BMW ASSETLIFE DISCLOSURES.

BMW FINANCIAL SERVICES. ALL IN. SIMPLY SMART.

Sheer Driving Pleasure

zest!life

Cover you can trust.

People you can depend on.

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GENERAL TERMS AND CONDITIONS.

Please note: This policy is for informational purposes only. Always refer the policy document as issued to you by Zestlife for the latest terms and condition.

These general terms and conditions are applicable to your cover under this Policy.

Who is the insured?
The person who is indicated on the Policy Document referred to as "You", "Your" and "Life Insured".

What is the meaning of certain key words and phrases?
Accident
is a sudden, uncertain and fortuitous event which happens at an identifiable time and place, independent of any other cause, with visible consequences and results in Bodily Injury. This does not include sickness or disease or any naturally occurring condition or degenerative process. Self-inflicted injury and suicide are excluded from this definition. Accidental has a corresponding meaning.

Applicable Laws
means the Insurance Act 18 of 2017 and/or the Long-term Insurance Act 52 of 1998, the Policyholder Protection Rules (Long-term Insurance), 2017 and the Protection of Personal Information Act 4 of 2013, and any Protection of Personal Information Act 4 of 2013 and any other legislation relating to or regulating the protection or processing of data of Personal Information, direct marketing or unsolicited electronic communications and which may be applicable in the Republic of South Africa from time-to- time.

Beneficiary
means the person you have nominated in the Policy Schedule who will be entitled to a Policy Benefit where applicable, if there are excess Policy Benefits available only after the Credit Agreements specified in the Policy Schedule have been settled.

Benefit
means the Benefits you have selected and for which the appropriate premium, or portion of premiums have been paid, and for which you are covered in case of a Claim Event occurring, as defined, during the currency of this Policy. It is the amount that the Insurer shall pay the Credit Provider(s), or where applicable the Life Insured or the Beneficiary.

Bodily Injury
means physical bodily injury to the Insured caused by an Accident. Bodily Injury shall be deemed to include death by starvation, thirst and/or exposure to the elements.

Claim
means, unless the context indicates otherwise, a Claimant's demand for the Policy Benefits in relation to this Policy, irrespective of whether or not such Claimant's demand is valid, made by submitting a completed claim form and supporting documentation to us.

Claimant
is the person who makes a Claim in relation to this Policy.

Claim Event
means the insured risks provided by this Policy, being the Insured Events.

Claim Event Date
means the date on which the Claim Event occurs giving rise to a Claim.

Commencement Date
means the date on which your cover commences, which date is specified in this Policy.

Cooling-off Period
means a period of 31 (thirty-one) Days from the date you receive this Policy document, or from a reasonable date on which it can be deemed that you received this Policy document in which you can cancel this Policy, provided that no Benefit has yet been paid or claimed or the Claim Event insured against has not yet occurred, by giving notice to us and any premium paid will be refunded in full.

Credit Agreement
means a personal loan agreement or an agreement for the financing of an asset concluded between you and a Credit Provider, which meets the criteria for credit agreements as set out in section 8 of the National Credit Act, No 34 of 2005 (as amended).

Credit Provider
means the entity which has provided the finance or personal loan to you in terms of a Credit Agreement.

Critical Illness
means any of the medical illnesses, conditions or procedures that are specified and covered under this Policy. The Critical Illness must be confirmed by a Medical Practitioner with the appropriate specialist knowledge.

Exclusion
means the losses or risk events not covered under the Policy. Should a Claim Event arise from such Exclusion(s), no Benefit will be payable.

Insured Event
means the event which gave rise to your Claim in terms of this Policy based on your selection of Benefits at the Commencement Date of the Policy or at subsequent policy endorsements date and which is confirmed in the Policy Schedule.

Insurer
means the insurance company that underwrites this insurance, namely Guardrisk Life Limited (registration number 1999/013922/06 and FSP number 76), an authorised financial services provider and an insurer licensed to conduct life insurance business in terms of the Insurance Act 18 of 2017. See the disclosure notice for details.

Life Insured
means you, the person who has entered into the Credit Agreement or who is surety and co- principal debtor on behalf of the juristic person who has entered into the Credit Agreement and who is covered for Benefits under this Policy. The Life Insured shall also be referred to as the Policyholder.

Medical Practitioner
means a legally and duly qualified medical practitioner registered with the Health Professions Council of South Africa with a valid practice number.

Outstanding Balance
means the balance due on the Credit Agreements at the date of the Insured Event including any interest, fees and charges that are due and payable to the Credit Provider which have accrued in the last 12 months prior to the Insured Event.

Period of Grace
is the period of 31 (thirty-one) days after the premium payment due date where the cover is still in force, but the premium has not been paid. If any Claim Event occurs during this period which results in a valid Claim, the unpaid premium/s will be deducted from any Benefit payable. Failure to pay the premium/s by the expiry of this period will result in the Policy lapsing. A Claim Event that arises in the period after the Policy has lapsed will not be covered.

GENERAL TERMS AND CONDITIONS.

Personal Information
means the personal information as defined in the Protection of Personal Information Act, No 4 of 2013.

Policy
means this Policy, the terms and conditions, and any endorsements thereto.

Policyholder
means the Life Insured, the person who has entered into the Credit Agreement or who is surety and co-principal debtor on behalf of the juristic person who has entered into the Credit Agreement and who is covered for Benefits under this Policy.

Policy Schedule
means the schedule stating the Benefit details and respective premium rate as attached to this Policy.

Pre-existing Medical Condition
shall mean any illness, infirmity, physical defect, disability or Bodily Injury sustained or contracted by the Life Insured or a condition arising directly or indirectly or contributed or traceable to or resultant from any medical condition (including any physical defect, illness, Bodily Injury or infirmity) which the Life Insured was aware of; or ought reasonably to have been aware of and/or for which the Life Insured received medical treatment, tests or advice, referral or recommendation for from a Medical Practitioner in the 12 (twelve) months preceding the Commencement Date that results in a Claim event after the Commencement Date.

Repudiate
in relation to a Claim means any action by which an Insurer rejects or refuses to pay a Claim, or any part of a Claim, for any reason, and includes instances where a Claimant lodges a Claim;
- in respect of a loss event or risk not covered by this Policy; and
- in respect of a loss event or risk covered by this Policy, but the premium or premiums payable inrespect of this Policy are not paid.

and **Repudiation** shall have a corresponding meaning.

Retrenchment
means suffering an involuntary loss of employment, as a result of the implementation of a staff reduction program, adverse business conditions, the introduction of new technology or the reorganization of the business by the employer in accordance with the Labour Relations Act of 1955. Retrenched shall have a corresponding meaning.

RoadCover Subscription
is a non-underwritten benefit offered to you by RoadCover, which gives the subscribers who are victims of Motor Vehicle Accidents immediate access to an effective Road Accident Fund (RAF) claims management system at no cost to them. RoadCover manages the claims with the RAF from start to finish, enabling the victims of Motor Vehicle Accidents to be compensated by the RAF in full.

