Oneplan Health Insurance Policy Wording

Underwritten by

Bryte

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The Oneplan Health Insurance Plan is a unique combination of short-term insurance cover and non-insurance cover which has been combined to offer you, our valued client, the best of both worlds at an affordable monthly premium. It is important to take note of each section, its cover, limitations, waiting periods and excesses payable to ensure you fully understand the unique cover of each section. This policy wording is generic and must be read in conjunction with your schedule as not all cover may be applicable to the plan or option that you have selected. Oneplan is not a medical aid and under no circumstances must it be considered as a replacement for the benefits offered by a medical aid, nor does it offer cover equivalent to the structure or benefits offered by a medical aid.

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SECTION 1

1 DEFINITIONS, GENERAL CONDITIONS AND LIMITATIONS

1.1 DEFINITIONS

In this policy all words and expressions signifying the singular shall include the plural and vice versa. Words and expressions implying the masculine gender shall include the feminine. The following words and expressions shall have the following meanings:

1.1.1 "Accident" means a sudden, unexpected, unforeseen, unusual, unintended event which occurs at a specific time and place, excluding suicide or attempted suicide, the result of which incident requires immediate medical attention.

1.1.2 "Admission" means a prolonged stay (overnight as an in-patient) in a facility that meets the definition of a hospital; this does not include casualty wards.

1.1.3 "Application Form" means the form that the Principal Insured completes, that shall be the basis for the selection of cover. This may be electronic or recorded applications.

1.1.4 "Children" means the Principal Insured's unmarried minor child, who has not been emancipated and who has not yet reached the age of twenty one. There will be no age restriction for children who are either mentally or physically incapacitated from maintaining themselves, provided that the children are dependent on the Principal Insured for support and maintenance.

1.1.5 "Chronic" means any illness or disease that requires medication and treatment for an uninterrupted period of more than three months.

1.1.6 "Congenital" means a condition existing at birth and often before birth or that develops during the first month of life.

1.1.7 "Contact sport" means a sport, such as (but not limited to) football, hockey, rugby or boxing that involves physical contact between players as part of the normal play.

1.1.8 "Day" means where an Insured Person has been admitted before 24h00 as an in-patient in a medical facility and then follows to include a portion of the next consecutive 24 hour period.

1.1.9 "Dependant" means a spouse, partner, children under the age of twenty one or children over the age of twenty one dependent upon the Principal Insured due to mental or physical ability and how has been selected assuch by the Principal Insured in the Application Form.

1.1.10 "Disability" means an Insured person who has sustained an injury whereby they cannot perform ordinary tasks or occupations with the same ability as a person without such disability.

1.1.11 "Dread Disease" means specifically defined critical, high cost conditions that may influence the longevity of life. The terms of this policy specify only the following conditions as Dread Diseases: heart attack, coronary artery disease requiring surgery, heart valve replacement, aorta surgery, stroke, cancer, acute kidney failure, brain tumours and major organ transplants.

1.1.12 "Excess" means the amount of the claim that will not be payable by the Insurer on behalf of the Insured.

1.1.13 "Exclusions" means any conditions or illnesses that are excluded for a period as determined by the Underwriters.

1.1.14 "Family" means a social unit who reside together or form a social grouping and consists of a Principal Insured who is older than eighteen, his/her spouse or life partner and their children as per the defined above.

1.1.15 "Grace Period" means the period of grace allowed for non-payment of Premium. The Grace Period is fifteen days from the first day of the month in which the Premium was due. During the Grace Period, the policy will be suspended and no claims will be entertained. The Insurer reserves the right to cancel the policy after non-receipt of a Premium within the Grace Period.

1.1.16 "Health loading" means an increase in Premium due to an actuarial calculation based on the probability of risk per Insured Person.

1.1.17 "HIV" means the Human Immunodeficiency Virus that breaks down the human body's immune system and can cause Acquired Immunodeficiency Syndrome (AIDS). AIDS is a condition where the immune system begins to fail, leading to life-threatening opportunistic infections.

1.1.18 "Hospital" means an institution for health care which provides patient treatment by specialized staff and equipment, for sick or injured persons where they are given surgical or medical treatment and providing for longer-term patient stays. This excludes places of recovery and or rehabilitation, drug or otherwise as well as mental institutions.

1.1.19 "Illness" means any unforeseen sickness, illness or disease originating, contracted, commencing or first manifesting itself during the period of insurance. Should the illness re-occur within a six month period, it will be deemed to be part of the initial illness and associated claim.

