • A day is 24 hours • The life covered does not qualify for a payment for any other listed severe illness under this benefit • The survival period applies from the date the claim definition has been met	100%
	Lung Transplant	One of the following: • Undergoing a lung transplant (this includes the whole lung or a lobe of the lung) • Inclusion on a lung transplant waiting list (as a recipient), that is recognised by Old Mutual as being an official waiting list for such a procedure Requirements for a claim to be considered: • Confirmation by the treating specialist with supportive evidence	100%

Senses	Loss of hearing	Confirmed diagnosis of loss of hearing in both ears by the treating ENT specialist. Requirements for a claim to be considered: • Average auditory threshold, measured at 500, 1000, 2000 and 3000 Hertz in the better ear using a pure tone audiogram, of between 90 or more decibels • This must be confirmed by audiometry conducted with hearing aids	100%
	Loss of sight	Confirmed diagnosis of loss of sight by the treating ophthalmologist. The loss of sight can't be improved through refractive correction or medication. Requirements for a claim to be considered One of the following must be present: • A reading of 6/60 or worse (or equivalent measure on a non-metric scale) in each eye , after best correction • A visual field loss to a 10° radius, after best correction • Severe proliferative diabetic retinopathy • Grade IV hypertensive retinopathy • Permanent hemianopia in both eyes Exclusions: • Loss of sight due to cataracts, unless there is evidence of failed cataract surgery or contraindications to cataract surgery	100%
	Loss of speech	Total permanent and irreversible loss of the ability to speak as a result of physical injury or disease as diagnosed by the treating ENT specialist, neurologist or neurosurgeon. Requirements for a claim to be considered: • The loss of speech has to be present for a continuous period of at least 6 months Exclusions: Loss of speech due to psychiatric causes	100%
Terminal Illness	Terminal Illness	Confirmed diagnosis of a medical condition that is or has become incurable by a treating specialist. In the opinion of the treating specialist and as confirmed by our medical officer, the condition is likely to result in death within 12 months after the diagnosis.	100%

Trauma	Accidental brain injury	Death of brain tissue due to traumatic injury as a result of an accident resulting in neurological deficit, confirmed by neuroimaging investigation and appropriate clinical findings by a specialist neurologist. Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months. Requirements for a claim to be considered One of the following must be present: • A Whole Person Impairment (WPI) of 11%20%. WPI figures are calculated as per the latest version of the American Medical Association Guides to the Evaluation of Permanent Impairment NOTE: • An accident is an unexpected and visible event of external origin that causes traumatic bodily injury and is not traceable, even indirectly, to the child's state of mental or physical health before the event.	100%
	Major Burns	Confirmed diagnosis of external third degree burns (full thickness burns) by the treating plastic surgeon or trauma specialist. Requirements for a claim to be considered One of the following must be present: • At least 20% of total body surface affected, as measured on the Lund and Browder Chart or equivalent • 30% of the surface area of the face affected, which for the purposes of this definition includes the forehead and ears Exclusions: • Sunburn or sun exposure	100%
	Accidental near drowning	ICU admission that results from accidental near drowning. Requirements for a claim to be considered: • The accidental near drowning results in ICU admission for 48 hours or more NOTE: • An accident is an unexpected and visible event of external origin that causes traumatic bodily injury and is not traceable, even indirectly, to the child's state of mental or physical health before the event	100%
	Accidental asphyxiation	ICU admission that results from accidental asphyxiation. Requirements for a claim to be considered: • The accidental asphyxiation results in ICU admission for 48 hours or more NOTE: • An accident is an unexpected and visible event of external origin that causes traumatic bodily injury and is not traceable, even indirectly, to the child's state of mental or physical health before the event	100%
Musculoskeletal	Amputation of limb	Any organic disease or severe physical injury that results in the medically necessary, complete physical severance of: • A hand or hands at the level of the wrist joint or above, or • A foot or feet at the level of the ankle and above Requirements for a claim to be considered: • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	100%

