PRODUCT AND BENEFIT RULES
OLD MUTUAL PROTECT LIFE 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 Life Cover. It pays the cover amount when the insured person dies or becomes terminally ill. 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, no premium is payable on the contract and the premium would have increased, we will decrease the cover amount instead.

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.

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, the cover amount will automatically increase every year on the scheduled yearly 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.
Currency-linked	the currency exchange rate as set by us and as adjusted by a percentage you have chosen. If you have chosen to adjust the currency exchange rate by an inflation linked percentage, it is the foreign inflation as set by us.

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, no premium is payable on the contract and the premium would have increased, we will decrease the cover amount instead.

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.

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.

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.

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.

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 LIFE COVER BENEFIT

What is it?

This benefit pays the cover amount when the insured person (whose name appears on Personal, product and benefit details) dies or becomes terminally ill after the cover started.

The insured person is **terminally ill** if he/she is diagnosed by his/her treating specialist with a medical condition that is or has become incurable and which, in the opinion of the treating specialist and as confirmed by our medical officer, is likely to result in his/her death within 12 months.

How much and when does Old Mutual pay?

The cover amount for the insured person can be claimed when he/she dies or becomes terminally ill. The starting cover amount is shown on Personal, product and benefit details.

We will pay the cover amount that applies on the date of death or terminal illness as confirmed by our medical officer, whichever is applicable.

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.

When does cover start?

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

When does cover stop?

The cover stops:

- when the insured person dies,
- if we do not receive your premiums and the grace period has passed, or
- if your contract is cancelled,

whichever happens first.

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).

When does cover stop?

The cover stops:

- when the insured person dies,
- on the cover end date shown on Personal, product and benefit details,
- if we do not receive your premiums and the grace period has passed, or
- if your contract is cancelled,

whichever happens first.

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).

When does cover for terminal illness stop?

In addition to the reasons listed under "When does cover stop?", the insured person's terminal illness cover stops 12 months before the cover end date shown on Personal, product and benefit details.

When will Old Mutual not pay the cover amount?

We will not pay the cover amount:

- if the insured person's death or terminal illness is before the cover start date, or
- if the insured person's death or terminal illness is because of an excluded event, activity or condition (as explained below).

Excluded events, activities or conditions

We will not recognise the claim if it is directly or indirectly caused by an event, activity or condition that is specifically or generally excluded.

Specific exclusions apply to certain contracts but not to others. Any specific exclusions that apply to this benefit, are shown on Personal, product and benefit details.

General exclusions always apply. We will not pay if the insured person commits suicide within the first two years from the cover start date.

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.

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.

Funeral support – transportation of the body

On the death of an insured person at least 50 kilometres away from the place of burial in Namibia, you or a beneficiary may claim for the body of the deceased to be brought to a funeral home nearest the place of burial in Namibia. Old Mutual and its service provider will arrange for the transportation of the deceased and one accompanying relative.

You or a beneficiary may only claim this service once per insured person or stillborn even if he/she was covered under more than one of your policies.

This service will be provided to you until the contract has been cancelled. You may not choose to receive cash instead of this service. Call (061) 299 3003 to claim this benefit and make sure that you have the:

- contract number and ID number of the owner,
- names, surnames and dates of birth of the claimant and insured person and
- cellphone number of the claimant

ready when you call.

ABOUT THE PHYSICAL IMPAIRMENT COVER BENEFIT

What is it?

This benefit pays a percentage of its cover amount when the insured person (whose name appears on Personal, product and benefit details) becomes physically impaired after the cover started and if the survival period is met. Its premium is included in the starting premium for the product on Personal, product and benefit details.

What is a survival period?

A survival period is the number of consecutive days or months the insured person must survive after becoming physically impaired before we will pay the cover amount. It starts on the date of the physical impairment as confirmed by our medical officer. The survival period is 6 months. You must continue to pay your premiums during the survival period and while we decide if your claim is valid. If your contract is cancelled before the survival period ends, we will not pay the cover amount.

Physically impaired means that the insured person has permanently and irreversibly suffered and met the requirements of a qualifying physical impairment. See the list of physical impairments that qualify at the end of this document.

Permanent and irreversible means that the insured person cannot recover from the sickness or injury despite following reasonable medical advice, adequate medical treatment and having achieved maximum medical improvement as confirmed by our medical officer.

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.

Maximum medical improvement means that the insured person's condition cannot be improved any further. It can mean that the insured person has fully recovered from his medical condition or that his/her medical condition has stabilised to the point that no medical or emotional change can be expected despite continuing medical treatment or rehabilitative programs.

How much and when does Old Mutual pay?

The cover amount for the insured person can be claimed when he/she becomes physically impaired. The starting cover amount is shown on Personal, product and benefit details.

We will pay a percentage of the cover amount that applies on the date of the physical impairment as confirmed by our medical officer. The percentage of the cover amount depends on the severity of the physical impairment. The physical impairments, their requirements and the percentage of the cover amount payable in each case are shown in the list of physical impairments that qualify at the end of this document.

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

You can claim more than once and for the same physical impairment if it is more severe than was previously claimed for.

Each time we pay a claim under this benefit, its cover amount will decrease by the amount paid and the benefit will continue unless the amount paid was 100% of the cover amount.

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.

Claim for the same physical impairment if it is more severe than was previously claimed for - John has a Physical Impairment Cover benefit with N$500 000 cover. John suffers loss of sight in one eye and qualifies for a payment equal to 25% of the cover amount. We pay N$125 000 (N$500 000 * 25%) and we decrease John's Physical Impairment Cover benefit's cover amount to N$375 000 (N$500 000 – N$125 000). One year later, John suffers loss of sight in the other eye and qualifies for a payment equal to 100% of the cover amount. The cover amount at the date of the physical impairment was N$375 000. John receives N$375 000 (N$375 000 * 100%) and we decrease John's Physical Impairment Cover benefit's cover amount to N$0 and John's Physical Impairment Cover benefit stops.

Cover decreases after a claim is paid - Jack has a Physical Impairment Cover benefit with N$500 000 cover. Jack's house burns down and he suffers major burns and qualifies for a payment equal to 50% of the cover amount. We pay N$250 000 (N$500 000 * 50%) and we decrease Jack's Physical Impairment Cover benefit's cover amount to N$250 000 (N$500 000 – N$250 000).

Two months later, Jack suffers loss of hearing in one ear and qualifies for a payment equal to 25% of the cover amount. The cover amount at the date of the physical impairment was N$250 000. We pay N$62 500 (N$250 000 * 25%) and we decrease Jack's Physical Impairment Cover benefit's cover amount to N$187 500 (N$250 000 – N$62 500).

One year later, Jack is permanently confined to a wheelchair and qualifies for a payment equal to 100% of the cover amount. The cover amount at the date of the physical impairment was N$206 250 (N$187 500 + 10% scheduled yearly cover increase of N$18 750). We pay N$206 250 (N$206 250 * 100%) and we decrease Jack's Physical Impairment Cover benefit's cover amount to N$0 and Jack's Physical Impairment Cover benefit stops.

How does a claim on this benefit affect the other benefits in the contract?

Each time we pay a claim under this benefit, the Life Cover benefit's cover amount will decrease by the amount paid and the Life Cover benefit will continue unless the amount paid was 100% of the Life Cover benefit's cover amount.

If you also have a Severe Illness Cover benefit in this contract, its cover amount will be decreased to equal the Life Cover benefit's cover amount if its cover amount is higher than the new cover amount of the Life Cover benefit.

If the insured person qualifies for a claim on this benefit and the Life Cover benefit at the same time, we will pay the claim on the Life Cover benefit.

Claim on this benefit affects other benefits in the contract - Jack bought Old Mutual Protect Life Cover which has a Life Cover benefit with N$1 000 000 cover, a Physical Impairment Cover benefit with N$500 000 cover and a Severe Illness Cover benefit with N$800 000. Jack is permanently confined to a wheelchair and qualifies for a payment equal to 100% of the cover amount on the Physical Impairment Cover benefit. We pay N$500 000 (N$500 000 * 100%) and we decrease Jack's Physical Impairment Cover benefit's cover amount to N$0 and Jack's Physical Impairment Cover benefit stops. We decrease Jack's Life Cover benefit's cover amount to N$500 000 (N$1 000 000 – N$500 000) and we decrease his Severe Illness Cover benefit's cover amount to N$500 000 so that it is the same as the Life Cover benefit's cover amount.

Claim on this benefit stops the Life Cover benefit - Joshua bought Old Mutual Protect Life Cover which has a Life Cover benefit with N$500 000 cover and a Physical Impairment Cover benefit with N$500 000 cover. Joshua is in an accident and both his legs are amputated – he qualifies for a payment equal to 100% of the cover amount on the Physical Impairment Cover benefit. We pay N$500 000 (N$500 000 * 100%) and we decrease Joshua's Physical Impairment Cover benefit's cover amount to N$0 and Joshua's Physical Impairment Cover benefit stops. We decrease Joshua's Life Cover benefit's cover amount to N$0 (N$500 000 – N$500 000) and Joshua's Life Cover benefit and the contract stops.

When does cover start?

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

When does cover stop?

The insured person's cover stops:

- if he/she dies,
- if we do not receive your premiums and the grace period has passed,
- if 100% of the cover amount is paid,
- 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 your contract is cancelled, or
- if this benefit is removed from your contract,

whichever happens first.

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 we do not receive your premiums and the grace period has passed,
- if 100% of the cover amount is paid,
- 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 your contract is cancelled, or
- if this benefit is removed from your contract,

whichever happens first.

When will Old Mutual not pay the cover amount?

We will not pay the cover amount:

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

When will Old Mutual not recognise the insured person's physical impairment?

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

- that is not on the list of physical impairment,
- at the severity that the contract does not cover, or
- that does not permanently and irreversibly meet all the requirements that the physical impairment must meet to qualify.

Excluded events, activities or conditions

We will not recognise the claim if it is directly or indirectly caused by an event, activity or condition that is specifically or generally excluded.

Specific exclusions apply to certain contracts but not to others. Any specific exclusions that apply to this benefit, are shown on Personal, product and benefit details.

General exclusions always apply. 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 physical impairment 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 THE DISABILITY COVER BENEFIT

What is it?

This benefit pays the cover amount when the insured person (whose name appears on Personal, product and benefit details) becomes:

- occupationally disabled or
- functionally impaired

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

Occupationally disabled means that the insured person is permanently and irreversibly unable to perform the main duties of his/her occupation (as shown on Personal, product and benefit details) or another occupation for which he/she is reasonably suited, because of a sickness or injury.

Permanent and irreversible means that the insured person cannot recover from the sickness or injury despite following reasonable medical advice, adequate medical treatment and having achieved maximum medical improvement as confirmed by our medical officer.

Reasonably suited means an occupation that the insured person could reasonably do after re-skilling and taking into account his/her education, training, experience and employment history.

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.

Maximum medical improvement means that the insured person's condition cannot be improved any further. It can mean that the insured person has fully recovered from his medical condition or that his/her medical condition has stabilised to the point that no major medical or emotional change can be expected despite continuing medical treatment or rehabilitative programs.

Functionally impaired means that the insured person has permanently and irreversibly suffered and met the requirements of a qualifying functional impairment. See the list of functional impairments that qualify at the end of this document.

Permanent and irreversible means that the insured person cannot recover from the sickness or injury despite following reasonable medical advice, adequate medical treatment and having achieved maximum medical improvement as confirmed by our medical officer.

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.

How much and when does Old Mutual pay?

The cover amount for the insured person can be claimed when he/she becomes occupationally disabled or functionally impaired. The starting cover amount is shown on Personal, product and benefit details.

We will pay 100% of the cover amount that applies on the date of the occupational disability or functional impairment as confirmed by our medical officer.

After we have paid a claim under this benefit, the cover under it will stop.

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.

How does a claim on this benefit affect the other benefits in the contract?

A claim under this benefit will decrease the Life Cover benefit's cover amount and the Life Cover benefit will continue unless the amount paid was 100% of the Life Cover benefit's cover amount.

If you also have a Severe Illness Cover benefit in this contract, its cover amount will be decreased to equal the Life Cover benefit's cover amount if its cover amount is higher than the new cover amount of the Life Cover benefit.

If the insured person qualifies for a claim on this benefit and the Life Cover benefit at the same time, we will pay the claim on the Life Cover benefit.

When does cover start?

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

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.

Maximum medical improvement means that the insured person's condition cannot be improved any further. It can mean that the insured person has fully recovered from his medical condition or that his/her medical condition has stabilised to the point that no medical or emotional change can be expected despite continuing medical treatment or rehabilitative programs.

Payment of claim on Disability Cover benefit reduces Disability Cover benefit's cover amount to N$0 and stops the benefit – Zane has Old Mutual Protect Life Cover with a Life Cover benefit with N$1 000 000 cover and a Disability Cover benefit with N$500 000 cover. Zane becomes occupationally disabled and qualifies for a payment of N$500 000 (N$500 000 * 100%) under the Disability Cover benefit. Because the full cover amount under the Disability Cover benefit has been paid, cover under this benefit stops and the cover amount under the Life Cover benefit reduces to N$500 000 (N$1 000 000 – N$500 000).

Claim on this benefit affects other benefits in the contract - Zane bought Old Mutual Protect Life Cover which has a Life Cover benefit with N$1 000 000 cover, a Disability Cover benefit with N$800 000 cover and a Severe Illness Cover benefit with N$500 000 cover. Zane becomes occupationally disabled and qualifies for a payment equal to 100% of the cover amount on the Disability Cover benefit. We pay N$800 000 (N$800 000 * 100%) and we decrease Zane's Disability Cover benefit's cover amount to N$0 and his Disability Cover benefit stops. We decrease Zane's Life Cover benefit's cover amount to N$200 000 (N$1 000 000 – N$800 000) and his Severe Illness Cover benefit's cover amount to N$200 000 so that it is the same as the Life Cover benefit's cover amount.

Claim on this benefit stops the Life Cover benefit - Jamie bought Old Mutual Protect Life Cover which has a Life Cover benefit with N$500 000 cover and a Disability Cover benefit with N$500 000 cover. Jamie suffers chronic respiratory failure – he qualifies for a payment equal to 100% of the cover amount on the Disability Cover benefit. We pay N$500 000 (N$500 000 * 100%) and we decrease Jamie's Disability Cover benefit's cover amount to N$0 and Jamie's Disability Cover benefit stops. We decrease Jamie's Life Cover benefit's cover amount to N$0 (N$500 000 – N$500 000) and Jamie's Life Cover benefit and the contract stops.

When does cover stop?

The insured person's cover stops:

- if he/she dies,
- if we do not receive your premiums and the grace period has passed,
- if 100% of the cover amount is paid,
- 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 this benefit is removed from your contract, or
- if your contract is cancelled,

whichever happens first.

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 we do not receive your premiums and the grace period has passed,
- if 100% of the cover amount is paid,
- 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 this benefit is removed from your contract, or
- if your contract is cancelled,

whichever happens first.

When does cover for occupational disability stop?

In addition to the reasons listed under "When does cover stop?", the insured person's occupational disability cover stops on the:

- date on which he/she retires or
- on his/her 69th birthday,

whichever happens first.

Retires means to stop following any occupation that provides an income.

When will Old Mutual not pay the cover amount?

We will not pay the cover amount:

- if the insured person's occupational disability or functional impairment is before the cover start date,
- if the insured person is not occupationally disabled,
- if we do not recognise the insured person's functional impairment (as explained below), or
- if the insured person's occupational disability or functional impairment is because of an excluded event, activity or condition (as explained below).

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

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 permanently and irreversibly meet all the requirements that the functional impairment must meet to qualify.

Excluded events, activities or conditions

We will not recognise the claim if it is directly or indirectly caused by an event, activity or condition that is specifically or generally excluded.

Specific exclusions apply to certain contracts but not to others. Any specific exclusions that apply to this benefit, are shown on Personal, product and benefit details.

General exclusions always apply. 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, or to undergo re-skilling for an occupation for which he/she is reasonably suited,
- the insured person's occupational disability or functional impairment 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.

ABOUT THE OWN OCCUPATION BENEFIT

What is it?

The Disability Cover benefit pays on occupational disability when the insured person is permanently and irreversibly unable to perform the main duties of his/her occupation (as shown on Personal, product and benefit details) or another occupation for which he/she is reasonably suited, because of a sickness or injury. The Own Occupation Benefit will pay on occupational disability when the insured person is permanently and irreversibly unable to perform the main duties of his/her occupation (as shown on Personal, product and benefit details) because of a sickness or injury regardless of whether he/she is able to do another occupation for which he/she is reasonably suited. Its premium is included in the starting premium for the product on Personal, product and benefit details.

For the purposes of this benefit, **occupational disability** means that the insured person is permanently and irreversibly unable to perform the main duties of his/her occupation (as shown on Personal, product and benefit details) because of a sickness or injury.

How much and when does Old Mutual pay?

We will pay 100% of the Disability Cover benefit's cover amount that applies on the date of the occupational disability as confirmed by our medical officer.

If the insured person qualifies for a claim on this benefit and on the Disability Cover benefit at the same time, we will only pay the claim on this benefit.

When we pay a claim under this benefit, the cover under it and under the Disability Cover benefit will stop.

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.

How does a claim on this benefit affect the other benefits in the contract?

This is explained under the same heading earlier under "ABOUT THE DISABILITY COVER BENEFIT".

When does cover start?

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

When does cover stop?

This is explained under the same heading earlier under "ABOUT THE DISABILITY COVER BENEFIT". In addition, cover under this benefit stops if it is removed from your contract.

When does cover for occupational disability stop?

This is explained under the same heading earlier under "ABOUT THE DISABILITY COVER BENEFIT".

When will Old Mutual not pay the cover amount?

We will not pay the cover amount:

- if the insured person's occupational disability is before the cover start date,
- if the insured person is not occupationally disabled,
- if the insured person's occupational disability is because of an excluded event, activity or condition (as explained below).

Excluded events, activities or conditions

We will not recognise the claim if it is directly or indirectly caused by an event, activity or condition that is specifically or generally excluded.

Specific exclusions apply to certain contracts but not to others. Any specific exclusions that apply to this benefit, are shown on Personal, product and benefit details.

General exclusions always apply. 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 occupational disability 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.

ABOUT THE PARTIAL FUNCTIONAL IMPAIRMENT BENEFIT

What is it?

The Disability Cover benefit pays on functional impairment at 100% of the cover amount when the insured person has permanently and irreversibly suffered any of that benefit's qualifying functional impairments. The Partial Functional Impairment Benefit will pay on functional impairment at a percentage, that will be less than 100%, of the Disability Cover benefit's cover amount when the insured person has permanently and irreversibly suffered any of this benefit's qualifying functional impairments and if the survival period is met. See the list of functional impairments that qualify at the end of this document. The percentage of the Disability Cover benefit's cover amount depends on the severity of the functional impairment. Its premium is included in the starting premium for the product on Personal, product and benefit details.

How much and when does Old Mutual pay?

We will pay a percentage of the Disability Cover benefit's cover amount that applies on the date of the functional impairment as confirmed by our medical officer. The percentage of the Disability Cover benefit's cover amount depends on the severity of the functional impairment. The functional impairments, their requirements and the percentage of the Disability Cover benefit's cover amount payable in each case are shown in the list of functional impairments that qualify at the end of this document.

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

You can claim for the same functional impairment if it is more severe than was previously claimed for.

Each time we pay a claim under this benefit, the Disability Cover benefit's cover amount will decrease by the amount paid and the benefit will continue unless the amount paid was 100% of the cover amount.

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.

How does a claim on this benefit affect the other benefits in the contract?

Each time we pay a claim under this benefit, the Disability Cover benefit's cover amount and the Life Cover benefit's cover amount will decrease by the amount paid. The Disability Cover benefit and the Life Cover benefit will continue.

If you also have a Severe Illness Cover benefit in this contract, its cover amount will be decreased to equal the Life Cover benefit's cover amount if its cover amount is higher than the new cover amount of the Life Cover benefit.

If the insured person qualifies for a claim on this benefit and the Life Cover benefit at the same time, we will pay the claim on the Life Cover benefit.

When does cover start?

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

Claim for the same functional impairment if it is more severe than was previously claimed for - John has a Disability Cover benefit with N$500 000 cover and a Partial Functional Impairment Benefit. John suffers loss of sight in one eye and qualifies for a payment equal to 25% of the cover amount. We pay N$125 000 (N$500 000 * 25%) and we decrease John's Disability Cover benefit's cover amount to N$375 000 (N$500 000 – N$125 000). One year later, John suffers loss of sight in the other eye and qualifies for a payment equal to 100% of the cover amount. The cover amount at the date of the functional impairment was N$375 000. John receives N$375 000 (N$375 000 * 100%) and we decrease John's Disability Cover benefit's cover amount to N$0 and John's Disability Cover benefit stops.

Cover decreases after a claim is paid - Jack has a Disability Cover benefit with N$500 000 cover and a Partial Functional Impairment Benefit. Jack's house burns down and he suffers major burns and qualifies for a payment equal to 50% of the cover amount. We pay N$250 000 (N$500 000 * 50%) and we decrease Jack's Disability Cover benefit's cover amount to N$250 000 (N$500 000 – N$250 000).

Two months later, Jack suffers loss of hearing in one ear and qualifies for a payment equal to 25% of the cover amount. The cover amount at the date of the functional impairment was N$250 000. We pay N$62 500 (N$250 000 * 25%) and we decrease Jack's Disability Cover benefit's cover amount to N$187 500 (N$250 000 – N$62 500).

One year later, Jack suffers loss of sight and qualifies for a payment equal to 100% of the cover amount. The cover amount at the date of the functional impairment was N$206 250 (N$187 500 + 10% scheduled yearly cover increase of N$18 750). We pay N$206 250 (N$206 250 * 100%) and we decrease Jack's Disability Cover benefit's cover amount to N$0 and Jack's Disability Cover benefit stops.

Claim on this benefit affects other benefits in the contract – Zoe bought Old Mutual Protect Life Cover which has a Life Cover benefit with N$1 000 000 cover, a Disability Cover benefit with N$900 000 cover and a Partial Functional Impairment Benefit and a Severe Illness Cover benefit with N$500 000 cover. Zoe was involved in a car accident and suffered severe burns. Her plastic surgeon confirmed that she had third degree burns covering at least 25% of her body surface. Since the definition for 100% functional impairment payment requires third degree burns on at least 30% of the body surface, she doesn't qualify for payment under the Disability Cover benefit. She qualifies for a payment of 50% of the cover amount under the Partial Functional Impairment Benefit under the definition of major third degree burns and we pay N$450 000 (50% * N$900 000 cover on the Disability Cover benefit). Zoe's cover under the Disability Cover benefit reduces to N$450 000 (N$900 000 – N$450 000), her Life Cover benefit's cover reduces to N$550 000 (N$1 000 000 – N$450 000) and her Severe Illness Cover benefit's cover remains at N$500 000 since it is not higher than the Life Cover benefit's cover.

When does cover stop?

This is explained under the same heading earlier under "ABOUT THE DISABILITY COVER BENEFIT". In addition, cover under this benefit stops if it is removed from your contract.

When will Old Mutual not pay the cover amount?

We will not pay the cover amount:

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

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 permanently and irreversibly meet all the requirements that the functional impairment must meet to qualify.

Excluded events, activities or conditions

We will not recognise the claim if it is directly or indirectly caused by an event, activity or condition that is specifically or generally excluded.

Specific exclusions apply to certain contracts but not to others. Any specific exclusions that apply to this benefit, are shown on Personal, product and benefit details.

General exclusions always apply. 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 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.

ABOUT THE CHILD IMPAIRMENT BENEFIT

What is it?

This benefit pays up to 10% of the cover amount on the Disability Cover benefit if the child qualifies for an insured event as confirmed by our medical officer and if the survival period is met. Its premium is included in the starting premium for the product on Personal, product and benefit details.

The **child** is the biological, step or legally adopted child of the insured person on the Disability Cover benefit.

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 Namibian law.

Insured event means:

- congenital birth defects of biological children; and
- child impairments.

See the list of congenital birth defects and child impairments that qualify at the end of this document.

What is a survival period?

A survival period is the number of consecutive days or months the child must survive after the insured event happened before we will pay the cover amount. It starts on the date of the insured event as confirmed by our medical officer. The survival period is 10 days. You must continue to pay your premiums during the survival period and while we decide if your claim is valid. If your contract is cancelled before the survival period ends, we will not pay the cover amount.

How much and when does Old Mutual pay?

A percentage of the Child Impairment Benefit's cover amount can be claimed when an insured event happens.

The Child Impairment Benefit's cover amount is the smaller of:

- 10% of the Disability Cover benefit's cover amount on the date of the insured event, and
- N$500 000.

The percentage of the cover amount depends on the severity of the insured event. The insured events, their requirements and the percentage of the cover amount payable in each case are shown at the end of this document.

We will never pay more than N$500 000 per child across all Child Impairment Benefits across all Disability Cover benefits for the same insured person.

We will pay a maximum of one claim per child for up to two children. If more than one insured event happens to the same child at the same time, we will pay the claim that results in the highest cover amount.

The Child Impairment Benefit's 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.

The **date of the insured event** will be:

- date of birth for congenital birth defects and
- date of child impairment as confirmed by our medical officer for child impairments.

Multiple Child Impairment Benefits taken out for the same insured person and the cover amount is limited to N$500 000 - Abulela takes out two Old Mutual Protect Life Cover contracts, one with N$6 000 000 cover and the other with N$2 000 000 cover - both with a Disability Cover benefit and Child Impairment Benefit. The cover on the Disability Cover benefits are N$5 000 000 and N$1 000 000 respectively. A year later, his child Zinhle meets the criteria for total loss of hearing, which qualifies for 100% of the cover amount under the Child Impairment Benefit.

Abulela's total cover on the Disability Cover benefits is N$6 000 000. If we considered his two contracts separately, he would be able to claim for N$500 000 [10% of N$5 000 000] and N$100 000 [10% of N$1 000 000] or a total of N$600 000 for Zinhle.

However, a maximum of N$500 000 applies per child and per insured person, across all Child Impairment Benefits and a percentage of this amount will be paid based on the severity of the insured event. In this case, the insured event qualifies for 100% so 100% x N$500 000 = N$500 000 will be paid.

Multiple Child Impairment Benefits taken out for two different insured persons and the cover amount is limited to N$500 000 for each insured person's Child Impairment Benefits – Abulela's wife, Ntombi, has two Old Mutual Protect Disability Cover contracts with Child Impairment Benefits. Cover on the Disability Cover benefits are N$2 000 000 and N$2 500 000 respectively. Ntombi also claims for Zinhle's total loss of hearing.

Ntombi's total cover is N$4 500 000. If we considered her two contracts separately, she would be able to claim for N$200 000 [10% of N$2 000 000] and N$250 000 [10% of N$2 500 000] or a total of N$450 000 for Zinhle. We will pay a percentage, based on the severity of the insured event, of the N$450 000. In this case, the insured event qualifies for 100% so 100% x N$450 000 = N$450 000 will be paid. In total we will pay N$950 000 [N$500 000 from Abulela's contracts and N$450 000 from Ntombi's ones]. The claim for Zinhle will also stop her cover under both her parents' Child Impairment Benefits because we will only pay one valid claim for her.

How does a claim on this benefit affect the other benefits in the contract?

A claim on this benefit does not affect the other benefits in the contract.

When does cover start?

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

When does cover stop?

Cover under this benefit stops:

- 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 this benefit, or
- if this benefit is removed from your contract,

whichever happens first.

When does cover stop?

Cover under this benefit stops:

- on the 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 this benefit, or
- if this benefit is removed from your contract,

whichever happens first.

When does cover for a child stop?

In addition to the reasons listed under "When does cover stop?", cover for a child under this benefit stops:

- at his/her 18th birthday,
- once we have paid one valid claim for him/her, or
- once we have paid N$500 000 for him/her across all Child Impairment Benefits across all Disability Cover benefits for the same insured person,

whichever happens first.

When will Old Mutual not pay the cover amount?

We will not pay the cover amount:

- if the insured event is before the cover start date,
- if we do not recognise the insured event (as explained below),
- if the insured event is because of an excluded event, activity or condition (as explained below), or
- if the survival period is not met.

When will Old Mutual not recognise the insured event?

We will not recognise the insured event if the child suffers an insured event:

- that is not on the list of congenital birth defects and child impairments,
- at the severity that the contract does not cover, or
- that does not meet all the requirements that the insured event must meet to qualify.

Excluded events, activities or conditions

We will not recognise the claim if it 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"),
- if the claim is because of:
  - unrest, war or terrorist activity,
  - radioactivity or nuclear explosion,
- if the claim for a child impairment is because of:
  - a self-inflicted injury,
  - you or the 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,
  - the use of alcohol, poison, drugs or non-prescribed medication,
  - a condition that was diagnosed:
    - before or within six months after this benefit's benefit start date,
    - before the child was legally adopted or became the stepchild of the insured person under the Disability Cover benefit,
- the claim for a congenital birth defect if the child was born before or within nine months after this benefit's benefit start date or if it is because of:
  - a self-inflicted injury by the biological mother of the child,
  - you or the biological mother provoking, committing or attempting to commit a crime, or
  - the use of alcohol, poison, drugs or non-prescribed medication by the biological mother of the child.

ABOUT THE FUNCTIONAL IMPAIRMENT COVER BENEFIT

What is it?

This benefit pays the cover amount when the insured person (whose name appears on Personal, product and benefit details) becomes functionally impaired after the cover started. Its premium is included in the starting premium for the product on Personal, product and benefit details.

How much and when does Old Mutual pay?

The cover amount for the insured person can be claimed when he/she becomes functionally impaired. The starting cover amount is shown on Personal, product and benefit details.

We will pay 100% of the cover amount that applies on the date of the functional impairment as confirmed by our medical officer.

After we have paid a claim under this benefit, the cover under it will stop.

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.

Functionally impaired means that the insured person has permanently and irreversibly suffered and met the requirements of a qualifying functional impairment. See the list of functional impairments that qualify at the end of this document.

Permanent and irreversible means that the insured person cannot recover from the sickness or injury despite following reasonable medical advice, adequate medical treatment and having achieved maximum medical improvement as confirmed by our medical officer.

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.