1.1.20 "Inception Date" means the date on which the policy first became active. This will always fall on the first day of a calendar month.

1.1.21 "Injury" means physical injury, cut, abrasion, bruise, burn or disfigurement, bodily harm, sickness or disease caused to a person by an unforeseen accident.

1.1.22 "Insured Event" means an event that would cause the Insurer to pay a claim as per the cover provided in this policy.

1.1.23 "Insured Person" means a natural person who has applied and been accepted by the Insurer and whose Premium is paid and up to date.

1.1.24 "Insurer" means Bryte Insurance Company Limited.

1.1.25 "Life threatening" means an event in which failure to treat the injury or illness immediately (within one hour of onset) will result in permanent damage to the Insured.

1.1.26 "Medical Expenses" means the costs resulting from treatment for a disease or an accident by a medical doctor or other medical practitioner, in the form of medication or therapy, in hospital (including hospital stay), medical practice or at home (out-patient treatment).

1.1.27 "Month" means one full calendar month commencing on the first day of each month.

1.1.28 "NAEDO" means an advanced debit order mechanism which is automatically activated due to non-receipt of the Premium or any other associated fees. NAEDO will deduct funds immediately from the account holders' bank account when there are funds available and therefore may possibly not be deducted on the nominated date.

1.1.29 "Onecard" means the transactional debit card onto which Health Cover claims are loaded through the advanced mobile claim system, namely USSD. The Onecard may be swiped directly at the provider and proof of payment in the form of an invoice or statement must be kept for record and auditing purposes.

1.1.30 "Pre-Existing Condition" means a medical condition that was in existence prior to this policy's Inception Date, or in existence during the first three months during the waiting period or that was newly diagnosed within the first three months from the Inception Date of the policy, whether it was known or unknown to the Insured.

1.1.31 "Premium" means the fixed monthly amount as stipulated by the Insurer in order to indemnify the Insured for specific events as defined in the Schedule.

1.1.32 "Principal Insured" means the natural person in whose name the agreement is entered into and whose name is reflected on the Schedule.

1.1.33 "Professional Sport" means the Insured's participation in a sporting activity, from which the majority of the Insured's income is earned.

1.1.34 "Schedule" means the document that lists the detail of the Insured amounts.

1.1.35 "South African Borders" means the land within the registered and published national boundaries of the Republic of South Africa.

1.1.36 "Specialist" means a doctor who has completed advanced education and clinical training in a specific field of medicine, for example a physician such as, but not limited to a neurologist, pulmonologist etc. or surgeon such as, but not limited to a general surgeon, orthopaedic surgeon etc.

1.1.37 "Spouse" means a partner in marriage, civil union, domestic partnership or common-law marriage.

1.1.38 "Symptom" means any sensation or change in bodily function experienced by an individual that could be associated with a particular disease and is regarded as evidence of existence of a disease or illness. This includes, but is not limited to, pain, nausea, recurrent infections or weakness etc.

1.1.39 "Triage" means assessing of emergency patients into categories of priority based on the urgency of treatment required based on national / international scales.

1.1.40 "Underwriter" means Oneplan Underwriting Managers (Pty) Ltd.

1.1.41 "Waiting period" means the period during which no claims will be entertained.

1.2 GENERAL CONDITIONS

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

1.2.1 After Premiums have been paid consecutively, without interruption, for a twelve month period, the restrictions applicable to pre-existing conditions shall no longer apply in accordance with specific underwriting conditions that may apply.

1.2.2 The minimum entry age of the Principal Insured is eighteen years old.

1.2.3 The maximum entry age of the Principal Insured cannot exceed sixty five years (age next birthday) if not specifically agreed otherwise.

1.2.4 Third generation dependants will not be covered.

1.2.5 Only one policy may be issued to any one Insured Person.

1.2.6 The Insured Person agrees to submit to medical examinations at the expense of the Insurers as often as shall be required in connection with any claim after a claim has been accepted. Further, the Insured agrees to present on request from the Insurer, any documents or other information necessary to enrol the said Insured on the policy and to facilitate ongoing cover or claims processing.

1.2.7 It is the responsibility of the Insured to seek medical assistance immediately from when the Insured becomes aware of a medical condition that requires treatment. The Insurer will not be liable to indemnify the Insured as a result of misconduct/negligence in the treatment of medical requirements.