ACTIVITIES OF DAILY LIVING UNDER THE FAMILY SUPPORT BENEFIT

Basic activities of daily living:	
Activity	**Description**
Bathing	The ability to wash/bathe oneself independently
Transferring	The ability to move oneself from a bed to a chair or from a bed to a toilet independently
Dressing	The ability to take off and put on one's clothes independently
Eating	The ability to feed oneself independently. This does not include the making of food
Toileting	The ability to use a toilet and cleanse oneself thereafter, independently
Locomotion on a level surface	The ability to walk on a flat surface, independently
Locomotion on an incline	The ability to walk up a gentle slope, or a flight of steps independently

Advanced activities of daily living:	
Activity	**Description**
Driving a car	The ability to open a car door, change gears or use a steering wheel
Medical care	The ability to prepare and take the correct medication
Money management	The ability to do one's own banking and to make rational financial decisions
Communicative activities	The ability to communicate either verbally or written
Shopping	The ability to choose and lift groceries from shelves as well as carry them in bags
Food preparation	The ability to prepare food for cooking as well as using kitchen utensils
Housework	The ability to clean a house or iron clothing
Community ambulation with or without assistive device, but not requiring a mobility device	The ability to walk around in public places using only a walking stick if necessary
Moderate activities	Activities like moving a table, pushing a vacuum cleaner, bowling, golf
Vigorous activities	Able to partake in running, heavy lifting, sports

STANDARDISED CRITICAL ILLNESS DEFINITIONS OF ASSOCIATION FOR SAVINGS AND INVESTMENT SOUTH AFRICA (ASISA) THAT QUALIFY UNDER THE FAMILY SUPPORT BENEFIT

Severe Illness	Requirements that the severe illness must meet to qualify	Percentage of the cover amount payable
Stroke	Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in neurological deficit lasting longer than 24 hours, confirmed by neuro-imaging investigation and appropriate clinical findings by a specialist neurologist. For the above definition, the following are not covered: • transient ischaemic attack; • vascular disease affecting the eye or optic nerve; • migraine and vestibular disorders; • traumatic injury to brain tissue or blood vessels. Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months. Level D: Stroke with almost full recovery Almost full recovery, with little residual symptoms or signs, as measured by: • the ability to do all basic and advanced ADL's, or • a Whole Person Impairment (WPI) of 10% or less. WPI figures are calculated as per the American Medical Association Guides to the Evaluation of Permanent Impairment 6th edition. **Basic activities of daily living:** • **Bathing** the ability to wash/bathe oneself independently • **Transferring** the ability to move oneself from a bed to a chair or from a bed to a toilet independently • **Dressing** the ability to take off and put on one's clothes independently • **Eating** the ability to feed oneself independently. This does not include the making of food • **Toileting** the ability to use a toilet and cleanse oneself thereafter, independently • **Locomotion on a level surface** the ability to walk on a flat surface, independently • **Locomotion on an incline** the ability to walk up a gentle slope, or a flight of steps independently **Advanced activities of daily living:** • **Driving a car** the ability to open a car door, change gears or use a steering wheel • **Medical care** the ability to prepare and take the correct medication • **Money management** the ability to do one's own banking and to make rational financial decisions • **Communicative activities** the ability to communicate either verbally or written • **Shopping** the ability to choose and lift groceries from shelves as well as carry them in bags • **Food preparation** the ability to prepare food for cooking as well as using kitchen utensils • **Housework** the ability to clean a house or iron clothing • **Community ambulation with or without assistive device, but not requiring a mobility device** the ability to walk around in public places using only a walking stick if necessary • **Moderate activities** activities like moving a table, pushing a vacuum cleaner, bowling, golf • **Vigorous activities** able to partake in running, heavy lifting, sports	0%