Maximum medical improvement means that the insured person's condition cannot be improved any further. It can mean that the insured person has fully recovered from his medical condition or that his/her medical condition has stabilised to the point that no medical or emotional change can be expected despite continuing medical treatment or rehabilitative programs.

Payment of claim on Functional Impairment Cover benefit reduces Functional Impairment Cover benefit's cover amount to N$0 and stops the benefit – Zane has Old Mutual Protect Life Cover with a Life Cover benefit of N$1 000 000 cover and a Functional Impairment Cover benefit with N$500 000 cover. Zane becomes functionally impaired and qualifies for a payment of N$500 000 (N$500 000 * 100%) under the Functional Impairment Cover benefit. Because the full cover amount under the Functional Impairment Cover benefit has been paid, cover under this benefit stops and the cover amount under the Life Cover benefit reduces to N$500 000 (N$1 000 000 – N$500 000).

How does a claim on this benefit affect the other benefits in the contract?

A claim under this benefit will decrease the Life Cover benefit's cover amount and the Life Cover benefit will continue unless the amount paid was 100% of the Life Cover benefit's cover amount.

If you also have a Severe Illness Cover benefit in this contract, its cover amount will be decreased to equal the Life Cover benefit's cover amount if its cover amount is higher than the new cover amount of the Life Cover benefit.

If the insured person qualifies for a claim on this benefit and the Life Cover benefit at the same time, we will pay the claim on the Life Cover benefit.

Claim on this benefit affects other benefits in the contract - Zane bought Old Mutual Protect Life Cover which has a Life Cover benefit with N$1 000 000 cover, a Functional Impairment Cover benefit with N$800 000 cover and a Severe Illness Cover benefit with N$500 000. Zane becomes functionally impaired and qualifies for a payment equal to 100% of the cover amount on the Functional Impairment Cover benefit. We pay N$800 000 (N$800 000 * 100%) and we decrease Zane's Functional Impairment Cover benefit's cover amount to N$0 and his Functional Impairment Cover benefit stops. We decrease Zane's Life Cover benefit's cover amount to N$200 000 (N$1 000 000 – N$800 000) and his Severe Illness Cover benefit's cover amount to N$200 000 so that it is the same as the Life Cover benefit's cover amount.

Claim on this benefit stops the Life Cover benefit - Brendon bought Old Mutual Protect Life Cover which has a Life Cover benefit with N$500 000 cover and a Functional Impairment Cover benefit with N$500 000 cover. Brendon suffers chronic respiratory failure – he qualifies for a payment equal to 100% of the cover amount on the Functional Impairment Cover benefit. We pay N$500 000 (N$500 000 * 100%) and we decrease Brendon's Functional Impairment Cover benefit's cover amount to N$0 and Brendon's Functional Impairment Cover benefit stops. We decrease Brendon's Life Cover benefit's cover amount to N$0 (N$500 000 – N$500 000) and Brendon's Life Cover benefit and the contract stops.

When does cover start?

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

When does cover stop?

The insured person's cover stops:

- if he/she dies,
- if we do not receive your premiums and the grace period has passed,
- if 100% of the cover amount is paid,
- 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"), or
- if your contract is cancelled,

whichever happens first.

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 we do not receive your premiums and the grace period has passed,
- if 100% of the cover amount is paid,
- 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"), 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 is before the cover start date,
- if we do not recognise the insured person's functional impairment (as explained below),
- if the insured person's functional impairment is because of an excluded event, activity or condition (as explained below).

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 permanently and irreversibly meet all the requirements that the functional impairment must meet to qualify.

Excluded events, activities or conditions

We will not recognise the claim if it is directly or indirectly caused by an event, activity or condition that is specifically or generally excluded.

Specific exclusions apply to certain contracts but not to others. Any specific exclusions that apply to this benefit, are shown on Personal, product and benefit details.

General exclusions always apply. 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 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 THE PARTIAL FUNCTIONAL IMPAIRMENT BENEFIT

What is it?

The Functional Impairment Cover benefit pays on functional impairment at 100% of the cover amount when the insured person has permanently and irreversibly suffered any of that benefit's qualifying functional impairments. The Partial Functional Impairment Benefit will pay on functional impairment at a percentage, that will be less than 100%, of the Functional Impairment Cover benefit's cover amount when the insured person has permanently and irreversibly suffered any of this benefit's qualifying functional impairments and if the survival period is met. See the list of functional impairments that qualify at the end of this document. The percentage of the Functional Impairment Cover benefit's cover amount depends on the severity of the functional impairment. Its premium is included in the starting premium for the product on Personal, product and benefit details.

How much and when does Old Mutual pay?

We will pay a percentage of the Functional Impairment Cover benefit's cover amount that applies on the date of the functional impairment as confirmed by our medical officer. The percentage of the Functional Impairment Cover benefit's cover amount depends on the severity of the functional impairment. The functional impairments, their requirements and the percentage of the Functional Impairment Cover benefit's cover amount payable in each case are shown in the list of functional impairments that qualify at the end of this document.

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

You can claim for the same functional impairment if it is more severe than was previously claimed for.

Each time we pay a claim under this benefit, the Functional Impairment Cover benefit's cover amount will decrease by the amount paid and the benefit will continue unless the amount paid was 100% of the cover amount.

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.

Claim for the same functional impairment if it is more severe than was previously claimed for - John has a Functional Impairment Cover benefit with N$500 000 cover and a Partial Functional Impairment Benefit. John suffers loss of sight in one eye and qualifies for a payment equal to 25% of the cover amount. We pay N$125 000 (N$500 000 * 25%) and we decrease John's Functional Impairment Cover benefit's cover amount to N$375 000 (N$500 000 – N$125 000). One year later, John suffers loss of sight in the other eye and qualifies for a payment equal to 100% of the cover amount. The cover amount at the date of the functional impairment was N$375 000. John receives N$375 000 (N$375 000 * 100%) and we decrease John's Functional Impairment Cover benefit's cover amount to N$0 and John's Functional Impairment Cover benefit stops.

Cover decreases after a claim is paid - Jack has a Functional Impairment Cover benefit with N$500 000 cover and a Partial Functional Impairment Benefit. Jack's house burns down and he suffers major burns and qualifies for a payment equal to 50% of the cover amount. We pay N$250 000 (N$500 000 * 50%) and we decrease Jack's Functional Impairment Cover benefit's cover amount to N$250 000 (N$500 000 – N$250 000).

Two months later, Jack suffers loss of hearing in one ear and qualifies for a payment equal to 25% of the cover amount. The cover amount at the date of the functional impairment was N$250 000. We pay N$62 500 (N$250 000 * 25%) and we decrease Jack's Functional Impairment Cover benefit's cover amount to N$187 500 (N$250 000 – N$62 500).

One year later, Jack suffers loss of sight and qualifies for a payment equal to 100% of the cover amount. The cover amount at the date of the functional impairment was N$206 250 (N$187 500 + 10% scheduled yearly cover increase of N$18 750). We pay N$206 250 (N$206 250 * 100%) and we decrease Jack's Functional Impairment Cover benefit's cover amount to N$0 and Jack's Functional Impairment Cover benefit stops.

How does a claim on this benefit affect the other benefits in the contract?

Each time we pay a claim under this benefit, the Functional Impairment Cover benefit's cover amount and the Life Cover benefit's cover amount will decrease by the amount paid. The Functional Impairment Cover benefit and the Life Cover benefit will continue.

If you also have a Severe Illness Cover benefit in this contract, its cover amount will be decreased to equal the Life Cover benefit's cover amount if its cover amount is higher than the new cover amount of the Life Cover benefit.

If the insured person qualifies for a claim on this benefit and the Life Cover benefit at the same time, we will pay the claim on the Life Cover benefit.

Claim on this benefit affects other benefits in the contract – Zoe bought Old Mutual Protect Life Cover which has a Life Cover benefit with N$1 000 000 cover, a Functional Impairment Cover benefit with N$900 000 cover and a Partial Functional Impairment Benefit and a Severe Illness Cover benefit with N$500 000 cover. Zoe was involved in a car accident and suffered severe burns. Her plastic surgeon confirmed that she had third degree burns covering at least 25% of her body surface. Since the definition for 100% functional impairment payment requires third degree burns on at least 30% of the body surface, she doesn't qualify for payment under the Functional Impairment Cover benefit. She qualifies for a payment of 50% of the cover amount under the Partial Functional Impairment Benefit under the definition of major third degree burns and we pay N$450 000 (50% * N$900 000 cover on the Functional Impairment Cover benefit). Zoe's cover under the Functional Impairment Cover benefit reduces to N$450 000 (N$900 000 – N$450 000), her Life Cover benefit's cover reduces to N$550 000 (N$1 000 000 – N$450 000) and her Severe Illness Cover benefit's cover remains at N$500 000 since it is not higher than the Life Cover benefit's cover.

When does cover start?

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

When does cover stop?

This is explained under the same heading earlier under "ABOUT THE FUNCTIONAL IMPAIRMENT COVER BENEFIT". In addition, cover under this benefit stops if it is removed from your contract.

When will Old Mutual not pay the cover amount?

We will not pay the cover amount:

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

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 permanently and irreversibly meet all the requirements that the functional impairment must meet to qualify.

Excluded events, activities or conditions

We will not recognise the claim if it is directly or indirectly caused by an event, activity or condition that is specifically or generally excluded.

Specific exclusions apply to certain contracts but not to others. Any specific exclusions that apply to this benefit, are shown on Personal, product and benefit details.

General exclusions always apply. 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 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.

ABOUT THE CHILD IMPAIRMENT BENEFIT

What is it?

This benefit pays up to 10% of the cover amount on the Functional Impairment Cover benefit if the child qualifies for an insured event as confirmed by our medical officer and if the survival period is met. Its premium is included in the starting premium for the product on Personal, product and benefit details.

The **child** is the biological, step or legally adopted child of the insured person on the Functional Impairment Cover benefit.

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 Namibian law.

Insured event means:

- congenital birth defects of biological children; and
- child impairments.

See the list of congenital birth defects and child impairments that qualify at the end of this document.

What is a survival period?

A survival period is the number of consecutive days or months the child must survive after the insured event happened before we will pay the cover amount. It starts on the date of the insured event as confirmed by our medical officer. The survival period is 10 days. You must continue to pay your premiums during the survival period and while we decide if your claim is valid. If your contract is cancelled before the survival period ends, we will not pay the cover amount.

How much and when does Old Mutual pay?

A percentage of the Child Impairment Benefit's cover amount can be claimed when an insured event happens.

The Child Impairment Benefit's cover amount is the smaller of:

- 10% of the Functional Impairment Cover benefit's cover amount on the date of the insured event, and
- N$500 000.

The percentage of the cover amount depends on the severity of the insured event. The insured events, their requirements and the percentage of the cover amount payable in each case are shown at the end of this document.

We will never pay more than N$500 000 per child across all Child Impairment Benefits across all Functional Impairment Cover benefits for the same insured person.

We will pay a maximum of one claim per child for up to two children. If more than one insured event happens to the same child at the same time, we will pay the claim that results in the highest cover amount.

The Child Impairment Benefit's 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.

The **date of the insured event** will be:

- date of birth for congenital birth defects and
- date of child impairment as confirmed by our medical officer for child impairments.

Multiple Child Impairment Benefits taken out for the same insured person and the cover amount is limited to N$500 000 - Abulela takes out two Old Mutual Protect Life Cover contracts, one with a Life Cover benefit with N$6 000 000 cover and the other with N$2 000 000 cover - both with a Functional Impairment Cover benefit and Child Impairment Benefit. The cover on the Functional Impairment Cover benefits are N$5 000 000 and N$1 000 000 respectively. A year later, his child Zinhle meets the criteria for total loss of hearing, which qualifies for 100% of the cover amount under the Child Impairment Benefit.

Abulela's total cover on the Functional Impairment Cover benefits is N$6 000 000. If we considered his two contracts separately, he would be able to claim for N$500 000 [10% of N$5 000 000] and N$100 000 [10% of N$1 000 000] or a total of N$600 000 for Zinhle.

However, a maximum of N$500 000 applies per child and per insured person, across all Child Impairment Benefits and a percentage of this amount will be paid based on the severity of the insured event. In this case, the insured event qualifies for 100% so 100% x N$500 000 = N$500 000 will be paid.

Multiple Child Impairment Benefits taken out for two different insured persons and the cover amount is limited to N$500 000 for each insured person's Child Impairment Benefits – Abulela's wife, Ntombi, also has two Old Mutual Protect Life Cover contracts with Functional Impairment Cover and Child Impairment Benefits. Cover on the Functional Impairment Cover benefits are N$2 000 000 and N$2 500 000 respectively. Ntombi also claims for Zinhle's total loss of hearing.

Ntombi's total cover is N$4 500 000. If we considered her two contracts separately, she would be able to claim for N$200 000 [10% of N$2 000 000] and N$250 000 [10% of N$2 500 000] or a total of N$450 000 for Zinhle. We will pay a percentage, based on the severity of the insured event, of the N$450 000. In this case, the insured event qualifies for 100% so 100% x N$450 000 = N$450 000 will be paid. In total we will pay N$950 000 [N$500 000 from Abulela's contracts and N$450 000 from Ntombi's ones]. The claim for Zinhle will also stop her cover under both her parents' Child Impairment Benefits because we will only pay one valid claim for her.

How does a claim on this benefit affect the other benefits in the contract?

A claim on this benefit does not affect the other benefits in the contract.

When does cover start?

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

When does cover stop?

Cover under this benefit stops:

- 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 this benefit, or
- if this benefit is removed from your contract,

whichever happens first.

When does cover stop?

Cover under this benefit stops:

- on the 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 this benefit, or
- if this benefit is removed from your contract,

whichever happens first.

When does cover for a child stop?

In addition to the reasons listed under "When does cover stop?", cover for a child under this benefit stops:

- at his/her 18th birthday,
- once we have paid one valid claim for him/her, or
- once we have paid N$500 000 for him/her across all Child Impairment Benefits across all Functional Impairment Cover benefits for the same insured person,

whichever happens first.

When will Old Mutual not pay the cover amount?

We will not pay the cover amount:

- if the insured event is before the cover start date,
- if we do not recognise the insured event (as explained below),
- if the insured event is because of an excluded event, activity or condition (as explained below), or
- if the survival period is not met.

When will Old Mutual not recognise the insured event?

We will not recognise the insured event if the child suffers an insured event:

- that is not on the list of congenital birth defects and child impairments,
- at the severity that the contract does not cover, or
- that does not meet all the requirements that the insured event must meet to qualify.

Excluded events, activities or conditions

We will not recognise the claim if it 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"),
- if the claim is because of:
  - unrest, war or terrorist activity,
  - radioactivity or nuclear explosion,
- if the claim for a child impairment is because of:
  - a self-inflicted injury,
  - you or the 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,
  - the use of alcohol, poison, drugs or non-prescribed medication,
  - a condition that was diagnosed:
    - before or within six months after this benefit's benefit start date,
    - before the child was legally adopted or became the stepchild of the insured person under the Functional Impairment Cover benefit,
- the claim for a congenital birth defect if the child was born before or within nine months after this benefit's benefit start date or if it is because of:
  - a self-inflicted injury by the biological mother of the child,
  - you or the biological mother provoking, committing or attempting to commit a crime, or
  - the use of alcohol, poison, drugs or non-prescribed medication by the biological mother of the child.

ABOUT THE SEVERE ILLNESS COVER BENEFIT

What is it?

This benefit pays the cover amount if the insured person (whose name appears on Personal, product and benefit details) suffers a severe illness after the cover started. Its premium is included in the starting premium for the product on Personal, product and benefit details.

Severe illness means that the insured person 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.

How much and when does Old Mutual pay?

We will pay a percentage of the cover amount that applies on the date of the severe illness as confirmed by our medical officer. The percentage of the cover amount depends on the severity of the severe illness. The severe illnesses, their definitions and the percentage of the cover amount payable in each case are shown in the list of severe illnesses that qualify at the end of this document.

You can claim more than once if:

- the insured person suffers another severe illness at least 30 days after the previous severe illness, and
- for the same related severe illness, it is more severe than was previously claimed for.

If the insured person suffers more than one severe illness within 30 days, we will pay the claim under the benefit in this contract that results in the highest cover amount.

Each time we pay a claim under this benefit, its cover amount will decrease by the amount paid and the benefit will continue unless the amount paid was 100% of the cover amount.

We will pay 15% of the cover amount that applies at the time of the severe illness for any of the early diagnosed illnesses that are in the list of early diagnosed illnesses that qualify at the end of this document. Each payment is limited to N$100 000. We will not pay for the same early diagnosed illness more than once.

We will pay 25% of the cover amount that applies at the time of the severe illness for the Cancer Enhancer if the insured person:

- suffers cancer on the list of severe illnesses that qualify at the end of this document and the percentage of the cover amount is 25% or 50%, and
- can no longer perform at least two basic activities of daily living or four advanced activities of daily living for a period of at least 3 consecutive months, as confirmed by the treating specialist and our medical officer. Failure to perform the activities of daily living must be because of the cancer (including its treatment or complications of its treatment or hospitalisation because of it).

You can qualify for a Cancer Enhancer:

- for related cancers, if we have not previously paid a Cancer Enhancer or
- ·or unrelated cancers, if the insured person meets the requirements for the Cancer Enhancer as explained above.

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.

Same related severe illness - Sally has a Severe Illness Cover benefit with N$500 000 cover. She is diagnosed with stage I breast cancer and qualified for a payment equal to 25% of the cover amount, N$125 000. One year later her breast cancer has progressed to stage IV which qualified for a payment equal to 100% of the cover amount. As we had already made a 25% payment and we decreased the cover amount to N$375 000, her subsequent claim will be limited to 100% of the remaining cover amount, N$375 000.

Same related severe illness at same severity - Sibongile has a Severe Illness Cover benefit with N$500 000 cover. She is diagnosed with stage I breast cancer and qualified for a payment equal to 25% of the cover amount, N$125 000. Sibongile responded to the medical treatment she received however one year later her breast cancer has returned at stage I. Because we had already made a 25% payment for related stage I breast cancer, Sibongile does not qualify for a further payment.

Our medical officer, supported by published medical evidence, determines if severe illnesses 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. You will find a list of what we will or may consider related for each severe illness under "Severe illnesses that qualify under ..." at the end of this document. This may change over time.

Cover decreases after a claim is paid - Vuyo has a Severe Illness Cover benefit with N$500 000 cover. Vuyo suffers chronic respiratory failure and qualifies for a payment equal to 50% of the cover amount. We pay N$250 000 (N$500 000 * 50%) and we decrease Vuyo's Severe Illness Cover benefit's cover amount to N$250 000 (N$500 000 – N$250 000).

Two months later, Vuyo suffers a stroke and qualifies for a payment equal to 25% of the cover amount. The cover amount at the date of the severe illness was N$250 000. We pay N$62 500 (N$250 000 * 25%) and we decrease Vuyo's Severe Illness Cover benefit's cover amount to N$187 500 (N$250 000 – N$62 500).

One year later, Vuyo suffers a heart attack and qualifies for a payment equal to 100% of the cover amount. The cover amount at the date of the severe illness was N$206 250 (N$187 500 + 10% scheduled yearly cover increase of N$18 750). We pay N$206 250 (N$206 250 * 100%) and we decrease Vuyo's Severe Illness Cover benefit's cover amount to N$0 and Vuyo's Severe Illness Cover benefit stops.

Early diagnosis illness - Li has a Severe Illness Cover benefit of N$1 500 000. She is diagnosed with early stage breast cancer. We pay an Early Breast Cancer payment equal to N$100 000 (15% of N$1 500 000 or N$100 000, whichever is less). We decrease Li's Severe Illness Cover benefit's cover amount to N$1 400 000. Li's cancer then progresses and she qualifies for a payment equal to 100% of the cover amount. We pay N$1 400 000 (100% * N$1 400 000) and we decrease Li's Severe Illness Cover benefit's cover amount to N$0 and Li's Severe Illness Cover benefit stops.

Cancer Enhancer - Previn has a Severe Illness Cover benefit of N$1 000 000. He suffers cancer and qualifies for a payment equal to 25% of the cover amount. We pay N$250 000 (N$1 000 000 x 25%). We decrease Previn's Severe Illness Cover benefit's cover amount to N$750 000. After not being able to perform at least two basic activities of daily living for 3 months thereafter, he qualifies for a Cancer Enhancer payment. We pay N$187 500 (N$750 000 x 25%). We decrease Previn's Severe Illness Cover benefit's cover amount to N$562 500 (N$750 000 – N$187 500). His cancer then further progresses and he qualifies for 100% of the cover amount. We pay N$562 500 (N$562 500 * 100%) and we decrease Previn's Severe Illness Cover benefit's cover amount to N$0 and Previn's Severe Illness Cover benefit stops.

How does a claim on this benefit affect the other benefits in the contract?

Each time we pay a claim under this benefit, the Life Cover benefit's cover amount will decrease by the amount paid and the Life Cover benefit will continue unless the amount paid was 100% of the Life Cover benefit's cover amount.

If you also have a Physical Impairment Cover benefit, Disability Cover benefit or Functional Impairment Cover benefit in this contract, its cover amount will be decreased to equal the Life Cover benefit's cover amount if its cover amount is higher than the new cover amount of the Life Cover benefit.

If the insured person qualifies for a claim on this benefit and the Life Cover benefit at the same time, we will pay the claim on the Life Cover benefit.

Claim on this benefit affects other benefits in the contract - George bought Old Mutual Protect Life Cover which has a Life Cover benefit with N$1 000 000 cover, a Physical Impairment Cover benefit with N$800 000 cover and a Severe Illness Cover benefit with N$500 000 cover. George suffers cancer and qualifies for a payment equal to 100% of the cover amount on the Severe Illness Cover benefit. We pay N$500 000 (N$500 000 * 100%) and we decrease George's Severe Illness Cover benefit's cover amount to N$0 and George's Severe Illness Cover benefit stops. We decrease George's Life Cover benefit's cover amount to N$500 000 (N$1 000 000 – N$500 000) and we decrease his Physical Impairment Cover benefit's cover amount to N$500 000 so that it is the same as the Life Cover benefit's cover amount.

Claim on this benefit stops the Life Cover benefit - Pamela bought Old Mutual Protect Life Cover which has a Life Cover benefit with N$500 000 cover and a Severe Illness Cover benefit with N$500 000 cover. Pamela undergoes a heart transplant – she qualifies for a payment equal to 100% of the cover amount on the Severe Illness Cover benefit. We pay N$500 000 (N$500 000 * 100%) and we decrease Pamela's Severe Illness Cover benefit's cover amount to N$0 and Pamela's Severe Illness Cover benefit stops. We decrease Pamela's Life Cover benefit's cover amount to N$0 (N$500 000 – N$500 000) and Pamela's Life Cover benefit and the contract stops.

When does cover start?

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

When does cover stop?

Cover under this benefit stops :

- if the insured person dies,
- if we do not receive your premiums and the grace period has passed,
- 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"),
- if your contract is cancelled,
- if this benefit is removed from your contract, or
- if 100% of the cover amount is paid,

whichever happens first.

When does cover stop?

Cover under this benefit stops :

- if the insured person dies,
- on the cover end date shown on Personal, product and benefit details,
- if we do not receive your premiums and the grace period has passed,
- 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"),
- if your contract is cancelled,
- if this benefit is removed from your contract, or
- if 100% of the cover amount is paid,

whichever happens first.

When will Old Mutual not pay the cover amount?

We will not pay the cover amount:

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

When will Old Mutual not recognise the insured person's severe illness?

We will not recognise the insured person's severe illness if he/she 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.

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

Excluded events, activities or conditions

We will not recognise the claim if it is directly or indirectly caused by an event, activity or condition that is specifically or generally excluded.

Specific exclusions apply to certain contracts but not to others. Any specific exclusions that apply to this benefit, are shown on Personal, product and benefit details.

General exclusions always apply. 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's illness 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.

ABOUT THE TOP-UP BENEFIT

What is it?

The Severe Illness Cover benefit will pay a percentage of the cover amount that depends on the severity of the severe illness if the insured person suffers a severe illness. The severe illnesses, their definitions and the percentage of the cover amount payable in each case are shown in the list of severe illnesses that qualify at the end of this document.

This Top-up Benefit will pay 100% of the Severe Illness Cover benefit's cover amount that applies at the time if an insured person suffers any qualifying severe illness that qualifies for less than 100% of the cover amount.

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

How much and when does Old Mutual pay?

We will pay 100% of the Severe Illness Cover benefit's cover amount that applies on the date of the severe illness as confirmed by our medical officer.

After we have paid a claim under this benefit, the cover under it will stop.

The Top-up Benefit does not apply to any early diagnosed illnesses that are in the list of early diagnosed illnesses that qualify under the Severe Illness Cover benefit at the end of this document or to the Cancer Enhancer.

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.

How does a claim on this benefit affect the other benefits in the contract?

When we pay a claim under this benefit, the Severe Illness Cover benefit's cover amount and the Life Cover benefit's cover amount will decrease by the amount paid. The Severe Illness Cover benefit will stop and the Life Cover benefit will continue unless the amount paid was 100% of the Life Cover benefit's cover amount.

If you also have a Physical Impairment Cover benefit, Disability Cover benefit or Functional Impairment Cover benefit in this contract, its cover amount will be decreased to equal the Life Cover benefit's cover amount if its cover amount is higher than the new cover amount of the Life Cover benefit.

If the insured person qualifies for a claim on this benefit and the Life Cover benefit at the same time, we will pay the claim on the Life Cover benefit.

When does cover start?

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

When does cover stop?

This is explained under the same heading earlier under "ABOUT THE SEVERE ILLNESS COVER BENEFIT". In addition, cover under this benefit stops if it is removed from your contract.

When will Old Mutual not pay the cover amount?

This is explained under the same heading earlier under "ABOUT THE SEVERE ILLNESS COVER BENEFIT".

Top-up Benefit - Jane has a Severe Illness Cover benefit with the Top-up benefit with cover of N$1 000 000. She has a stroke and qualifies for a payment equal to 25% of the cover amount. Because she has the Top-up benefit, regardless of the severity of the severe illness, we make a N$1 000 000 payment equal to 100% of the cover amount (N$1 000 000 x 100%). We decrease Jane's Severe Illness Cover benefit's cover amount to N$0 and Jane's Severe Illness Cover benefit stops.

Claim on this benefit affects other benefits in the contract - Tim bought Old Mutual Protect Life Cover which has a Life Cover benefit with N$1 000 000 cover, a Physical Impairment Cover benefit with N$800 000 cover, a Severe Illness Cover benefit with N$500 000 and the Top-up Benefit . Tim suffers cancer and qualifies for a payment equal to 25% of the cover amount on the Severe Illness Cover benefit but because he has the Top-up Benefit, regardless of the severity of the severe illness, we make a payment equal to 100% of the cover amount N$500 000 (N$500 000 x 100%) and we decrease Tim's Severe Illness Cover benefit's cover amount to N$0 and Tim's Severe Illness Cover benefit stops. We decrease Tim's Life Cover benefit's cover amount to N$500 000 (N$1 000 000 – N$500 000) and we decrease his Physical Impairment Cover benefit's cover amount to N$500 000 so that it is the same as the Life Cover benefit's cover amount.

ABOUT THE CHILD ILLNESS BENEFIT

What is it?

This benefit pays up to 10% of the cover amount on the Severe Illness Cover benefit if the child qualifies for an insured event as confirmed by our medical officer and if the survival period is met. Its premium is included in the starting premium for the product on Personal, product and benefit details.

The **child** is the biological, step or legally adopted child of the insured person on the Severe Illness Cover benefit.

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 Namibian law.

Insured event means:

- congenital birth defects of biological children; and
- child illnesses.

See the list of congenital birth defects and child 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.

What is a survival period?

A survival period is the number of consecutive days or months the child must survive after suffering certain insured events before we will pay the cover. It starts on the date of the insured event as confirmed by our medical officer. The survival period is 10 days. You will find the details about any applicable survival period in the list of congenital birth defects and child illnesses that qualify at the end of this document. You must continue to pay your premiums during the survival period and while we decide if your claim is valid. If your contract is cancelled before the survival period ends, we will not pay the cover amount.

How much and when does Old Mutual pay?

A percentage of the Child Illness Benefit's cover amount can be claimed when an insured event happens.

The Child Illness Benefit's cover amount is the smaller of:

- 10% of the Severe Illness Cover benefit's cover amount on the date of the insured event, and
- N$500 000.

The percentage of the Child Illness Benefit's cover amount depends on the severity of the insured event. The insured events, their definitions and the percentage of the cover amount payable in each case are shown at the end of this document.

We will never pay more than N$500 000 per child across all Child Illness Benefits across all Severe Illness Cover benefits for the same insured person.

We will pay a maximum of one claim per child for up to two children. If you claim for more than one insured event for the same child at the same time, we will pay the claim that results in the highest amount.

The Child Illness Benefit's 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.

The **date of the insured event** will be:

- date of birth for congenital birth defects and
- date of child illness as confirmed by our medical officer for child illnesses

Multiple Child Illness Benefits taken out by the same insured person and the cover amount is limited to N$500 000 - Abulela takes out two Old Mutual Protect Life Cover contracts - both with Severe Illness Cover benefits and Child Illness Benefits. Cover on the Severe Illness Cover benefits are N$5 000 000 and N$1 000 000 respectively. A year later, his child Zinhle meets the criteria for total loss of hearing, which qualifies for 100% of the cover amount under the Child Illness Benefit.

Abulela's total cover amount is N$6 000 000. If we considered his two contracts separately, he would be able to claim for N$500 000 [10% of N$5 000 000] and N$100 000 [10% of N$1 000 000] or a total of N$600 000 for Zinhle.

However, a maximum of N$500 000 applies per child and per insured person, across all Child Illness Benefits and a percentage of this amount will be paid based on the severity of the severe illness. In this case, the insured event qualifies for 100% so 100% x N$500 000 = N$500 000 will be paid.

Multiple Child Illness Benefits taken out by two different insured persons and the cover amount is limited to N$500 000 for each insured person's Child Illness Benefits – Abulela's wife, Ntombi, also has two Old Mutual Protect Life Cover contracts - both with Severe Illness Cover benefits and Child Illness Benefits. The cover amount on the Severe Illness Cover benefits are N$2 000 000 and N$2 500 000 respectively. Ntombi also claims for Zinhle's total loss of hearing.