1.2.8 This policy is intended as a risk cover. Therefore, if it becomes evident that the Insured entered into this policy with prior knowledge of a foreseeable or predicted medical event that would ordinarily be covered under this policy, then the Insurer will not be liable to indemnify the client in terms of this schedule.

1.2.9 The Insured hereby gives the Insurer the right to claim from the Insured any payment or compensation received by the Insured from any third party due to an event that is covered by this policy and that the Insurer has paid to the client or on the clients behalf.

1.2.10 Should a pre-existing condition exist that results in the injury or illness becoming more severe, the Insured shall only be due the amount deemed to have been incurred specifically as a result of the specific accident or illness.

1.2.11 In the event that the Insured receives payment or service within this policy during the Grace Period and the Premium remains unpaid after the fifteen day period expires, the Insured undertakes to pay back to the Insurer any and all costs incurred as a result of this claim being authorized including any collection and/or legal fees.

1.2.12 It is the duty of the Insured to ensure that no cover is requested or authorised while the Insured is inside the waiting periods specified. The Insured will have no claim against the Insurer should there be an error in this regard, and no damages may be claimed financially or in any other form should the Insured incur costs or other damages as a result of any misinterpretation hereof.

1.2.13 In certain instances the Insurer may elect to carry the cost of excess or additional amounts over and above the cover stipulated herein. It will be the responsibility of the Insured to repay any additional costs incurred over and above the cover stated back to the Insurer.

1.2.14 Any leniency offered in the processing of claims or extension of cover to the Insured is not deemed to be leniency on an ongoing basis and the terms of this policy remain in full force and effect.

1.2.15 It is the responsibility of the Insured to notify the Insurer or the Insurer's collection department should the Premium fail to be deducted from the specified account.

1.2.17 It is the duty of the Insured to declare / disclose all medical and health information when applying for the policy. It is the responsibility of the Insured to supply and assist in obtaining any medical history reports from any medical practitioner or facility if requested to do so to enable the Underwriter to entertain any request or authorisation for any operation or procedure.

1.2.18 No Certificate of Insurance will be issued in the event that Premiums are unpaid.

1.2.19 Proof of insurance will be issued on written request from the Insured to the Insurer. The policy must be active and a period of thirty days from the receipt of the first Premium must have passed.

1.2.20 It remains the duty of the Insured to inform the Insurer of any material changes which may affect the terms and conditions of the policy, such as a change in medical condition or personal details.

1.2.21 Only Insured Events that occur within the South African Borders will be covered.

1.2.22 Where the Schedule refers to specified cover types or exclusion per year (twelve calendar months), the year is calculated as a twelve month period from the of date of inception.

1.3 GENERAL EXCLUSIONS, EXCEPTIONS AND LIMITATIONS

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

1.3.1 Nuclear weapons or nuclear material or by ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel. For the purpose of this exception combustion shall include any self-sustaining process of nuclear fission.

1.3.2 War, invasion, act of foreign enemy, hostilities or warlike operations (whether war be declared or not) or civil war.

1.3.3 Mutiny, military rising, military, martial law or state of siege, insurrection, rebellion or revolution.

1.3.4 Cost of operations, treatments and procedures that are not medically justifiable i.e. all other lines of conservative treatment must first be considered.

1.3.5 Cosmetic procedures include, but are not limited to, breast augmentation, breast reduction, gastroplasty, gender reversal operations, lipectomy, epilation, otoplasty / reconstruction of the ear etc.

1.3.6 Costs, tests and examinations and tests requested for immigration, emigration, visas, insurance policies, employment, admission to schools and universities, court medical reports, muscle-function tests, fitness examinations and test, adoption of children and retirement because of ill health.

1.3.7 Costs incurred for the treatment of obesity and health holidays.

1.3.8 The purchase of the following:

1.3.8.1 Bandages cotton wool and plasters on prescription not used in practitioners' rooms, casualty or wound care facility as part of a procedure

1.3.8.2 Food substitutes, food supplements and patent food, including baby food

1.3.8.3 Incontinence supplies (nappies)

1.3.8.4 Diabetic strips and other diabetic consumables

1.3.8.5 Stoma care products (bags, clips and adhesives)

1.3.8.6 Home pregnancy test kits

1.3.8.7 Slimming products and appetite suppressants, treatment for obesity

1.3.8.8 Prescribed toothpastes, mouthwashes and ointments for oral hygiene

1.3.8.9 Toiletries and beauty preparations

1.3.8.10 Contraceptives (oral and contraceptive intra-uterine devices and sterilisation)

1.3.8.11 Medical appliances including, but not limited to, hearing aids, nebuliser and humidifier, home oxygen, blood pressure machines, and CPAP machines