Stroke (continued)	Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in neurological deficit lasting longer than 24 hours, confirmed by neuro-imaging investigation and appropriate clinical findings by a specialist neurologist. For the above definition, the following are not covered: • transient ischaemic attack; • vascular disease affecting the eye or optic nerve; • migraine and vestibular disorders; • traumatic injury to brain tissue or blood vessels. Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months. <u>Level C: Stroke with mild impairment</u> Can function independently, but has impairment as measured by: • the inability to do 3 or more advanced ADL's, or • a Whole Person Impairment (WPI) of 11% to 20%. WPI figures are calculated as per the American Medical Association Guides to the Evaluation of Permanent Impairment 6th edition. **Basic activities of daily living:** • **Bathing** the ability to wash/bathe oneself independently • **Transferring** the ability to move oneself from a bed to a chair or from a bed to a toilet independently • **Dressing** the ability to take off and put on one's clothes independently • **Eating** the ability to feed oneself independently. This does not include the making of food • **Toileting** the ability to use a toilet and cleanse oneself thereafter, independently • **Locomotion on a level surface** the ability to walk on a flat surface, independently • **Locomotion on an incline** the ability to walk up a gentle slope, or a flight of steps independently **Advanced activities of daily living:** • **Driving a car** the ability to open a car door, change gears or use a steering wheel • **Medical care** the ability to prepare and take the correct medication • **Money management** the ability to do one's own banking and to make rational financial decisions • **Communicative activities** the ability to communicate either verbally or written • **Shopping** the ability to choose and lift groceries from shelves as well as carry them in bags • **Food preparation** the ability to prepare food for cooking as well as using kitchen utensils • **Housework** the ability to clean a house or iron clothing • **Community ambulation with or without assistive device, but not requiring a mobility device** the ability to walk around in public places using only a walking stick if necessary • **Moderate activities** activities like moving a table, pushing a vacuum cleaner, bowling, golf • **Vigorous activities** able to partake in running, heavy lifting, sports	100%

Stroke (continued)	Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in neurological deficit lasting longer than 24 hours, confirmed by neuro-imaging investigation and appropriate clinical findings by a specialist neurologist. For the above definition, the following are not covered: • transient ischaemic attack; • vascular disease affecting the eye or optic nerve; • migraine and vestibular disorders; • traumatic injury to brain tissue or blood vessels. Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months. <u>Level B: Stroke with moderate impairment</u> Cannot function independently, as measured by: • the inability to do 6 or more advanced ADL's, or • a Whole Person Impairment (WPI) of 21% to 35%. WPI figures are calculated as per the American Medical Association Guides to the Evaluation of Permanent Impairment 6th edition. **Basic activities of daily living:** • **Bathing** the ability to wash/bathe oneself independently • **Transferring** the ability to move oneself from a bed to a chair or from a bed to a toilet independently • **Dressing** the ability to take off and put on one's clothes independently • **Eating** the ability to feed oneself independently. This does not include the making of food • **Toileting** the ability to use a toilet and cleanse oneself thereafter, independently • **Locomotion on a level surface** the ability to walk on a flat surface, independently • **Locomotion on an incline** the ability to walk up a gentle slope, or a flight of steps independently **Advanced activities of daily living:** • **Driving a car** the ability to open a car door, change gears or use a steering wheel • **Medical care** the ability to prepare and take the correct medication • **Money management** the ability to do one's own banking and to make rational financial decisions • **Communicative activities** the ability to communicate either verbally or written • **Shopping** the ability to choose and lift groceries from shelves as well as carry them in bags • **Food preparation** the ability to prepare food for cooking as well as using kitchen utensils • **Housework** the ability to clean a house or iron clothing • **Community ambulation with or without assistive device, but not requiring a mobility device** the ability to walk around in public places using only a walking stick if necessary • **Moderate activities** activities like moving a table, pushing a vacuum cleaner, bowling, golf • **Vigorous activities** able to partake in running, heavy lifting, sports	100%