Ntombi's total cover amount is N$4 500 000. If we considered her two contracts separately, she would be able to claim for N$200 000 [10% of N$2 000 000] and N$250 000 [10% of N$2 500 000] or a total of N$450 000 for Zinhle. We will pay a percentage, based on the severity of the severe illness, of the N$450 000. In this case, the insured event qualifies for 100% so 100% x N$450 000 = N$450 000 will be paid. In total we will pay N$950 000 [N$500 000 from Abulela's contracts and N$450 000 from Ntombi's ones]. The claim for Zinhle will also stop her cover under both her parents' Child Illness Benefits because we will only pay one valid claim for her.

How does a claim on this benefit affect the other benefits in the contract?

A claim on this benefit does not affect the other benefits in the contract.

When does cover start?

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

When does cover stop?

Cover under this benefit stops:

- 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 this benefit, or
- if this benefit is removed from your contract,

whichever happens first.

When does cover stop?

Cover under this benefit stops:

- on the 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 this benefit, or
- if this benefit is removed from your contract,

whichever happens first.

When does cover for a child stop?

In addition to the reasons listed under "When does cover stop?", cover for a child under this benefit stops:

- at his/her 18th birthday,
- once we have paid one valid claim for him/her, or
- once we have paid N$500 000 for him/her across all Child Illness Benefits across all Severe Illness Cover benefits for the same insured person,

whichever happens first.

When will Old Mutual not pay the cover amount?

We will not pay the cover amount:

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

When will Old Mutual not recognise the insured event?

We will not recognise the insured event if the child suffers an insured event:

- that is not on the list of congenital birth defects and child impairments,
- at the severity that the contract does not cover, or
- that does not meet all the requirements that the insured event must meet to qualify.

Excluded events, activities or conditions

We will not recognise the claim if it is directly or indirectly caused by an event, activity or condition that is specifically or generally excluded.

Specific exclusions apply to certain contracts but not to others. Any specific exclusions that apply to this benefit, are shown on Personal, product and benefit details.

General exclusions always apply. 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"),
- if the claim is because of:
  - unrest, war or terrorist activity,
  - radioactivity or nuclear explosion,
- if the claim for a child illness is because of:
  - you or the 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,
  - the use of alcohol, poison, drugs or non-prescribed medication,
  - self-inflicted injury,
  - a condition that was diagnosed:
    - before or within six months after this benefit's benefit start date, or
    - before the child was legally adopted or became the stepchild of the insured person under the Severe Illness Cover benefit.
- the claim for a congenital birth defect if the child was born before or within nine months after this benefit's benefit start date or if it is because of:
  - a self-inflicted injury by the biological mother of the child,
  - you or the biological mother provoking, committing or attempting to commit a crime, or
  - the use of alcohol, poison, drugs or non-prescribed medication by the biological mother of the child.

ABOUT THE MILD ILLNESS BENEFIT

What is it?

This benefit will pay 30% of the Severe Illness Cover benefit's cover amount when the insured person suffers any of the Mild Illness Benefit's qualifying severe illnesses as confirmed by our medical officer. See the list of severe illnesses that qualify at the end of this document. Its premium is included in the starting premium for the product on Personal, product and benefit details.

How much and when does Old Mutual pay?

We will pay 30% of the Severe Illness Cover benefit's cover amount that applies on the date of the severe illness as confirmed by our medical officer. The severe illnesses and their definitions in each case are shown in the list of severe illnesses that qualify at the end of this document.

You cannot claim more than once under the Mild Illness Benefit for the same related severe illness.

If the insured person suffers more than one severe illness within 30 days, we will pay the claim under the benefit in this contract that results in the highest cover amount.

Each time we pay a claim under this benefit, its cover amount will decrease by the amount paid and the benefit will continue.

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.

Cover decreases after a claim is paid - Thembeka has a Severe Illness Cover benefit with N$500 000 cover and a Mild Illness Benefit. Thembeka suffers cerebral aneurysm and qualifies for a payment equal to 30% of the cover amount under the Mild Illness Benefit. We pay N$150 000 (N$500 000 * 30%) and we decrease Thembeka's Mild Illness Benefit's cover amount to N$350 000 (N$500 000 – N$150 000).

Two months later, Thembeka suffers a minor stroke and qualifies for a payment equal to 30% of the cover amount under the Mild Illness Benefit. The cover amount at the date of the severe illness was N$350 000. We pay N$105 000 (N$350 000 * 30%) and we decrease Thembeka's Mild Illness Benefit's cover amount to N$245 000 (N$350 000 – N$105 000).

One year later, Thembeka suffers encephalitis and qualifies for a payment equal to 30% of the cover amount. The cover amount at the date of the severe illness was N$269 500 (N$245 000 + 10% scheduled yearly cover increase of N$24 500). We pay N$80 850 (N$269 500 * 30%) and we decrease Thembeka's Mild Illness Benefit's cover amount to N$188 650 (N$269 500 – N$80 850) and Thembeka's Mild Illness Benefit continues.

How does a claim on this benefit affect the other benefits in the contract?

Each time we pay a claim under this benefit, the Severe Illness Cover benefit's cover amount and the Life Cover benefit's cover amount will decrease by the amount paid. The Severe Illness Cover benefit and the Life Cover benefit will continue.

If you also have a Physical Impairment Cover benefit, Disability Cover benefit or Functional Impairment Cover benefit in this contract, its cover amount will be decreased to equal the Life Cover benefit's cover amount if its cover amount is higher than the new cover amount of the Life Cover benefit.

If the insured person qualifies for a claim on this benefit and the Life Cover benefit at the same time, we will pay the claim on the Life Cover benefit.

Claim on this benefit affects other benefits in the contract - Lizanne bought Old Mutual Protect Life Cover which has a Life Cover benefit with N$1 000 000 cover, a Physical Impairment Cover benefit with N$900 000 cover, a Severe Illness Cover benefit with N$500 000 and the Mild Illness Benefit . Lizanne suffers an eye stroke and qualifies for a payment equal to 30% of the cover amount N$150 000 (N$500 000 * 30%) on the Mild Illness Benefit and we decrease Lizanne's Mild Illness Benefit's cover amount to N$350 000, we decrease her Severe Illness Cover benefit's cover amount to N$350 000 and both benefits continue. We decrease Lizanne's Life Cover benefit's cover amount to N$850 000 (N$1 000 000 – N$150 000) and we decrease her Physical Impairment Cover benefit's cover amount to N$850 000 so that it is the same as the Life Cover benefit's cover amount.

When does cover start?

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

When does cover stop?

Cover under this benefit stops :

- if the insured person dies,
- if we do not receive your premiums and the grace period has passed,
- 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"),
- if your contract is cancelled, or
- if this benefit is removed from your contract,

whichever happens first.

When does cover stop?

Cover under this benefit stops :

- if the insured person dies,
- on the cover end date shown on Personal, product and benefit details,
- if we do not receive your premiums and the grace period has passed,
- 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"),
- if your contract is cancelled, or
- if this benefit is removed from your contract,

whichever happens first.

When will Old Mutual not pay the cover amount?

We will not pay the cover amount:

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

When will Old Mutual not recognise the insured person's severe illness?

We will not recognise the insured person's severe illness if he/she 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.

Excluded events, activities or conditions

We will not recognise the claim if it is directly or indirectly caused by an event, activity or condition that is specifically or generally excluded.

Specific exclusions apply to certain contracts but not to others. Any specific exclusions that apply to this benefit, are shown on Personal, product and benefit details.

General exclusions always apply. 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's severe illness 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.

ABOUT THE FOR WOMEN BENEFIT

What is it?

This benefit will pay a percentage of the Severe Illness Cover benefit's cover amount when the insured person suffers any of this benefit's qualifying severe illnesses as confirmed by our medical. See the list of severe illnesses that qualify at the end of this document. The percentage of the Severe Illness Cover benefit's cover amount depends on the severity of the severe illness. Its premium is included in the starting premium for the product on Personal, product and benefit details.

How much and when does Old Mutual pay?

We will pay a percentage of the Severe Illness Cover benefit's cover amount that applies on the date of the severe illness as confirmed by our medical officer. The percentage of the Severe Illness Cover benefit's cover amount depends on the severity of the severe illness. The severe illnesses, their definitions and the percentage of the Severe Illness Cover benefit's cover amount payable in each case are shown in the list of severe illnesses that qualify at the end of this document.

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

You can claim more than once if:

- the insured person suffers another severe illness at least 30 days after the previous severe illness, and
- for the same related severe illness, it is more severe than was previously claimed for.

If the insured person suffers more than one severe illness within 30 days, we will pay the claim under the benefit in this contract that results in the highest cover amount.

Each time we pay a claim under this benefit, its cover amount will decrease by the amount paid and the benefit will continue unless the amount paid was 100% of the cover amount.

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.

Cover decreases after a claim is paid - Zara has a Severe Illness Cover benefit with N$500 000 cover and a For Women Benefit. Zara falls pregnant and suffers eclampsia and qualifies for a payment equal to 25% of the cover amount. We pay N$125 000 (N$500 000 * 25%) and we decrease Zara's For Women Benefit and Severe Illness Cover benefit's cover amount to N$375 000 (N$500 000 – N$125 000).

Two years later, Zara falls pregnant again and suffers antepartum haemorrhage and qualifies for a payment equal to 25% of the cover amount. The cover amount at the date of the severe illness was N$375 000. We pay N$93 750 (N$375 000 * 25%) and we decrease Zara's For Women Benefit and Severe Illness Cover benefit's cover amount to N$281 250 (N$375 000 – N$93 750).

How does a claim on this benefit affect the other benefits in the contract?

Each time we pay a claim under this benefit, the Severe Illness Cover benefit's cover amount and the Life Cover benefit's cover amount will decrease by the amount paid. The Severe Illness Cover benefit and the Life Cover benefit will continue.

If you also have a Physical Impairment Cover benefit, Disability Cover benefit or Functional Impairment Cover benefit in this contract, its cover amount will be decreased to equal the Life Cover benefit's cover amount if its cover amount is higher than the new cover amount of the Life Cover benefit.

If the insured person qualifies for a claim on this benefit and the Life Cover benefit at the same time, we will pay the claim on the Life Cover benefit.

Claim on this benefit affects other benefits in the contract - Karin bought Old Mutual Protect Life Cover which has a Life Cover benefit with N$1 000 000 cover, a Physical Impairment Cover benefit with N$900 000 cover, a Severe Illness Cover benefit with N$500 000 and the For Women Benefit. Karin falls pregnant and suffers eclampsia and qualifies for a payment equal to 25% of the cover amount N$125 000 (N$500 000 * 25%) on the For Women Benefit and we decrease Karin's For Women Benefit's cover amount to N$375 000, we decrease her Severe Illness Cover benefit's cover amount to N$375 000 and both benefits continue. We decrease Karin's Life Cover benefit's cover amount to N$875 000 (N$1 000 000 – N$125 000) and we decrease her Physical Impairment Cover benefit's cover amount to N$875 000 so that it is the same as the Life Cover benefit's cover amount.

When does cover start?

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

When does cover stop?

Cover under this benefit stops:

- if the insured person dies,
- if we do not receive your premiums and the grace period has passed,
- 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"),
- if your contract is cancelled, or
- if this benefit is removed from your contract,

whichever happens first.

When does cover stop?

Cover under this benefit stops:

- if the insured person dies,
- on the cover end date shown on Personal, product and benefit details,
- if we do not receive your premiums and the grace period has passed,
- 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"),
- if your contract is cancelled, or
- if this benefit is removed from your contract,

whichever happens first.

When will Old Mutual not pay the cover?

We will not pay the cover:

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

When will Old Mutual not recognise the insured person's severe illness?

We will not recognise the insured person's severe illness if he/she 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.

Excluded events, activities or conditions

We will not recognise the claim if it is directly or indirectly caused by an event, activity or condition that is specifically or generally excluded.

Specific exclusions apply to certain contracts but not to others. Any specific exclusions that apply to this benefit, are shown on Personal, product and benefit details.

General exclusions always apply. 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's illness 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,
    - self-inflicted injury, or
- the claim for any severe illness that relates to a complication during pregnancy is within nine months after this benefit's benefit start date.

ABOUT THE PREMIUM PROTECTION DEATH BENEFIT

What is it?

This benefit waives the contract's premiums when the insured person dies. The name of the insured person for this benefit is shown on Personal, product and benefit details. Its premium is included in the starting premium for the product on Personal, product and benefit details. The premium for this benefit is reviewed every year.

How does the cover amount or premium on the contract change while Old Mutual is waiving its premiums?

If you have chosen currency-linked scheduled yearly cover increases, the cover amount and premium will still increase yearly, but:

- the percentage cover increase is limited to the inflation rate as set by us, and
- we will waive the increased premium.

Your premium will increase each year with the compulsory yearly increase you have chosen and we will waive this increased premium.

If, at the end of a guarantee term, your premium would have increased while we are waiving this contract's premiums, we will decrease the cover amount and continue to waive the premium that applies at that time. If your premium would have decreased, we will decrease the premium and continue to waive the decreased premium.

When does cover start?

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

When will Old Mutual start waiving the contract's premiums?

Once all our requirements have been met, we will start waiving the contract's premiums for a valid claim from the date of death of the insured person. If we have received any premiums after the date of death, we will refund those premiums. We will not pay interest on this refund.

When will Old Mutual stop waiving the contract's premiums?

We will stop waiving the contract's premiums:

- on this benefit's cover end date shown on Personal, product and benefit details,
- if your contract is cancelled, or
- if this benefit is removed from the contract,

whichever happens earlier.

When we stop waiving the contract's premiums and the contract continues, you must start paying your premiums again.

Waives the contract's premiums means that the cover continues while no premiums are payable.

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).

Start paying premiums again after we stop waiving premiums - Jane takes out an Old Mutual Protect contract where Johan, her husband is the insured person. The term of that benefit is for life. Jane also takes out a Premium Protection Death benefit on her life. At the time of taking out this benefit, Jane is 60 years old. The term of the Premium Protection Death benefit will be 20 years because the maximum cease age for this benefit is 80. If Jane were to die 2 years after taking out her contract, we will waive the contract's premiums for 18 years, until the Premium Protection Death benefit ends. Thereafter, Jane's replacement owner will need to start paying the contract's premiums.

When does cover stop?

The cover stops:

- on this 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, or
- if this benefit is removed from the contract,

whichever happens earlier.

When will Old Mutual not waive the contract's premiums?

We will not waive the contract's premiums:

- if the insured person's death is before the cover start date, or
- if the insured person's death is because of an excluded event, activity or condition (as explained below).

Excluded events, activities or conditions

We will not waive the contract's premiums if the insured person's death 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 waive the contract's premiums if the insured person's death is because of:

- 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
- suicide within the first two years from the cover start date.

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

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.

ABOUT THE PREMIUM PROTECTION DISABILITY BENEFIT

What is it?

This benefit waives the contract's premiums if the insured person (whose name appears on Personal, product and benefit details) becomes:

- occupationally disabled or
- functionally impaired

after the cover started and if the waiting period is met. Its premium is included in the starting premium for the product on Personal, product and benefit details. The premium for this benefit is reviewed every year.

Waives the contract's premiums means that the cover continues while no premiums are payable.

Occupationally disabled means that the insured person is, in part or completely and despite following reasonable medical advice and adequate medical treatment, unable to perform the main duties of his/her occupation as stated on Personal, product and benefit details or another occupation for which he/she is reasonably suited, because of a sickness or injury.

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.

Reasonably suited means an occupation that the insured person could reasonably do after re-skilling and taking into account his/her education, training, experience and employment history.

Functionally impaired means that the insured person has suffered and met the requirements of a qualifying functional impairment. See the list of functional impairments that qualify 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 occupational disability or functional impairment must have continued before we will start waiving the contract's premiums. It starts on the date of the occupational disability or functional impairment as confirmed by our medical officer. The waiting period is 6 months. You must continue to pay your premiums during the waiting period and while we decide if your claim is valid. If your contract is cancelled before the waiting period ends, we will not start waiving the contract's premiums.

We may not apply the waiting period if the insured person was occupationally disabled or functionally impaired, recovers and then becomes occupationally disabled or functionally impaired from a related event within six months after his/her recovery.

If we do not apply the waiting period, we will start waiving the contract's premiums from the date of the occupational disability or functional impairment.

Waiting period end – Frank is diagnosed with chronic gastrointestinal disease on 1 January 2016. The waiting period starts on 1 January and ends at midnight on 30 June 2016. We will start waiving the contract's premiums from 1 July 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 is functionally impaired for the 6-month waiting period so we will start waiving the contract's premiums from month seven. She recovers twelve months after her diagnosis and we stop waiving the contract's premiums. Two months later she is diagnosed with chronic liver disease and is again functionally impaired. Because we consider chronic liver and gastrointestinal diseases to be related functional impairments and because her second functional impairment happened within six months of her recovery from the first functional impairment, Sally chooses to not apply another 6-month waiting period and we will start waiving the contract's premiums immediately.

Unrelated event and the waiting period is applied again - Sally is diagnosed with chronic gastrointestinal disease and is functionally impaired She is functionally impaired for the 6-month waiting period so we will start waiving the contract's premiums from month seven. She recovers twelve months after her diagnosis and we stop waiving the contract's premiums. Two months later she is diagnosed with hypertension and is again functionally impaired. Because chronic gastrointestinal disease is unrelated to hypertension and despite the short time between her recovery from the first functional impairment and her diagnosis with the second, we will apply another 6-month waiting period and will start waiving the contract's premiums only from month seven.

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 does the cover amount or premium on the contract change while Old Mutual is waiving its premiums?

If you have chosen currency-linked scheduled yearly cover increases, the cover amount and premium will still increase yearly, but:

- the percentage cover increase is limited to the inflation rate as set by us, and
- we will waive the increased premium.

Your premium will increase each year with the compulsory yearly increase you have chosen and we will waive this increased premium.

If, at the end of a guarantee term, your premium would have increased while we are waiving this contract's premiums, we will decrease the cover amount and continue to waive the premium that applies at that time. If your premium would have decreased, we will decrease the premium and continue to waive the decreased premium.

When does cover start?

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

When will Old Mutual start waiving the contract's premiums?

Once all our requirements have been met, we will start waiving the contract's premiums for a valid claim at the end of the waiting period. If we have received any premiums after the end of the waiting period, we will refund those premiums. We will not pay interest on this refund.

When will Old Mutual stop waiving the contract's premiums?

We will stop waiving the contract's premiums:

- on this benefit's cover end date shown on Personal, product and benefit details,
- if the insured person recovers from his/her occupational disability or functional impairment,
- if the insured person fails to meet our requirements for following reasonable medical advice or adequate medical treatment and regular evaluation of his/her occupational disability or functional impairment or to undergo re-skilling for an occupation for which he/she is reasonably suited,
- when we have waived the contract's premiums for 24 months in total while the insured person was unable to perform the main duties of his/her occupation as stated on Personal, product and benefit details from related events (as explained below),
- if the insured person dies,
- 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"),
- if your contract is cancelled, or
- if this benefit is removed from the contract, or
- when his/her occupational disability cover stops (as explained under "When does occupational disability cover stop?") while we are waiving the contract's premiums because of occupational disability,

whichever happens first.

If we have stopped waiving the contract's premiums because we have waived the contract's premiums for 24 months in total because the insured person was unable to perform the main duties of his/her occupation from related events, we will re-evaluate the claim. If we determine that the insured person is unable to perform the main duties of another occupation for which he/she is reasonably suited or is functionally impaired, we will continue to waive the contract's premiums until we stop waiving the contract's premiums for one of the other reasons listed above. If not, we will stop waiving the contract's premiums but the benefit will continue until the cover end date and you can claim in future for occupational disability or functional impairment.

If we have stopped waiving the contract's premiums because the insured person's occupational disability cover has stopped, we will re-evaluate the claim. If the insured person is functionally impaired, we will continue to waive the contract's premiums until we stop waiving the contract's premiums for one of the other reasons listed above. If not, we will stop waiving the contract's premiums but the benefit will continue until the cover end date and you can claim in future for functional impairment.

We will determine the number of the contract's premiums to waive, in line with the period of time the life covered is occupationally disabled or functionally impaired which may not exceed the average recommended period of recovery according to the latest edition of *The Medical Disability Advisor: Workplace Guidelines for Disability Duration, by Presley Reed, M.D.*, or its replacement as determined by us. We will consider waiving further contract premiums if the treating doctor can provide us with sufficient medical motivation in the form of specialist reports and/or test results. Any supporting medical proof that we need will be at your own cost.

When we stop waiving the contract's premiums and the contract continues, you must start paying your premiums again.

Start paying premiums again after we stop waiving premiums - Jane takes out an Old Mutual Protect contract where Johan, her husband is the insured person. The term of that benefit is for life. Jane also takes out a Premium Protection Disability benefit on her life. At the time of taking out this benefit, Jane is 45 years old. The term of the Premium Protection Disability benefit will be 20 years because the maximum cease age for this benefit is 65. If Jane were to become functionally impaired 2 years after taking out her contract, we will waive the contract's premiums for 18 years, until the Premium Protection Disability benefit ends. Thereafter, Jane will need to start paying the contract's premiums.

When does cover stop?

The cover stops:

- if the insured person dies,
- on this benefit's cover end date shown on Personal, product and benefit details,
- 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"),
- if we do not receive your premiums and the grace period has passed,
- if your contract is cancelled, or
- if this benefit is removed from the contract,

whichever happens earlier.

When does cover for occupational disability stop?

In addition to the reasons listed under "When does cover stop?", the insured person's occupational disability cover stops on the date on which he/she retires.

Retires means to stop following any occupation that provides an income.

When will Old Mutual not waive the contract's premiums?

We will not waive the contract's premiums:

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

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

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

occupational disability?

We will not recognise the insured person's occupational disability if he/she is able to do more than 75% of the main duties of his/her occupation.

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, or
- that does not meet all the requirements that the functional impairment must meet to qualify.

Excluded events, activities or conditions

We will not waive the contract's premiums if the insured person's occupational disability or functional impairment 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 waive the contract's premiums 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, or to undergo re-skilling for an occupation for which he/she is reasonably suited,
- the insured person's occupational disability or functional impairment 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.

ABOUT THE PREMIUM PROTECTION FUNCTIONAL IMPAIRMENT BENEFIT

What is it?

This benefit waives the contract's premiums if the insured person (whose name appears on Personal, product and benefit details) becomes functionally impaired after the cover started and if the waiting period is met. Its premium is included in the starting premium for the product on Personal, product and benefit details. The premium for this benefit is reviewed every year.

Waives the contract's premiums means that the cover continues while no premiums are payable.

Functionally impaired means that the insured person has suffered and met the requirements of a qualifying functional impairment. See the list of functional impairments that qualify 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 before we will start waiving the contract's premiums. It starts on the date of the functional impairment as confirmed by our medical officer. The waiting period is 6 months. You must continue to pay your premiums during the waiting period and while we decide if your claim is valid. If your contract is cancelled before the waiting period ends, we will not start waiving the contract's premiums.

We may not apply the waiting period if the insured person was functionally impaired, recovers and then becomes functionally impaired from a related event within six months after his/her recovery.

If we do not apply the waiting period, we will start waiving the contract's premiums from the date of the functional impairment.

Waiting period end – Frank is diagnosed with chronic gastrointestinal disease on 1 January 2016. The waiting period starts on 1 January and ends at midnight on 30 June 2016. We will start waiving the contract's premiums from 1 July 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 is functionally impaired for the 6-month waiting period so we will start waiving the contract's premiums from month seven. She recovers twelve months after her diagnosis and we stop waiving the contract's premiums. Two months later she is diagnosed with chronic liver disease and is again functionally impaired. Because we consider chronic liver and gastrointestinal diseases to be related functional impairments and because her second functional impairment happened within six months of her recovery from the first functional impairment, Sally chooses to not apply another 6-month waiting period and we will start waiving the contract's premiums immediately.

Unrelated event and the waiting period is applied again - Sally is diagnosed with chronic gastrointestinal disease and is functionally impaired She is functionally impaired for the 6-month waiting period so we will start waiving the contract's premiums from month seven. She recovers twelve months after her diagnosis and we stop waiving the contract's premiums. Two months later she is diagnosed with hypertension and is again functionally impaired. Because chronic gastrointestinal disease is unrelated to hypertension and despite the short time between her recovery from the first functional impairment and her diagnosis with the second, we will apply another 6-month waiting period and will start waiving the contract's premiums only from month seven.

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 does the cover amount or premium on the contract change while Old Mutual is waiving its premiums?

If you have chosen currency-linked scheduled yearly cover increases, the cover amount and premium will still increase yearly, but:

- the percentage cover increase is limited to the inflation rate as set by us, and
- we will waive the increased premium.

Your premium will increase each year with the compulsory yearly increase you have chosen and we will waive this increased premium.

If, at the end of a guarantee term, your premium would have increased while we are waiving this contract's premiums, we will decrease the cover amount and continue to waive the premium that applies at that time. If your premium would have decreased, we will decrease the premium and continue to waive the decreased premium.

When does cover start?

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

When will Old Mutual start waiving the contract's premiums?

Once all our requirements have been met, we will start waiving the contract's premiums for a valid claim at the end of the waiting period. If we have received any premiums after the end of the waiting period, we will refund those premiums. We will not pay interest on this refund.

When will Old Mutual stop waiving the contract's premiums?

We will stop waiving the contract's premiums:

- on this benefit's cover end date shown on Personal, product and benefit details,
- if the insured person recovers from his/her functional impairment,
- if the insured person fails to meet our requirements for following reasonable medical advice or adequate medical treatment and regular evaluation of his/her functional impairment,
- if the insured person dies,
- 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"),
- if your contract is cancelled, or
- if this benefit is removed from the contract,

whichever happens first.

We will determine the number of the contract's premiums to waive, in line with the period of time the life covered is functionally impaired which may not exceed the average recommended period of recovery according to the latest edition of *The Medical Disability Advisor: Workplace Guidelines for Disability Duration, by Presley Reed, M.D.,* or its replacement as determined by us. We will consider waiving further contract premiums if the treating doctor can provide us with sufficient medical motivation in the form of specialist reports and/or test results. Any supporting medical proof that we need will be at your own cost.

When we stop waiving the contract's premiums and the contract continues, you must start paying your premiums again.

Start paying premiums again after we stop waiving premiums - Jane takes out an Old Mutual Protect contract where Johan, her husband is the insured person. The term of that benefit is for life. Jane also takes out a Premium Protection Functional Impairment benefit on her life. At the time of taking out this benefit, Jane is 45 years old. The term of the Premium Protection Functional Impairment benefit will be 20 years because the maximum cease age for this benefit is 65. If Jane were to become functionally impaired 2 years after taking out her contract, we will waive the contract's premiums for 18 years, until the Premium Protection Functional Impairment benefit ends. Thereafter, Jane will need to start paying the contract's premiums.

When does cover stop?

The cover stops:

- if the insured person dies,
- on this benefit's cover end date shown on Personal, product and benefit details,
- 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"),
- if we do not receive your premiums and the grace period has passed,
- if your contract is cancelled, or
- if this benefit is removed from the contract,

whichever happens earlier.

When will Old Mutual not waive the contract's premiums?

We will not waive the contract's premiums:

- if the insured person's functional impairment is before the cover start date,
- if we do not recognise the insured person's functional impairment (as explained below),
- if the insured person's functional impairment 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, or
- that does not meet all the requirements that the functional impairment must meet to qualify.

Excluded events, activities or conditions

We will not waive the contract's premiums if the insured person's functional impairment 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 waive the contract's premiums 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 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 THE PREMIUM PROTECTION RETRENCHMENT BENEFIT

What is it?

This benefit waives the contract's premiums if the insured person (whose name appears on Personal, product and benefit details) is retrenched after the cover started and if the waiting period is met. Its premium is included in the starting premium for the product on Personal, product and benefit details. The premium for this benefit is reviewed every year.

What is a waiting period?

A waiting period is the number of consecutive days or months during which the insured person does not become employed before we will start waiving the contract's premiums. It starts on the date of retrenchment as confirmed by us and ends one month later. You must continue to pay your premiums during the waiting period and while we decide if your claim is valid. If your contract is cancelled before the waiting period ends, we will not start waiving the contract's premiums.

How does the cover amount or premium on the contract change while Old Mutual is waiving its premiums?

If you have chosen currency-linked scheduled yearly cover increases, the cover amount and premium will still increase yearly, but:

- the percentage cover increase is limited to the inflation rate as set by us, and
- we will waive the increased premium.

Your premium will increase each year with the compulsory yearly increase you have chosen and we will waive this increased premium.

If, at the end of a guarantee term, your premium would have increased while we are waiving this contract's premiums, we will decrease the cover amount and continue to waive the premium that applies at that time. If your premium would have decreased, we will decrease the premium and continue to waive the decreased premium.

Waives the contract's premiums means that the cover continues while no premiums are payable.

Retrenched means that the insured person stops practising his/her occupation as stated on Personal, product and benefit details because his/her employment is terminated by his/her employer because or in anticipation of, business conditions or decisions that result in staff reduction.

The insured person is not retrenched if:

- he/she retires,
- he/she resigns or takes voluntary retrenchment,
- he/she is dismissed,
- his/her fixed term employment contract comes to an end or
- he/she is medically boarded because of a nervous breakdown, stress, burnout, disability or sickness.

Employment and Employed means a contractual relationship between two parties in terms of which an employer pays an employee to perform a job, service or task.

Date of retrenchment is the day after the insured person's last day of employment.

When the waiting period ends – The date of Frank's retrenchment is 1 January 2016. . The one-month waiting period would end at midnight on 31 January 2016. If the premium is due on the 1st of the month, we will start waiving the contract's premiums on 1 February 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).

When does cover start?

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

When will Old Mutual start waiving the contract's premiums?

Once all our requirements have been met, we will start waiving the contract's premiums for a valid claim at the end of the waiting period. If we have received any premiums after the end of the waiting period, we will refund those premiums. We will not pay interest on this refund.

When will Old Mutual stop waiving the contract's premiums?

We will stop waiving the contract's premiums:

- on this benefit's cover end date shown on Personal, product and benefit details,
- if the insured person dies,
- if the insured person becomes employed,
- when we have waived the contract's last premium that the insured person qualifies for (as explained under "For how long will Old Mutual waive the contract's premiums?"),
- 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"),
- if your contract is cancelled, or
- if this benefit is removed from the contract,

whichever happens first.