1.3.9 Participation in civil commotion, labour disturbances, riot, strike or the activities of locked out workers.

1.3.10 Participation in any form of race or speed test other than on foot or in non-mechanically propelled watercraft.

1.3.11 The cost of any treatment which is recoverable from another party.

1.3.12 Expenses incurred by the Insured or dependants of the Insured in the case of wilfully self-inflicted injuries or professional sport.

1.3.13 Cost of treatment for infertility.

1.3.14 Any sexual transmitted diseases, unless as a direct result of rape or crime that has been officially reported to the South African Police Services.

1.3.15 Services rendered by persons not registered with the SA Medical and Dental Council the SA Nursing Council or the South African Health Service Professions Board.

1.3.16 As a result of the influence of alcohol, drugs or narcotics upon such Insured Person unless administered by or prescribed by and taken in accordance with the instructions of a member of the medical profession other than himself.

1.3.17 A criminal act as defined by the laws governing the Republic of South Africa, this specifically includes driving under the influence of Alcohol or non-prescription drugs.

1.3.18 Caused as a direct or indirect result of negligence to the Insured's medical needs or health.

1.3.19 All costs incurred during any waiting period and for conditions not disclosed.

1.3.20 All costs that exceed the stated and maximum allowed cover.

1.3.21 All costs incurred for permanently excluded conditions.

1.3.22 Costs incurred as a result of failure to carry out the instructions or advice of a medical doctor or dentist.

1.3.23 Mental illness, psychiatric disorders, symptoms and related treatment and hospitalisation.

1.3.24 Admissions indicated for investigations / diagnostic procedures to confirm a diagnosis of a condition. Diagnostic tests will only be covered under the applicable Health Cover up to the limits specified as per the Schedule. Diagnostic CT and MRI scans will be covered under the Radiology Cover and diagnostic gastroscopies will be covered under the applicable Specialist Cover.

1.3.25 Corrective procedures for optometry related conditions, including the cost of artificial lenses and the cost of the insertion of these lenses for treatment of eye conditions.

1.3.26 Any treatment relating to non-disclosure, whether intentionally or unintentionally, of a condition.

1.3.27 There is no surrender or maturity value for the policy.

1.3.28 Consequential loss or damage which is not directly caused by an Insured risk.

1.3.29 Declined or repudiated claims re-submitted after the waiting period has expired will not be covered.

1.3.30 Congenital disorders, diseases or abnormalities.

1.3.31 Any birth control procedures such as, but not limited to, sterilisation, vasectomies and tubal ligation.

1.3.32 Third party claims such a Compensation Fund claims, Workmen's Compensation claims and Road Accident Fund claims.

1.3.33 Specialised dentistry, dental conditions and dental operations including, but not limited to, wisdom teeth removal, jaw surgery, orthodontic procedures and treatment of dental abscesses.

1.4 OTHER CONDITIONS

1.4.1 Premium Payments

1.4.1.1 All Premiums are payable monthly in advance.

1.4.1.2 The period of grace allowed for non-payment of Premiums is fifteen days from the first of the month in which the Premium was due. During the period of grace, the policy will be suspended and no claims will be entertained.

1.4.1.3 If the Premiums are not paid within the Grace Period, the policy may lapse. Should Premiums, in whole or in part, be in arrears, then no claim shall be payable.

1.4.1.4 The Grace Period will commence from the second month of the policy inception after successful collection of the first Premium.

1.4.1.5 The Insurer reserves the right to collect any failed or rejected Premium through NAEDO and / or double debit the nominated bank account. This may incur additional charges for which the Insurer is not responsible.

1.4.1.6 NAEDO payments may run at any time from the date of notification by the collection agent of the failed / returned debit order and therefore will not be collected on the nominated debit order date.

1.4.1.7 The onus is on the Insured to ensure that the Premium is received by the Insurer. It is the responsibility of the Insured to notify the Insurer or the Insurer's collection department should the Premium fail to be deducted from the specified account.