Sum Insured
shall mean the amount stated in the Policy Schedule for the Benefits that is based on the aggregate of the Credit Agreement(s). In case of a Claim, a Benefit will be paid as described in the Policy wording.

Unclaimed Benefit
means a benefit in terms of an approved Claim where the benefit can't be paid to the Nominated Beneficiary within 3 (three) months of the Claim having been approved because the Nominated Beneficiary is not contactable. In other words, the Nominated Beneficiary cannot be located, his/her emails are undelivered, his/her post is returned to Zestlife and/or his/her contact number is no longer in use; and **"Unclaimed Benefits"** shall have a corresponding meaning.

Variation
means any act that results in a change to –
i) the premium;
ii) any terms;
iii) any condition;
iv) any Policy Benefit;
v) any Exclusion; or
vi) the duration of this Policy.
and Vary and Variation have corresponding meanings.

Waiting Period
means the period from the Commencement Date, where applicable, in which you will not be covered for any Policy Benefits and where no cover will be provided. Any Claim Event arising during and within the Waiting Period will not be covered and will remain uncovered even after the Waiting Period has expired. The applicable Waiting Periods are specified in the Policy Schedule.

WAITING PERIODS AND PRE-EXISTING CONDITIONS.

Are there any periods during which you are not covered?
The Waiting Period(s) appliable to this Policy are stated under each Benefit section in the Policy.

There is also a Pre-existing Medical Condition Exclusion applicable under this Policy, as defined.

If you disclosed a specific Pre-existing Medical Condition to us before commencement of this Policy it will only be Excluded if you were at that stage clearly informed of the Pre-Existing Medical Condition Exclusion.

If you increase your Benefit amount as you are entitled to do after the commencement of this Policy, the Insurer will apply the above 12-months Pre-existing Medical Condition Exclusion to the increased portion of cover.

If this Policy is replacing a similar credit life Policy then the Pre-existing Medical Condition and Waiting Periods will not be applied again if they had already expired under your previous Policy and only the unexpired portion of any Pre-existing Medical Condition period and Waiting Period will be applied.

How do you qualify for the Policy Benefits?
In order to qualify you must be a South African resident and you must have reached your 18th birthday but not your 61st birthday at the commencement of the Policy.

You will only qualify for the Benefits if the purpose of taking out the Policy is to cover your liability on Credit Agreements.

You may be required by the Insurer to provide written proof of the existence of the Credit Agreements listed in the Policy Schedule and depending on the amount of the Benefit you may be required by the Insurer to provide evidence of your good health and insurability.
Whilst the medical information on your health is being obtained, the Benefits will only be paid if the Insured Event occurs as a result of an Accident.

Once the Insurer has received the medical information it will advise you in writing whether you are accepted for the Benefits or declined. From the date of your acceptance by the Insurer your Benefit will no longer be restricted to Accident only.

Can you increase your Benefit after the commencement of the Policy?
You can increase your Benefit to cover the liability of any other or new Credit Agreement you have. You can also increase your Benefit to double the Outstanding Balances on the Credit Agreement/s specified in the Policy Schedule under Cession details. The increase in your Benefit are subject to certain maximum Benefit amounts imposed by the Insurer.

The Benefit can be increased by contacting us. You may be required by the Insurer to provide written proof of the existence of the additional Credit Agreements and depending on the amount of the increased Benefit you may be required by the Insurer to provide evidence of your good health. Whilst the medical information on your health is being obtained the increased Benefit will only be paid if the Insured Event occurs as a result of an Accident.

In the event that you increase your Benefit your premium will be increased accordingly.

How much will you have to pay?
The amount of the Premium you will need to pay is stated in the Policy Schedule. Premiums are age related and will change each year on the anniversary of the policy taking inflation into account.

Your premiums must be paid every month. You will be entitled to a Period of Grace of 31 (thirty-one) days from the premium due date reflected on the Policy Schedule in which to pay the premium. Failure to pay the premium/s by the expiry of this period will result in the Policy lapsing. A Claim Event that arises in the period after the Policy has lapsed will not be covered.

The Insurer will consider reinstating the Policy within 2 (two) months after the Policy has been cancelled. Premiums remain payable whilst a Claim is being assessed and during any Waiting Period. Premiums will not be payable during the period that a Claim is being paid for Unemployment, Retrenchment or Temporary Disability.

The Insurer will review the premium rate annually based on the various factors used to determine the premium.

The Insurer furthermore reserves the right to review the premium rate at any time should there be reasonable actuarial grounds to change or Vary the premium rate or when the Variation will be to the benefit of the Life Insured.

Any changes to the premium rate will be notified to the Life Insured 31 (thirty-one) Days prior to the change taking effect. Such notification will provide appropriate details of the reasons for the change to the premium rate and will afford the Policyholder with reasonable steps, such as an option to terminate the Policy, to mitigate the impact of the increase on the Policyholder.

The premium rates may be amended or changed, based on the following factors: past and future expected economic factors (for example, but not limited to, interest rates, tax and inflation), past and future claims experience, past and future expected lapse experience, past and future expected mortality experience, expected future reinsurance, any regulatory and legislative changes impacting this Policy or any other factor impacting the premium that the Insurer deems material at the time.

From what date are you entitled to Benefits?
You are entitled to Benefits from the Commencement Date of the Policy as stated in the Policy Schedule taking into account any of the applicable Waiting Periods.

How do you Claim a Benefit?
If you want to Claim a Benefit you must contact us on the number stated in the Contact Details below not later than 6 (six) months after the incident. Refer to each Benefit section of this Policy for the Claim requirements. Claims reported outside this period will not be considered unless there are extenuating circumstances for the late submission supported by a valid motivation letter.

The cost of obtaining all relevant information required by the Insurer in the event of a Claim is for your account. No Benefit payable shall carry interest. The Insurer will be entitled to delay the payment of a Claim if further Claim investigation is necessary.

Payment by the Insurer of the Policy Benefit to the nominated Beneficiary or cessionary shall be a full and final settlement of the Insurer's liability under this Policy. The Insurer shall not be liable for any Claim under this Policy unless you have complied with all the Policy conditions.

What do You do if You are not happy with the Insurer's decision on a Claim and the Time Bar?
In the event of a Claim being Repudiated or the Claimant disputes the quantum of the Benefit amount paid by the Insurer, the Claimant is entitled to make representation to us in respect of our decision to Repudiate the Claim or as to the manner in which the quantum of the Benefit amount was calculated for a period of 180 (one-hundred and eighty) Days from the date of receipt of the Repudiation letter or the date of the Claim payment.

WAITING PERIODS AND PRE-EXISTING CONDITIONS.

If the representation is unsuccessful or the dispute is not resolved at the end of this 180 (one-hundred and eighty) Day period then the Claimant has an additional 6 (six) months to institute legal action against us by way of a summons, failing which we will no longer be liable in respect of the Claim and such legal action will no longer be possible.