When we stop waiving the contract's premiums and the contract continues, you must start paying your premiums again.

How long will Old Mutual waive the contract's premiums for?

We will waive the contract's premiums for up to 12 months for each claim. A maximum of three claims can qualify provided that the insured person was continuously employed and qualified for this benefit for at least 12 months before he/she was retrenched again.

When does cover stop?

The cover stops:

- on this benefit's cover end date shown on Personal, product and benefit details,
- if the insured person dies,
- 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"),
- after three valid claims,
- if we do not receive your premiums and the grace period has passed,
- if your contract is cancelled, or
- if this benefit is removed from the contract,

whichever happens earlier.

Start paying premiums again after we stop waiving premiums - Johan takes out an Old Mutual Protect contract where he is the insured person. He also takes out a Premium Protection Retrenchment benefit. Johan is retrenched for two years – we will waive his contract's premiums for 12 months because we will only waive the contract's premiums for up to 12 months. After this, Johan will need to start paying the contract's premiums again.

When will Old Mutual not waive the contract's premiums?

We will not waive the contract's premiums:

- if the insured person receives notice of retrenchment at any time before the cover start date,
- if the insured person is retrenched or receives notice of retrenchment within 12 months from the cover start date,
- after three valid claims,
- if insured person:
  - was not continuously employed for, or
  - did not qualify for this benefit at any time during, the 12 months before he/she was retrenched again,
- if the insured person's retrenchment is because of an excluded event (as explained below), or
- if the waiting period is not met.

Excluded events, activities or conditions

We will not waive the contract's premiums if the insured person's retrenchment 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") or
- the insured person is retrenched as a result of government action.

Government action means regulatory actions taken by a government in order to affect or interfere with decisions made by individuals, groups, or organisations regarding social and economic matters.

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 servicing postal 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 Life 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, and
- if the person entitled to the benefits is not in Namibia or South Africa, the cost to travel to Namibia or South Africa if we need him/her to meet with us.

You must pay the costs related to satisfying our requirements for your Functional Impairment 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.

You must pay the costs related to satisfying our requirements for your Physical Impairment 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.

You must pay the costs related to satisfying our requirements for your Disability 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.

You must pay the costs related to satisfying our requirements for your Disability 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,
- the cost of reasonable medical advice or adequate medical treatment as determine by our medical officer, and
- the cost of learning a new occupation for which the insured person is reasonably suited given his/her experience, skills.

You must pay the costs related to satisfying our requirements for your Severe Illness 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.

You must pay the costs related to satisfying our requirements for your Premium Protection Death 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, and
- if the person entitled to the benefits is not in Namibia or South Africa, the cost to travel to Namibia or South Africa if we need him/her to meet with us.

You must pay the costs related to satisfying our requirements for your Premium Protection Disability 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,
- the cost of reasonable medical advice or adequate medical treatment as determined by our medical officer, and
- the cost of learning a new occupation for which the insured person is reasonably suited given his/her experience, skills if required.

You must pay the costs related to satisfying our requirements for your Premium Protection Functional Impairment 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.

You must pay the costs related to satisfying our requirements for your Premium Protection Retrenchment 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 person entitled to the benefits is not in Namibia or South Africa, the cost to travel to Namibia or South Africa if we need him/her to meet with us.

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 PHYSICAL IMPAIRMENT 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 and their effect on the contract, depend on whether you told us about the change or whether we found out about it.

What changes about the insured person	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)	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***

* 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 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.

*** 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.

CHANGES TO THE CIRCUMSTANCES OF THE INSURED PERSON ON THE SEVERE ILLNESS 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 and their effect on the contract, depend on whether you told us about the change or whether we found out about it.

What changes about the insured person	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)	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***

* 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.

CHANGES TO THE CIRCUMSTANCES OF THE INSURED PERSON ON THE DISABILITY 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 and their effect on the contract, depend on whether you told us about the change or whether we found out about it.

What changes about the insured person	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)	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 changes his/her occupation* (this includes when he/she was unemployed or retired and then starts working again or he/she worked and then becomes unemployed) or any detail of his/her occupation (this includes where a miner changes from working above the ground to working underground with or without explosives)	We may: • change the premium, • offer different terms**, • remove any benefits you no longer qualify for*** 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 changes the industry* he/she works in (for example he/she was working in the building industry and changed to the mining industry)	We may: • change the premium, • offer different terms**, • remove any benefits you no longer qualify for*** 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 changes how much time of his/her day is spent doing administrative or manual tasks and travelling*	We may: • change the premium, • offer different terms**, • remove any benefits you no longer qualify for*** 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 changes his/her employment type* (for example changing from a full time employee to a part time worker or becoming self-employed)	We may: • change the premium, • offer different terms**, • remove any benefits you no longer qualify for*** 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 starts/stops a second occupation* or changes the number of hours per week that he/she works	We may: • change the premium, • offer different terms**, • remove any benefits you no longer qualify for*** 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***

* 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 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.

*** 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.

CHANGES TO THE CIRCUMSTANCES OF THE INSURED PERSON ON THE FUNCTIONAL IMPAIRMENT 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 and their effect on the contract, depend on whether you told us about the change or whether we found out about it.

What changes about the insured person	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)	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***

* 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 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.

*** 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.

CHANGES TO THE CIRCUMSTANCES OF THE INSURED PERSON ON THE PREMIUM PROTECTION DISABILITY 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 waiving the contract's premiums at the time of the change. Some changes in circumstances will only affect waiving of the contract's premiums or the contract itself, while other changes may affect both. Any change to the insured person's circumstances while we are not waiving the contract's premiums will affect only the contract itself.

What changes about the insured person	**Actions we can take while we are waiving the contract's premiums**		**Actions we can take when we are not waiving the contract's premiums**	
	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 waiving of the contract's premiums 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 premiums we had already waived 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 changes his/her occupation* (this includes when he/she was unemployed or retired and then starts working again or he/she worked and then becomes unemployed) or any detail of his/her occupation (this includes where a miner changes from working above the ground to working underground with or without explosives)	Impacts on the waiving of the contract's premiums We may: • stop waiving the contract's premiums or • recover premiums we had already waived but that the insured person did not qualify for, from you Impacts on the contract itself We may: • change the premium, • offer different terms** or • remove any benefits that you no longer qualify for***	Same as under "You tell us about the change" on the left	We may: • change the premium, • offer different terms**, • remove any benefits you no longer qualify for*** or • recover premiums we had already waived 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 changes the industry* he/she works in (for example he/she was working in the building industry and changed to the mining industry)	Impacts on the waiving of the contract's premiums We may: • stop waiving the contract's premiums or • recover premiums we had already waived but that the insured person did not qualify for, from you Impacts on the contract itself We may: • change the premium, • offer different terms** or • remove any benefits that you no longer qualify for***	Same as under "You tell us about the change" on the left	We may: • change the premium, • offer different terms**, • remove any benefits you no longer qualify for*** or • recover premiums we had already waived 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 changes how much time of his/her day is spent doing administrative or manual tasks and travelling*	Impacts on the waiving of the contract's premiums We may: • stop waiving the contract's premiums or • recover premiums we had already waived but that the insured person did not qualify for, from you Impacts on the contract itself We may: • change the premium, • offer different terms** or • remove any benefits that you no longer qualify for***	Same as under "You tell us about the change" on the left	We may: • change the premium, • offer different terms**, • remove any benefits you no longer qualify for*** or • recover premiums we had already waived 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 changes his/her employment type* (for example changing from a full time employee to a part time worker or becoming self-employed)	Impacts on the waiving of the contract's premiums We may: • stop waiving the contract's premiums or • recover premiums we had already waived but that the insured person did not qualify for, from you Impacts on the contract itself We may: • change the premium, • offer different terms**, • remove any benefits that you no longer qualify for***	Same as under "You tell us about the change" on the left	We may: • change the premium, • offer different terms**, • remove any benefits you no longer qualify for*** or • recover premiums we had already waived 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 starts/ stops a second occupation* or changes the number of hours per week that he/she works	Impacts on the waiving of the contract's premiums We may: • stop waiving the contract's premiums or • recover premiums we had already waived but that the insured person did not qualify for, from you Impacts on the contract itself We may: • change the premium, • offer different terms** or • remove any benefits that you no longer qualify for***	Same as under "You tell us about the change" on the left	We may: • change the premium, • offer different terms**, • remove any benefits you no longer qualify for*** or • recover premiums we had already waived 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 waiving the contract's premiums	Impacts on the waiving of the contract's premiums We may: • stop waiving the contract's premiums or • recover premiums we had already waived 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	Impacts on the waiving of the contract's premiums We may: • stop waiving the contract's premiums or • recover premiums we had already waived but that the insured person did not qualify for, 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 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.

*** 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.

CHANGES TO THE CIRCUMSTANCES OF THE INSURED PERSON ON THE PREMIUM PROTECTION FUNCTIONAL IMPAIRMENT 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 waiving the contract's premiums at the time of the change. Some changes in circumstances will only affect waiving of the contract's premiums or the contract itself, while other changes may affect both. Any change to the insured person's circumstances while we are not waiving the contract's premiums will affect only the contract itself.

What changes about the insured person	**Actions we can take while we are waiving the contract's premiums**		**Actions we can take when we are not waiving the contract's premiums**	
	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 waiving of the contract's premiums 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 premiums we had already waived 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 waiving the contract's premiums	Impacts on the waiving of the contract's premiums We may: • stop waiving the contract's premiums or • recover premiums we had already waived 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	Impacts on the waiving of the contract's premiums We may: • stop waiving the contract's premiums or • recover premiums we had already waived but that the insured person did not qualify for, 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 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.

*** 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.

CHANGES TO THE CIRCUMSTANCES OF THE INSURED PERSON ON THE PREMIUM PROTECTION RETRENCHMENT 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 waiving the contract's premiums at the time of the change. Some changes in circumstances will only affect waiving of the contract's premiums or the contract itself, while other changes may affect both. Any change to the insured person's circumstances while we are not waiving the contract's premiums will affect only the contract itself.

What changes about the insured person	**Actions we can take while we are waiving the contract's premiums**		**Actions we can take when we are not waiving the contract's premiums**	
	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 changes his/her occupation* (this includes when he/she was unemployed or retired and then starts working again or he/she worked and then becomes unemployed) or any detail of his/her occupation (this includes where a miner changes from working above the ground to working underground with or without explosives)	Impacts on the waiving of the contract's premiums We may: • stop waiving the contract's premiums or • recover premiums we had already waived but that the insured person did not qualify for, from you Impacts on the contract itself We may: • change the premium, • offer different terms** or • remove any benefits that you no longer qualify for***	Same as under "You tell us about the change" on the left	We may: • change the premium, • offer different terms**, • remove any benefits you no longer qualify for*** or • recover premiums we had already waived 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 changes the industry* he/she works in (for example he/she was working in the building industry and changed to the mining industry)	Impacts on the waiving of the contract's premiums We may: • stop waiving the contract's premiums or • recover premiums we had already waived but that the insured person did not qualify for, from you Impacts on the contract itself We may: • change the premium, • offer different terms** or • remove any benefits that you no longer qualify for***	Same as under "You tell us about the change" on the left	We may: • change the premium, • offer different terms**, • remove any benefits you no longer qualify for*** or • recover premiums we had already waived 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 changes his/her employment type* (for example changing from a full time employee to a part time worker or becoming self-employed)	Impacts on the waiving of the contract's premiums We may: • stop waiving the contract's premiums or • recover premiums we had already waived but that the insured person did not qualify for, from you Impacts on the contract itself We may: • change the premium, • offer different terms**, • remove any benefits that you no longer qualify for***	Same as under "You tell us about the change" on the left	We may: • change the premium, • offer different terms**, • remove any benefits you no longer qualify for*** or • recover premiums we had already waived 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 starts/ stops a second occupation* or changes the number of hours per week that he/she works	Impacts on the waiving of the contract's premiums We may: • stop waiving the contract's premiums or • recover premiums we had already waived but that the insured person did not qualify for, from you Impacts on the contract itself We may: • change the premium, • offer different terms** or • remove any benefits that you no longer qualify for***	Same as under "You tell us about the change" on the left	We may: • change the premium, • offer different terms**, • remove any benefits you no longer qualify for*** or • recover premiums we had already waived 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 becomes: • a company director, • a business partner, or • an employee of a company that has its head office based outside South Africa or Namibia • employed in a family business where he/she is a member of the family	Impacts on the waiving of the contract's premiums We may: • stop waiving the contract's premiums or • recover premiums we had already waived but that the insured person did not qualify for, from you Impacts on the contract itself We may: • change the premium, • offer different terms**, • remove any benefits that you no longer qualify for***	Same as under "You tell us about the change" on the left	We may: • change the premium, • offer different terms**, • remove any benefits you no longer qualify for*** or • recover premiums we had already waived 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 dies	Impacts on the waiving of the contract's premiums We may: • stop waiving the contract's premiums or • recover premiums we had already waived but that the insured person did not qualify for, 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 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.

*** 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.

PHYSICAL IMPAIRMENTS THAT QUALIFY UNDER THE PHYSICAL IMPAIRMENT COVER BENEFIT

Body system	Physical impairment	Requirements that the physical impairment must meet to qualify	Percentage of the cover amount payable
Musculoskeletal Disorders	Combination of loss of use of an upper and lower limb	The total and permanent 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 orthopeadic or neurosurgeon.	100%
	Loss of use of both feet or legs	The total and permanent loss of use of: • both legs at or above the ankle joint up to the hip joint, or • both feet at the tranverse tarsal joint (Chopart's joint), or • one foot at the tranverse 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 leg	The total and permanent 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 and permanent loss of use of one foot at the tranverse tarsal joint (Chopart's joint), as confirmed by an orthopaedic or neurosurgeon.	50%
	Loss of use of both hands or arms	The total and permanent 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 one arm	The total and permanent 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 and permanent 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%
Senses	Loss of hearing	Total and permanent 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 and permanent 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%
	Loss of speech	The total and permanent 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%

Senses (continued)	Loss of sight	Confirmed diagnosis of total and permanent 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 total and permanent 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%
Trauma	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%
	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%
Activities of Daily Living	Permanent confinement to bed or wheelchair	Permanent confinement to a bed or wheelchair as confirmed by the treating specialist due to an organic disease or injury.	100%

SEVERE ILLNESSES THAT QUALIFY UNDER THE SEVERE ILLNESS COVER BENEFIT

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

Activities of daily living	Activities of daily living	Any illness, condition or event that results in the insured person being permanently unable to perform certain activities of daily living, as specified below.
		
		Old Mutual's Medical Officer must confirm that:
		
		• The insured person has undergone reasonable treatment and has reached an adequate level of functioning that can reasonably be expected of a person suffering from the illness, condition or event
		• 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 severe illness under this benefit
		
		Requirements for a claim to be considered
		
		• Both of the following must be present:
		  • A permanent inability to perform 2 or more Basic activities of daily living
		  • A permanent inability to perform 2 or more Advanced activities of daily living
			50%

		Any illness, condition or event that results in the insured person being permanently unable to perform certain activities of daily living, as specified below.
		
		Old Mutual's Medical Officer must confirm that:
		
		• The insured person has undergone reasonable treatment and has reached an adequate level of functioning that can reasonably be expected of a person suffering from the illness, condition or event
		• 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 severe illness under this benefit
		
		Requirements for a claim to be considered
		
		• Both of the following must be present:
		  • A permanent inability to perform 2 of the Basic activities of daily living
		  • A permanent inability to perform 3 of the Advanced activities of daily living
			75%

		Any illness, condition or event that results in the insured person being permanently unable to perform certain basic activities of daily living, as specified below. Old Mutual's Medical Officer must confirm that: • The insured person has undergone reasonable treatment and has reached an adequate level of functioning that can reasonably be expected of a person suffering from the illness, condition or event. • 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 severe illness under this benefit. **Requirements for a claim to be considered** • A permanent inability to perform 3 of the basic activities of daily living	100%

Activities of daily living (continued)	Activities of daily living	**Illnesses that will be considered related:** None **Illnesses that may be considered related:** All illnesses	
	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%
		The benefit terminates after a successful claim on this illness.	
Autoimmune	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 • Active rheumatoid arthritis in at least three joints (e.g. fingers, hands, wrists, knees, hips, elbows, shoulders) as evidenced by clinical signs and x-rays **Exclusions** • Reactive arthritis • Psoriatic arthritis	25%
		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	50%
		Illnesses that will be considered related: Advanced rheumatoid arthritis, Connective tissue disease **Illnesses that may be considered related:** Activities of daily living, Acute kidney failure, Cardiomyopathy, Chronic kidney failure, Chronic pancreatitis, Chronic respiratory failure, Loss of sight, Polymyositis, Terminal illness	

Autoimmune (continued)	Connective tissue disease	Confirmed diagnosis and treatment of one of the following connective tissue diseases by the treating rheumatologist: • Giant cell arteritis • Polyarteritis nodosa • Systemic Scleroderma • Systemic lupus erythematosus • Sarcoidosis • Wegener's granulomatosis **Requirements for a claim to be considered** • Serological markers, or tissue biopsy (as appropriate) confirming diagnosis • All clinical signs must be supported by special investigations • Despite adequate treatment for at least 6 months with high dose steroids, or disease modifying drugs including biologics, the disease remains unresponsive or poorly responsive **Exclusions** • All other connective tissue or auto-immune conditions not specifically listed above • Limited cutaneous systemic sclerosis • Discoid lupus erythematosus or subacute cutaneous lupus erythematosus • Drug-induced lupus erythematosus	50%

		Confirmed diagnosis and treatment of a specified connective tissue disease by the treating rheumatologist.
		The connective diseases covered are listed in the 50% definition above.
		Requirement for a claim to be considered
		• Serological markers, or tissue biopsy (as appropriate) confirming diagnosis
		• Despite adequate treatment for at least 6 months with high dose steroids, or disease modifying drugs including biologics, at least one of the following organ systems remains directly involved:
		  • Gastrointestinal tract
		  • Lungs
		  • Heart
		  • Kidneys
		• All clinical signs must be supported by special investigations and imaging appropriate to the organ affected
		Exclusions
		• All other connective tissue or auto-immune conditions not specifically listed above
		• Limited cutaneous systemic sclerosis
		• Discoid lupus erythematosus or subacute cutaneous lupus erythematosus
		• Drug-induced lupus erythematosus
			75%

Autoimmune (continued)	Connective tissue disease	Confirmed diagnosis and treatment of a specified connective tissue disease by the treating rheumatologist.
		
		The connective diseases covered are listed in the 50% definition above.
		
		Requirement for a claim to be considered
		
		• Serological markers, or tissue biopsy (as appropriate) confirming diagnosis
		• Despite adequate treatment for at least 6 months with high dose steroids, or disease modifying drugs including biologics, at least two of the following organ systems remains directly involved:
		  • Gastrointestinal tract
		  • Lungs
		  • Heart
		  • Kidneys
		• All clinical signs must be supported by special investigations and imaging appropriate to the organ affected
		
		Exclusions
		
		• All other connective tissue or auto-immune conditions not specifically listed above
		• Limited cutaneous systemic sclerosis
		• Discoid lupus erythematosus or subacute cutaneous lupus erythematosus
		• Drug-induced lupus erythematosus
			100%

		Illnesses that will be considered related: Advanced rheumatoid arthritis, Connective tissue disease **Illnesses that may be considered related:** Activities of daily living, Acute kidney failure, Cardiomyopathy, Chronic kidney failure, Chronic pancreatitis, Chronic respiratory Failure, Loss of sight, Polymyositis, Terminal illness	
	Polymyositis	Confirmed diagnosis of polymyositis by the treating specialist. **Requirements for a claim to be considered** • Positive serology findings • Electromyography positive • Supportive biopsy • Clinical confirmation of dysphonia (voice disorders) and dysphagia (difficulty swallowing)	100%
		Illnesses that will be considered related: Polymyositis **Illnesses that may be considered related:** Activities of daily living, Acute kidney failure, Advanced rheumatoid arthritis, Cardiomyopathy, Chronic kidney failure, Chronic pancreatitis, Chronic respiratory failure, Connective tissue disease, Loss of sight, Loss of speech, Prolonged mechanical ventilation, Terminal illness, Type 1 diabetes	

Cancer	Bone marrow failure (including severe aplastic anaemia)	Confirmed diagnosis of complete bone marrow failure by the treating haematologist.
		
		Requirements for a claim to be considered
		
		• The bone marrow failure must result in anaemia, neutropenia and thrombocytopenia.
		• The insured person must require a minimum of one of the following treatments:
		  • at least 1 blood transfusion per month for at least 3 months, or
		  • immunosuppressive therapy, or
		  • bone marrow stimulation therapy
		
		Exclusions
		
		• All other forms of anaemia and blood disorders
			25%

		Illnesses that will be considered related Bone marrow failure (incl severe aplastic anaemia), Chronic blood disorders, Hematopoietic stem cell (bone marrow) transplant **Illnesses that may be considered related** Activities of daily living, Acute kidney failure, Arrhythmia, Cancer, Cardiomyopathy, Chronic blood disorders, Chronic kidney failure, Chronic liver failure, Terminal illness	

	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 I by the American Joint Committee for Cancer are covered, where the following cancers are only covered as specified:
		
		• Prostate cancer is covered when histologically classified as Gleason score of more than 6, or at least TNM staging T2N0M0
		• Malignant melanoma is covered from T1N0M0
		• Ductal carcinoma in situ (DCIS) of the breast is covered if microinvasion is present
		• Borderline ovarian tumours from Stage I are covered
		• Brain tumours from WHO Grade II are covered
		
		Exclusions
		
		• All cancers which are histologically classified as any of the following:
		  • pre-malignant
		  • non-invasive
		  • cancer in situ, unless specified above
		  • having borderline malignancy, unless specified above
		  • tumours with low malignant potential
		
		• All prostate cancers, unless conforming to the specifications above
		• All skin cancers, except malignant melanoma as specified above
			25%

Cancer (continued)	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 (no bone marrow transplant)
		  • 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 to the specifications above
		• All skin cancers, except malignant melanoma as specified above
		• All blood cancers, unless as specified above
			50%

		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 III or IV by the American Joint Committee for Cancer are covered, where the following cancers are only covered as specified:
		
		• Prostate cancer is covered from Stage IV
		• Malignant melanoma is covered from Stage III
		• WHO Grade III and IV brain tumours
		• Blood cancers are covered at the stages specified below
		  • Acute Myeloid Leukemia
		  • Chronic Lymphocytic Leukemia, from Stage III on the Rai classification
		  • Chronic Myeloid Leukemia (requiring bone marrow transplant)
		  • Acute Lymphocytic Leukemia
		  • Hodgkin's/Non Hodgkin's lymphoma from Stage III on the Ann Arbor classification
		  • Multiple Myeloma Stage from Stage III 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 to the specifications above
		• All skin cancers, except malignant melanoma as specified above
		• All blood cancers, unless as specified above
			100%

Cancer (continued)	Cancer	**Illnesses that will be considered related** None **Illnesses that may be considered related** Activities of daily living, Bone marrow failure (including severe aplastic anaemia), Brain surgery, Cancer, Cancer Enhancer, Chronic blood disorders, Hematopoietic stem cell (bone marrow) transplant, Non-melanoma skin cancer Stage III or IV, Pancreatectomy, Partial mastectomy, Permanent ileostomy or colostomy, Prolonged mechanical ventilation, Terminal illness, Total colectomy, Total cystectomy, Total penectomy	
	Chronic blood disorders	Confirmed diagnosis of any chronic disorder of the blood by a specialist. **Requirements for a claim to be considered** • Objective evidence of the disorder including clinical records of supportive blood counts or bone marrow biopsies • At least four units of blood or blood products has been transfused per month for at least 3 consecutive months	50%
		Illnesses that will be considered related Bone marrow failure (including severe aplastic anaemia), Chronic blood disorders, Hematopoietic stem cell (bone marrow) transplant **Illnesses that may be considered related** Activities of daily living, Acute kidney failure, Arrhythmia, Cancer, Cardiomyopathy, Chronic kidney failure, Chronic liver failure, Stroke, Terminal illness	
	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%
	Non-melonoma skin cancer Stage III or IV	Confirmed diagnosis of any non-melanoma skin cancer classified as Stage III or IV by the American Joint Committee for Cancer.	100%
		Illnesses that will be considered related None **Illnesses that may be considered related** Activities of daily living, Cancer, Non-melanoma skin cancer Stage III or IV, Terminal illness	
	Partial mastectomy	The undergoing of a partial mastectomy for ductal or lobular carcinoma in situ. **Requirements for a claim to be considered** • Histological evidence of ductal or lobular carcinoma in situ • Surgical reports confirming the removal of at least 50% of the affected breast **Exclusions** • Lumpectomy • Quadrantectomy	25%
		Illnesses that will be considered related Partial mastectomy **Illnesses that may be considered related** Cancer	

Cardiovascular	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 NOTE: Branches of the aorta are covered under Artery surgery	50%
		The repair of a narrowing, obstruction, dissection or aneurysm of either the main thoracic or abdominal aorta through surgically opening the chest cavity (thoracotomy) or the abdominal cavity (laparotomy). **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis NOTE: Branches of the aorta are covered under Artery surgery	100%
		The survival period applies to all severities of this illness.	
		Illnesses that will be considered related Aortic surgery **Illnesses that may be considered related** Activities of daily living, Arrhythmia, Cardiomyopathy, Heart surgery, Heart transplant, Heart valve replacement or repair, Stroke, Terminal illness	

	Arrhythmia	Confirmed diagnosis of an arrhythmia by the treating cardiologist, with the insertion of a functioning defibrillator.
		
		Requirements for a claim to be considered
		
		• The arrhythmia must be documented on a 24 hour Holter ECG
		• One of the following devices must be surgically implanted:
		  • Implantable Cardioverter-Defibrillator (ICD)
		  • Cardiac Resynchronization Therapy with Defibrillator (CRT-D).
		
		Exclusions
		
		• Pacemaker insertion
		• Pathway ablation
			75%

		The survival period applies to all severities of this illness.	
		Illnesses that will be considered related Arrhythmia, Cardiomyopathy, Heart attack, Heart surgery, Heart transplant, Heart valve replacement or repair, Stroke **Illnesses that may be considered related** Activities of daily living, Terminal illness	

Cardiovascular (continued)	Artery surgery	One of the following:
		• The repair of a narrowing, obstruction, dissection or aneurysm of a specified artery, by means of any surgical technique. This includes keyhole or catheter techniques or bypass grafts. The following arteries are covered:
		  • Subclavian
		  • Brachiocephalic
		  • Splenic
		  • Renal
		  • Iliac
		  • Femoral
		• The undergoing of surgery to correct the narrowing of, or blockage to, any artery in the arms, hands legs or feet by means of a bypass graft
		Requirements for a claim to be considered:
		Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis
			25%

		The survival period applies to all severities of this illness.	
		Illnesses that will be considered related Artery surgery **Illnesses that may be considered related** Activities of daily living, Aortic Surgery, Carotid Artery Surgery, Peripheral Arterial Disease, Terminal illness	
	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	50%
		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 45%, measured twice at least 3 months apart	75%
		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 40%, measured twice at least 3 months apart	100%
		Illnesses that will be considered related Arrhythmia, Cardiomyopathy, Coronary artery bypass graft, Heart attack, Heart surgery, Heart transplant, Heart valve replacement or repair, Stroke **Illnesses that may be considered related** Activities of daily living, Chronic respiratory failure, Terminal illness	

Cardiovascular (continued)	Carotid artery surgery	The repair of a narrowing, obstruction, dissection or aneurysm of one carotid artery, by means of a bypass graft or endarterectomy. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	25%
		The repair of a narrowing, obstruction, dissection or aneurysm of both carotid arteries, by means of any surgical technique. This can be conducted over multiple surgeries, including bypass grafts, endarterectomies or endovascular procedures. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	100%
		The survival period applies to all severities of this illness.	
		Illnesses that will be considered related Carotid artery surgery, Stroke **Illnesses that may be considered related** Activities of daily living, Coma, Dementia (incl Alzheimer's disease), Paralysis, Terminal illness	
	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.	50%
		The undergoing of surgery to correct the narrowing of, or blockage to, two coronary arteries by means of a bypass graft.	75%
		The undergoing of surgery to correct the narrowing of, or blockage to, three or more coronary arteries by means of a bypass graft.	100%
		The survival period applies to all severities of this illness.	
		Illnesses that will be considered related Arrhythmia, Cardiomyopathy, Coronary artery bypass graft, Heart attack, Heart surgery, Heart transplant **Illnesses that may be considered related** Activities of daily living, Terminal illness	

	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
		• One 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)
			25%

Cardiovascular (continued)	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)
			50%

		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
		• One 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
		
		• IN ADDITION to the above, six weeks post infarction, there remains impairment of cardiac function as evidenced by both of the following:
		  • Left Ventricle Ejection Fraction (LVEF) of 40% - 50%
		  • Shortness of breath as per Class II or III New York Heart Association (NHYA) heart failure
		
		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)
			75%

Cardiovascular (continued)	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
		• One 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
		• IN ADDITION to the above, six weeks post infarction, there remains impairment of cardiac function as evidenced by both of the following:
		  • Left Ventricle Ejection Fraction (LVEF) of <40%
		  • Shortness of breath as per Class IV New York Heart Association (NYHA) heart failure
		
		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%

		The survival period applies to all severities of this illness.	
		Illnesses that will be considered related Arrhythmia, Cardiomyopathy, Coronary artery bypass graft, Heart attack, Heart surgery, Heart transplant **Illnesses that may be considered related** Activities of daily living, Lifestyle enhancer, Terminal illnes	
	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	75%
		The survival period applies to all severities of this illness.	
		Illnesses that will be considered related Arrhythmia, Coronary artery bypass graft, Heart surgery, Heart transplant, Heart valve replacement or repair **Illnesses that may be considered related** Activities of daily living, Cardiomyopathy, Terminal illness	

Cardiovascular (continued)	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%
		Illnesses that will be considered related Arrhythmia, Heart attack, Heart transplant, Stroke **Illnesses that may be considered related** Activities of daily living, Cardiomyopathy, Terminal illness	
	Heart valve replacement or repair	The undergoing of heart surgery to repair one or more diseased heart valves by means of any minimally invasive surgery. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any investigative procedure	50%
		The undergoing of heart surgery to repair one or more diseased heart valves, 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	75%
		The undergoing of heart surgery to replace one or more diseased heart valves, by means of any surgical technique. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any investigative procedure	100%
		The survival period applies to all severities of this illness.	
		Illnesses that will be considered related Arrhythmia, Heart surgery, Heart transplant, Heart valve replacement or repair, Stroke **Illnesses that may be considered related** Activities of daily living, Aortic surgery, Cardiomyopathy, Pulmonary artery surgery, Terminal illness	
	Pericardiectomy	The excision of a portion of the pericardium as treatment for a disease affecting the pericardium/pericardial sac, by means of any surgical technique. This includes endoscopic or keyhole procedures. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any investigative procedure	25%

Cardiovascular (continued)	Pericardiectomy	**The survival period applies to all severities of this illness.**	
		Illnesses that will be considered related Pericardiectomy **Illnesses that may be considered related** Activities of daily living, Heart surgery, Terminal illness	
	Peripheral arterial disease	Confirmed diagnosis of peripheral arterial disease by the treating vascular surgeon. **Requirements for a claim to be considered** • Abnormal diminished pulse on Doppler readings • Ankle-Brachial index (ABI) <0.9 • Pain as a result of peripheral arterial disease with claudication on minimal exercise lasting less than 10 minutes	50%

		Confirmed diagnosis of peripheral arterial disease by the treating vascular surgeon.
		