1.4.1.8 The Insurer reserves the right to increase Premiums, with thirty days (one calendar month) notice in writing, if the Insured's risk profile changes or if the Insured's claims increase above the actuarial calculated rate that was used for the Insured's current Premium.

1.4.1.9 Non-payment of Premiums for two consecutive months will result in automatic cancellation.

1.4.1.10 The Insured has agreed to the Underwriter submitting his details to ITC for credit ratings and credit record.

1.4.1.11 No Premium refunds will be completed unless the requirements of the Underwriter have been met.

1.4.1.12 Should Premiums not be received or be returned for any reason, the cover of this policy will become suspended for a fifteen day period within which period no cover will be payable to the Insured until receipt of the overdue Premiums have been received. Should this Premium not be received within the fifteen day Grace Period, all cover may be immediately cancelled and this agreement may be terminated.

1.4.1.13 No refund of Premiums will be authorised in the event of cancellation of the policy with no claim history or due to unsuccessful claims.

1.4.1.14 The Underwriter reserves the right to increase Premiums on a group basis at their discretion. The Insured will be informed of any amendment to the Premium and a minimum of thirty days (one calendar month) written notice will be provided before such an increase.

1.4.1.15 A Premium holiday may be granted at the Underwriter's discretion in the event of the Premium payer being unable to pay the Premium. Only one Premium holiday will be granted and no claims will be entertained during the period of the Premium holiday. Application for a Premium holiday must be done in writing. A Premium holiday shall not constitute a waiver of the Insurer or Underwriter's rights.

1.4.8.16 Premiums may be increased due to excessive claims in accordance with determined limits at the discretion of the Underwriter.

1.4.2 Claims

The Insurer shall pay claims to the Insured on the following basis:

1.4.2.1 Following an Insured Event the Insured shall at his own expense notify the Insurer as soon as is practicable.

1.4.2.2 Provide such proof, medical evidence or other information as the Insurer may reasonably request.

1.4.2.3 No claim shall be payable if the Insurer is not notified of an Insured Event within three months of its occurrence or within three months of the termination of this policy, whichever occurs first.

1.4.2.4 Claims submitted after four months will not be accepted. It is the responsibility of the Insured to ensure that the claim invoices have been received by the Insurer.

1.4.2.5 In the event of a claim being declined due to either being in the waiting period or due to being a pre-existing condition, it is the responsibility of the Insured to seek the necessary medical attention as recommended by their medical practitioner. Claims re-submitted after the waiting period will not be entertained.

1.4.2.6 For Health Cover refunds there is a seven day turn-around time from the date of receipt of the valid proof of payment.

1.4.2.7 Health Cover claims may be processed via USSD by dialling *120*17526# to pre-load funds onto the Onecard before consulting the practitioners as contemplated in Section 2.

1.4.2.8 For Hospital Risk Cover refunds there is a 30 (thirty) day turn-around time from the date of receipt of the specified account.

1.4.2.9 In the event that a service provider requests an upfront payment / deposit for an Insured Event, the Insured will be liable and refunds will only be done, subject to the Underwriters discretion, after the service was delivered and an account / invoice has been received and processed.

1.4.2.10 Only detailed / specified accounts will be accepted for payment / refunds of hospital claims (unclosing emergency unit / casualty claims). Statements will not be accepted.

1.4.2.11 In the event that a valid receipt / account has not been received within four weeks for funds utilised via the Onecard, the funds will be recovered from the Insured's nominated bank account. The Health Cover will remain suspended until such time as the funds are recovered.

1.4.2.12 Invalid Health Cover claims will carry an administration cost of R50.00 (Fifty Rand).

1.4.2.13 All receipts submitted must have valid practitioners stamp. The Health Cover will remain suspended until a valid receipt is received.

1.4.2.14 For auditing purposes a valid receipt / account may be requested for Onecard transactions for cards swiped at a valid provider.

1.4.3 The Correctness of Statements Made to The Insurer

1.4.3.1 The Insurer relies on the truth, completeness and correctness of all statements submitted. If the cover granted, or reinstatement thereof has been obtained through any misrepresentation or concealment, this policy shall be void and monies paid in respect thereof shall be forfeited.

1.4.3.2 Should any cover have been paid out on the basis of the information provided by the Insured to the Insurer and such information proves to be incorrect in any respect, the Insurer shall have the right to take such steps as may be required to put it in the same position as it would have been in if the correct information had been provided in the first instance.