Representation must be submitted in writing to the Insurer, where the Claimant is not satisfied with the response from us, the Claimant is entitled to escalate the matter/ complaint to the National Financial Ombud Scheme on the contact details provided below.

In terms of Section 15 of the Financial Services Ombudsman Schemes Act No. 37 of 2004, that on receipt of the official referral to the aforementioned Ombudsman, any applicable time barring clause in terms of this Policy or the running of prescription in terms of the Prescription Act No 68 of 1969 from the date of referral to the date of withdrawal of the referral, or determination of the referral by the Ombudsman, shall be stayed. If the dispute is not satisfactorily resolved in this manner, legal action may be instituted against the Insurer for the enforcement of the claim by way of the service of summons against the Insurer.

Summons must be served on the Insurer within 6 (six) months from the date the Claimant receives the outcome in respect of the representations made, failing which all Benefits in respect of such Claim shall be forfeited and no liability can arise in terms of such Claim.

What happens if there are Unclaimed Benefits?
If a benefit under this Policy is an Unclaimed Benefit, Zestlife will take action to determine if the Nominated Beneficiary is alive and/or aware of the benefit payable to him/her under this Policy. Specifically, in the 3 (three) year period after the Unclaimed Benefit arises, Zestlife may:

- attempt to contact the Nominated Beneficiary telephonically and electronically to advise them of the Unclaimed Benefit; or
- determine the last known contact information of the Nominated Beneficiary by comparing internal and external databases, including the use of internet search engines and/or social media; or
- appoint an external tracing company to locate the Nominated Beneficiary.Before the end of the 3 (three) year period referred to above, Zestlife will confirm the Unclaimed Benefit and transfer the amount of the Unclaimed Benefit to an account in the name of the Insurer, and the Insurer will accept liability for the Unclaimed Benefit.

Before the end of the 3 (three) year period referred to above, Zestlife will confirm the Unclaimed Benefit and transfer the amount of the Unclaimed Benefit to an account in the name of the Insurer, and the Insurer will accept liability for the Unclaimed Benefit.

What Exclusions will result in no Benefit being paid?
No Claim for any Benefit shall be payable in the event of the Claim arising directly or indirectly as a result of:

a) War (whether war be declared or not), invasions, hostilities, civil war, acts of foreign enemy, warlike actions, including accidental explosion and/or deliberate explosion of weapons of war, during war or directly as a result of previous war.
b) Acts of terrorism, where act of terrorism means an act:
    1. whether involving violence or the use of force or not; or
    2. the threat or the preparation thereof, of any person or group(s) of persons whether acting alone or on behalf of or in connection with any organisation(s) or government(s) which appears to be intended to intimidate or influence a de jure or de facto government or the public or a section of the public, or disrupt any segment of the economy; or
    3. from its nature or context is done in connection with political, social, religious, ideological or similar causes or objectives.

This Exclusion of acts of terrorism comprises any loss, damage, cost or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any act of terrorism regardless of any other cause or event contributing concurrently or in any other sequence to the loss or action taken in controlling, preventing, suppressing or in any way relating to any act of terrorism.

c) Strikes, riots and civil commotion.
d) Atomic energy and/or nuclear fission or reaction.
e) Aerial sports and air travel (other than as an ordinary passenger in a fully licensed passenger aircraft).
f) As a result of participation in any hazardous activities including but not limited to racing driving.
g) Active participation in the commission of any criminal activity resulting in a Claim Event.
h) Wilful exposure to danger, intentional self-inflicted injuries, suicide or attempt suicide.
i) You being under the influence of intoxicating liquor or drugs, unless such drugs have been prescribedand taken in accordance with the instructions of a Medical Practitioner or if a Claim Event has been accelerated directly or indirectly as a result of intoxicating liquor or drugs, unless such drugs have beenprescribed and taken in accordance with the instructions of a Medical Practitioner.
j) Any loss or expense of whatsoever nature directly or indirectly caused by, resulting from, or inconnection with any of the following:
    1. Use of nuclear, biological or chemical weapons, or any radioactive contamination.
    2. Attacks on or sabotage of facilities (including but not limited to nuclear power plants, reprocessing plants, final repository sites and research reactors) and storage depots which lead to the release of radioactivity or nuclear, biological or chemical warfare agents, irrespective of whether any of the aforesaid has been performed with the specific use of information technology.
k) A Pre-existing Medical Condition as defined.
l) The Life insured refusing medical treatment where such treatment will improve the disability or illness resulting in disability.

What is your obligation to disclose?
If any information that you have provided is incorrect or misleading, or if you did not disclose all relevant information when applying for the Policy the Insurer may Repudiate a Claim. In such an instance all premiums paid will be forfeited.

What do you do if your details change?
It is your responsibility to inform us within 14 (fourteen) days of any change to the original details supplied by you on the Policy Schedule, and at any other time during the term of your Policy.

Can the Policy be amended?
The Insurer will not change or Vary the terms and conditions during the first 12 (twelve) months after the Commencement Date of the Policy unless there are reasonable actuarial grounds to change or Vary the terms and conditions or when the Variation to the terms and conditions will be to the benefit of the Life Insured. After the first 12 (twelve) months, the Insurer reserves the right to change or Vary the terms and conditions annually. Any changes to the terms and conditions will be notified to the Life Insured 31 (thirty- one) days prior to the change taking effect. Such notification will provide appropriate details of the reasons for any change to the provisions, terms or conditions of the Policy and an explanation of the implications of the change. Any Variations and or changes will be binding on both the Insurer and the Insured and can be applied only after written communication of these changes has been sent to the Life Insured's last known address as it appears in our records at that time.

Can you cancel the Policy?
Should you not be completely satisfied with the Policy and wish to cancel the Policy, you must notify us in writing within the Cooling-off Period, 31 (thirty-one) days after receipt of the Policy or within 31 (thirty-one) days from the date on which it was deemed you have received the Policy. If there is no Claim outstanding or paid, any premium paid will be refunded less the cost of any risk cover enjoyed.

WAITING PERIODS AND PRE-EXISTING CONDITIONS.

You may cancel the Policy in writing at any time (after the initial 31 (thirty-one) day period from the Commencement Date of the Policy) by giving us 31 (thirty-one) days' notice. Any premium paid within this notice period will not be refunded but you enjoy cover during the notice period. Such a cancellation will not attract a refund of premiums paid.

Can the Insurer cancel the Policy?
The Insurer can cancel the Policy for whatsoever reason by giving you 31 (thirty-one) days' written notice of cancellation. The Insurer may immediately cancel this Policy or place it on hold, refuse any transaction or instructions, or take any other action considered necessary in order to comply with the law and prevent or stop any undesirable or criminal activity.

What happens in the case of fraud?
No Claim shall be paid under this Policy if it is in any way fraudulent or if any fraudulent means are used by you or anyone acting on your behalf to obtain any Benefit. In such an instance the Policy will be cancelled by the Insurer and any premium/s paid will not be refunded.