		Requirements for a claim to be considered
		
		• One of the following must be present:
		  • No recordable pulse on Doppler readings
		  • Gangrene secondary to peripheral arterial disease
			100%

		Illnesses that will be considered related Peripheral arterial disease **Illnesses that may be considered related** Activities of daily living, Amputation of limb, Terminal illness	
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, which could include 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%
		Illnesses that will be considered related Acquired intellectual or cognitive impairment, Dementia (including Alzheimer's disease), Psychiatric disorders **Illnesses that may be considered related** Accidental brain injury, Activities of daily living, Benign brain tumour, Brain surgery, Coma, Loss of hearing, Loss of sight, Loss of speech, Paralysis, Status epilepticus, Stroke, Terminal illness	

Central nervous system (continued)	Benign brain tumour	Confirmed diagnosis of a non-malignant tumour or cyst in the brain, cranial nerves or meninges within the skull. This includes pituitary macroadenomas. **Requirements for a claim to be considered** • Supportive imaging and neurological reports, including confirmation of the diagnosis • The tumour has been removed via complete resection, partial resection or is irresectable **Exclusions** • Pituitary microadenomas • Angiomas • Granuloma, hamartoma or malformation of the arteries or veins of the brain	25%
		Confirmed diagnosis of a non-malignant tumour or cyst in the brain, cranial nerves or meninges within the skull. This includes pituitary macroadenomas. **Requirements for a claim to be considered** • Supportive imaging and neurological reports, including confirmation of the diagnosis • The tumour causes permanent neurological deficit. Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months **Exclusions** • Pituitary microadenomas • Angiomas • Granuloma, hamartoma or malformation of the arteries or veins of the brain	50%
		Illnesses that will be considered related Benign brain tumour **Illnesses that may be considered related** Acquired Intellectual or Cognitive impairment, Activities of daily living, Brain surgery, Coma, Dementia (including Alzheimer's disease), Loss of hearing, Loss of sight, Loss of speech, Paralysis, Psychiatric disorders, Status epilepticus, Stroke, Terminal illness	
	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	50%
		Illnesses that will be considered related Brain surgery **Illnesses that may be considered related** Acquired intellectual or cognitive impairment, Activities of daily living, Benign brain tumour, Cancer, Coma, Dementia (including Alzheimer's disease), Loss of hearing , Loss of sight, Loss of speech, Paralysis, Psychiatric disorders, Spinal cord tumor, Status epilepticus, Stroke, Terminal illness	

Central nervous system (continued)	Cavernous sinus thrombosis	Confirmed diagnosis of cavernous sinus thrombosis by the treating specialist. **Requirements for a claim to be considered** • Supportive imaging and neurological reports	50%
		The survival period applies to all severities of this illness.	
		Illnesses that will be considered related Cavernous sinus thrombosis, Stroke **Illnesses that may be considered related** Acquired intellectual or cognitive impairment, Activities of daily living, Brain surgery, Coma, Dementia (including Alzheimer's disease), Loss of hearing , Loss of sight, Loss of speech, Paralysis, Psychiatric disorders, Status epilepticus, Terminal illness	

	Cerebral malaria	Confirmed diagnosis of cerebral malaria by the treating specialist.
		
		Requirements for a claim to be considered
		
		• Supportive blood tests showing malaria infection
		• Admission to ICU for more than 72 hours during which the insured person suffers both of the following:
		  • A coma, with a Glasgow Coma Scale of 8 or less, that lasts more than 6 hours
		  • Epileptic seizures as a complication of the cerebral malaria
			25%

		Confirmed diagnosis of cerebral malaria by the treating specialist. **Requirements for a claim to be considered** • Supportive blood tests showing malaria infection • The cerebral malaria causes permanent neurological deficit. Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months	50%
		The survival period applies to all severities of this illness.	
		Illnesses that will be considered related Cerebral malaria **Illnesses that may be considered related** Acquired intellectual or cognitive impairment, Activities of daily living, Coma, Dementia (including Alzheimer's disease), Loss of hearing, Loss of sight, Loss of speech, Paralysis, Psychiatric disorders, Status epilepticus, Stroke, Terminal illness	
	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 96hrs **Exclusions** • Medically induced comas • Comas due to the consumption of alcohol, drugs or medication not used as prescribed	50%

Central nervous system (continued)	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%
		The survival period applies to all severities of this illness.	
		Illnesses that will be considered related None **Illnesses that may be considered related** Accidental brain injury, Acquired intellectual or cognitive impairment, Activities of daily living, Brain surgery, Cavernous sinus thrombosis, Chronic kidney failure, Coma, Dementia (including Alzheimer's disease), Lifestyle enhancer, Loss of hearing, Loss of sight, Loss of speech, Major burns, Motor neurone disease, Multiple sclerosis, Paralysis, Parkinson's disease, Parkinson's plus syndrome, Prolonged mechanical ventilation, Psychiatric disorders, Status epilepticus, Stroke, Terminal illness	
	Dementia (including 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%
		Illnesses that will be considered related Acquired intellectual or cognitive impairment, Dementia (incl Alzheimer's disease), Psychiatric disorders **Illnesses that may be considered related** Activities of Daily Living, Brain surgery, Coma, Loss of speech, Motor neurone disease, Multiple sclerosis, Parkinson's disease, Parkinson's plus syndrome, Status epilepticus, Stroke, Terminal Illness	
	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)	25%
		Illnesses that will be considered related Motor neurone disease **Illnesses that may be considered related** Acquired intellectual or cognitive impairment, Activities of daily living, Coma, Dementia (incl Alzheimer's disease), Loss of speech, Paralysis, Prolonged mechanical ventilation, Psychiatric disorders, Terminal illness	

Central nervous system (continued)	Multiple sclerosis	Confirmed diagnosis of multiple sclerosis by the treating neurologist. **Requirements for a claim to be considered:** • Magnetic resonance imaging (MRI) showing lesion/s of demyelination in the brain or spinal cord characteristic of multiple sclerosis • At least 2 separate episodes resulting in neurological signs and symptoms must have occurred **Exclusions** • Possible multiple sclerosis and clinically or radiologically isolated syndromes suggestive but not diagnostic of multiple sclerosis	25%
		Confirmed diagnosis of multiple sclerosis by the treating neurologist. **Requirements for a claim to be considered** • Magnetic resonance imaging (MRI) showing lesion/s of demyelination in the brain or spinal cord characteristic of multiple sclerosis • The multiple sclerosis results in permanent neurological deficit. Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months **Exclusions** • Possible multiple sclerosis and clinically or radiologically isolated syndromes suggestive but not diagnostic of multiple sclerosis	50%
		Illnesses that will be considered related Multiple Sclerosis **Illnesses that may be considered related** Acquired intellectual or cognitive impairment, Activities of daily living, Chronic respiratory failure, Coma, Dementia (incl Alzheimer's disease), Loss of hearing, Loss of sight, Loss of speech, Paralysis, Prolonged mechanical ventilation, Psychiatric disorders, Status epilepticus, Stroke, Terminal illness	
	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	25%
		Illnesses that will be considered related Muscular dystrophy **Illnesses that may be considered related** Activities of daily living, Chronic respiratory failure, Paralysis, Prolonged mechanical ventilation, Terminal illness	
	Myasthenia gravis Class III or higher	Confirmed diagnosis of myasthenia gravis of at least severity Class III (as per the Myasthenia Gravis Foundation of America clinical classification), by the treating neurologist. **Requirements for a claim to be considered** • Supportive electro-diagnostic studies • There must be appropriate evidence, which could include anti–acetylcholine receptor (AChR) antibody (Ab) test positive, or anti-MuSK (muscle-specific kinase) antibody test positive **Exclusions** • Localized ocular myasthenia gravis	100%

Central nervous system (continued)	Myasthenia gravis Class III or higher	**Illnesses that will be considered related** Myasthenia Gravis Stage III or higher **Illnesses that may be considered related** Activities of daily living, Chronic respiratory failure, Dementia (incl Alzheimer's disease), Paralysis, Prolonged mechanical ventilation, Terminal illness	
	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	50%
		The total and permanent loss of use of two complete limbs. A limb is defined as a whole arm or a whole leg. **Requirements for a claim to be considered** • Permanence must be confirmed by the treating specialist • Supportive special investigations	100%
		The survival period applies to all severities of this illness.	
		Illnesses that will be considered related None **Illnesses that may be considered related** Accidental brain injury, Acquired intellectual or cognitive impairment, Activities of daily living, Acute kidney failure, Cavernous sinus thrombosis, Chronic kidney failure, Coma, Dementia (incl Alzheimer's disease), Kidney transplant, Lifestyle enhancer, Loss of hearing, Loss of sight, Loss of speech, Myasthenia Gravis Stage III or higher, Paralysis, Prolonged mechanical ventilation, Psychiatric disorders, Status epilepticus, Stroke, Terminal illness	
	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	25%
		Illnesses that will be considered related Parkinson's disease **Illnesses that may be considered related** Acquired intellectual or cognitive impairment, Activities of daily living, Coma, Dementia (incl Alzheimer's disease), Loss of speech, Paralysis, Psychiatric disorders, Stroke, Terminal illness	

Central nervous system (continued)	Parkinson's plus syndrome	Confirmed diagnosis of one of the following Parkinson Plus syndromes by the treating neurologist: • Multiple system atrophy • Progressive supranuclear palsy • Parkinsonism-dementia-amyotrophic lateral sclerosis complex • Corticobasal ganglionic degeneration • Diffuse Lewy body disease • Picks disease • Olivopontocerebellar atrophy **Requirements for a claim to be considered** • Supporting medical and clinical evidence **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	25%
		Illnesses that will be considered related Parkinson's disease, Parkinson's plus syndrome **Illnesses that may be considered related** Acquired intellectual or cognitive impairment, Activities of daily living ,Coma, Dementia (incl Alzheimer's disease), Loss of speech, Paralysis, Psychiatric disorders, Stroke, Terminal illness	
	Psychiatric disorders	Confirmed diagnosis of a psychiatric disorder 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) • Institutionalisation in a registered psychiatric facility for more than 6 consecutive months with appropriate medical certification • Undergoing of constant 24 supervision, with a permanent caregiver • Global Assessment Function (GAF) score of 40 or less certified under the DSM IV classification, or • WHODAS item-response-theory" (IRT) score of 100 which equals full disability The above must be confirmed by at least two independent psychiatric reports	100%
		Illnesses that will be considered related Acquired intellectual or cognitive impairment, Dementia (including Alzheimer's disease), Psychiatric disorders **Illnesses that may be considered related** Activities of daily living, Benign brain tumour, Coma, Status epilepticus, Stroke, Terminal illness	

Central nervous system (continued)	Spinal cord tumour	Confirmed diagnosis of a non-malignant tumour or cyst in the spinal cord, spinal nerves or meninges. **Requirements for a claim to be considered** • Supportive imaging and neurological reports, including confirmation of the diagnosis • The tumour has been removed via complete resection, partial resection or is irresectable • The tumour causes permanent neurological deficit. Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months **Exclusions** • Angiomas • Granuloma and hamartoma	50%
		Illnesses that will be considered related Spinal cord tumour **Illnesses that may be considered related** Activities of daily living, Benign brain tumor, Brain surgery, Cancer, Chronic respiratory failure, Paralysis, Prolonged mechanical ventilation, Terminal illness	
	Status epilepticus	An episode of status epilepticus confirmed by the treating neurologist. **Requirements for a claim to be considered** • Supportive imaging and neurological reports • The status epilepticus causes permanent neurological deficit. Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months	50%
		The survival period applies to all severities of this illness.	
		Illnesses that will be considered related Status epilepticus **Illnesses that may be considered related** Accidental brain injury, Acquired intellectual or cognitive impairment, Activities of daily living, Brain surgery, Cavernous sinus thrombosis, Coma, Dementia (incl Alzheimer's disease), Loss of hearing, Loss of sight, Loss of speech, Paralysis, Prolonged mechanical ventilation, Psychiatric disorders, Stroke, Terminal illness	
	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 neuroimaging investigation and appropriate clinical findings by a specialist neurologist. Stroke as a result of traumatic injury to brain tissue or blood vessels is included. **Exclusions** • Transient ischaemic attack • Vascular disease affecting the eye or optic nerve • Migraine and vestibular disorders	25%

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
		  • 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
			50%

		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 6 or more Advanced activities of daily living
		  • A Whole Person Impairment (WPI) of 21%- 35%. 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
			75%

		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 Basic activities of daily living
		  • A Whole Person Impairment (WPI) of greater than 35%. 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%

Central nervous system (continued)	Stroke	**The survival period applies to all severities of this illness.**	
		Illnesses that will be considered related Carotid Artery Surgery, Stroke **Illnesses that may be considered related** Acquired intellectual or cognitive impairment, Activities of daily living, Arrythmia, Brain surgery, Cavernous sinus thrombosis, Chronic blood disorders, Coma, Dementia (incl Alzheimer's disease), Lifestyle enhancer, Loss of hearing, Loss of sight, Loss of speech, Paralysis, Prolonged mechanical ventilation, Psychiatric disorders, Status epilepticus, Terminal illness	
Gastrointestinal	Acute kidney failure	A single episode of acute kidney failure requiring six or more treatments of haemodialysis. **Requirements for a claim to be considered** • Confirmation of acute kidney failure by the treating nephrologist • Blood tests supporting diagnosis • Evidence of number of haemodialysis treatments **Exclusions** • Any acute failure caused by the consumption of alcohol, drugs or medication not used as prescribed	50%
		Illnesses that will be considered related Acute kidney failure **Illnesses that may be considered related** Activities of daily living, Artery surgery, Cardiomyopathy, Chronic blood disorders, Chronic kidney failure, Chronic liver failure, Coma, Connective tissue disease, Dementia (incl Alzheimer's disease), Kidney transplant, Peripheral arterial disease, Polymyositis, Terminal illness	

	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:
		  • Chronic renal disease with an estimated Glomerular Filtration Rate (GFR) ≤ 40ml/min
		  • Chronic renal disease with creatinine clearance of ≤ 55ml/min, with clinically significant progressive renal function decline as confirmed by 3 renal function (creatinine clearance) measurements in a 12 month period
			50%

		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%

		Illnesses that will be considered related Chronic kidney failure, Kidney transplant **Illnesses that may be considered related** Activities of daily living, Acute kidney failure, Artery surgery, Cardiomyopathy, Chronic blood disorders, Chronic liver failure. Connective tissue disease, Coma, Dementia (incl Alzheimer's disease), Peripheral arterial disease, Polymyositis, Terminal illness	

Gastrointestinal (continued)	Chronic liver failure	Confirmed diagnosis of progressive chronic 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 A **Exclusions** • Liver disease caused by the consumption of alcohol, drugs or medication not used as prescribed	50%
		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 B **Exclusions** • Liver disease caused by the consumption of alcohol, drugs or medication not used as prescribed	75%
		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%
		Illnesses that will be considered related Chronic liver failure, Liver transplant **Illnesses that may be considered related** Activities of daily living, Acute kidney failure, Chronic kidney failure, Coma, Dementia (incl Alzheimer's disease), Terminal illness	
	Chronic pancreatitis	Confirmed diagnosis of chronic pancreatitis by the treating gastroenterologist or equivalent specialist. **Requirements for a claim to be considered** • Supportive clinical, laboratory and histological evidence • Malabsorption syndrome caused by exocrine pancreatic insufficiency • Impaired glucose metabolism caused by endocrine pancreatic insufficiency **Exclusions** • Pancreatic disease caused by the consumption of alcohol, drugs or medication not used as prescribed	50%
		Illnesses that will be considered related Chronic Pancreatitis, Pancreactomy or pancreas transplant **Illnesses that may be considered related** Activities of daily living, Cancer, Chronic liver failure , Terminal illness	

Gastrointestinal (continued)	Crohn's disease with specified surgery	Confirmed diagnosis of Crohn's disease by the treating gastroenterologist or equivalent specialist. **Requirements for a claim to be considered** • Supportive colonoscopy and histopathology findings • Despite adequate treatment for at least 6 consecutive months with diet, disease modifying drugs or immuno-modulators, the disease remains unresponsive or poorly responsive • The complications have resulted in at least one surgical intervention other than for diagnostic purposes	25%
		Confirmed diagnosis of Crohn's disease by the treating gastroenterologist or equivalent specialist. **Requirements for a claim to be considered** • Supportive colonoscopy and histopathology findings • Despite adequate treatment for at least 6 consecutive months with diet, disease modifying drugs or immuno-modulators, the disease remains unresponsive or poorly responsive • The complications have resulted in at least two surgical interventions, on two separate occasions, other than for diagnostic purposes	50%
		Illnesses that will be considered related Crohn's disease with specified surgery **Illnesses that may be considered related** Activities of daily living, Cancer, Chronic liver failure, Permanent ileostomy or colostomy, Terminal illness, Total colectomy	
	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%
		Illnesses that will be considered related Chronic kidney failure, Kidney transplant **Illnesses that may be considered related** Activities of daily living, Acute kidney failure, Artery surgery, Cardiomyopathy, Chronic Blood disorders, Chronic liver failure, Coma, Connective tissue disease, Dementia (incl Alzheimer's disease), Polymyositis, Terminal illness	
	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%
		Illnesses that will be considered related Chronic liver failure, Liver transplant **Illnesses that may be considered related** Activities of daily living, Acute kidney failure, Chronic kidney failure, Coma, Dementia (incl Alzheimer's disease), Terminal illness	

Gastrointestinal (continued)	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%
		Illnesses that will be considered related Chronic Pancreatitis, Pancreactomy or pancreas transplant **Illnesses that may be considered related** Activities of daily living, Cancer, Chronic liver failure, Coma , Terminal illness	
	Permanent ileostomy or colostomy	Any organic disease or severe physical injury that results in a colostomy or ileostomy which is intended to be permanent. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any temporary ostomy procedure	100%
		Illnesses that will be considered related Permanent ileostomy or colostomy **Illnesses that may be considered related** Activities of daily living, Cancer, Terminal illness, Total colectomy	
	Total colectomy	Any organic disease or severe physical injury that results in a total colectomy, where the entire colon is removed and the small intestine is connected to the rectum. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Partial colectomy • Segmental colectomy • Partial bowel resection	100%
		Illnesses that will be considered related Total colectomy **Illnesses that may be considered related** Activities of daily living, Cancer, Permanent ileostomy or colostomy, Terminal illness	
	Total cystectomy	Any organic disease or severe physical injury that results in a total cystectomy, which is the surgical removal of the entire bladder with the reconstruction of an ileal conduit or neo-bladder. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Partial cystectomy	100%

Gastrointestinal (continued)	Total cystectomy	**Illnesses that will be considered related** Total cystectomy **Illnesses that may be considered related** Activities of daily living, Acute kidney failure, Cancer, Chronic Kidney Failure	
	Total penectomy	Any organic disease or severe physical injury that results in total amputation of the penis (total penectomy) with the surgical construction of a perineal urethrostomy. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon **Exclusions** • Partial penectomy • Surgery due to gender dysphoria • Circumcision or any complications thereof	50%
		Illnesses that will be considered related Total penectomy **Illnesses that may be considered related** Cancer	
	Ulcerative colitis	Confirmed diagnosis of ulcerative colitis disease by the treating gastroenterologist. **Requirements for a claim to be considered** • Supportive colonoscopy and histopathology findings • Despite adequate treatment for at least 6 consecutive months with diet, disease modifying drugs or immuno-modulators, the disease remains unresponsive or poorly responsive • The complications have resulted in at least one surgical intervention other than for diagnostic purposes	25%
		Illnesses that will be considered related Ulcerative colitis **Illnesses that may be considered related** Activities of daily living, Chronic liver failure, Permanent ileostomy or colostomy, Terminal illness, Total colectomy	
HIV/AIDS	Accidental HIV for medical, dental or nurse practitioners	Infection with the human immunodeficiency virus (HIV) as a result of an accident while carrying out occupational duties of a medical, dental or nurse practitioner. For the purpose of this illness an accident is defined as an external, unexpected event that is not traceable, even indirectly, to the insured person's state of mental or physical health before the event. **Requirements for a claim to be considered** • The insured person must be registered as a medical or dental practitioner with the Health Professions Council of Namibia (HPCN) or as a member of the Namibian Nursing Council (NNC). Registered dental assistants and oral hygienists are also included • A supportive HIV antibody test must be taken within 48 hours after the accident, and the result must be negative • Proof that the health care institution's written protocol was followed, including the use of post-exposure prophylaxis drugs • Confirmed evidence of seroconversion to HIV must occur within 3 months of the accident	100%

HIV/AIDS (continued)	Accidental HIV for medical, dental or nurse practitioners (continued)	**Illnesses that will be considered related** Accidental HIV for medical, dental or nurse practitioners, Accidental HIV via a blood transfusion, Accidental HIV via a road traffic accident, Accidental HIV via an organ transplant, Accidental HIV via violent crime, rape or indecent assault, AIDS **Illnesses that may be considered related** Terminal illness	
	Accidental HIV via a blood transfusion	Infection with the human immunodeficiency virus (HIV) by infected blood received in a blood transfusion. **Requirements for a claim to be considered** • A recognised institution in the Republic of South Africa or Republic of Namibia must have performed the transfusion • The institution that provided the infected blood must admit liability • Confirmed evidence of seroconversion to HIV must occur within 3 months of the affected blood transfusion	100%
		Illnesses that will be considered related Accidental HIV for medical, dental or nurse practitioners, Accidental HIV via a blood transfusion, Accidental HIV via a road traffic accident, Accidental HIV via an organ transplant, Accidental HIV via violent crime, rape or indecent assault, AIDS **Illnesses that may be considered related** Terminal illness	
	Accidental HIV via a road traffic accident	Infection with the human immunodeficiency virus (HIV) as a result of involvement in, or assistance at the scene of, a road traffic accident. **Requirements for a claim to be considered** • The event must have been reported to the Namibian Police (NAMPOL) and a case number issued and/or criminal case opened • A medical examination must have been performed within 24 hours after the event • A supportive HIV antibody test must be taken within 48 hours after the accident, and the result must be negative • Confirmed evidence of seroconversion to HIV must occur within 3 months of the event	100%
		Illnesses that will be considered related Accidental HIV for medical, dental or nurse practitioners, Accidental HIV via a blood transfusion, Accidental HIV via a road traffic accident, Accidental HIV via an organ transplant, Accidental HIV via violent crime, rape or indecent assault, AIDS **Illnesses that may be considered related** Terminal illness	
	Accidental HIV via an organ transplant	Infection with the human immunodeficiency virus (HIV) by an infected organ received in an organ transplant. **Requirements for a claim to be considered** • A recognised institution in the Republic of South Africa or Republic of Namibia must have performed the transplant • The institution that provided the infected organ must admit liability • Confirmed evidence of seroconversion to HIV must occur within 3 months of the organ transplant	100%
		Illnesses that will be considered related Accidental HIV for medical, dental or nurse practitioners, Accidental HIV via a blood transfusion, Accidental HIV via a road traffic accident, Accidental HIV via an organ transplant, Accidental HIV via violent crime, rape or indecent assault, AIDS **Illnesses that may be considered related** Terminal illness	

HIV/AIDS (continued)	Accidental HIV via violent crime, rape or indecent assault	Infection with the human immunodeficiency virus (HIV) as a result of being a victim of a violent crime, rape or an indecent assault. **Requirements for a claim to be considered** • The event must have been reported to the Namibian Police (NAMPOL) and a case number issued and/or criminal case opened • A medical examination must have been performed within 24 hours after the event • A supportive HIV antibody test must be taken within 48 hours after the event, and the result must be negative • Confirmed evidence of seroconversion to HIV must occur within 3 months of the event	100%
		Illnesses that will be considered related Accidental HIV for medical, dental or nurse practitioners, Accidental HIV via a blood transfusion, Accidental HIV via a road traffic accident, Accidental HIV via an organ transplant, Accidental HIV via violent crime, rape or indecent assault, AIDS **Illnesses that may be considered related** Terminal illness	
	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%
		The benefit terminates after a successful claim on this illness.	

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 ≤50% predicted
		  • FVC (forced vital capacity) of ≤50% predicted
		  • DLCO (diffusing capacity of the lungs for carbon monoxide) of ≤50% predicted
			50%

		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%

		Illnesses that will be considered related Chronic respiratory failure, Lung transplant **Illnesses that may be considered related** Activities of daily living, Cardiomyopathy, Lung surgery, Pulmonary arterial hypertension, Prolonged mechanical ventilation, Terminal illness	

Respiratory (continued)	Lung surgery	The undergoing of surgery to remove more than one lobe of the lung due to any physical injury or disease. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
		The undergoing of surgery to remove a whole lung due to any physical injury or disease. **Requirements for a claim to be considered** Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	100%
		The survival period applies to all severities of this illness.	
		Illnesses that will be considered related Chronic respiratory failure, Lung surgery, Lung transplant **Illnesses that may be considered related** Activities of daily living, Cardiomyopathy, Prolonged mechanical ventilation, Pulmonary arterial hypertension, Recurrent pulmonary emboli	
	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%
		Illnesses that will be considered related Chronic respiratory failure, Lung surgery, Lung transplant **Illnesses that may be considered related** Activities of daily living, Cardiomyopathy, Prolonged mechanical ventilation, Pulmonary arterial hypertension, Terminal illness	

	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
		• This illness will only be considered if the insured person does not qualify for a payment for any other listed severe illness under this benefit
		• The survival period applies from the date this definition has been met
			100%

		The survival period applies to all severities of this illness.	

Respiratory (continued)	Prolonged mechanical ventilation	**Illnesses that will be considered related** None **Illnesses that may be considered related** Activities of daily living, Acquired intellectual or cognitive impairment, Coma, Dementia (incl Alzheimer's disease), Prolonged mechanical ventilation, Terminal illness	
	Pulmonary arterial hypertension	Confirmed diagnosis of pulmonary hypertension by the treating specialist. **Requirements for a claim to be considered** • Mean pulmonary artery pressure of between 25-40 mmHg at rest, measured by right heart catheterisation • Marked limitation in activity due to symptoms, even during less-than-ordinary activity, e.g. walking short distances (New York Heart Association (NYHA) Class III heart failure). Symptoms must be present for a continuous period of at least 3 months	50%
		Confirmed diagnosis of pulmonary hypertension by the treating specialist. **Requirements for a claim to be considered** • Mean pulmonary artery pressure of more than 40 mmHg at rest, measured by right heart catheterisation • Marked limitation of physical activities at rest (New York Heart Association (NYHA) Class IV heart failure). Symptoms must be present for a continuous period of at least 3 months	100%
		Illnesses that will be considered related Arrhythmia, Cardiomyopathy, Chronic respiratory failure, Heart surgery, Pulmonary arterial hypertension, Pulmonary artery surgery, Recurrent pulmonary emboli **Illnesses that may be considered related** Activities of daily living, Chronic blood disorders, Lung surgery, Prolonged mechanical ventilation, Terminal illness	
	Pulmonary artery surgery	The undergoing of surgery to the pulmonary artery through surgically opening the chest cavity (thoracotomy or sternotomy). There must be excision and replacement of a portion of the diseased pulmonary artery with a graft. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any investigative procedure • Any other surgical procedure, e.g. the insertion of stents or endovascular repair	75%
		The survival period applies to all severities of this illness.	
		Illnesses that will be considered related Arrhythmia, Cardiomyopathy, Chronic respiratory failure, Heart surgery, Pulmonary arterial hypertension, Pulmonary artery surgery, Recurrent pulmonary emboli **Illnesses that may be considered related** Activities of daily living, Chronic blood disorders, Lung surgery, Prolonged mechanical ventilation, Terminal illness	

Respiratory (continued)	Recurrent pulmonary emboli	The undergoing of a veno-caval filter insertion to treat recurrent pulmonary embolism. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any investigative procedure	50%
		The survival period applies to all severities of this illness.	
		Illnesses that will be considered related Arrhythmia, Cardiomyopathy, Chronic respiratory failure, Heart surgery, Pulmonary arterial hypertension, Pulmonary artery surgery, Recurrent pulmonary emboli **Illnesses that may be considered related** Activities of daily living, Chronic blood disorders, Lung surgery, Prolonged mechanical ventilation, Terminal illness	
Senses	Enucleation of the eye	The enucleation of one eye, which results from either trauma or the surgical treatment of an organic disease. **Requirements for a claim to be considered** • Confirmation by the treating specialist with supportive evidence	50%
		Illnesses that will be considered related None **Illnesses that may be considered related** Loss of sight	
	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 70-89 decibels • This must be confirmed by audiometry conducted with hearing aids	50%
		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%
		Illnesses that will be considered related Loss of hearing **Illnesses that may be considered related** Activities of daily living, Accidental brain injury, Terminal illness	

Senses (continued)	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 6/30 or worse (or equivalent measure on a non-metric scale) in each eye, after best correction
		  • A visual field loss to a 20° radius, after best correction
		  • Severe non-proliferative diabetic retinopathy
		  • Grade III hypertensive retinopathy
		
		Exclusions
		
		• Loss of sight due to cataracts, unless there is evidence of failed cataract surgery or contraindications to cataract surgery
			50%

		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%

		Illnesses that will be considered related Loss of sight **Illnesses that may be considered related** Activities of daily living, Accidental brain injury, Terminal illness	
	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%
		Illnesses that will be considered related Loss of speech **Illnesses that may be considered related** Activities of daily living, Accidental brain injury, Terminal illness	
	Retinitis pigmentosa	Confirmed diagnosis of retinitis pigmentosa by the treating ophthalmologist. **Requirements for a claim to be considered** • Supporting Electroretinogram (ERG) • Supporting visual field tests	25%

Senses (continued)	Retinitis pigmentosa	**Illnesses that will be considered related** Retinitis pigmentosa **Illnesses that may be considered related** Activities of daily living, Loss of sight	
Trauma	Accidental brain injury	Death of brain tissue due to traumatic injury as a result of an accident resulting in neurological deficit lasting longer than 24 hours, confirmed by neuroimaging investigation and appropriate clinical findings by a specialist neurologist. **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 insured person's state of mental or physical health before the event	25%

		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
		  • 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 insured person's state of mental or physical health before the event
			50%

		Death of brain tissue due to traumatic injury as a result of an accident, resulting in neurological deficit and confirmed by 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 6 or more Advanced activities of daily living
		  • A Whole Person Impairment (WPI) of 21%- 35%. 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 insured person's state of mental or physical health before the event
			75%

Trauma (continued)	Accidental brain injury	Death of brain tissue due to traumatic injury resulting in neurological deficit as a result of an accident, and confirmed by 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 Basic activities of daily living
		  • A Whole Person Impairment (WPI) of greater than 35%. 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 insured person's state of mental or physical health before the event
			100%

		The survival period applies to all severities of this illness.	
		Illnesses that will be considered related None **Illnesses that may be considered related** Accidental brain injury, Acquired intellectual or cognitive impairment, Activities of daily living, Brain surgery, Coma, Dementia (incl Alzheimer's disease), Lifestyle enhancer, Loss of hearing, Loss of sight, Loss of speech, Paralysis, Prolonged mechanical ventilation, Status epilepticus, Stroke, Terminal illness	
	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	50%
		The survival period applies to all severities of this illness.	
		Illnesses that will be considered related None **Illnesses that may be considered related** Activities of daily living, Amputation of limb, Terminal illness	

	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 10% of total body surface affected, as measured on the Lund and Browder Chart or equivalent
		  • 20% 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
			50%

Trauma (continued)	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
			75%

		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 30% of total body surface affected, as measured on the Lund and Browder Chart or equivalent
		  • 40% 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%

		The survival period applies to all severities of this illness.	
		Illnesses that will be considered related None **Illnesses that may be considered related** Activities of daily living, Acute kidney failure, Chronic kidney failure, Major burns, Paralysis, Prolonged mechanical ventilation, Terminal illness	

Basic Activities of Daily Living (BADL)	
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 clothing independently.
Eating	The ability to feed oneself independently.
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 Scale (AADL)	
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.