1.4.4 Liability of The Insurer

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

1.4.5 Cancellation or Alteration

1.4.5.1 Cover shall cease at 24H00 hours on the last day of the month in which Premium/s have been paid. If a Premium is not paid when due, or if a Premium debit is dishonoured, the Insured must prove to the satisfaction of the Insurer that this was an error by his paying agent.

1.4.5.2 Cancellation requests must be sent in writing to cancel@onegrp.co.za. There is a thirty day (one calendar month notice period for all cancellation requests and a R100.00 (one hundred rand) cancellation fee will be applicable.

1.4.5.3 Cover shall cease in respect of minor children at the end of the calendar month in which he gets married or attains the age of twenty one years.

1.4.5.4 Any alteration requests such as adding / removing of dependants or upgrades / downgrades will carry a thirty day (one calendar month) notice period.

1.4.5.5 The Insurer or Underwriter may alter the terms and conditions, policy wording and Premiums on a group or individual basis provided that at least one calendar month's written notice has been provided to the Insured. Once said notification has been issued the effective date of the new policy wording shall replace any previous policy wordings.

1.4.5.6 The Insurer or Underwriter reserves the right to cancel a policy provided that one calendar month's written notice has been provided. Upon receipt of this notice all the cover will be cancelled forthwith and all subsequent Premiums paid will be refunded.

1.4.5.7 The Insurer and Underwriter reserve the right to cancel the policy in the event of non-disclosure, misuse of cover or Onecard and change in health status and risk profile of the Insured.

1.4.6 Jurisdiction

1.4.6.1 The policy shall be subject to the laws of the Republic of South Africa whose courts shall have sole jurisdiction to the exclusion of the courts of any other country. Where payment is to be made to or by the Insurer it shall be made in the currency of the Republic of South Africa.

1.4.7 Acceptance of Cover

1.4.7.1 Application for cover may be made via telephonic recording or via an Application Form.

1.4.7.2 The policy will only be active after the application and risk has been accepted by the Insurer or Underwriter.

1.4.7.3 The Insurer and Underwriter will calculate the final Premium on the risk profile of each applicant and has the right to the increase the Premium according to each applicant's personal risk profile.

1.4.7.4 Foreign National applications are subject to strict underwriting conditions as determined by the Underwriter.

1.4.7.5 The Underwriter is not obligated to accept all applications for insurance and do not have to provide reasons for an application that has not been accepted.

1.4.8 Health Loadings

1.4.8.1 The Underwriter may increase Premiums due to the Insured's medical history and/or current medical conditions that the Insured may have.

1.4.8.2 Any new applications or amendments to existing policies may be subject to underwriting and health loadings.

1.4.8.3 Loadings are calculated based on the actuarial calculation on the probability of risk per Insured Person.

1.4.9 Policy Suspension

1.4.9.1 In the event of non-receipt of Premium or valid proof of payments for cash withdrawals (for any of the cover provided under Health Cover) from the Onecard, the policy will automatically be suspended.

1.4.9.2 In the event of suspension, no claims will be entertained.

1.4.10 Communication

1.4.10.1 The Insurer will communicate policy documentation, Schedules and any other communication, by using the Internet and electronic communication methods.

1.4.10.2 The Insured agrees and accepts that the onus is on the Insured to specifically request another communication method to be used.

1.4.11 Upgrades / Downgrades

1.4.11.1 A new Application Form must be completed for an upgrade of a plan type in order that the Insured's risk profile may be evaluated. The Underwriter reserves the right to increase the Premiums accordingly.

1.4.11.2 A calendar months' notice must be given for the upgrade / downgrade of any plans.

1.4.11.3 The maximum age of the Principal Insured cannot exceed sixty years (age next birthday) for upgrades to a higher plan.

1.4.11.4 Waiting periods as per cover type will apply for any additional cover from the effective date of the upgrade.

1.4.11.5 For Hospital Risk Cover there will be a minimum three month waiting period for the new cover limits to be effective. For claims related to any pre-existing condition, including pregnancy, there will be a new twelve month waiting period for the new cover limit from the effective date of the upgrade.

1.4.11.6 After an upgrade, should further treatment be required for a previous Hospital Risk Cover claim, the current claim will form part of the previous claim limit and the initial cover limit and claim period will apply.

1.4.11.7 After a downgrade, a six month period must lapse before the Insured may upgrade again.

1.4.11.8 The applicable claim limits will decrease from the effective date of the downgrade. This is applicable to any active / open hospital claims.