Are there any territorial limits on your cover?
If you are going to be outside South Africa for more than 90 (ninety) days in a row, you need to let the Insurer know in writing and provide relevant details of where you are and the purpose of your travel. The Insurer may or may not accept this change or may accept this change with conditions. If the Insurer does not accept the change, your Policy will terminate. The Insurer may ask and consider any relevant information to make a decision. The latest Policy terms and conditions will apply if the change is made.

What currency and laws apply?
All payments in terms of this Policy shall be in South African currency and any question of law arising shall be decided according to the laws of the Republic of South Africa.

Processing and Protection of Personal Information
Your privacy is of utmost importance to Us. We will take the necessary measures to ensure that any and all information, including Personal Information (as defined in the Protection of Personal Information Act 4 of 2013) provided by You or which is collected from You is processed in accordance with the provisions of the Protection of Personal Information Act 4 of 2013 and further, is stored in a safe and secure manner.

You hereby agree to give honest, accurate and up-to-date Personal Information and to maintain and update such information when necessary. You accept that your Personal Information collected by Us may be used for the following reasons:

1) to establish and verify Your identity in terms of the Applicable Laws;
2) to enable Us to fulfil our obligations in terms of this Policy;
3) to enable Us to take the necessary measures to prevent any suspicious or fraudulent activity in terms of the Applicable Laws; and
4) reporting to the relevant Regulatory Authority/Body, in terms of the Applicable Laws.

We may share Your information for further processing, with the following third parties, which third parties have an obligation to keep Your Personal Information secure and confidential:

1) Payment processing service providers, merchants, banks and other persons that assist with the processing of Your payment instructions;
2) Law enforcement and fraud prevention agencies and other persons tasked with the prevention and prosecution of crime;
3) Regulatory authorities, industry ombudsman, governmental departments, local and international tax authorities, and other persons that we, under the law, have to share your information with;
4) Credit Bureaus;
5) Our service providers, agents and sub-contractors like couriers and other persons we use to offer and provide products and services to any Policyholder; and
6) Persons to whom we cede our rights or delegate our authority to in terms of this Policy.

You acknowledge that any Personal Information supplied to Us in terms of this Policy is provided according to the Applicable Laws.

Unless consented to by Yourself, We will not sell, exchange, transfer, rent or otherwise make available Your Personal Information (such as Your name, address, email address, telephone or fax number) to any other parties and You indemnify Us from any Claims resulting from disclosures made with Your consent.

You understand that if We have utilised Your Personal Information contrary to the Applicable Laws, You have the right to lodge a complaint with Guardrisk. Should the Insurer not resolve the complaint to Your satisfaction, You have the right to escalate the complaint to the Information Regulator.

Treating Customers Fairly
The TCF principles are viewed seriously by the Insurer and all 6 (six) Outcomes are practiced at all times. We will, in all Our interactions with any client, endeavour to deliver excellent customer experiences which we will achieve through the ongoing review of all our business practices and analysis of complaints. It is our objective to be fair in Our treatment of all clients and partners and being compliant, in all aspects, of the 6 (six) Outcomes of the Treating Customers Fairly framework. These Outcomes are:

- You are confident that Your fair treatment is key to Our culture;
- Products and services are designed to meet your needs;
- We will communicate clearly, appropriately and on time;
- We provide advice which is suitable to your needs and circumstances;
- Our products and services meet your standards and are of an acceptable level; and
- There are no barriers to access our services or lodge a complaint or to submit a Claim.

DISCLOSURES.

OUR COMPLAINTS RESOLUTION PROCEDURE

Procedure when submitting a complaint to us
If any of our representatives provided you with financial advice or any other intermediary service, and you feel that we or our representative:

- did not comply with the Financial Advisory and Intermediary Services Act and that you suffered financial prejudice as a result;
- intentionally or negligently gave financial advice or rendered an intermediary service to you which caused prejudice or damage or is likely to cause damage; or
- treated you unfairly, or if your Claim is not successful, or if you do not agree with the value of your Claim and you have additional evidence that you think we have not considered, then you must please write an email to **complaints@guardrisk.co.za** or contact Complaints Department on Tel: 086 033 3361 with the following information:
- Your name, surname and contact details.
- A complete description of your complaint.
- The name of the person who provided you with financial advice or an intermediary service.
- The date on which the matter complained about happened.
- All documentation relating to your complaint.
- How you would prefer to receive communication from us regarding your complaint i.e. by e-mail, fax, post and please provide us with the e-mail address, fax number or address where you would prefer to receive such communication.

Our procedure when receiving your complaint

- When we receive your complaint, we will send you an acknowledgement of receipt within 3 (three) working days.
- We will investigate your complaint and provide you with feedback within 5 (five) working days of receipt of your complaint.
- If we are unable to resolve your complaint within 15 (fifteen) working days or are unable to resolve the complaint to your satisfaction, you have the right to refer your complaint to the Ombud appointed specifically for this purpose. The contact details of the Ombud as provided below under the contact details.

What are the contact details?

Insurer
Guardrisk Life Ltd
PO Box 786015
Sandton
2146
Tel: 011 669 1000
Email: **info@guardrisk.co.za**

Compliance Officer for Guardrisk Life Ltd
The Compliance Manager
Tel: 011 669 1000
Email: **compliance@guardrisk.co.za**

For any queries regarding the Policy, you may contact:

Zestlife Complaints relating to applications
Complaints Department
Tel: 021 180 4220
Email: **complaints@zestlife.co.za**

In the event that you have any complaints regarding the Policy, you may contact:

Particulars of the National Financial Ombud Scheme
Claremont Central
Building, 6th Floor,
6 Vineyard Road,
Claremont,7708
or
110 Oxford Road,
Houghton Estate,
Johannesburg, 2198

Tel: 0860 800 900
Email: **info@nfosa.co.za**
Website: **www.nfosa.co.za**

Financial Sector Conduct Authority (FSCA)
PO Box 35655
Menlo Park Pretoria 0102
Tel: 012 428 8000
Fax: 012 346 6941
Email: **info@fsca.co.za**

Financial Advisory and Intermediary Services (FAIS) Ombudsman
PO Box 41
Menlyn Park 0063
Tel: 012 762 5000
Sharecall: 0860 663 274
Email: **info@faisombud.co.za**

Particulars of Information Regulator
(For complaints relating to the use of Personal Information)
PO Box 31533 Braamfontein
Johannesburg 2017
Tel: 010 023 5200
Email: **POPIAComplaints@inforegulator.org.za**

DISCLOSURES.

DEATH BENEFIT

When will the Death Benefit be paid?
The Death Benefit will be paid in the case of your death. This is a lump sum Benefit in the amount stated in the Policy Schedule.

Once a valid claim for Permanent Disability has been paid, the Policy will cease and there will be no cover for Death or any other Benefit.

For how long will you be covered for the Death Benefit?
Provided you continue paying premiums you will be covered for any Claim as a result of your death until you reach your 70th (seventieth) birthday.