Stroke (continued)	Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in neurological deficit lasting longer than 24 hours, confirmed by neuro-imaging investigation and appropriate clinical findings by a specialist neurologist. For the above definition, the following are not covered: • transient ischaemic attack; • vascular disease affecting the eye or optic nerve; • migraine and vestibular disorders; • traumatic injury to brain tissue or blood vessels. Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months. Level A: Stroke with severe impairment Needs constant assistance, as measured by: • the inability to do 3 or more basic ADL's, or • a Whole Person Impairment (WPI) of greater than 35%. WPI figures are calculated as per the American Medical Association Guides to the Evaluation of Permanent Impairment 6th edition. **Basic activities of daily living:** • **Bathing** the ability to wash/bathe oneself independently • **Transferring** the ability to move oneself from a bed to a chair or from a bed to a toilet independently • **Dressing** the ability to take off and put on one's clothes independently • **Eating** the ability to feed oneself independently. This does not include the making of food • **Toileting** the ability to use a toilet and cleanse oneself thereafter, independently • **Locomotion on a level surface** the ability to walk on a flat surface, independently • **Locomotion on an incline** the ability to walk up a gentle slope, or a flight of steps independently **Advanced activities of daily living:** • **Driving a car** the ability to open a car door, change gears or use a steering wheel • **Medical care**the ability to prepare and take the correct medication • **Money management** the ability to do one's own banking and to make rational financial decisions • **Communicative activities** the ability to communicate either verbally or written • **Shopping** the ability to choose and lift groceries from shelves as well as carry them in bags • **Food preparation** the ability to prepare food for cooking as well as using kitchen utensils • **Housework** the ability to clean a house or iron clothing • **Community ambulation with or without assistive device, but not requiring a mobility device** the ability to walk around in public places using only a walking stick if necessary • **Moderate activities** activities like moving a table, pushing a vacuum cleaner, bowling, golf • **Vigorous activities** able to partake in running, heavy lifting, sports	100%
Coronary artery bypass graft	The undergoing of surgery to correct the narrowing of, or blockage to, any one coronary artery by means of a by-pass graft.	100%
	The undergoing of surgery to correct the narrowing of, or blockage to, the left main or proximal left anterior descending coronary artery by means of a by-pass graft.	100%
	The undergoing of surgery to correct the narrowing of, or blockage to, two coronary arteries by means of a by-pass graft.	100%
	The undergoing of surgery to correct the narrowing of, or blockage to, three or more coronary arteries by means of a by-pass graft.	100%

Heart attack	Level D: Mild heart attack of specified severity This is defined as the death of heart muscle, due to inadequate blood supply, as evidenced by all three of the following criteria: 1. Compatible clinical symptoms and 2. Characteristic ECG changes indicative of myocardial ischaemia or myocardial infarction and 3. Raised cardiac biomarkers defined as any one of the following Troponin or Non-Troponin Markers:	100%

Sensitive Troponin Markers:

Marker		**Value****	
***Assay (test)**	**Troponin Type**	**Unit: ng/L**	**Unit: ng/ml**
Roche hsTnT	TnT	>500	>0,5
Abbott ARCHITECT	TnI	>1500	>1,5
Beckman AccuTnI	TnI	>2500	>2,5
Siemens Centaur Ultra	TnI	>3000	>3,0
Siemens Dimension RxL	TnI	>3000	>3,0
Siemens Stratus CS	TnI	>3000	>3,0

***** Use the relevant manufacturer's assay (test) as it appears on the laboratory report.

** Values represent multiples of the World Health Organisation (WHO) MI rule in levels and not the 99th percentile values (upper limit of normal) as quoted on the laboratory result.

Conventional Troponin Markers:

Marker		**Value**	
Assay (test)	**Troponin Type**	**Unit: ng/L**	**Unit: ng/ml**
Conventional TnT	TnT	>500	>0,5
Conventional AccuTnI***	TnI	>250	>0,25

******* or equivalent threshold with other Troponin I methods

Non-Troponin Markers:

Marker	**Value**
Raised CK-MB mass	Raised above the upper limit of normal laboratory reference range but not meeting the severity C definition (i.e. below 2 times the upper limit of normal laboratory reference range) in acute presentation phase.
Total CPK elevation	Raised above the upper limit of normal laboratory reference range but not meeting the severity C definition (i.e. below 2 times the upper limit of normal laboratory reference range) in acute presentation phase, with at least 6% being CK-MB.