1.4.11.9 No downgrade will be allowed within six months of an Illness in Hospital Claim and / or a Natural Birth Claim and within twelve months from Dread Disease Claims.

SECTION 2

2 ONEPLAN HEALTH COVER

The Insurers will pay to the Insured, on behalf of the Insured Person or his estate, up to the cover amount as per the Schedule if during the Period of Insurance any Insured Person needs medical attention in the event of an unforeseen event as defined in this policy wording. Any claim amounts over the cover limit will be for the Insured Person's own account.

2.1 GENERAL PRACTITIONER VISITS (DOCTORS VISITS)

2.1.1 Definition and Defined Events

The Insurer will indemnify the Insured Person up to the maximum cover amount as per the Schedule should the Insured visit a registered general practitioner due to the occurrence of an unforeseen health event that requires treatment or consultation. The amount will be paid directly to your Onecard, subject to the available annual limit and cover limits as per the Schedule. The Insured Person will be responsible to pay the practitioner directly. You need to keep the practitioner's account on record as the Underwriter may ask for a valid proof of payment in order to validate the claim.

2.1.2 Waiting Periods

The cover has a thirty day (one calendar month) waiting period from the Inception Date of the policy.

2.1.3 Special Conditions

2.1.3.1 Please refer to Appendix A for a list of practitioners that are excluded from cover.

2.1.3.2 All treatment and procedures completed in the rooms will be included in this cover amount. This includes, but is not limited to, ECG, removal of lesions and basic tests such as urine dipsticks and blood glucose.

2.1.3.3 This cover amount may be combined with the scripted medication cover limit should the general practitioner be a dispensing doctor. Self-dispensing doctors need to specify the medication prescribed on the account / invoice. Cover limits will apply as per each cover type.

2.2 SCRIPTED MEDICATION (PRESCRIPTIONS)

2.2.1 Definition and Defined Events

The Insurer will indemnify the Insured Person up to the maximum cover amount as per the Schedule on submission of a registered script for medication as prescribed by a registered general practitioner, which is medically justifiable and necessary to cure or treat the unforeseen condition, as result of a claim contemplated in Section 2.1. Claims are paid via the Mediscor electronic claim system directly at your pharmacy subject to the available annual limit and cover limit as specified on the Schedule. The Insured Person will be responsible to pay the practitioner directly. You need to keep the practitioner's account on record as the Underwriter may ask for a valid proof of payment in order to validate the claim.

2.2.2 Waiting Periods Scripted Medication

The cover has a thirty day (One Calendar Month) waiting period from the Inception Date of the policy.

2.2.3 Special Conditions

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

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

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

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

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

2.2.3.6 Contraceptives, immunisations (excluding standard child and flu immunisations), vaccinations for travelling, impotency medication, infertility medication, Roaccutane and Retain A (including the generic or therapeutic replacement thereof) or any skin-lightening agents, multivitamin and multi-mineral supplements in combination or alone with stimulants / tonics and medication for treatment related to specific exclusions as defined in this policy is excluded from cover.

2.3 PATHOLOGY (BLOOD TESTS)

2.3.1 Definition and Defined Events

The Insurer will indemnify the Insured Person up to the maximum cover amount as per the Schedule should a registered general practitioner request any blood tests that are medically justifiable due to the occurrence of an unforeseen health event, as a result of a claim contemplated in Section 2.1. The amount will be paid directly to your Onecard, subject to the available annual limit and cover limit as per the limits specified on the Schedule. The Insured Person will be responsible to pay the pathologist directly. You need to keep the practitioner's account on record as the Underwriter may ask for a valid proof of payment in order to validate the claim. In the event of an accident or hospitalisation, any related blood tests are covered under the Hospital Risk Cover if the cover is relevant to your chosen plan option.

2.3.2 Waiting Period

The cover has a 30 day (one calendar month) from the Inception Date of the policy.

2.3.3 Special Conditions

2.3.3.1 Pathology includes all laboratory tests to examine blood, tissue, bodily fluids, smears, swabs and biopsy samples performed to diagnose a condition.