To whom will the Death Benefit be paid?
The Death Benefit is intended to settle the Outstanding Balances on the Credit Agreements specified in the Policy Schedule. The Benefit will first be paid to the nominated Credit Providers and if there is a balance remaining after the Credit Agreements have been settled, the remaining balance will be paid to your nominated Beneficiaries.

What documents are required to assess a Death Benefit Claim?
The following documents will be required to assess the Claim:
- Completed claim form.
- Copy of the Identity Document of the deceased and the Claimant.
- Copy of the death certificate.
- Copy of notice of death form completed by the Medical Practitioner who certified the death. This is the DHAI663 form.
- Identity Document of Beneficiary/ies or copy of birth certificate/s.
- Proof of bank details of the Beneficiary/ies not older than 3 (three) months.
- Certificate of balance for each Credit Provider covered by this Policy, reflecting the Outstanding Balance(s) of the Credit Agreement(s).
- Proof of bank details of the Credit Provider not older than 3 (three) months.

The following documentation may be required where applicable:
- Proof of legal guardianship if the Beneficiary is a minor.
- Proof of bank details of the legal guardian not older than 3 (three) months.
- Copy of the drivers' license of the driver of the vehicle if the death was due to a motor vehicle accident.
- Copy of the pathology/toxicology test results if the death was due to a motor vehicle accident andthe deceased was the driver.
- Copy of the police report and the post-mortem/autopsy report, if the death was due to unnatural causes.
- Copy of the medical report if the death was within 12 (twelve) months from Commencement Date.

The Insurer reserves the right to request further documentation when deemed necessary.

RETRENCHMENT BENEFIT

When will the Retrenchment Benefit be paid?
The Retrenchment Benefit will become payable after your Retrenchment, subject to the Waiting Period.

What is the Retrenchment Benefit?
This is a monthly Benefit in the amount specified in the Policy Schedule. The Retrenchment Benefit will be paid to you or to the Credit Providers if the Policy Benefits have been ceded to a Credit Provider on the due dates of the monthly instalments.

The payment of this monthly Benefit will commence in the second month after the date that you become retrenched until the occurrence of any of the following events:
- the completion of the Retrenchment Benefit period stated in the Policy Schedule.
- you are employed, whichever occurs first.

The total monthly Retrenchment Benefit payable will be subject to the monthly maximum stipulated in the Policy Schedule.

For how long will you be covered for the Retrenchment Benefit?
Provided you continue paying premiums you will be covered for any Claim as a result of your Retrenchment until you reach your 65th (sixty-fifth) birthday.

What are the Waiting Periods for the Retrenchment Benefit?
The Retrenchment Benefit will not be paid if you have been employed by your employer for less than 12 (twelve) months prior to your Retrenchment or if you are Retrenched within the first 6 (six) months from the Commencement Date or reinstatement date of the Policy.

Please note that these Retrenchment Benefit Waiting Periods where cover is excluded for a period of time will not be applied if you were covered for retrenchment in a Policy which you held previously and which is being replaced by this Policy provided that the time periods applicable to the Waiting Periods in your previous Policy have been met.

Are there circumstances when the Retrenchment Benefit will not be paid?
You will NOT be entitled to a Retrenchment Benefit under the following circumstances;
- If you are self-employed, whether as a sole proprietor, partner in a firm or association, member of a close corporation or a sole director.
- If you are employed in a business owned by a member of your family.
- If you resign or accept any form of voluntary Retrenchment.
- The expiry of a non-renewable fixed term contract or the termination of a contract of temporary or casual nature.
- If you retire or you are dismissed by your employer.
- If you or your employer was aware that you were to be Retrenched prior to the date the Policy commenced.
- If you lose your job due to fraud, dishonesty or any illegal conduct on your part.
- If your loss of employment is directly or indirectly due to any sickness, disease, injury or medical condition.
- If you are on a temporary, casual or fixed term contract and it reaches its natural end (your services are terminated on the stated date when your contract comes to an end and your contract is not extended or renewed).
- If you are not employed or a pensioner.

What documents are required to assess a Retrenchment Benefit Claim?
The following documents will be required to assess the Claim:
- Completed claim form.
- Copy of the Identity Document of the Life Insured.
- Employer declaration.
- Copy of the employer notice of retrenchment communication (the terms and conditions).
- Copy of UI19 record.
- Copy of employment contract.
- Copies of payslips or bank statements as proof of income or loss of earnings,
- Certificate of balance for each Credit Provider covered by this Policy, reflecting the outstandingbalance of the Credit Agreement.
- Proof of bank details of the Credit Provider not older than 3 (three) months.

The Insurer reserves the right to request further documentation when deemed necessary.

DISCLOSURES.

TOTAL AND PERMANENT DISABILITY BENEFIT

What is the meaning of Total and Permanent Disability?
Total and Permanent Disability means your continuous, total and permanent inability due to injury, disease or illness, to perform the material and substantial duties of any occupation in the open labour market for which you are qualified or suited or could reasonably be expected to become qualified or suited taking into account the degree of Disability and your knowledge, training, education, ability, age and experience. You will however only be considered to be Totally and Permanently Disabled if your Total and Permanent Disability results in you experiencing a loss of income and the Insurer is satisfied that the Disability will remain total and permanent. Disability, Disablement and Totally and Permanently Disabled shall have a corresponding meaning.

When will the Total and Permanent Disability be paid?
The Total and Permanent Disability Benefit will be paid if you become Totally and Permanently Disabled. This is a lump sum Benefit in the amount stated in the Policy Schedule. This Benefit will only be paid after a 6 (six) month period from your date of Total and Permanent Disability as determined by the Insurer or on such earlier date provided that the Insurer is satisfied that you are Totally and Permanently Disabled.

To whom will the Total and Permanent Disability Benefit be paid?
The Total and Permanent Disability Benefit is intended to settle the Outstanding Balances on the Credit Agreements specified in the Policy Schedule. Therefore, the Benefit will first be paid to the nominated Credit Providers and if there is a balance remaining after the Credit Agreements have been settled, that balance will be paid to you.

For how long will you be covered for the Total and Permanent Disability Benefit?
Provided you continue paying premiums you will be covered for any Claim as a result of your Total and Permanent Disability until you reach your 65th (sixty-fifth) birthday.

Are there circumstances when the Permanent Disability Benefit will not be paid?
You will not be paid a Permanent Disability Benefit if your disability Claim has arisen from any of the following;

- Mental health disorder, including anxiety disorders, depression, stress, adjustment disorders, emotional or behavioural disorders, disorders related to fatigue including chronic fatigue syndrome, myalgic encephalomyelitis, fibromyalgia (chronic widespread pain), post viral fatigue syndrome, fatigue, exhaustion, burnout, psychosomatic disorders, and any other mental and functional nervous disorder, or treatment/complications of any such mental health disorders; shall be excluded.
- Disease or disorder of, or injury to, the spine, its intervertebral discs, joints, nerve roots, spinal cord or supporting musculature and ligaments and any neurological complications including any treatment and/or complications thereof. However, the accidental, total and irrecoverable loss of function of 2 (two) or more limbs due to injury of the limbs, spinal cord or brain, shall not be excluded, provided that Total and Permanent Disability is established. Such functional loss must be considered to be permanent by a neurologist and such injury must have arisen as a result of an Accident only independent of any other cause, occurring after the Commencement Date.