EARLY DIAGNOSED ILLNESSES THAT QUALIFY UNDER THE SEVERE ILLNESS COVER BENEFIT

Body system	Severe Illness	Requirements that the severe illness must meet to qualify	Percentage of the cover amount payable
Early diagnosed illnesses	Early bladder cancer	Carcinoma in situ of the urinary bladder. **Requirements for a claim to be considered** • Histological confirmation **Exclusions** • Non-invasive papillary carcinoma (Stage Ta bladder cancer)	15%
		Illnesses that will be considered related Early bladder cancer **Illnesses that may be considered related** Cancer, Cancer enhancer	
	Early breast cancer	The undergoing of either a mastectomy, lumpectomy or quadrantectomy for carcinoma in situ (without micro-invasion) in one or both breasts. **Requirements for a claim to be considered** • Histological confirmation • Relevant surgical reports by the treating surgeon	15%
		Illnesses that will be considered related Early breast cancer **Illnesses that may be considered related** Cancer, Cancer enhancer	
	Early cervical cancer	The undergoing of a hysterectomy for carcinoma in situ of the cervix uteri. Cervical intraepithelial neoplasia grade 3 (CIN3) is included. **Requirements for a claim to be considered** • Histological confirmation • Relevant surgical reports by the treating surgeon **Exclusions** • All other forms of treatment including trachelectomy (removal of the cervix), loop excision, laser surgery, conisation and cryosurgery	15%
		Illnesses that will be considered related Early cervical cancer **Illnesses that may be considered related** Cancer, Cancer enhancer	
	Early oesophageal cancer	The undergoing of surgery to remove carcinoma in situ of the oesophagus. **Requirements for a claim to be considered** • Histological confirmation • Relevant surgical reports by the treating surgeon **Exclusions** • Treatment by any other method • Barrett's oesophagus (with or without surgery)	15%

Early diagnosed illnesses (continued)	Early oesophageal cancer	**Illnesses that will be considered related** Early oesophageal cancer **Illnesses that may be considered related** Cancer, Cancer enhancer	
	Early ovarian cancer	The undergoing of an oophorectomy for carcinoma in situ of one or both ovaries. **Requirements for a claim to be considered** • Histological confirmation • Relevant surgical reports by the treating surgeon	15%
		Illnesses that will be considered related Early ovarian cancer **Illnesses that may be considered related** Cancer, Cancer enhancer	
	Early prostate cancer	The undergoing of either a prostatectomy or radiotherapy for a tumour in the prostate. **Requirements for a claim to be considered** • Histological confirmation that the tumour is classified as Gleason score of between 2-6 inclusive, and at least TNM staging T1N0M0 • Relevant surgical reports by the treating surgeon	15%
		Illnesses that will be considered related Early prostate cancer **Illnesses that may be considered related** Cancer, Cancer enhancer	
	Early testicular cancer	The undergoing of an orchidectomy for germ cell neoplasia in situ (GCNIS). **Requirements for a claim to be considered** • Histological confirmation • Relevant surgical reports by the treating surgeon	15%
		Illnesses that will be considered related Early testicular cancer **Illnesses that may be considered related** Cancer, Cancer enhancer	
	Gastrointestinal stromal tumour	The undergoing of surgery for a gastrointestinal stromal tumour of low malignant potential. **Requirements for a claim to be considered** • Histological confirmation • Relevant surgical reports by the treating surgeon	15%
		Illnesses that will be considered related Gastrointestinal stromal tumour **Illnesses that may be considered related** Cancer, Cancer enhancer	
	Neuroendocrine tumour	The undergoing of surgery for a neuroendocrine tumour of low malignant potential. **Requirements for a claim to be considered** • Histological confirmation • Relevant surgical reports by the treating surgeon	15%

Early diagnosed illnesses (continued)	Neuroendocrine tumour	**Illnesses that will be considered related** Neuroendocrine tumour **Illnesses that may be considered related** Cancer, Cancer enhancer

STANDARDISED CRITICAL ILLNESS DEFINITIONS OF ASSOCIATION FOR SAVINGS AND INVESTMENT SOUTH AFRICA (ASISA) THAT QUALIFY UNDER THE SEVERE ILLNESS COVER 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. <u>Level D: Stroke with almost full recovery</u> 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	25%

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	50%

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	75%

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 A: Stroke with severe impairment</u> 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%
	The survival period applies to all severities of this illness.	
	Illnesses that will be considered related Carotid Artery Surgery, Stroke **Illnesses that may be considered related** Acquired intellectual or cognitive impairment, Activities of daily living, Arrythmia, Brain surgery, Cavernous sinus thrombosis, Chronic blood disorders, Coma, Dementia (incl Alzheimer's disease), Lifestyle enhancer, Loss of hearing, Loss of sight, Loss of speech, Paralysis, Prolonged mechanical ventilation, Psychiatric disorders, Status epilepticus, Terminal illness	
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.	50%
	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.	50%
	The undergoing of surgery to correct the narrowing of, or blockage to, two coronary arteries by means of a by-pass graft.	75%
	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%

Coronary artery bypass graft (continued)	**The survival period applies to all severities of this illness.** **Illnesses that will be considered related** Arrhythmia, Cardiomyopathy, Coronary artery bypass graft, Heart attack, Heart surgery, Heart transplant **Illnesses that may be considered related** Activities of daily living, Terminal illness	
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: **Sensitive Troponin Markers:**	50%

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.

Definition of ECG changes

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	50%

<table>
<tr>
<td>Heart attack (continued)</td>
<td>

Non-Troponin Markers:

<table>
<tr><th>Marker</th><th>Value</th></tr>
<tr><td>Raised CK-MB mass</td><td>Raised 2 times or more the upper limit of normal laboratory reference range in acute presentation phase.</td></tr>
<tr><td>Total CPK elevation</td><td>Raised 2 times or more the upper limit of normal laboratory reference range in acute presentation phase, with at least 6% being CK-MB.</td></tr>
</table>

Definition of ECG changes:

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.

Definition of new pathological Q-waves:

- 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.

Level B: Heart attack with mild permanent impairment in function

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>

</td>
<td>75%</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></td><td colspan="2">The survival period applies to all severities of this illness.</td></tr>
<tr><td></td><td colspan="2">Illnesses that will be considered related

Arrhythmia, Cardiomyopathy, Coronary artery bypass graft, Heart attack, Heart surgery, Heart transplant

Illnesses that may be considered related

Activities of daily living, Lifestyle enhancer, Terminal illness</td></tr>
</table>

Cancer	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 D - Stage 1 cancer Tiering of prostate cancer • Severity D - Stage 2 (T2, N0, M0 any Gleason) Severity D - Stage 2 (T1a-c, N0, M0 Gleason >7) Exclusions: Stage 1 (T1a, N0, M0, Gleason <4) • Stage 2 (T1a, N0, M0, Gleason 5-6) • Stage 2 (T1b-c, N0, M0 Gleason 2-6) Tiering of leukemia and lymphoma • 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. Tiering of brain tumours • Severity D - WHO grade II without neurological deficit.	25%

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.	50%
	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%
	Illnesses that will be considered related None **Illnesses that may be considered related** Activities of daily living, Bone marrow failure (including severe aplastic anaemia), Brain surgery, Cancer, Cancer Enhancer, Chronic blood disorders, Hematopoietic stem cell (bone marrow) transplant, Non-melanoma skin cancer Stage III or IV, Pancreatectomy, Partial mastectomy, Permanent ileostomy or colostomy, Prolonged mechanical ventilation, Terminal illness, Total colectomy, Total cystectomy, Total penectomy	

SEVERE ILLNESSES THAT QUALIFY UNDER THE CHILD ILLNESS BENEFIT

Body system	Severe Illness	Requirements that the severe illness must meet to qualify	Percentage of the cover amount payable
Activities of daily living	Child-specific catch-all	Any illness, condition or event that results in the insured child having permanent impairment as specified below. Old Mutual's Medical Officer must confirm that: • The insured child has undergone reasonable treatment, and has reached an adequate level of recovery that can reasonably be expected of a person suffering from the illness, condition or event • The insured child 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 child illness under this benefit **Requirements for a claim to be considered** • In the opinion of the treating specialist and as confirmed by our medical officer, the condition has permanently impaired physical and/or mental development to the extent that both the following are met: • At least 35% whole person impairment (WPI) according to the latest edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment • The impairment meets the criteria of a class 4 impairment according to the latest edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment	100%
	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%
Autoimmune	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 • Active rheumatoid arthritis in at least three joints (e.g. fingers, hands, wrists, knees, hips, elbows, shoulders) as evidenced by clinical signs and x-rays **Exclusions** • Reactive arthritis • Psoriatic arthritis	100%

Autoimmune (continued)	Connective tissue disease	Confirmed diagnosis and treatment of one of the following connective tissue diseases by the treating rheumatologist: • Giant cell arteritis • Polyarteritis nodosa • Systemic Scleroderma • Systemic lupus erythematosus • Sarcoidosis • Wegener's granulomatosis **Requirements for a claim to be considered** • Serological markers, or tissue biopsy (as appropriate) confirming diagnosis • All clinical signs must be supported by special investigations • Despite adequate treatment for at least 6 months with high dose steroids, or disease modifying drugs including biologics, the disease remains unresponsive or poorly responsive **Exclusions** • All other connective tissue or auto-immune conditions not specifically listed above • Limited cutaneous systemic sclerosis • Discoid lupus erythematosus or subacute cutaneous lupus erythematosus • Drug-induced lupus erythematosus	100%
	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 joints (e.g. fingers, hands, wrists, knees, hips, elbows, shoulders) as evidenced by clinical signs and x-rays	100%
	Polymyositis	Confirmed diagnosis of polymyositis by the treating specialist. **Requirements for a claim to be considered** • Positive serology findings • Electromyography positive • Supportive biopsy • Clinical confirmation of dysphonia (voice disorders) and dysphagia (difficulty swallowing)	100%

Cancer	Bone marrow failure (including severe aplastic anaemia)	Confirmed diagnosis of complete bone marrow failure by the treating haematologist.
		Requirements for a claim to be considered
		• The bone marrow failure must result in anaemia, neutropenia and thrombocytopenia.
		• The insured person must require a minimum of one of the following treatments:
		  • at least 1 blood transfusion per month for at least 3 months, or
		  • immunosuppressive therapy, or
		  • bone marrow stimulation therapy
		Exclusions
		• All other forms of anaemia and blood disorders
			100%

Cancer (continued)	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 I by the American Joint Committee for Cancer are covered, where the following cancers are only covered as specified:
		
		• Prostate cancer is covered when histologically classified as Gleason score of more than 6, or at least TNM staging T2N0M0
		• Malignant melanoma is covered from T1N0M0
		• Ductal carcinoma in situ (DCIS) of the breast is covered if microinvasion is present
		• Borderline ovarian tumours from Stage I are covered
		• Brain tumours from WHO Grade II are covered
		
		Exclusions
		
		• All cancers which are histologically classified as any of the following:
		  • pre-malignant
		  • non-invasive
		  • cancer in situ, unless specified above
		  • having borderline malignancy, unless specified above
		  • tumours with low malignant potential
		• All prostate cancers, unless conforming to the specifications above
		• All skin cancers, except malignant melanoma as specified above
			100%

	Chronic blood disorders	Confirmed diagnosis of any chronic disorder of the blood by a specialist. **Requirements for a claim to be considered** • Objective evidence of the disorder including clinical records of supportive blood counts or bone marrow biopsies • At least four units of blood or blood products has been transfused per month for at least 3 consecutive months	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%
	Non-melonoma skin cancer Stage III or IV	Confirmed diagnosis of any non-melanoma skin cancer classified as Stage III or IV by the American Joint Committee for Cancer.	100%
	Partial mastectomy	The undergoing of a partial mastectomy for ductal or lobular carcinoma in situ. **Requirements for a claim to be considered** • Histological evidence of ductal or lobular carcinoma in situ • Surgical reports confirming the removal of at least 50% of the affected breast **Exclusions** • Lumpectomy • Quadrantectomy	100%

Cardiovascular	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 NOTE: Branches of the aorta are covered under Artery surgery	100%
		The survival period applies to this illness.	

	Arrhythmia	Confirmed diagnosis of an arrhythmia by the treating cardiologist, with the insertion of a functioning defibrillator.
		
		Requirements for a claim to be considered
		
		• The arrhythmia must be documented on a 24 hour Holter ECG
		• One of the following devices must be surgically implanted:
		  • Implantable Cardioverter-Defibrillator (ICD)
		  • Cardiac Resynchronization Therapy with Defibrillator (CRT-D).
		
		Exclusions
		
		• Pacemaker insertion
		• Pathway ablation
			100%

		The survival period applies to this illness.	

	Artery surgery	One of the following:
		
		• The repair of a narrowing, obstruction, dissection or aneurysm of a specified artery, by means of any surgical technique. This includes keyhole or catheter techniques or bypass grafts. The following arteries are covered:
		  • Subclavian
		  • Brachiocephalic
		  • Splenic
		  • Renal
		  • Iliac
		  • Femoral
		
		• The undergoing of surgery to correct the narrowing of, or blockage to, any artery in the arms, hands legs or feet by means of a bypass graft
		
		Requirements for a claim to be considered:
		
		Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis
			100%

		The survival period applies to this illness.	
	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%
	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%
		The survival period applies to this illness.	

Cardiovascular (continued)	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
		• One 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%

		The survival period applies to this illness.	
	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%
		The survival period applies to this illness.	
	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%
	Heart valve replacement or repair	The undergoing of heart surgery to repair one or more diseased heart valves by means of any minimally invasive surgery. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any investigative procedure	100%
		The survival period applies to this illness.	

Cardiovascular (continued)	Pericardiectomy	The excision of a portion of the pericardium as treatment for a disease affecting the pericardium/pericardial sac, by means of any surgical technique. This includes endoscopic or keyhole procedures. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any investigative procedure	100%
		The survival period applies to this illness.	
	Peripheral arterial disease	Confirmed diagnosis of peripheral arterial disease by the treating vascular surgeon. **Requirements for a claim to be considered** • Abnormal diminished pulse on Doppler readings • Ankle-Brachial index (ABI) <0.9 • Pain as a result of peripheral arterial disease with claudication on minimal exercise lasting less than 10 minutes	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, which could include 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%
	Benign brain tumour	Confirmed diagnosis of a non-malignant tumour or cyst in the brain, cranial nerves or meninges within the skull. This includes pituitary macroadenomas. **Requirements for a claim to be considered** • Supportive imaging and neurological reports, including confirmation of the diagnosis • The tumour has been removed via complete resection, partial resection or is irresectable **Exclusions** • Pituitary microadenomas • Angiomas • Granuloma, hamartoma or malformation of the arteries or veins of the brain	100%

Central nervous system (continued)	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%
	Cavernous sinus thrombosis	Confirmed diagnosis of cavernous sinus thrombosis by the treating specialist. **Requirements for a claim to be considered** • Supportive imaging and neurological reports	100%
		The survival period applies to this illness.	

	Cerebral malaria	Confirmed diagnosis of cerebral malaria by the treating specialist.
		
		Requirements for a claim to be considered
		
		• Supportive blood tests showing malaria infection
		• Admission to ICU for more than 72 hours during which the insured person suffers both of the following:
		  • A coma, with a Glasgow Coma Scale of 8 or less, that lasts more than 6 hours
		  • Epileptic seizures as a complication of the cerebral malaria
			100%

		The survival period applies to this illness.	
	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 96hrs **Exclusions** • Medically induced comas • Comas due to the consumption of alcohol, drugs or medication not used as prescribed	100%
		The survival period applies to this illness.	
	Dementia (including 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%
	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%

Central nervous system (continued)	Multiple sclerosis	Confirmed diagnosis of multiple sclerosis by the treating neurologist. **Requirements for a claim to be considered:** • Magnetic resonance imaging (MRI) showing lesion/s of demyelination in the brain or spinal cord characteristic of multiple sclerosis • At least 2 separate episodes resulting in neurological signs and symptoms must have occurred **Exclusions** • Possible multiple sclerosis and clinically or radiologically isolated syndromes suggestive but not diagnostic of multiple sclerosis	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%
	Myasthenia gravis Class III or higher	Confirmed diagnosis of myasthenia gravis of at least severity Class III (as per the Myasthenia Gravis Foundation of America clinical classification), by the treating neurologist. **Requirements for a claim to be considered** • Supportive electro-diagnostic studies • There must be appropriate evidence, which could include anti–acetylcholine receptor (AChR) antibody (Ab) test positive, or anti-MuSK (muscle-specific kinase) antibody test positive **Exclusions** • Localized ocular myasthenia gravis	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%
		The survival period applies to this illness.	
	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%

Central nervous system (continued)	Parkinson's plus syndrome	Confirmed diagnosis of one of the following Parkinson Plus syndromes by the treating neurologist: • Multiple system atrophy • Progressive supranuclear palsy • Parkinsonism-dementia-amyotrophic lateral sclerosis complex • Corticobasal ganglionic degeneration • Diffuse Lewy body disease • Picks disease • Olivopontocerebellar atrophy **Requirements for a claim to be considered** • Supporting medical and clinical evidence **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%
	Psychiatric disorders	Confirmed diagnosis of a psychiatric disorder 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) • Institutionalisation in a registered psychiatric facility for more than 6 consecutive months with appropriate medical certification • Undergoing of constant 24 supervision, with a permanent caregiver • Global Assessment Function (GAF) score of 40 or less certified under the DSM IV classification, or • WHODAS item-response-theory" (IRT) score of 100 which equals full disability The above must be confirmed by at least two independent psychiatric reports	100%
	Spinal cord tumour	Confirmed diagnosis of a non-malignant tumour or cyst in the spinal cord, spinal nerves or meninges. **Requirements for a claim to be considered** • Supportive imaging and neurological reports, including confirmation of the diagnosis • The tumour has been removed via complete resection, partial resection or is irresectable • The tumour causes permanent neurological deficit. Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months **Exclusions** • Angiomas • Granuloma and hamartoma	100%
	Status epilepticus	An episode of status epilepticus confirmed by the treating neurologist. **Requirements for a claim to be considered** • Supportive imaging and neurological reports • The status epilepticus causes permanent neurological deficit. Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months	100%
		The survival period applies to this illness.	

Central nervous system (continued)	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 neuroimaging investigation and appropriate clinical findings by a specialist neurologist. Stroke as a result of traumatic injury to brain tissue or blood vessels is included. **Exclusions** • Transient ischaemic attack • Vascular disease affecting the eye or optic nerve • Migraine and vestibular disorders	100%
		The survival period applies to this illness.	

Endocrine	Type 1 diabetes	Confirmed diagnosis of type 1 diabetes by the treating paediatric endocrinologist or endocrinologist, according to the latest World Health Organisation criteria.
		
		Requirements for a claim to be considered
		
		• The diagnosis must be confirmed by the presence of at least 3 of the following:
		  • Anti-GAD65 antibody levels indicative of type 1 diabetes
		  • Islet-cell antibody levels indicative of type 1 diabetes
		  • C-peptide levels indicative of type 1 diabetes
		  • Insulin levels indicative of type 1 diabetes
		
		Exclusions
		
		• Type 2 diabetes requiring insulin
		• Gestational Diabetes
			100%

Gastrointestinal	Acute kidney failure	A single episode of acute kidney failure requiring six or more treatments of haemodialysis. **Requirements for a claim to be considered** • Confirmation of acute kidney failure by the treating nephrologist • Blood tests supporting diagnosis • Evidence of number of haemodialysis treatments **Exclusions** • Any acute failure caused by the consumption of alcohol, drugs or medication not used as prescribed	100%

	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:
		  • Chronic renal disease with an estimated Glomerular Filtration Rate (GFR) ≤ 40ml/min
		  • Chronic renal disease with creatinine clearance of ≤ 55ml/min, with clinically significant progressive renal function decline as confirmed by 3 renal function (creatinine clearance) measurements in a 12 month period
			100%

	Chronic liver failure	Confirmed diagnosis of progressive chronic 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 A **Exclusions** • Liver disease caused by the consumption of alcohol, drugs or medication not used as prescribed	100%

Gastrointestinal (continued)	Chronic pancreatitis	Confirmed diagnosis of chronic pancreatitis by the treating gastroenterologist or equivalent specialist. **Requirements for a claim to be considered** • Supportive clinical, laboratory and histological evidence • Malabsorption syndrome caused by exocrine pancreatic insufficiency • Impaired glucose metabolism caused by endocrine pancreatic insufficiency **Exclusions** • Pancreatic disease caused by the consumption of alcohol, drugs or medication not used as prescribed	100%
	Crohn's disease with specified surgery	Confirmed diagnosis of Crohn's disease by the treating gastroenterologist or equivalent specialist. **Requirements for a claim to be considered** • Supportive colonoscopy and histopathology findings • Despite adequate treatment for at least 6 consecutive months with diet, disease modifying drugs or immuno-modulators, the disease remains unresponsive or poorly responsive • The complications have resulted in at least one surgical intervention other than for diagnostic purposes	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%
	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%
	Permanent ileostomy or colostomy	Any organic disease or severe physical injury that results in a colostomy or ileostomy which is intended to be permanent. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any temporary ostomy procedure	100%

Gastrointestinal (continued)	Total colectomy	Any organic disease or severe physical injury that results in a total colectomy, where the entire colon is removed and the small intestine is connected to the rectum. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Partial colectomy • Segmental colectomy • Partial bowel resection	100%
	Total cystectomy	Any organic disease or severe physical injury that results in a total cystectomy, which is the surgical removal of the entire bladder with the reconstruction of a ileal conduit or neo-bladder. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Partial cystectomy	100%
	Total penectomy	Any organic disease or severe physical injury that results in total amputation of the penis (total penectomy) with the surgical construction of a perineal urethrostomy. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon **Exclusions** • Partial penectomy • Surgery due to gender dysphoria • Circumcision or any complications thereof	100%
	Ulcerative colitis	Confirmed diagnosis of ulcerative colitis disease by the treating gastroenterologist. **Requirements for a claim to be considered** • Supportive colonoscopy and histopathology findings • Despite adequate treatment for at least 6 consecutive months with diet, disease modifying drugs or immuno-modulators, the disease remains unresponsive or poorly responsive • The complications have resulted in at least one surgical intervention other than for diagnostic purposes	100%
HIV/AIDS	Accidental HIV for medical, dental or nurse practitioners	Infection with the human immunodeficiency virus (HIV) as a result of an accident while carrying out occupational duties of a medical, dental or nurse practitioner. For the purpose of this illness an accident is defined as an external, unexpected event that is not traceable, even indirectly, to the insured person's state of mental or physical health before the event. **Requirements for a claim to be considered** • The insured person must be registered as a medical or dental practitioner with the Health Professions Council of Namibia (HPCN) or as a member of the Namibian Nursing Council (NNC). Registered dental assistants and oral hygienists are also included • A supportive HIV antibody test must be taken within 48 hours after the accident, and the result must be negative • Proof that the health care institution's written protocol was followed, including the use of post-exposure prophylaxis drugs • Confirmed evidence of seroconversion to HIV must occur within 3 months of the accident	100%

HIV/AIDS (continued)	Accidental HIV via a blood transfusion	Infection with the human immunodeficiency virus (HIV) by infected blood received in a blood transfusion. **Requirements for a claim to be considered** • A recognised institution in the Republic of South Africa or Republic of Namibia must have performed the transfusion • The institution that provided the infected blood must admit liability • Confirmed evidence of seroconversion to HIV must occur within 3 months of the affected blood transfusion	100%
	Accidental HIV via a road traffic accident	Infection with the human immunodeficiency virus (HIV) as a result of involvement in, or assistance at the scene of, a road traffic accident. **Requirements for a claim to be considered** • The event must have been reported to the Namibian Police (NAMPOL) and a case number issued and/or criminal case opened • A medical examination must have been performed within 24 hours after the event • A supportive HIV antibody test must be taken within 48 hours after the accident, and the result must be negative • Confirmed evidence of seroconversion to HIV must occur within 3 months of the event	100%
	Accidental HIV via an organ transplant	Infection with the human immunodeficiency virus (HIV) by an infected organ received in an organ transplant. **Requirements for a claim to be considered** • A recognised institution in the Republic of South Africa or Republic of Namibia must have performed the transplant • The institution that provided the infected organ must admit liability • Confirmed evidence of seroconversion to HIV must occur within 3 months of the organ transplant	100%
	Accidental HIV via violent crime, rape or indecent assault	Infection with the human immunodeficiency virus (HIV) as a result of being a victim of a violent crime, rape or an indecent assault. **Requirements for a claim to be considered** • The event must have been reported to the Namibian Police (NAMPOL) and a case number issued and/or criminal case opened • A medical examination must have been performed within 24 hours after the event • A supportive HIV antibody test must be taken within 48 hours after the event, and the result must be negative • Confirmed evidence of seroconversion to HIV must occur within 3 months of the event	100%
	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 ≤50% predicted
		  • FVC (forced vital capacity) of ≤50% predicted
		  • DLCO (diffusing capacity of the lungs for carbon monoxide) of ≤50% predicted
			100%

	Lung surgery	The undergoing of surgery to remove more than one lobe of the lung due to any physical injury or disease. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	100%
		The survival period applies to this illness.	
	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%

	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
		• This illness will only be considered if the insured person does not qualify for a payment for any other listed severe illness under this benefit
		• The survival period applies from the date this definition has been met
			100%

		The survival period applies to this illness.	
	Pulmonary arterial hypertension	Confirmed diagnosis of pulmonary hypertension by the treating specialist. **Requirements for a claim to be considered** • Mean pulmonary artery pressure of between 25-40 mmHg at rest, measured by right heart catheterisation • Marked limitation in activity due to symptoms, even during less-than-ordinary activity, e.g. walking short distances (New York Heart Association (NYHA) Class III heart failure). Symptoms must be present for a continuous period of at least 3 months	100%

Respiratory (continued)	Pulmonary artery surgery	The undergoing of surgery to the pulmonary artery through surgically opening the chest cavity (thoracotomy or sternotomy). There must be excision and replacement of a portion of the diseased pulmonary artery with a graft. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any investigative procedure • Any other surgical procedure, e.g. the insertion of stents or endovascular repair	100%
		The survival period applies to this illness.	
	Recurrent pulmonary emboli	The undergoing of a veno-caval filter insertion to treat recurrent pulmonary embolism. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any investigative procedure	100%
		The survival period applies to this illness.	
Senses	Enucleation of the eye	The enucleation of one eye, which results from either trauma or the surgical treatment of an organic disease. **Requirements for a claim to be considered** • Confirmation by the treating specialist with supportive evidence	100%
	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 70-89 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 6/30 or worse (or equivalent measure on a non-metric scale) in each eye, after best correction
		  • A visual field loss to a 20° radius, after best correction
		  • Severe non-proliferative diabetic retinopathy
		  • Grade III hypertensive retinopathy
		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%

Senses (continued)	Retinitis pigmentosa	Confirmed diagnosis of retinitis pigmentosa by the treating ophthalmologist. **Requirements for a claim to be considered** • Supporting Electroretinogram (ERG) • Supporting visual field tests	100%
Trauma	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 insured child's state of mental or physical health before the event	100%
		The survival period applies to this illness.	
	Accidental brain injury	Death of brain tissue due to traumatic injury as a result of an accident resulting in neurological deficit lasting longer than 24 hours, confirmed by neuroimaging investigation and appropriate clinical findings by a specialist neurologist. **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 insured person's state of mental or physical health before the event	100%
		The survival period applies to this illness.	
	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 insured child's state of mental or physical health before the event	100%
		The survival period applies to this illness.	
	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%
		The survival period applies to this illness.	
	Dog bites	The undergoing of facial plastic surgery under general anaesthesia to treat a dog bite to the face. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	100%
		The survival period applies to this illness.	