The evidence must show a definite acute myocardial infarction. Other acute coronary syndromes, including but not limited to angina, are not covered by this definition.

Heart attack (continued)	**Post coronary artery intervention Myocardial Infarction (MI)**
	1. Confirmed acute MI that has occurred post percutaneous coronary intervention (PCI) with a detection of cardiac biomarkers as follows:
	Marker / **Parameter**
	Cardiac troponin assay — As it appears in the definition of at least a heart attack of mild severity (Level D) post intervention.
	Raised CK-MB mass — Raised above the upper limit of normal laboratory reference range but below 4 times the upper limit of normal laboratory reference range post intervention.
	2. Confirmed acute MI that has occurred post coronary artery bypass graft (CABG) with a detection of cardiac biomarkers as follows:
	Marker / **Parameter**
	Cardiac troponin assay — As it appears in the definition of at least a heart attack of moderate severity (Level C) post intervention.
	Raised CK-MB mass — Raised 4 times or more the upper limit of normal laboratory reference range post intervention.
	<u>Definition of ECG changes</u>
	ECG changes indicative of Myocardial Ischaemia that may progress to Myocardial Infarction:
	• Patients with ST-segment elevation:
	  • New or presumed new ST segment elevation at the J point in two or more contiguous leads with the cut-off points greater than or equal to 0.2mV in leads V1, V2, or V3, and greater than or equal to 0.1mV in other leads.
	  • Contiguity in the frontal plane is defined by the lead sequence AVL, I and II, AVF, III.
	• Patients without ST-segment elevation:
	  • ST-segment depression of at least 0.1 mV;
	T-wave abnormalities only.	

Heart attack (continued)	<u>Level C: Moderate heart attack of specified severity</u> This is defined as the death of heart muscle, due to inadequate blood supply, as evidenced by any of the following combinations of criteria: 1. Compatible clinical symptoms AND raised cardiac biomarkers OR 2. Compatible clinical symptoms AND new pathological Q-waves on ECG as defined OR 3. New pathological Q-waves on ECG as defined AND raised cardiac biomarkers OR 4. ST-segment and T-wave changes on ECG indicative of myocardial injury as defined AND raised cardiac biomarkers. Where raised cardiac biomarkers are referenced above, they are defined as any one of the following Troponin or Non-Troponin Markers: **Sensitive Troponin Markers:** **Marker** / **Value**** ***Assay (test)** / **Troponin Type** / **Unit: ng/L** / **Unit: ng/ml** Roche hsTnT / TnT / >1000 / >1,0 Abbott ARCHITECT / TnI / >3000 / >3,0 Beckman AccuTnI / TnI / >5000 / >5,0 Siemens Centaur Ultra / TnI / >6000 / >6,0 Siemens Dimension RxL / TnI / >6000 / >6,0 Siemens Stratus CS / TnI / >6000 / >6,0 * Use the relevant manufacturer's assay (test) or equivalent as it appears on the laboratory report. ** Values represent multiples of the World Health Organisation (WHO) MI rule in levels and not the 99th percentile values (upper limit of normal) as quoted on the laboratory result. **Conventional Troponin Markers:** **Marker** / **Value** **Assay (test)** / **Troponin Type** / **Unit: ng/L** / **Unit: ng/ml** Conventional TnT / TnT / >1000 / >1,0 Conventional AccuTnI*** / TnI / >500 / >0,5 *** or equivalent threshold with other Troponin I methods **Non-Troponin Markers:** **Marker** / **Value** Raised CK-MB mass / Raised 2 times or more the upper limit of normal laboratory reference range in acute presentation phase. Total CPK elevation / Raised 2 times or more the upper limit of normal laboratory reference range in acute presentation phase, with at least 6% being CK-MB.	100%

<table>
<tr>
<td>Heart attack (continued)</td>
<td>
<u>Definition of ECG changes:</u>

ECG changes indicative of Myocardial Ischaemia that may progress to Myocardial Infarction:
• Patients with ST-segment elevation:
  • New or presumed new ST segment elevation at the J point in two or more contiguous leads with the cut-off points greater than or equal to 0.2mV in leads V1, V2, or V3, and greater than or equal to 0.1mV in other leads.
  • Contiguity in the frontal plane is defined by the lead sequence AVL, I and II, AVF, III.
• Patients without ST-segment elevation:
  • ST-segment depression of at least 0.1 mV;
  • T-wave abnormalities only.