You will also not be paid the Permanent Disability Benefit If you are not employed or a pensioner.

What documents are required to assess a Total and Permanent Disability Benefit Claim?
The following documents will be required to assess the Claim:

- Completed claim form.
- Copy of the Identity Document of the Life Insured.
- Employer declaration.
- Copy of the job description of the Life Insured.
- Copies of sick leave records.
- Medical report completed by the Medical Practitioner who treated the Life Insured.
- Copies of any Medical Specialist reports supporting the Disability.
- Copies of pathology and radiology results.
- Proof of Life insured qualifications - copies of certificate/s, diplomas/degree/s.
- Certificate of balance for each Credit Provider covered by this Policy, reflecting the outstanding balance of the Credit Agreement.
- Proof of bank details of the Credit Provider not older than 3 (three) months.

The Insurer reserves the right to request further documentation when deemed necessary.

TEMPORARY DISABILITY BENEFIT FOLLOWED BY THE TOTAL AND PERMANENT DISABILITY BENEFIT

What is the meaning of Temporary Disability?
Temporary Disability means Temporary Disability as a result of an illness, injury or Accident which in the opinion of the Insurer makes you unable to do your normal job or a similar job to the one you did for remuneration immediately before becoming Disabled, for a period of at least one month and which has resulted in the total loss in your ability to earn an income for a period of one month or more.

What is the meaning of Total and Permanent Disability?
Total and Permanent Disability means your continuous, total and permanent inability due to injury, disease or illness, to perform the material and substantial duties of any occupation in the open labour market for which you are qualified or suited or could reasonably be expected to become qualified or suited taking into account the degree of Disability and your knowledge, training, education, ability, age and experience.

You will however only be considered to be Totally and Permanently Disabled if your Total and Permanent Disability results in you experiencing a loss of income and the Insurer is satisfied that the Disability will remain total and permanent. Disability, Disablement and Totally and Permanently Disabled shall have a corresponding meaning.

What is the Temporary Disability Benefit followed by the Total and Permanent Disability Benefit?
This is a monthly Benefit which can be used to cover the monthly instalments on your Credit Agreements which is paid if you are Temporarily Disabled . This may be followed by a lump sum Benefit if you are Totally and Permanently Disabled.

The payment of the monthly Temporary Disability specified in the Schedule will commence in the second month after the date that you become Temporally Disabled and it will continue for a maximum period of 11 (eleven) months provided that you remain Temporarily Disabled during this payment period.

The monthly Benefit will cease at the end of the month that you are deemed by the Insurer to no longer be Temporarily Disabled. This Benefit will be paid to you or to the Credit Providers if the Policy Benefits have been ceded to a Credit Provider on the due dates of the monthly instalments. No repeat Claims for the Temporary Disability Benefit that arise from the same Claim event will be permitted.

The Total and Permanent Disability Benefit will be paid if you are Totally and Permanently Disabled. This is a lump sum Benefit in the amount stated in the Policy Schedule which will be paid after the monthly Temporary Disability payments have ceased or at an earlier date as determined by the Insurer when you are deemed to be Totally and Permanently Disabled provided that the monthly Temporary Disability Benefits will cease upon the payment of the lump sum Total and Permanent Disability Benefit.

DISCLOSURES.

For how long will you be covered for the Temporary Benefit followed by the Total and Permanent Disability Benefit?
Provided you continue paying premiums you will be covered for any Claim as a result of your Disability until you reach your 65th (sixty-fifth) birthday.

Are there circumstances when the Temporary Disability Benefit followed by the Total and Permanent Disability Benefit will not be paid?
You will not be paid this Benefit if your Disability Claim has arisen from any of the following;

- Mental health disorder, including anxiety disorders, depression, stress, adjustment disorders, emotional or behavioural disorders, disorders related to fatigue including chronic fatigue syndrome, myalgic encephalomyelitis, fibromyalgia (chronic widespread pain), post viral fatigue syndrome, fatigue, exhaustion, burnout, psychosomatic disorders, and any other mental and functional nervous disorder, or treatment/complications of any such mental health disorders; shall be excluded.
- Disease or disorder of, or injury to, the spine, its intervertebral discs, joints, nerve roots, spinal cord or supporting musculature and ligaments and any neurological complications including any treatment and/or complications thereof;

However, the Accidental, total and irrecoverable loss of function of two or more limbs due to injury of the limbs, spinal cord or brain, shall not be excluded, provided that Temporary or Total Permanent Disability is established. Such functional loss must be considered to be temporary or permanent by a neurologist and such injury must have arisen as a result of an Accident occurring after the Commencement Date.

You will not be paid a Temporary Disability Benefit or a Total and Permanent Disability Benefit, if you are not employed or a pensioner.

What documents are required to assess a Temporary Disability Benefit Claim?
The following documents will be required to assess the Claim:

- Completed claim form.
- Copy of the Identity Document of the Life Insured.
- Employer declaration.
- Copy of the job description of the Life Insured.
- Copies of sick leave records.
- Medical report completed by the Medical Practitioner who treated the Life Insured
- Copies of any Medical Specialist reports supporting the Disability.
- Copies of pathology and radiology results.
- Proof of Life insured qualifications - copies of certificate/s, diplomas/degree/s.
- Certificate of balance for each Credit Provider covered by this Policy, reflecting the outstanding balance of the Credit Agreement.
- Proof of bank details of the Credit Provider not older than 3 (three) months.

The Insurer reserves the right to request further documentation when deemed necessary.

CRITICAL ILLNESS BENEFIT

Which Critical Illness conditions are covered?
The Policy covers you in case you are diagnosed with one of the Critical Illnesses that are listed and defined in the "Critical Illnesses Definitions" section below.

When will the Critical Illness Benefit be paid?
The Critical Illness Benefit is the lump sum Benefit specified in the Policy Schedule which will be paid if you suffer from a Critical Illness, as defined below. To qualify for this Benefit you must survive for a period of at least 14 (fourteen) days that will be calculated from the date of diagnosis of the Critical Illness.

To whom will the Critical Illness Benefit be paid?
The Critical Illness Benefit is intended to settle the Outstanding Balances on the Credit Agreements specified in the Policy Schedule. Therefore the Benefit will first be paid to the nominated Credit Providers and if there is a balance remaining after the Credit Agreements have been settled the remaining balance will be paid to you.

For how long will you be covered for the Critical Illness Benefit?
Provided you continue paying premiums you will be covered for any Claim as a result of your Critical Illness until you reach your 65th (sixty-fifth) birthday.

What are the Waiting Periods for the Critical Illness Benefit?
The Critical Illness Benefit will not be paid for Critical Illnesses that occur within 6 (six) months from the commencement of this Policy.