Trauma (continued)	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 10% of total body surface affected, as measured on the Lund and Browder Chart or equivalent
		  • 20% 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%

		The survival period applies to this illness.	

CONGENITAL BIRTH DEFECTS THAT QUALIFY UNDER THE CHILD ILLNESS BENEFIT

Body system	Congenital birth defect	Requirements that the congenital birth defect must meet to qualify	Percentage of the cover amount payable
Congenital birth defects	Achondroplasia	The undergoing of surgery to treat complications of achondroplasia. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
		The survival period applies to this illness.	
	Anal atresia	The undergoing of surgery to correct anal atresia. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
		The survival period applies to this illness.	
	Autosomal recessive polycystic kidney disease	Confirmed diagnosis of autosomal recessive polycystic kidney disease by the treating specialist. **Requirements for a claim to be considered** • Supportive genetic tests	100%
		The survival period applies to this illness.	
	Biliary atresia	Confirmed diagnosis of biliary atresia by the treating specialist. **Requirements for a claim to be considered** • Supportive imaging and blood tests	100%
		The survival period applies to this illness.	
	Brain and skull disorders	Confirmed diagnosis of one of the following disorders by the treating specialist: • Microcephaly • Hydrocephaly • Craniostenosis • Craniosynostosis **Requirements for a claim to be considered** • Supportive imaging and blood tests • The disorder results in severe neurological deficit	100%
		The survival period applies to this illness.	

	Cerebral palsy	Confirmed diagnosis of cerebral palsy by the treating specialist.
		Requirements for a claim to be considered
		• One of the following must be present for at least 6 months:
		  • Spastic diplegia
		  • Spastic hemiplegia
		  • Spastic quadriplegia
			100%

		The survival period applies to this illness.	

Congenital birth defects (continued)	Choanal atresia	The undergoing of surgery to correct choanal atresia. **Requirements for a claim to be considered** • The complications have resulted in at least two surgical interventions, on two separate occasions, other than for diagnostic purposes • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
		The survival period applies to this illness.	
	Cleft lip and complete cleft palate	Confirmed diagnosis of cleft lip and complete cleft palate (hard and soft palate) by the treating specialist.	50%
		The survival period applies to this illness.	
	Clubbed feet (talipes)	The undergoing of surgery to correct a clubbed foot. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	25%
		The undergoing of surgery to correct bilateral clubbed feet. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
		The survival period applies to this illness.	
	Congenital blindness	Confirmed diagnosis of total visual loss in one eye at birth by the treating specialist. **Requirements for a claim to be considered** • Supportive clinical evidence	50%
		Confirmed diagnosis of total visual loss in both eyes at birth by the treating specialist. **Requirements for a claim to be considered** • Supportive clinical evidence	100%
		The survival period applies to this illness.	
	Congenital deafness	Confirmed diagnosis of total hearing loss in one ear at birth by the treating specialist. **Requirements for a claim to be considered** • Supportive clinical evidence using the Automated Otoacoustic Emission Test or the Automated Brainstem Response Test (or equivalent measure)	50%
		Confirmed diagnosis of total hearing loss in both ears at birth by the treating specialist. **Requirements for a claim to be considered** • Supportive clinical evidence using the Automated Otoacoustic Emission Test or the Automated Brainstem Response Test (or equivalent measure)	100%
		The survival period applies to this illness.	

Congenital birth defects (continued)	Congenital heart disease	The correction of any congenital structural abnormality of the heart, through any minimally invasive surgery. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any investigative procedure • Patent ductus arteriosus	50%
		The correction of any congenital 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	100%
		The survival period applies to this illness.	
	Congenital hip dislocation	The undergoing of surgery to correct congenital unilateral hip dislocation. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	25%
		The undergoing of surgery to correct congenital bilateral hip dislocation. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
		The survival period applies to this illness.	
	Cystic fibrosis	Confirmed diagnosis of cystic fibrosis by the treating specialist. **Requirements for a claim to be considered** • A diagnostic sweat test • Pulmonary complications (e.g. recurrent pneumonia, suppurative lung disease, lung abscesses) confirmed by radiological investigations	100%
		The survival period applies to this illness.	
	Down syndrome	Confirmed diagnosis of Down syndrome by the treating specialist. **Requirements for a claim to be considered** • Supportive genetic tests	100%
		The survival period applies to this illness.	

Congenital birth defects (continued)	Duchenne syndrome or congenital myotonic dystrophy	Confirmed diagnosis of one of the following by the treating specialist: • Duchenne muscular dystrophy • Congenital myotonic muscular dystrophy (MMD 1) **Requirements for a claim to be considered** For Duchenne muscular dystrophy: • Evidence of clinical symptoms • Raised creatine kinase • Muscle biopsy with abnormal levels of dystrophin protein For congenital myotonic muscular dystrophy: • Supportive genetic tests	100%
		The survival period applies to this illness.	

	Haemophilia	Confirmed diagnosis of haemophilia by the treating haematologist.
		Requirements for a claim to be considered
		• Despite adequate treatment for at least 6 consecutive months, both of the following are present:
		  • 1% of the normal clotting factor in the blood
		  • At least four units of blood or blood products has been transfused per month for at least 3 consecutive months
			50%

		The survival period applies to this illness.	
	Hirschsprung's disease	Confirmed diagnosis of Hirschsprung's disease by the treating specialist. **Requirements for a claim to be considered** • Full-thickness rectal biopsy	50%
		The survival period applies to this illness.	
	Hydrocephalus	The surgical insertion of a shunt to treat congenital hydrocephalus. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
		The survival period applies to this illness.	
	Hypospadias	The undergoing of surgery to treat hypospadias in a male child. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
		The survival period applies to this illness.	
	Inborn metabolic disorders	Confirmed diagnosis of one of the following inborn errors of metabolism by the treating specialist: • Gaucher's disease • Glycogen storage disease • Tay Sachs Disease • Mucopolysaccharidosis **Requirements for a claim to be considered** • Supportive laboratory tests	100%
		The survival period applies to this illness.	
	Klinefelter's syndrome	Confirmed diagnosis of Klinefelter's syndrome by the treating specialist. **Requirements for a claim to be considered** • Supportive genetic tests	25%
		The survival period applies to this illness.	

Congenital birth defects (continued)	Myelomeningocele	Confirmed diagnosis of myelomeningocele by the treating specialist. **Requirements for a claim to be considered** • Supportive imaging and blood tests	100%
		The survival period applies to this illness.	
	Necrotising enterocolitis	The undergoing of surgery to treat necrotising enterocolitis. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
		The survival period applies to this illness.	
	Neurodevelopmental disorders	Confirmed diagnosis of one of the following developmental disorders of the by the treating specialist: • Symptomatic Rett syndrome with a MECP2 mutation • Symptomatic fragile X syndrome with a FMR1 mutation • Symptomatic tuberous sclerosis with a TSC2 mutation • Symptomatic neurofibromatosis **Requirements for a claim to be considered** • Supportive genetic tests • Supportive clinical evidence	100%
		The survival period applies to this illness.	
	Tracheooesophageal fistula or oesophageal atresia	Confirmed diagnosis of a tracheo-oesophageal fistula or oesophageal atresia by the treating specialist. **Requirements for a claim to be considered** • Supportive imaging and blood tests • Pulmonary complications (e.g. recurrent pneumonia, suppurative lung disease, lung abscesses) confirmed by radiological investigations	50%
		The survival period applies to this illness.	

STANDARDISED CRITICAL ILLNESS DEFINITIONS OF ASSOCIATION FOR SAVINGS AND INVESTMENT SOUTH AFRICA (ASISA) THAT QUALIFY UNDER THE CHILD ILLNESS 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	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%

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: **Sensitive Troponin Markers:**	100%

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.
	
	Definition of ECG changes
	
	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.	

Cancer	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.
		100%

SEVERE ILLNESSES THAT QUALIFY UNDER THE MILD ILLNESS BENEFIT

Body system	Severe Illness	Requirements that the severe illness must meet to qualify	Percentage of the cover amount payable
Cardiovascular	Angioplasty and/or stenting	The undergoing of angioplasty and/or the insertion of one or more stents to correct the narrowing of, or blockage to, one or more arteries. Coronary, carotid and peripheral arteries are included. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	30%
		The survival period applies to this illness.	
		Previous illnesses under the Severe Illness Cover Benefit that will be considered related Arrhythmia, Cardiomyopathy, Carotid artery surgery, Coronary artery bypass graft, Heart attack, Heart surgery, Heart transplant **Previous illnesses under the Severe Illness Cover Benefit that may be considered related** Artery surgery	
		Illnesses that will be considered related Angioplasty and/or stenting **Illnesses that may be considered related** Pacemaker insertion, Pathway ablation	
	Minor heart surgery	The correction of any structural abnormality of the heart, through an endoscopic or keyhole procedure. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Any investigative procedure	30%
		Previous illnesses under the Severe Illness Cover Benefit that will be considered related Arrhythmia, Cardiomyopathy, Coronary artery bypass graft, Heart attack, Heart surgery, Heart transplant, Heart valve replacement or repair, Pericardiectomy **Previous illnesses under the Severe Illness Cover Benefit that may be considered related** None	
		Illnesses that will be considered related Minor heart surgery **Illnesses that may be considered related** Pacemaker insertion	
	Pacemaker insertion	Confirmed diagnosis of an arrhythmia by the treating cardiologist, with the permanent insertion of a medically necessary, functioning pacemaker. **Requirements for a claim to be considered** • The arrhythmia must be documented on a 24 hour Holter ECG	30%

Cardiovascular (continued)	Pacemaker insertion	**The survival period applies to this illness.**	
		Previous illnesses under the Severe Illness Cover Benefit that will be considered related Arrhythmia, Cardiomyopathy, Coronary artery bypass graft, Heart attack, Heart surgery, Heart transplant, Heart valve replacement or repair **Previous illnesses under the Severe Illness Cover Benefit that may be considered related** None	
		Illnesses that will be considered related Pacemaker insertion, Pathway ablation **Illnesses that may be considered related** Angioplasty and/or Stenting, Minor heart surgery	
	Pathway ablation	Confirmed diagnosis of an arrhythmia by the treating cardiologist, with the undergoing of pathway ablation. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	30%
		The survival period applies to this illness.	
		Previous illnesses under the Severe Illness Cover Benefit that will be considered related Arrhythmia, Cardiomyopathy, Coronary artery bypass graft, Heart attack, Heart surgery, Heart transplant, Heart valve replacement or repair **Previous illnesses under the Severe Illness Cover Benefit that may be considered related** None	
		Illnesses that will be considered related Pacemaker insertion, Pathway ablation **Illnesses that may be considered related** Angioplasty and/or stenting	
Central nervous system	Bacterial meningitis	Confirmed diagnosis of bacterial meningitis by the treating neurologist, causing inflammation of the membranes of the brain or spinal cord. **Requirements for a claim to be considered** • Growth of pathogenic bacteria from cerebrospinal fluid culture • ICU admission for more for more than 72 hours **Exclusions** • All other forms of meningitis, including aseptic, viral, parasitic or non-infectious meningitis	30%
		The survival period applies to this illness.	
		Illnesses that will be considered related Bacterial meningitis **Illnesses that may be considered related** Eye stroke, Minor stroke, Moderate loss of hearing	
	Cerebral aneurysm	The repair of a cerebral aneurysm by means of any surgical technique. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	30%

Central nervous system (continued)	Cerebral aneurysm	**The survival period applies to this illness.**	
		Previous illnesses under the Severe Illness Cover Benefit that will be considered related None **Previous illnesses under the Severe Illness Cover Benefit that may be considered related** Coma, Stroke	
		Illnesses that will be considered related Cerebral aneurysm **Illnesses that may be considered related** Eye stroke, Minor stroke	
	Cerebral arteriovenous malformation	The repair of a cerebral arteriovenous malformation by means of endovascular treatment using coils or other materials (embolisation). **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	30%
		Illnesses that will be considered related Cerebral arteriovenous malformation **Illnesses that may be considered related** Eye stroke, Minor stroke	
	Encephalitis	Confirmed diagnosis of viral encephalitis by the treating neurologist. **Requirements for a claim to be considered** • Typical clinical symptoms and cerebrospinal fluid findings • ICU admission for more for more than 72 hours **Exclusions** • Encephalitis caused by bacterial or protozoal infections • Myalgic or paraneoplastic encephalomyelitis • Encephalitis caused by a pandemic virus	30%
		The survival period applies to this illness.	
		Illnesses that will be considered related Encephalitis **Illnesses that may be considered related** Minor stroke	

	Eye stroke	Confirmed diagnosis of loss of sight in one eye by the treating ophthalmologist, as a result of central retinal artery or vein occlusion or haemorrhage. 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), after best correction
		  • A visual field loss to a 10° radius, after best correction
		
		Exclusions
		
		• Occlusion or haemorrhage in any branches of the retinal artery or vein
		• Visual loss as a result of traumatic injury
			30%

Central nervous system (continued)	Eye stroke	**Previous illnesses under the Severe Illness Cover Benefit that will be considered related** None **Previous illnesses under the Severe Illness Cover Benefit that may be considered related** Retinitis pigmentosa, Stroke	
		Illnesses that will be considered related Eye stroke **Illnesses that may be considered related** Minor stroke	

	Guillain Barre syndrome with incomplete recovery	Confirmed diagnosis of Guillain Barre syndrome by the treating specialist. The symptoms required below should persist despite adequate treatment for at least 6 weeks.
		
		Requirements for a claim to be considered
		
		• Objective laboratory findings
		• Two of the following must be present:
		  • Motor paralysis- life covered is unable to stand or walk on their own without an aid despite reasonable strength
		  • Cranial nerves III-VII or IX-XII involvement
		  • Sensory changes
		  • Autonomic changes
		  • Respiratory involvement
			30%

		Previous illnesses under the Severe Illness Cover Benefit that will be considered related None **Previous illnesses under the Severe Illness Cover Benefit that may be considered related** Prolonged mechanical ventilation	
		Illnesses that will be considered related Guillain Barre syndrome with incomplete recovery **Illnesses that may be considered related** None	
	Minor stroke	Death of brain tissue due to inadequate blood supply or haemorrhage within the skull. **Requirements for a claim to be considered** • Neurological deficit lasting longer than 1 hour but less than 24 hours, confirmed by neuroimaging investigation and appropriate clinical findings by a specialist neurologist	30%
		Previous illnesses under the Severe Illness Cover Benefit that will be considered related Arrhythmia, Cardiomyopathy, Carotid artery surgery, Cavernous sinus thrombosis, Heart transplant, Heart valve replacement or repair, Stroke **Previous illnesses under the Severe Illness Cover Benefit that may be considered related** Accidental brain injury, Benign brain tumour, Brain surgery, Cerebral malaria, Chronic blood disorders, Coma , Dementia (incl Alzheimer's disease), Multiple sclerosis, Paralysis, Parkinson's disease, Parkinson's plus syndrome, Psychiatric disorders, Status epilepticus	

Central nervous system (continued)	Minor stroke	**Illnesses that will be considered related** Minor stroke **Illnesses that may be considered related** Eye stroke, Moderate loss of hearing	
Endocrine	Cushing's disease	Confirmed diagnosis of primary Cushing's disease by the treating endocrinologist. **Requirements for a claim to be considered** • Supportive blood tests **Exclusions** • Exogenous or secondary Cushings's syndrome	30%
		Illnesses that will be considered related Cushing's disease **Illnesses that may be considered related** None	
	Nephrectomy	Any organic disease or severe physical injury that results in a total or partial nephrectomy. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Nephrectomy resulting from analgesic nephropathy • Nephrectomy done for donor purposes	30%
		Previous illnesses under the Severe Illness Cover Benefit that will be considered related Chronic kidney failure, Kidney transplant **Previous illnesses under the Severe Illness Cover Benefit that may be considered related** Acute kidney failure, Cardiomyopathy, Cancer, Chronic blood disorders, Chronic liver failure, Connective tissue disease, Dementia (incl Alzheimer's disease), Peripheral arterial disease, Polymyositis	
		Illnesses that will be considered related Nephrectomy **Illnesses that may be considered related** None	

	Type 1 diabetes	Confirmed diagnosis of type 1 diabetes by the treating paediatric endocrinologist or endocrinologist, according to the latest World Health Organisation criteria.
		
		Requirements for a claim to be considered
		
		• The diagnosis must be confirmed by the presence of at least 3 of the following:
		  • Anti-GAD65 antibody levels indicative of type 1 diabetes
		  • Islet-cell antibody levels indicative of type 1 diabetes
		  • C-peptide levels indicative of type 1 diabetes
		  • Insulin levels indicative of type 1 diabetes
		
		Exclusions
		
		Type 2 diabetes requiring insulin
		
		Gestational Diabetes
			30%

Endocrine (continued)	Type 1 diabetes	**Previous illnesses under the Severe Illness Cover Benefit that will be considered related** None **Previous illnesses under the Severe Illness Cover Benefit that may be considered related** Advanced rheumatoid arthritis, Connective tissue disease, Polymyositis, Chronic pancreatitis, Pancreatectomy or pancreas transplant	
		Illnesses that will be considered related Type 1 diabetes **Illnesses that may be considered related** None	
Respiratory	Lobectomy	The undergoing of a lobectomy to remove one entire lobe of the lung due to any physical injury or disease. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** • Segmentectomy, irrespective of how many lobes affected	30%
		The survival period applies to this illness.	
		Previous illnesses under the Severe Illness Cover Benefit that will be considered related Lung transplant, Lung surgery **Previous illnesses under the Severe Illness Cover Benefit that may be considered related** None	
		Illnesses that will be considered related Lobectomy **Illnesses that may be considered related** Pulmonary embolism	
	Pulmonary embolism	Confirmed diagnosis of pulmonary embolism by the treating specialist. **Requirements for a claim to be considered** • Supportive imaging	30%
		The survival period applies to this illness.	
		Previous illnesses under the Severe Illness Cover Benefit that will be considered related Pulmonary arterial hypertension, Pulmonary artery surgery, Recurrent pulmonary emboli **Previous illnesses under the Severe Illness Cover Benefit that may be considered related** Chronic respiratory failure, Lung surgery, Prolonged mechanical ventilation	
		Illnesses that will be considered related Pulmonary Embolism **Illnesses that may be considered related** Lobectomy	

Senses	Moderate loss of hearing	Confirmed diagnosis of loss of hearing in one ear 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 affected ear using a pure tone audiogram, of 70 decibels or more • This must be confirmed by audiometry, which may be conducted without hearing aids	30%
		Previous illnesses under the Severe Illness Cover Benefit that will be considered related Loss of hearing **Previous illnesses under the Severe Illness Cover Benefit that may be considered related** None	
		Illnesses that will be considered related Moderate loss of hearing **Illnesses that may be considered related** Minor stroke	

Trauma	Less extensive 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 5% of total body surface affected, as measured on the Lund and Browder Chart or equivalent
		  • 10% 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
			30%

		Previous illnesses under the Severe Illness Cover Benefit that will be considered related None **Previous illnesses under the Severe Illness Cover Benefit that may be considered related** Major burns, Paralysis, Prolonged mechanical ventilation	
		Illnesses that will be considered related None **Illnesses that may be considered related** Less extensive burns	

Trauma (continued)	Trauma	Hospitalisation, ICU admission or surgery that results from a severe physical injury inflicted in an accident.
		
		Requirements for a claim to be considered
		
		• One of the following must be present:
		  • The accident results in hospitalisation within 1 day, for at least 28 consecutive days
		  • The accident results in ICU admission for 7 consecutive days or more, during which assisted ventilation is instituted for at least 4 days
		  • The accident results in multiple traumatic injuries and surgical intervention in at least 2 of the following body regions:
		  • head or neck
		  • face
		  • chest
		  • abdominal or pelvic contents
		  • extremities or pelvic girdle
		
		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 insured person's state of mental or physical health before the event
		• A day is defined as 24 hours
			30%

		The survival period applies to this illness.	
		Illnesses that will be considered related None **Illnesses that may be considered related** Trauma	

SEVERE ILLNESSES THAT QUALIFY UNDER THE FOR WOMEN BENEFIT

Body system	Severe Illness	Requirements that the severe illness must meet to qualify	Percentage of the cover amount payable
Cancer	Prophylactic bilateral mastectomy	The undergoing of a bilateral mastectomy, at the recommendation of the treating specialist. **Requirements for a claim to be considered** • BRCA1 or BRCA2 mutation must be present • Relevant surgical reports by the treating surgeon	25%
Complications during pregnancy	Amniotic fluid embolism	Confirmed diagnosis of amniotic fluid embolism by the treating specialist. **Requirements for a claim to be considered** • A blood transfusion of at least 1 unit • ICU admission for at least 24 hours **Exclusions** Women are not covered after their 40th birthday	50%
		The survival period applies to this illness.	
	Antepartum haemorrhage	Confirmed diagnosis of abruptio placenta or placenta praevia by the treating specialist. **Requirements for a claim to be considered** • The gestational age must be at least 28 weeks, as confirmed by objective imaging • A blood transfusion of at least 1 unit **Exclusions** Women are not covered after their 40th birthday	25%
		The survival period applies to this illness.	
	Disseminated intravascular coagulopathy	Confirmed diagnosis of acute diffuse intravascular coagulation by the treating specialist. This may occur during pregnancy or in the 6 week post-partum period. **Requirements for a claim to be considered** • A blood transfusion of at least 1 unit • Supportive blood tests	50%
		The survival period applies to this illness.	

	Eclampsia	Confirmed diagnosis of severe pre-eclampsia by the treating specialist. This may occur during pregnancy or in the 6 week post-partum period.
		Requirements for a claim to be considered
		• At least three of the following must be present:
		  • Systolic blood pressure > 160 mm Hg
		  • Diastolic blood pressure > 110 mm Hg
		  • Proteinuria (24 h - urine containing > 3 g protein)
		  • Oedema
			25%

		Confirmed diagnosis of eclampsia by the treating specialist. This may occur during pregnancy or in the 6 week post-partum period. **Requirements for a claim to be considered** • New onset seizures (convulsions) or a coma, with a Glasgow Coma Scale of 8 or less that lasts more than 6 hours, due to eclampsia	50%
		The survival period applies to this illness.	

Complications during pregnancy (continued)	Ectopic pregnancy	The undergoing of surgery as a result of ectopic pregnancy. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	25%
	Miscarriage due to diagnostic procedures	Confirmed foetal loss that results within 72 hours from the performance of medically indicated amniocentesis or chorionic villus sampling. **Exclusions** Foetal loss as a result of any other condition, injury or cause	25%
		The survival period applies to this illness.	

	Postpartum haemorrhage	Confirmed diagnosis of postpartum haemorrhage by the treating specialist.
		Requirements for a claim to be considered
		• One of the following must be present:
		  • ICU admission for at least 72 hours
		  • The diagnosis of Sheehan's syndrome, supported by blood tests and a MRI scan
			50%

		The survival period applies to this illness.	
	Severe vaginal tearing	• The repair of a recto-vaginal fistula due to third- or fourth-degree vaginal tears during childbirth, by means of any surgical technique. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
		The survival period applies to this illness.	
	Stillbirth	Confirmed foetal loss due to natural causes or unintentional trauma. **Requirements for a claim to be considered** • The gestational age must be at least 26 weeks, as confirmed by objective imaging	25%
		The survival period applies to this illness.	
	Uterine rupture	The undergoing of an emergency hysterectomy for acute rupture of the uterus during vaginal delivery. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
		The survival period applies to this illness.	
Fertility-related	Endometriosis stage III or IV	The undergoing of a hysterectomy for endometriosis Stage III or higher. Staging is per the revised classification of the American Society of Reproductive Medicine. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	15%
	Multi-fibroid uterus	The undergoing of a hysterectomy for uterine fibroids. **Requirements for a claim to be considered** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions** Women are not covered after their 40th birthday	15%

Fertility-related (continued)	Premature ovarian failure	Confirmed diagnosis of premature ovarian failure by the treating specialist. **Requirements for a claim to be considered** • Amenorrhea, hypoestrogenism, and elevated serum gonadotropin levels **Exclusions** Women are not covered after their 40th birthday	15%
	Prophylactic bilateral oophorectomy	The undergoing of a bilateral oophorectomy, at the recommendation of the treating specialist. **Requirements for a claim to be considered** • BRCA1 or BRCA2 mutation must be present • Relevant surgical reports by the treating surgeon	15%

FUNCTIONAL IMPAIRMENTS THAT QUALIFY UNDER THE DISABILITY 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 requirements which need to be permanent and irreversible, 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%
	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 requirements which need to be permanent and irreversible: • 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%
	Hypertension	The diagnosis of uncontrolled hypertension confirmed by a medical specialist. With evidence of diastolic pressure permanently greater than or equal to 110mmHg on adequate treatment and complicated by 2 or more of the following requirements which need to be permanent and irreversible: • 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%
	Peripheral Arterial Disease	The diagnosis of peripheral arterial disease of the lower limbs by a vascular surgeon. With evidence of a permanently absent pulse on Doppler readings, and 1 of the following requirements which need to be permanent and irreversible: • Severe Vascular Ulceration, or • Gangrene secondary to peripheral arterial disease.	100%
Respiratory	Chronic Respiratory Failure	The diagnosis of a chronic respiratory failure by a pulmonologist. With evidence of at least 1 of the following requirements which need to be permanent and irreversible: • 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%

Respiratory (continued)	Pulmonary Arterial Hypertension	The diagnosis of pulmonary hypertension by a medical specialist. With evidence of a permanent Systolic Pulmonary Artery Pressure greater than 70mmHg and complicated by at least 1 of the following requirements which need to be permanent and irreversible: • Right sided heart failure, or • Shortness of breath so severe that symptoms are present at rest (NYHA Class IV).	100%
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%
	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 requirements which need to be permanent and irreversible: • 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%
	Chronic Liver Failure	The diagnosis of permanent and irreversible chronic end-stage liver failure, with a Child Pugh Classification of class C, by a gastroenterologist or equivalent specialist.	100%
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 requirements which need to be permanent and irreversible: • 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 requirements which need to be permanent and irreversible: • 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%
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%

Central Nervous System (continued)	Aphasia	The diagnosis of aphasia by a neurologist or neurosurgeon. With evidence of the following requirements which need to be permanent and irreversible: • 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 VII	The diagnosis of facial nerve paralysis confirmed by a neurologist or neurosurgeon. With evidence of the following requirements which need to be permanent and irreversible: • Slight or no movement of the face, and • An inability to actively close the eyelids, and • Slight or no movement of the mouth.	100%
	Cranial Nerve VIII	The diagnosis of Vestibulocochlear nerve paralysis confirmed by a neurologist or neurosurgeon. With evidence of the following requirements which need to be permanent and irreversible: • Nerve damage with severe imbalance resulting in limitation of activities of daily living such that the insured person is permanently unable to perform 3 of the Basic Activities of Daily Living or 4 of the Advanced Activities of Daily Living.	100%
	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 requirements which need to be permanent and irreversible: • An inability to swallow or process oral secretions without choking, and • Need for external suctioning device, and • Medical findings confirming organic disease.	100%
	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 requirements which need to be permanent and irreversible: • 3 or more generalised seizures per week, and • An inability to perform 3 of the Basic Activities of Daily Living or 4 of the Advanced Activities of Daily Living.	100%
	Hemiplegia	The total and permanent 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%
	Dementia (incl. Alzheimer's Disease)	The diagnosis of dementia by a neurologist, physician or neurosurgeon With evidence of the following requirements which need to be permanent and irreversible: • 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%

Central Nervous System (continued)	Paraplegia / Diplegia	The total and permanent 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 and permanent 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 requirements which need to be permanent and irreversible: • 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 total and permanent 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%
	Loss of hearing	Total and permanent 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%
	Loss of speech	The total and permanent 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%

Endocrine	Endocrine Disorders	The diagnosis of an endocrine disorder, which despite adequate medical and surgical treatment, has resulted in permanent 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 permanent institutionalisation and with evidence of the following: • permanent GAF score of 40 or less certified under the DSM IV classification, or • permanent WHODAS average domain score of 4 certified under the DSM 5 classification	100%
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%
Haematology	Clotting Disorders	The diagnosis of a clotting disorder, which despite adequate medical and surgical treatment, has resulted in permanent 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 requirements which need to be permanent and irreversible: • Hb less than 8g/dL, and • Requiring 2-3U of blood every 2 weeks.	100%
	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 requirements which need to be permanent and irreversible: • 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%

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 permanent and irreversible as 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 permanent and irreversible 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%
	Combination of loss of use of an upper and lower limb	The total and permanent 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 orthopeadic or neurosurgeon.	100%
	Loss of use of both hands or arms	The total and permanent 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 and permanent 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%

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, bronchi or lungs,
		3. Oral hairy leukoplakia,
		4. Pneumocystis carinii pneumonia,
		5. Extra pulmonary Cryptococcus,
		6. Cytomegalo virus infection of an internal organ other than the liver,
		7. Disseminated atypical mycobacteriosis,
		8. Visceral leischmaniasis
			100%

Activities of Daily Living	Activities of Daily Living	Any illness, condition or event that results in the insured person being permanently unable to perform certain Basic Activities of Daily Living and / or Advanced Activities of Daily Living, as specified below. • A permanent 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%

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 or access public transport.
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

FUNCTIONAL IMPAIRMENTS THAT QUALIFY UNDER THE PARTIAL FUNCTIONAL IMPAIRMENT 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 requirements which need to be permanent and irreversible, 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 requirements which need to be permanent and irreversible: • 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%
	Hypertension	The diagnosis of uncontrolled hypertension confirmed by a medical specialist. With evidence of diastolic pressure permanently greater than 105mmHg on adequate treatment and complicated by 1 of the following requirements which need to be permanent and irreversible: • 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 the following requirements which need to be permanent and irreversible: • 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 requirements which need to be permanent and irreversible: • 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 evidence of at least 1 of the following requirements which need to be permanent and irreversible: • 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 permanent Systolic Pulmonary Artery Pressure of 40-70 mmHg and complicated by at least 1 of the following requirements which need to be permanent and irreversible: • 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	A permanent and irreversible stoma 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 requirements which need to be permanent and irreversible: • 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 requirements which need to be permanent and irreversible: • 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 requirements which need to be permanent and irreversible: • 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 permanent and irreversible 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 the following requirements which need to be permanent and irreversible: • Bowel dysfunction which impacts on activities of daily living, such that the insured person is permanently unable to perform 2 of the Basic Activities of Daily Living and 2 of the Advanced Activities of Daily Living.	50%