<u>Definition of new pathological Q-waves:</u>
• Any new Q-wave in leads V1 through V3;
• A Q-wave greater than or equal to 40 ms (0.04s) in leads I, II, AVL, AVF, V4, V5 or V6;
• The Q-wave changes must be present in any two contiguous leads, and be greater than or equal to 1mm in depth;

Appearance of new complete bundle branch block.
</td>
<td></td>
</tr>
<tr>
<td></td>
<td>
<u>Level B: Heart attack with mild permanent impairment in function</u>

A heart attack that meets the criteria as defined under Level C, with permanent impairment in one or more of the following functional criteria, as measured 6 weeks post-infarction:
<table>
<tr><th>Criterion</th><th>Value</th></tr>
<tr><td>METS</td><td>2 - 7</td></tr>
<tr><td>LVEF</td><td>30% - 50%</td></tr>
<tr><td>LVEDD</td><td>59 - 72</td></tr>
<tr><td>Ultrasound FS in %</td><td>16% - 25%</td></tr>
</table>

Survival period of 10 days applies.

Illnesses that will be considered related*:

Heart attack, heart surgery, coronary artery bypass graft, heart transplant, cardiomyopathy, angioplasty and/or stenting, pacemaker insertion, pathway ablation, life threatening arrhythmia

Illnesses that may be considered related*:

Terminal illness, activities of daily living
</td>
<td>100%</td>
</tr>
</table>

<table>
<tr>
<td>Heart attack (continued)</td>
<td>
<u>Level A: Heart attack with severe permanent impairment in function</u>

A heart attack that meets the criteria as defined under Level C, with permanent impairment in one or more of the following functional criteria, as measured 6 weeks post-infarction:

<table>
<tr><th>Criterion</th><th>Value</th></tr>
<tr><td>NYHA classification</td><td>Class 4</td></tr>
<tr><td>METS</td><td>1 or less</td></tr>
<tr><td>LVEF</td><td><30%</td></tr>
<tr><td>LVEDD</td><td>>72</td></tr>
<tr><td>Ultrasound FS in %</td><td><16%</td></tr>
</table>

Notes:

If more than one functional criterion is impaired, but their values do not conform to one severity level (for example one impaired value is Level A and another Level B), the final severity level should be determined by giving preference to the more objective criteria, that is in the following order:

1. LVEF
2. LVEDD
3. Ultrasound FS
4. METS
5. NYHA
</td>
<td>100%</td>
</tr>
<tr>
<td>Cancer</td>
<td>
A malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukaemia, lymphoma and sarcoma.

The following conditions are excluded from this definition:

• All cancers in situ and all pre-malignant conditions or conditions with low malignant potential, or classified as borderline malignancy.
• All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.
• All skin cancers are excluded. The only exception is malignant melanoma that has been histologically classified as T1N0M0 or worse.

<u>Tiering of all Cancers except prostate, leukemia, lymphoma and brain tumours</u>

The levels are correlated to the general classification used by the American Joint Committee for Cancer for the type of cancer involved:

Level D - Stage 1 cancer

<u>Tiering of prostate cancer</u>

Severity D - Stage 2 (T2, N0, M0 any Gleason)

<u>Severity D - Stage 2 (T1a-c, N0, M0 Gleason >7)</u>

Exclusions:

<u>Stage 1 (T1a, N0, M0, Gleason <4)</u>

• Stage 2 (T1a, N0, M0, Gleason 5-6)
• Stage 2 (T1b-c, N0, M0 Gleason 2-6)

<u>Tiering of leukemia and lymphoma</u>

Level D - This benefit will pay for any one of the following:

• Chronic Lymphocytic Leukaemia (Stage 0 or 1);
• Hairy cell leukaemia;
• Hodgkins/Non Hodgkins lymphoma Stage 1 on Ann Arbor classification.