Please note that this Critical Illness Benefit Waiting Period where cover is excluded for a period of time will not be applied if you were covered for Critical Illness in a Policy which you held previously and which is being replaced by this Policy provided that the time periods applicable to the Waiting Periods in your previous Policy have been met.

If you increase your Critical Illness Benefit amount as you are entitled to do after the commencement of this Policy, the Insurer will apply the 6 (six) month Critical Illness Waiting Period to the increased portion of cover.

What documents are required to assess a Critical Illness Benefit Claim?
The following documents will be required to assess the Claim:

- Completed claim form.
- Copy of the Identity Document of the Life Insured.
- Medical report completed by the Medical Practitioner who treated the Life Insured.
- Copies of any Medical Specialist reports supporting the Critical Illness.
- Copies of pathology and radiology results.
- Certificate of balance for each Credit Provider covered by this Policy, reflecting the outstanding balance of the Credit Agreement.
- Proof of bank details of the Credit Provider not older than 3 (three) months.

The Insurer reserves the right to request further documentation when deemed necessary.

Critical Illnesses Definitions
The Insurer requires proof that all the definitions in this document have been met according to generally accepted medical practice. The definitions of the covered Critical Illnesses are provided below.

1. Stroke

What is a Stroke?
A Stroke occurs when the blood supply to a portion of the brain is obstructed and this part of the brain tissue dies. It can also happen when there is bleeding into the brain tissue due to a weakening or abnormality of the blood vessel wall. A common cause of the rupture of a brain blood vessel is longstanding uncontrolled high blood pressure.

What is the definition of a Stroke that qualifies for a Benefit payment?
Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in neurological deficit lasting longer than 24 (twenty-four) hours, confirmed by neuro-imaging investigation and appropriate clinical findings by a specialist neurologist.

DISCLOSURES.

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.

The Benefit will be paid even if there is almost full recovery, with little residual symptoms or signs.

2. Coronary Artery By-pass Graft Surgery (CABG)

What is CABG?
Coronary artery bypass graft surgery, also called heart bypass or bypass surgery, is a surgical procedure performed to relieve chest pain and reduce the risk of death from heart disease.

Arteries or veins from elsewhere in the patient's body (most commonly the leg) are joined to the coronary arteries of the heart to bypass the narrowing's of the affected or diseased arteries. This improves the blood supply and circulation to the heart muscle. The terms "single bypass", "double bypass", "triple bypass", "quadruple bypass" and "quintuple bypass" refer to the number of coronary arteries bypassed in the procedure.

This surgery is usually performed with the heart stopped necessitating the usage of highly specialised theatre equipment to keep the heart and the lungs working during the course of the operation.

What is the definition of a CABG that qualifies for a Benefit payment?
The undergoing of surgery to correct the narrowing of, or blockage to, any one coronary artery by means of a by-pass graft.

3. Heart Attack

What is a Heart Attack?
A heart attack or myocardial infarction means the death of a portion of the heart muscle, as a result of an acute interruption of blood supply to the myocardium.

What is the definition of a heart attack that qualifies for a Benefit payment?
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, e.g. ST-segment and T-wave changes indicative of myocardial ischemia or myocardial infarction, and
3) Raised cardiac markers:
   - Trop T > 0,5 ng/ml or Trop I > 0,25 ng/ml, or
   - Raised CK-MB mass
     * Up to 2 times normal values in acute presentation phase, or
     * Up to 4 times normal values post-intervention.

Total CPK elevation of up to 2x normal values, 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.

ECG changes indicative of myocardial ischemia that may progress to Myocardial Infarction are defined as:
1) 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. (Ref. 1)
2) Patients without ST-segment elevation:
   * ST-segment depression of at least 0.1 mV;
   * T-wave abnormalities only. (Ref. 1)

4. Cancer

What is Cancer?
Cancer is an uncontrolled growth that spreads into the normal tissue surrounding the organ where the Cancer originates.

What is the definition of Cancer that qualifies for a Benefit payment?
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 also included in this definition:
- Acute Myeloid Leukaemia
- Chronic Lymphocytic Leukaemia (Stage 0 or higher on the Rai classification)
- Chronic Myeloid Leukaemia (whether requiring bone marrow transplant or not)
- Acute Lymphocytic Leukaemia
- Hodgkins/Non Hodgkins lymphoma Stage 1 or higher on Ann Arbor classification
- Multiple Myeloma Stage 1 or higher on the Durie-Salmon Scale
- Hairy cell leukaemia

The following conditions are excluded from this definition:
- All cancers in situ and all pre-malignant conditions.
- 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, other than malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin).

5. Kidney Failure

What is the definition of Kidney Failure that qualifies for a Benefit payment?
The end stage irreversible failure of both kidneys to function the result of which necessitates regular dialysis. End stage kidney failure is when both kidneys' permanent functioning is at less than 10% of their capacity and results in the kidneys no longer able to filter the blood, help control blood pressure and excrete wastes.

6. Major Organ Transplant

What is the definition of Major Organ Transplant that qualifies for a Benefit payment?
The actual undergoing of a transplant of any of the below organs as a recipient or the inclusion on an official organ transplant waiting list for any of the below organs:
- one of the following whole human organs: heart, lung, liver, kidney, pancreas, or
- human bone marrow using haematopoietic stem cells preceded by total bone marrow ablation

The transplant must be medically necessary and based on objective confirmation of organ failure. Other than the above stem cell transplants are excluded.

7. Paraplegia, Quadriplegia, Diplegia, Hemiplegia and Tetraplegia

What is the definition of Paraplegia, Quadriplegia, Diplegia, Hemiplegia and Tetraplegia that qualifies for a Benefit payment?
The total loss of function of two or more limbs due to injury or disease of the spinal cord or brain, where such functional loss is considered to be permanent by a neurologist. Loss of function of limbs classified as Diplegia, Hemiplegia, Tetraplegia and Quadriplegia are included.

DISCLOSURES.

8. Major burns

What is the definition of major burns that qualifies for a Benefit payment?
For the Claim to be valid, the burns must extend to the subcutaneous tissue and the burn at this level must cover at least 20% of the total body surface as assessed by the Lund and Browder chart or its equivalent. Burns to the epidermis or dermis levels only shall not deem to be part of the minimum 20% level.

9. Coma

What is the definition of coma that qualifies for a Benefit payment?
A state of continuous and persistent unconsciousness not induced by sedation, and a Glasgow Scale of less than 9 prior to ventilation, lasting for at least 96 hours with no reaction to internal or external stimuli and the use of life support systems such as ventilators or intravenous nourishment.

Parameter	Response	Score
Eye opening	Spontaneous To voice To pain None	4 3 2 1
Verbal response	Oriented Confused Inappropriate Incomprehensible sounds None	5 4 3 2 1
Motor response	Localises pain Withdraws to pain Flexion response to pain Extension response to pain None	5 4 3 2 1

Road Accident Protection
What is the meaning of certain key words and phrases?

Collision
is the act of a moving Motor Vehicle striking into another Motor Vehicle or an object.