Urogenital	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 requirements which need to be permanent and irreversible: • 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: • Decreased level of consciousness, with a Glasgow Coma Scale of less than 9, which is constant and present for greater than 96hrs.	50%
	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 requirements which need to be permanent and irreversible: • 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 evidence of the following requirements which need to be permanent and irreversible: • 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 requirements which need to be permanent and irreversible: • Nerve damage with moderately-severe imbalance resulting in limitation of activities of daily living such that the insured person is permanently unable to perform 2 of the Basic Activities of Daily Living and 2 of the Advanced Activities of Daily Living.	50%
	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 requirements which need to be permanent and irreversible: • 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 requirements which need to be permanent and irreversible: • 6 or more generalised seizures per month, and • An inability to perform 2 of the Basic Activities of Daily Living and 2 of the Advanced Activities of Daily Living.	50%

Central Nervous System (continued)	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 requirements which need to be permanent and irreversible: • 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 correlating with objective medical findings. With evidence of the following requirements which need to be permanent and irreversible: • 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%
	Dementia (including Alzheimer's Disease)	The diagnosis of dementia by a neurologist, physician or neurosurgeon With evidence of the following requirements which need to be permanent and irreversible: • 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%
Senses	Loss of sight	Confirmed diagnosis of total and permanent 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 total and permanent 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 and permanent 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%

Senses (continued)	Loss of hearing	Total and permanent 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%
	Loss of speech	The permanent 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 which need to be permanent and irreversible: • 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%
Psychiatric	Psychiatric Disorder	The diagnosis of a psychiatric disorder, as confirmed by a specialist psychiatrist. Requires constant supervision on a permanent basis and with evidence of the following: • permanent GAF score of 40 or less certified under the DSM IV classification, or • permanent WHODAS average domain score of 4 certified under the DSM 5 classification	75%
Trauma	Major Burns	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 permanent tracheostomy.	50%
Haematology	Red Blood Cell Disorders	The diagnosis of severe chronic anaemia by a physician or haematologist. With evidence of the following requirements which need to be permanent and irreversible: • Hb 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 requirements which need to be permanent and irreversible: • 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 two of the four requirements listed below, which must be permanent and irreversible as 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.	50%
		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 permanent and irreversible as 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%
	Loss of use of one arm	The total and permanent 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%

Musculoskeletal (continued)	Loss of use of one hand	The total and permanent 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 and permanent loss of use of one thumb, as confirmed by an orthopaedic or neurosurgeon.	25%
	Loss of use of one leg	The total and permanent 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 and permanent loss of use of one foot at the transverse tarsal joint (Chopart's joint), as confirmed by an orthopaedic or neurosurgeon.	50%
Activities of Daily Living	Activities of Daily Living	Any illness, condition or event that results in the insured person being permanently unable to perform certain Basic Activities of Daily Living and / or Advanced Activities of Daily Living, as specified below. • A permanent 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%

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 or access public transport.
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

CHILD IMPAIRMENTS AND CONGENITAL BIRTH DEFECTS THAT QUALIFY UNDER THE CHILD IMPAIRMENT BENEFIT

Body system	Child impairment or congenital birth defect	Requirements that the child impairment or congenital birth defect must meet to qualify	Percentage of the cover amount payable
Congenital Birth Defects	Achondroplasia	The undergoing of surgery to treat complications of achondroplasia. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
	Anal atresia	The undergoing of surgery to correct anal atresia. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
	Biliary Atresia	Confirmed diagnosis of biliary atresia by the treating specialist. **Requirements for a claim to be considered:** • Supportive imaging and blood tests	50%
	Brain and skull disorders	Confirmed diagnosis of one of the following disorders by the treating specialist: • Microcephaly • Hydrocephaly • Craniostenosis • Craniosynostosis **Requirements for a claim to be considered:** • Supportive imaging and blood tests • The disorder results in severe neurological deficit.	100%
	Cerebral Palsy	Confirmed diagnosis of cerebral palsy by the treating specialist. **Requirements for a claim to be considered:** One of the following must be present for at least 6 months: • Spastic diplegia • Spastic hemiplegia • Spastic quadriplegia	100%
	Choanal atresia	The undergoing of surgery to correct choanal atresia. **Requirements for a claim to be considered:** • The complications have resulted in at least two surgical interventions, on two separate occasions, other than for diagnostic purposes • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
	Cleft lip and complete cleft palate	Confirmed diagnosis of cleft lip and complete cleft palate (hard and soft palate) by the treating specialist.	50%
	Clubbed feet (Talipes)	The undergoing of surgery to correct bilateral clubbed feet. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
		The undergoing of surgery to correct a clubbed foot. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	25%

Congenital Birth Defects (continued)	Congenital blindness	Confirmed diagnosis of total visual loss in both eyes at birth, by the treating specialist. **Requirements for a claim to be considered:** • Supportive clinical evidence	100%
		Confirmed diagnosis of total visual loss in one eye at birth, by the treating specialist. **Requirements for a claim to be considered:** • Supportive clinical evidence	50%
	Congenital deafness	Confirmed diagnosis of total hearing loss in both ears at birth by the treating specialist. **Requirements for a claim to be considered:** • Supportive clinical evidence using the Automated Otoacoustic Emission test or the Automated Auditory Brainstem Response test (or equivalent measure).	100%
		Confirmed diagnosis of total hearing loss in one ear at birth by the treating specialist. **Requirements for a claim to be considered:** • Supportive clinical evidence using the Automated Otoacoustic Emission test or the Automated Auditory Brainstem Response test (or equivalent measure).	50%
	Congenital heart disease	The correction of any congenital 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	100%
		The correction of any congenital structural abnormality of the heart, through any minimally invasive surgery. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions:** • Any investigative procedure • Patent ductus arteriosus	50%
	Congenital hip dislocation	The undergoing of surgery to correct congenital bilateral hip dislocation. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
		The undergoing of surgery to correct congenital unilateral hip dislocation. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	25%

Congenital Birth Defects (continued)	Cystic fibrosis	Confirmed diagnosis of cystic fibrosis by the treating specialist. **Requirements for a claim to be considered:** • A diagnostic sweat test • Pulmonary complications (e.g. recurrent pneumonia, suppurative lung disease, lung abscesses) confirmed by radiological investigations	100%
	Down Syndrome	Confirmed diagnosis of Down syndrome by the treating specialist. **Requirements for a claim to be considered:** • Supportive genetic tests	100%
	Duchenne Syndrome or Congenital Myotonic Dystrophy	Confirmed diagnosis of one of the following by the treating specialist: • Duchenne muscular dystrophy • Congenital myotonic muscular dystrophy (MMD 1) **Requirements for a claim to be considered:** For Duchenne muscular dystrophy: • Evidence of clinical symptoms • Raised creatine kinase • Muscle biopsy with abnormal levels of dystrophin protein For Congenital myotonic muscular dystrophy: • Supportive genetic tests	100%
	Haemophilia	Confirmed diagnosis of haemophilia by the treating haematologist. **Requirements for a claim to be considered:** • Despite adequate treatment for at least 6 consecutive months, both of the following are present: • 1% of the normal clotting factor in the blood • At least four units of blood or blood products has been transfused per month for at least 3 consecutive months	50%
	Hirschsprung's disease	Confirmed diagnosis of Hirschprung's disease by the treating specialist. **Requirements for a claim to be considered:** • Full-thickness rectal biopsy	50%
	Hydrocephalus	The surgical insertion of a shunt to treat congenital hydrocephalus. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
	Hypospadias	The undergoing of surgery to treat hypospadias in a male child. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
	Inborn metabolic disorders	Confirmed diagnosis of one of the following inborn errors of metabolism by the treating specialist: • Gaucher's disease • Glycogen storage disease • Tay Sachs Disease • Mucopolysaccharidosis **Requirements for a claim to be considered:** • Supportive laboratory tests	100%
	Autosomal recessive polycystic kidney disease	Confirmed diagnosis of autosomal recessive polycystic kidney disease by the treating specialist. **Requirements for a claim to be considered:** • Supportive genetic tests	100%

Congenital Birth Defects (continued)	Klinefelter's syndrome	Confirmed diagnosis of Klinefelter's syndrome by the treating specialist. **Requirements for a claim to be considered:** • Supportive genetic tests	25%
	Necrotising enterocolitis	The undergoing of surgery to treat necrotising enterocolitis. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
	Neurodevelopmental disorders	Confirmed diagnosis of one of the following developmental disorders of the by the treating specialist: • Symptomatic Rett syndrome with a MECP2 mutation • Symptomatic fragile X syndrome with a FMR1 mutation • Symptomatic tuberous sclerosis with a TSC2 mutation • Symptomatic neurofibromatosis **Requirements for a claim to be considered:** • Supportive genetic tests • Supportive clinical evidence	100%
	Myelomeningocele	Confirmed diagnosis of myelomeningocele by the treating specialist. **Requirements for a claim to be considered:** • Supportive imaging and blood tests	100%
	Tracheooesophageal Fistula or Oesophageal Atresia	Confirmed diagnosis of a tracheo-oesophageal fistula or oesophageal atresia by the treating specialist. **Requirements for a claim to be considered:** • Supportive imaging and blood tests • Pulmonary complications (e.g. recurrent pneumonia, suppurative lung disease, lung abcesses) confirmed by radiological investigations	50%
Central Nervous System	Paraplegia, hemiplegia or quadriplegia	Total and permanent paralysis of 2 or more limbs from any cause.	100%
Senses	Loss of Hearing	The total and permanent loss of hearing of greater than 70dB in both ears as diagnosed by an Ear, Nose and Throat Specialist. The measurements are done with the use of hearing aids for the assessment of hearing impairment.	100%
	Loss of Sight	Confirmed diagnosis of total and permanent 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 • A visual field loss to a 10° radius in the better eye. Loss of sight due to cataracts is excluded.	100%
	Loss of Speech	The total and permanent 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%

Trauma	Major Burns	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.	100%
	Accidental brain damage	Permanent impairment of intellectual capacity as a result of brain damage sustained in an accident, as defined. Confirmation of intellectual impairment by neuropsychological testing. 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%
	Trauma	An accident resulting in severe physical injury. With evidence of the following: • Requires mechanical ventilation in an intensive care unit for at least 48 hours , and • Results in permanent neurological deficit. 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%
		An accident resulting in severe physical injury, requiring mechanical ventilation in an intensive care unit for at least 96 hours. 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.	50%
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 child is permanently confined to a bed or a wheelchair, or • Stage IV cancer	100%
Terminal Illness	Terminal Illness	The diagnosis of a medical condition which, according to Old Mutual's Medical Officer, will result in death within 12 months. The claim must be received within this 12 month period.	100%
Activities of Daily Living	Permanent confinement to a bed or a wheelchair	Permanent confinement to a bed or a wheelchair, as confirmed by the treating specialist due to an organic disease or injury.	100%

FUNCTIONAL IMPAIRMENTS THAT QUALIFY UNDER THE FUNCTIONAL IMPAIRMENT 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 requirements which need to be permanent and irreversible, 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%
	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 requirements which need to be permanent and irreversible: • 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%
	Hypertension	The diagnosis of uncontrolled hypertension confirmed by a medical specialist. With evidence of diastolic pressure permanently greater than or equal to 110mmHg on adequate treatment and complicated by 2 or more of the following requirements which need to be permanent and irreversible: • 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%
	Peripheral Arterial Disease	The diagnosis of peripheral arterial disease of the lower limbs by a vascular surgeon. With evidence of a permanently absent pulse on Doppler readings, and 1 of the following requirements which need to be permanent and irreversible: • Severe Vascular Ulceration, or • Gangrene secondary to peripheral arterial disease.	100%
Respiratory	Chronic Respiratory Failure	The diagnosis of a chronic respiratory failure by a pulmonologist. With evidence of at least 1 of the following requirements which need to be permanent and irreversible: • 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%

Respiratory (continued)	Pulmonary Arterial Hypertension	The diagnosis of pulmonary hypertension by a medical specialist. With evidence of a permanent Systolic Pulmonary Artery Pressure greater than 70mmHg and complicated by at least 1 of the following requirements which need to be permanent and irreversible: • Right sided heart failure, or • Shortness of breath so severe that symptoms are present at rest (NYHA Class IV).	100%
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%
	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 requirements which need to be permanent and irreversible: • 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%
	Chronic Liver Failure	The diagnosis of permanent and irreversible chronic end-stage liver failure, with a Child Pugh Classification of class C, by a gastroenterologist or equivalent specialist.	100%
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 requirements which need to be permanent and irreversible: • 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 requirements which need to be permanent and irreversible: • 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%
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%

Central Nervous System (continued)	Aphasia	The diagnosis of aphasia by a neurologist or neurosurgeon. With evidence of the following requirements which need to be permanent and irreversible: • 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 VII	The diagnosis of facial nerve paralysis confirmed by a neurologist or neurosurgeon. With evidence of the following requirements which need to be permanent and irreversible: • Slight or no movement of the face, and • An inability to actively close the eyelids, and • Slight or no movement of the mouth.	100%
	Cranial Nerve VIII	The diagnosis of Vestibulocochlear nerve paralysis confirmed by a neurologist or neurosurgeon. With evidence of the following requirements which need to be permanent and irreversible: • Nerve damage with severe imbalance resulting in limitation of activities of daily living such that the insured person is permanently unable to perform 3 of the Basic Activities of Daily Living or 4 of the Advanced Activities of Daily Living.	100%
	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 requirements which need to be permanent and irreversible: • An inability to swallow or process oral secretions without choking, and • Need for external suctioning device, and • Medical findings confirming organic disease.	100%
	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 requirements which need to be permanent and irreversible: • 3 or more generalised seizures per week, and • An inability to perform 3 of the Basic Activities of Daily Living or 4 of the Advanced Activities of Daily Living.	100%
	Hemiplegia	The total and permanent 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%
	Dementia (incl. Alzheimer's Disease)	The diagnosis of dementia by a neurologist, physician or neurosurgeon With evidence of the following requirements which need to be permanent and irreversible: • 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%
	Paraplegia / Diplegia	The total and permanent 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%

Central Nervous System (continued)	Quadriplegia	The total and permanent 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 requirements which need to be permanent and irreversible: • 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 total and permanent 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%
	Loss of hearing	Total and permanent 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%
	Loss of speech	The total and permanent 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%
Endocrine	Endocrine Disorders	The diagnosis of an endocrine disorder, which despite adequate medical and surgical treatment, has resulted in permanent 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 permanent institutionalisation and with evidence of the following: • permanent GAF score of 40 or less certified under the DSM IV classification, or • permanent WHODAS average domain score of 4 certified under the DSM 5 classification	100%
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%
Haematology	Clotting Disorders	The diagnosis of a clotting disorder, which despite adequate medical and surgical treatment, has resulted in permanent 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 requirements which need to be permanent and irreversible: • Hb less than 8g/dL, and • Requiring 2-3U of blood every 2 weeks.	100%
	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 requirements which need to be permanent and irreversible: • 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%

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 permanent and irreversible as 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 permanent and irreversible 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%
	Combination of loss of use of an upper and lower limb	The total and permanent 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 orthopeadic or neurosurgeon.	100%
	Loss of use of both hands or arms	The total and permanent 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 and permanent loss of use of: 1. both legs at or above the ankle joint up to the hip joint, or 2. both feet at the transverse tarsal joint (Chopart's joint), or 3. 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%

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, bronchi or lungs,
		3. Oral hairy leukoplakia,
		4. Pneumocystis carinii pneumonia,
		5. Extra pulmonary Cryptococcus,
		6. Cytomegalo virus infection of an internal organ other than the liver,
		7. Disseminated atypical mycobacteriosis,
		8. Visceral leischmaniasis
			100%

Activities of Daily Living	Activities of Daily Living	Any illness, condition or event that results in the insured person being permanently unable to perform certain Basic Activities of Daily Living and / or Advanced Activities of Daily Living, as specified below. • A permanent 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%

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 or access public transport.
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

FUNCTIONAL IMPAIRMENTS THAT QUALIFY UNDER THE PARTIAL FUNCTIONAL IMPAIRMENT 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 requirements which need to be permanent and irreversible, 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 requirements which need to be permanent and irreversible: • 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%
	Hypertension	The diagnosis of uncontrolled hypertension confirmed by a medical specialist. With evidence of diastolic pressure permanently greater than 105mmHg on adequate treatment and complicated by 1 of the following requirements which need to be permanent and irreversible: • 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 the following requirements which need to be permanent and irreversible: • 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 requirements which need to be permanent and irreversible: • 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 evidence of at least 1 of the following requirements which need to be permanent and irreversible: • 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 permanent Systolic Pulmonary Artery Pressure of 40-70 mmHg and complicated by at least 1 of the following requirements which need to be permanent and irreversible: • 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	A permanent and irreversible stoma 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 requirements which need to be permanent and irreversible: • 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 requirements which need to be permanent and irreversible: • 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 requirements which need to be permanent and irreversible: • 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 permanent and irreversible 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 the following requirements which need to be permanent and irreversible: • Bowel dysfunction which impacts on activities of daily living, such that the insured person is permanently unable to perform 2 of the Basic Activities of Daily Living and 2 of the Advanced Activities of Daily Living.	50%

Urogenital	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 requirements which need to be permanent and irreversible: • 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: • Decreased level of consciousness, with a Glasgow Coma Scale of less than 9, which is constant and present for greater than 96hrs.	50%
	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 requirements which need to be permanent and irreversible: • 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 evidence of the following requirements which need to be permanent and irreversible: • 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 requirements which need to be permanent and irreversible: • Nerve damage with moderately-severe imbalance resulting in limitation of activities of daily living such that the insured person is permanently unable to perform 2 of the Basic Activities of Daily Living and 2 of the Advanced Activities of Daily Living.	50%
	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 requirements which need to be permanent and irreversible: • 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 requirements which need to be permanent and irreversible: • 6 or more generalised seizures per month, and • An inability to perform 2 of the Basic Activities of Daily Living and 2 of the Advanced Activities of Daily Living.	50%

Central Nervous System (continued)	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 requirements which need to be permanent and irreversible: • 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 correlating with objective medical findings. With evidence of the following requirements which need to be permanent and irreversible: • 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%
	Dementia (including Alzheimer's Disease)	The diagnosis of dementia by a neurologist, physician or neurosurgeon With evidence of the following requirements which need to be permanent and irreversible: • 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%
Senses	Loss of sight	Confirmed diagnosis of total and permanent 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 total and permanent 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 and permanent 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%

Senses (continued)	Loss of hearing	Total and permanent 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%
	Loss of speech	The permanent 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 which need to be permanent and irreversible: • 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%
Psychiatric	Psychiatric Disorder	The diagnosis of a psychiatric disorder, as confirmed by a specialist psychiatrist. Requires constant supervision on a permanent basis and with evidence of the following: • permanent GAF score of 40 or less certified under the DSM IV classification, or • permanent WHODAS average domain score of 4 certified under the DSM 5 classification	75%
Trauma	Major Burns	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 permanent tracheostomy.	50%
Haematology	Red Blood Cell Disorders	The diagnosis of severe chronic anaemia by a physician or haematologist. With evidence of the following requirements which need to be permanent and irreversible: • Hb 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 requirements which need to be permanent and irreversible: • 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 two of the four requirements listed below, which must be permanent and irreversible as 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.	50%
		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 permanent and irreversible as 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%
	Loss of use of one arm	The total and permanent 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%

Musculoskeletal (continued)	Loss of use of one hand	The total and permanent 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 and permanent loss of use of one thumb, as confirmed by an orthopaedic or neurosurgeon.	25%
	Loss of use of one leg	The total and permanent 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 and permanent loss of use of one foot at the transverse tarsal joint (Chopart's joint), as confirmed by an orthopaedic or neurosurgeon.	50%
Activities of Daily Living	Activities of Daily Living	Any illness, condition or event that results in the insured person being permanently unable to perform certain Basic Activities of Daily Living and / or Advanced Activities of Daily Living, as specified below. • A permanent 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%

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 or access public transport.
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

CHILD IMPAIRMENTS AND CONGENITAL BIRTH DEFECTS THAT QUALIFY UNDER THE CHILD IMPAIRMENT BENEFIT

Body system	Child impairment or congenital birth defect	Requirements that the child impairment or congenital birth defect must meet to qualify	Percentage of the cover amount payable
Congenital Birth Defects	Achondroplasia	The undergoing of surgery to treat complications of achondroplasia. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
	Anal atresia	The undergoing of surgery to correct anal atresia. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
	Biliary Atresia	Confirmed diagnosis of biliary atresia by the treating specialist. **Requirements for a claim to be considered:** • Supportive imaging and blood tests	50%
	Brain and skull disorders	Confirmed diagnosis of one of the following disorders by the treating specialist: • Microcephaly • Hydrocephaly • Craniostenosis • Craniosynostosis **Requirements for a claim to be considered:** • Supportive imaging and blood tests • The disorder results in severe neurological deficit.	100%
	Cerebral Palsy	Confirmed diagnosis of cerebral palsy by the treating specialist. **Requirements for a claim to be considered:** One of the following must be present for at least 6 months: • Spastic diplegia • Spastic hemiplegia • Spastic quadriplegia	100%
	Choanal atresia	The undergoing of surgery to correct choanal atresia. **Requirements for a claim to be considered:** • The complications have resulted in at least two surgical interventions, on two separate occasions, other than for diagnostic purposes • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
	Cleft lip and complete cleft palate	Confirmed diagnosis of cleft lip and complete cleft palate (hard and soft palate) by the treating specialist.	50%
	Clubbed feet (Talipes)	The undergoing of surgery to correct bilateral clubbed feet. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
		The undergoing of surgery to correct a clubbed foot. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	25%

Congenital Birth Defects (continued)	Congenital blindness	Confirmed diagnosis of total visual loss in both eyes at birth, by the treating specialist. **Requirements for a claim to be considered:** • Supportive clinical evidence	100%
		Confirmed diagnosis of total visual loss in one eye at birth, by the treating specialist. **Requirements for a claim to be considered:** • Supportive clinical evidence	50%
	Congenital deafness	Confirmed diagnosis of total hearing loss in both ears at birth by the treating specialist. **Requirements for a claim to be considered:** • Supportive clinical evidence using the Automated Otoacoustic Emission test or the Automated Auditory Brainstem Response test (or equivalent measure).	100%
		Confirmed diagnosis of total hearing loss in one ear at birth by the treating specialist. **Requirements for a claim to be considered:** • Supportive clinical evidence using the Automated Otoacoustic Emission test or the Automated Auditory Brainstem Response test (or equivalent measure).	50%
	Congenital heart disease	The correction of any congenital 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	100%
		The correction of any congenital structural abnormality of the heart, through any minimally invasive surgery. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis **Exclusions:** • Any investigative procedure • Patent ductus arteriosus	50%
	Congenital hip dislocation	The undergoing of surgery to correct congenital bilateral hip dislocation. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
		The undergoing of surgery to correct congenital unilateral hip dislocation. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	25%

Congenital Birth Defects (continued)	Cystic fibrosis	Confirmed diagnosis of cystic fibrosis by the treating specialist. **Requirements for a claim to be considered:** • A diagnostic sweat test • Pulmonary complications (e.g. recurrent pneumonia, suppurative lung disease, lung abscesses) confirmed by radiological investigations	100%
	Down Syndrome	Confirmed diagnosis of Down syndrome by the treating specialist. **Requirements for a claim to be considered:** • Supportive genetic tests	100%
	Duchenne Syndrome or Congenital Myotonic Dystrophy	Confirmed diagnosis of one of the following by the treating specialist: • Duchenne muscular dystrophy • Congenital myotonic muscular dystrophy (MMD 1) **Requirements for a claim to be considered:** For Duchenne muscular dystrophy: • Evidence of clinical symptoms • Raised creatine kinase • Muscle biopsy with abnormal levels of dystrophin protein For Congenital myotonic muscular dystrophy: • Supportive genetic tests	100%
	Haemophilia	Confirmed diagnosis of haemophilia by the treating haematologist. **Requirements for a claim to be considered:** • Despite adequate treatment for at least 6 consecutive months, both of the following are present: • 1% of the normal clotting factor in the blood • At least four units of blood or blood products has been transfused per month for at least 3 consecutive months	50%
	Hirschsprung's disease	Confirmed diagnosis of Hirschprung's disease by the treating specialist. **Requirements for a claim to be considered:** • Full-thickness rectal biopsy	50%
	Hydrocephalus	The surgical insertion of a shunt to treat congenital hydrocephalus. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
	Hypospadias	The undergoing of surgery to treat hypospadias in a male child. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
	Inborn metabolic disorders	Confirmed diagnosis of one of the following inborn errors of metabolism by the treating specialist: • Gaucher's disease • Glycogen storage disease • Tay Sachs Disease • Mucopolysaccharidosis **Requirements for a claim to be considered:** • Supportive laboratory tests	100%
	Autosomal recessive polycystic kidney disease	Confirmed diagnosis of autosomal recessive polycystic kidney disease by the treating specialist. **Requirements for a claim to be considered:** • Supportive genetic tests	100%

Congenital Birth Defects (continued)	Klinefelter's syndrome	Confirmed diagnosis of Klinefelter's syndrome by the treating specialist. **Requirements for a claim to be considered:** • Supportive genetic tests	25%
	Necrotising enterocolitis	The undergoing of surgery to treat necrotising enterocolitis. **Requirements for a claim to be considered:** • Relevant surgical reports by the treating surgeon, including confirmation of the diagnosis	50%
	Neurodevelopmental disorders	Confirmed diagnosis of one of the following developmental disorders of the by the treating specialist: • Symptomatic Rett syndrome with a MECP2 mutation • Symptomatic fragile X syndrome with a FMR1 mutation • Symptomatic tuberous sclerosis with a TSC2 mutation • Symptomatic neurofibromatosis **Requirements for a claim to be considered:** • Supportive genetic tests • Supportive clinical evidence	100%
	Myelomeningocele	Confirmed diagnosis of myelomeningocele by the treating specialist. **Requirements for a claim to be considered:** • Supportive imaging and blood tests	100%
	Tracheooesophageal Fistula or Oesophageal Atresia	Confirmed diagnosis of a tracheo-oesophageal fistula or oesophageal atresia by the treating specialist. **Requirements for a claim to be considered:** • Supportive imaging and blood tests • Pulmonary complications (e.g. recurrent pneumonia, suppurative lung disease, lung abcesses) confirmed by radiological investigations	50%
Central Nervous System	Paraplegia, hemiplegia or quadriplegia	Total and permanent paralysis of 2 or more limbs from any cause.	100%
Senses	Loss of Hearing	The total and permanent loss of hearing of greater than 70dB in both ears as diagnosed by an Ear, Nose and Throat Specialist. The measurements are done with the use of hearing aids for the assessment of hearing impairment.	100%
	Loss of Sight	Confirmed diagnosis of total and permanent 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 • A visual field loss to a 10° radius in the better eye. • Loss of sight due to cataracts is excluded.	100%
	Loss of Speech	• The total and permanent 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%

Trauma	Major Burns	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.	100%
	Accidental brain damage	Permanent impairment of intellectual capacity as a result of brain damage sustained in an accident, as defined. Confirmation of intellectual impairment by neuropsychological testing. 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%
	Trauma	An accident resulting in severe physical injury. With evidence of the following: • Requires mechanical ventilation in an intensive care unit for at least 48 hours , and • Results in permanent neurological deficit. 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%
		An accident resulting in severe physical injury, requiring mechanical ventilation in an intensive care unit for at least 96 hours. 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.	50%
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 child is permanently confined to a bed or a wheelchair, or • Stage IV cancer	100%
Terminal Illness	Terminal Illness	The diagnosis of a medical condition which, according to Old Mutual's Medical Officer, will result in death within 12 months. The claim must be received within this 12 month period.	100%
Activities of Daily Living	Permanent confinement to a bed or a wheelchair	Permanent confinement to a bed or a wheelchair, as confirmed by the treating specialist due to an organic disease or injury.	100%

FUNCTIONAL IMPAIRMENTS THAT QUALIFY UNDER THE PREMIUM PROTECTION DISABILITY BENEFIT

Body system	Functional impairment	Requirements that the functional impairment must meet to qualify
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.
	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.
	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).
	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.
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%.
	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).
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.

Gastrointestinal (continued)	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.
	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.
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.
	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.
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.
	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.
	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.
	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.

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.
	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.
	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.
	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.
	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.
	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.
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

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.
	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.
	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.
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
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
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.
	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.

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
	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.
	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.
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.
	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 orthopeadic or neurosurgeon.

Musculoskeletal (continued)	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.
	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.
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, bronchi or lungs, 3. Oral hairy leukoplakia, 4. Pneumocystis carinii pneumonia, 5. Extra pulmonary Cryptococcus, 6. Cytomegalo virus infection of an internal organ other than the liver, 7. Disseminated atypical mycobacteriosis, 8. Visceral leischmaniasis
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.

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

FUNCTIONAL IMPAIRMENTS THAT QUALIFY UNDER THE PREMIUM PROTECTION FUNCTIONAL IMPAIRMENT BENEFIT

Body system	Functional impairment	Requirements that the functional impairment must meet to qualify
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.
	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.
	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).
	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.
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%.
	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).
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.

Gastrointestinal (continued)	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.
	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.
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.
	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.
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.
	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.
	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.
	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.

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.
	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.
	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.
	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.
	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.
	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.
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

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.
	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.
	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.
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
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
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.
	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.

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
	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.
	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.
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.
	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 orthopeadic or neurosurgeon.

Musculoskeletal (continued)	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.
	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.
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, bronchi or lungs, 3. Oral hairy leukoplakia, 4. Pneumocystis carinii pneumonia, 5. Extra pulmonary Cryptococcus, 6. Cytomegalo virus infection of an internal organ other than the liver, 7. Disseminated atypical mycobacteriosis, 8. Visceral leischmaniasis
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.

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