<u>Tiering of brain tumours</u>

Severity D - WHO grade II without neurological deficit.
</td>
<td>0%</td>
</tr>
</table>

Cancer (continued)	A malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukaemia, lymphoma and sarcoma. The following conditions are excluded from this definition: • All cancers in situ and all pre-malignant conditions or conditions with low malignant potential, or classified as borderline malignancy. • All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0. • All skin cancers are excluded. The only exception is malignant melanoma that has been histologically classified as T1N0M0 or worse. Tiering of all Cancers except prostate, leukemia, lymphoma and brain tumours The levels are correlated to the general classification used by the American Joint Committee for Cancer for the type of cancer involved: Level C - Stage 2 cancer Tiering of prostate cancer Severity C - Stage 3 (T3, N0, M0 any Gleason) Tiering of leukemia and lymphoma Level C - This benefit will pay for any one of the following diagnoses: • Chronic Lymphocytic Leukaemia (stage II on the Rai classification); • Acute Lymphocytic Leukaemia (children); • Chronic Myeloid Leukaemia (no bone marrow transplantation); • Hodgkins/Non Hodgkins lymphoma Stage II on Ann Arbor classification system; • Multiple myeloma Stage I and II on the Durie-Salmon scale. Tiering of brain tumours Severity C - WHO grade II with neurological deficit.	100%
	A malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukaemia, lymphoma and sarcoma. The following conditions are excluded from this definition: • All cancers in situ and all pre-malignant conditions or conditions with low malignant potential, or classified as borderline malignancy. • All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0. • All skin cancers are excluded. The only exception is malignant melanoma that has been histologically classified as T1N0M0 or worse. Tiering of all Cancers except prostate, leukemia, lymphoma and brain tumours The levels are correlated to the general classification used by the American Joint Committee for Cancer for the type of cancer involved: Level B - Stage 3 cancer Tiering of prostate cancer Severity B - Stage 4 (T4, N0, M0 any Gleason) Tiering of leukemia and lymphoma Level B - This benefit will pay for any one of the following diagnoses: • Hodgkins and Non Hodgkins lymphoma Stage III on Ann Arbor classification system. Tiering of brain tumours Severity B - WHO grade III on diagnosis.	100%

Cancer (continued)	A malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukaemia, lymphoma and sarcoma. The following conditions are excluded from this definition: • All cancers in situ and all pre-malignant conditions or conditions with low malignant potential, or classified as borderline malignancy. • All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0. • All skin cancers are excluded. The only exception is malignant melanoma that has been histologically classified as T1N0M0 or worse. Tiering of all Cancers except prostate, leukemia, lymphoma and brain tumours The levels are correlated to the general classification used by the American Joint Committee for Cancer for the type of cancer involved: Level A - Stage 4 cancer Tiering of prostate cancer Severity A - Stage 4 (Any T, N1-3, M0 any Gleason) Severity A - Stage 4 (Any T, any N, M1, any Gleason) Tiering of leukemia and lymphoma Level A: This benefit will pay for any one of the following diagnoses: • Acute Myeloid Leukaemia; • Chronic Lymphocytic Leukaemia, stage III or IV on the Rai classification; • Chronic Myeloid Leukaemia (requiring bone marrow transplant); • Acute Lymphocytic Leukaemia (adults); • Hodgkins/Non Hodgkins lymphoma Stage IV on Ann Arbor classification system; • Multiple Myeloma Stage III on the Durie-Salmon Scale. Tiering of brain tumours Severity A - WHO grade IV on diagnosis.	100%