Hospital
means an institution which:
- Is licensed in accordance with the applicable laws of the jurisdiction in which it is located:
- Is primarily engaged in providing, for compensation from its patient, diagnostic, medical and surgical facilities for the care and treatment of insured persons:
- Has staff of one or more qualified physicians available at all times;
- Has 24-hour day nursing services by registered graduate nurses under the permanent supervision of the physician in charge.
- Maintains in-patient facilities;
- Maintains a daily medical record of each of its patients;
- Does not include any institution which is primarily a rest or convalescent facility, rehabilitation wards or centres, a place for custodial care, hospices, a facility for the aged or alcoholics or drug addicts or a nursing home even if it is registered as a hospital or clinic.

Immediate Family Member
means your current spouse in terms of a legal marriage and your unmarried dependent natural Children, step-Children or legally adopted Children who have not yet reached their 21st (twenty-first) birthday.

Motor Vehicle
means any vehicle designed or adapted for propulsion or haulage on a road by means of fuel, gas or electricity, including a trailer, a caravan, an agricultural or any other implement designed or adapted to be drawn by such motor vehicle.

Motor Vehicle Accident
means an unexpected and sudden event which is caused solely and directly by a Collision causing injury to the occupants or a pedestrian. Such injury must be independent of any other cause. Such accident must result in external, visible injury confirmed by clinical examination and appropriate testing and excludes the following:
- Any event that is traceable to psychiatric trauma and the insured person's state of mental or physical health prior to or after the event giving rise to a claim;
- Non-visible soft tissue injuries;
- Any other injuries not sustained as a direct result of the Collision.

Pre-existing Bodily Injury
means an injury sustained by a Life Insured or an Immediate Family Member for which he or she has or should reasonably have received relevant medical treatment or advice by a Medical Practitioner, prior to the Commencement Date of the Policy, including but not limited to, any physical disease, defect, infirmity or condition which existed prior to the Policy commencing.

Spouse
is your partner to whom you are legally married in accordance with law or custom, or a common law partner with whom you live as if you were married.

When will the Road Accident Benefit be paid?
The Road Accident Protection Benefit is a lump sum Benefit in the amount stipulated in the Policy Schedule that will be paid if you or your Immediate Family Member who suffers personal injury caused in a Motor Vehicle Accident on a public road in the Republic of South Africa. This Benefit will only be paid if as a result of the injuries sustained you or your Immediate Family Member is admitted to Hospital as an in- patient not later than 24 (twenty-four) hours after the Motor Vehicle Accident and remains in Hospital for 5 (five) consecutive nights.

This Benefit may not be paid if, in the reasonable opinion of the Insurer based on objective medical evidence, the injuries sustained by the insured person were not sufficiently serious so as to warrant a 5 (five) night stay in Hospital or if the admission period appears exaggerated in any way.

The Road Accident Benefit will not be paid if the Claim has arisen whilst you or your immediate family were driving a Motor Vehicle without a valid drivers' license or were passengers in a Motor Vehicle Accident when the driver did not hold a valid drivers' license irrespective if you or an Immediate Family Member were aware of this fact.

For how long will you be covered for the Road Accident Benefit?
Provided you continue paying premiums you will be covered for the Road Accident Benefit until you reach your 65th (sixty-fifth) birthday.

To whom will the Road Accident Benefit be paid?
The Road Accident Benefit will be paid directly to you.

Are there circumstances when the Road Accident Benefit will not be paid?
The Insurer will not be liable to pay a Road Accident Benefit in respect of any Claim for an injury which is directly or indirectly caused by, any of the following:
- You or an Immediate Family Member are admitted into Hospital where the cause of admission does not warrant a stay in excess of the MDG guidelines and where such a treatment can be administered, in the opinion of the Insurer's Chief Medical Officer, on an out-patient basis.
- You or an Immediate Family Member is admitted into Hospital where there is no objective indications or impairment in normal health.

DISCLOSURES.

- You or an Immediate Family Member is admitted into an establishment which is not a Hospital as defined under this Policy.
- You or an Immediate Family Member is admitted into Hospital for the investigation of pain or for pain management or for pain-related conditions and treatment in this context shall include bed rest, traction, physiotherapy, spinal blocks, analgesics or intravenous pain medication.
- You or an Immediate Family Member is admitted for a Pre-existing Bodily Injury as defined.

What documents are required to assess a Road Accident Claim?
The following documents will be required to assess the Claim:
- Completed claim form.
- Copy of the Identity Document of the Life Insured.
- Medical report completed by the Medical Practitioner who treated the Life Insured.
- Copy of the Police accident report.
- Copies of the hospital account and hospital records.

The Insurer reserves the right to request further documentation when deemed necessary.

What is the maximum Road Accident Benefit amount that will be payable
The maximum Road Accident Benefit payable in aggregate in any 12-month period for you and your Immediate Family Members is R300 000.

RoadCover Subscription (Non-Underwritten Benefit)
The RoadCover Subscription gives victims of Motor Vehicle Accidents immediate access to an effective Road Accident Fund (RAF) Claims management system with NO costs to themselves. This service offering manages your Claim with the RAF from start to finish, allowing its members who become Motor Vehicle Accident victims, to be compensated by the RAF in full.

The RoadCover Subscription is not part of the Policy. It is a non-underwritten benefit that is not offered by the Insurer and this benefit is not regulated in terms of the Financial Advisory and Intermediary Services Act ("FAIS Act") and you are therefore not afforded the same protections which apply in respect of financial products or services which are regulated in terms of the FAIS Act. All queries and requests regarding this service must be directed to RoadCover by contacting them on 0860 RCOVER/726837.

Who is entitled to a Claim?
- A person who was personally injured except a driver who was the sole cause of the accident
- The dependant of a deceased victim
- A close relative of the deceased in respect of funeral expenses
- A Claimant under the age of 18 who must be assisted by a parent or legal guardian

What you could Claim from RAF:
- Medical expenses (past and future)
- Funeral expenses
- Loss of earnings or income if a person is disabled (past and future)
- Loss of support for a dependant of a deceased victim (breadwinner, past and future)
- General damages for pain, suffering and disfigurement in the case of an injury.

The Benefits of RoadCover
- Members will have a dedicated RoadCover Legal practitioner to formulate their Claim with the RAF
- RoadCover manages the entire Claim from start to finish, effectively halving the Claim turnaround time
- Members receive 100% of the RAF pay-out – RoadCover charges no additional fees
- For the duration of the Claim the individual receives the following:
  - Legal representation
  - Administration and Claims management
  - Accident reconstruction
  - Required Medico-legal reports
  - Required actuarial reports
  - Past and future loss of earning reports
  - Past and future loss of support reports

How to contact RoadCover
Phone RoadCover (0860 RCOVER/726837) during office hours (8:30 to 16:30) and give the particulars of your case.

BMW Financial Services
1 Bavaria Avenue
Randjespark Ext. 17
Midrand
1685

Tel: 0860 100 269

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