2.3.3.2 Sperm count and / or any fertility tests and DNA testing is specifically excluded.

2.3.3.3 Tests completed in consecutive days over a six day period will be deemed to be one claim event.

2.4 RADIOLOGY (X-RAYS)

2.4.1 Definition and Defined Events

The Insurer will indemnify the Insured Person up to the maximum cover amount as per the Schedule should the a registered general practitioner request any radiology that is medically justifiable due to the occurrence of an unforeseen health event, as a result of a claim contemplated in Section 2.1. The amount will be paid directly to your Onecard, subject to the available annual limit and cover limit as per the limits specified on the Schedule. The Insured Person will be responsible to pay the radiologist directly. You need to keep the practitioner's account on record as the Underwriter may ask for a valid proof of payment in order to validate the claim. In the event of an accident or hospitalisation, any related x-rays and scans are covered under the Hospital Risk Cover section if the cover is relevant to your chosen plan option.

2.4.2 Waiting Period

The cover has a thirty day (one calendar month) waiting period from the Inception Date of the policy.

2.4.3 Special Conditions

2.4.3.1 Radiology includes all imaging screening to diagnose a condition. This includes, but is not limited to x-rays, sonars, ultrasounds, CT and MRI scans, mammograms, bone density tests, real-time imaging of the digestive tract or blood flow (fluoroscopy and angiography) and nuclear imaging / scans.

2.5 DENTISTRY

2.5.1 Definition and Defined Events

The Insurer will indemnify the Insured Person up to the maximum cover amount as per the Schedule should the Insured visit a registered dental practitioner due to the occurrence of a medically justifiable dental event subject to the limits specified on the Schedule. The amount will be paid directly to your Onecard, subject to the available annual limit and cover limit as per the limits specified on the Schedule. The Insured Person will be responsible to pay the practitioner directly. You need to keep the Practitioner's account on record as the Underwriter may ask for a valid proof of payment in order to validate your claim.

2.5.2 Waiting Period

The cover has a ninety day (three calendar months) waiting period from the Inception Date of the policy.

2.5.3 Special Conditions

2.5.3.1 Any costs for dentistry related claims that exceed the cover amount are for the Insured Person's own account.

2.5.3.2 No specialist dentistry or operation is covered under this policy.

2.5.3.3 Please refer to Appendix A for a list of practitioners not covered.

2.5.3.4 Gum guards and gold inlays are excluded from cover.

2.6 SPECIALIST COVER

2.6.1 Definition and Defined Events

The Insurer will indemnify the Insured Person up to the maximum cover amount as per the Schedule should the Insured consult a specialist as a result of a claim contemplated in Section 2.1 subject to the limits specified on the Schedule. The amount will be paid directly to your Onecard, subject to the available annual limit and cover limit as per the limits specified on the Schedule. The policy holder will be responsible to pay the practitioner directly. You need to keep the Practitioner's account on record as the Underwriter may ask for a valid proof of payment in order to validate your claim.

2.6.2 Waiting period

The cover has a ninety day (three calendar months) waiting period from the Inception Date of the policy.

2.6.3 Special Conditions

2.6.3.1 A general practitioner needs to refer the Insured for a medically justifiable reason to a registered specialist.

2.6.3.2 A referral letter from the referring practitioner must be sent to the Underwriter for authorisation.

2.6.3.3 Only policies that specifically include this cover enjoy specialist cover as stated in the Schedule.

2.6.3.4 A specialist visit will only be approved if the health event cannot be treated by a general practitioner and is not covered under Section 2.1.

2.6.3.5 Specialised dentistry, physiotherapy and optometry are not covered under this cover.

2.6.3.6 Psychiatric and related mental health events are not included and are not covered by this policy under any circumstances.

2.6.3.7 Please refer to Appendix A for a list of Specialists and General Practitioners not covered.

2.6.3.8 Maternity related visits will only be covered under Section 2.1 or Section 2.7.

2.6.3.9 No pathology, radiology or medication prescribed will be covered under this section. It will be covered under the applicable section only.

2.6.3.10 Included in the cover amount is any procedure done in the rooms or by a clinical / medical technologist for example ECG or nerve studies.

2.6.3.11 Sleep studies are specifically excluded.

2.6.3.12 Follow-up visits and routine check-up will be covered under Section 2.1.

2.6.3.13 Follow up visits within six weeks after a hospital admission will not require a referral letter. These visits will be covered under this section or Section 2.1.

2.6.3.14 Any claims that have not been authorised will be covered under Section 2.1. This includes claims that that exceed the maximum number of visits allowed or the once the annual limit has been reached.

2.6.3.15 Treatment for acne and related conditions will be deemed cosmetic and will therefore not be covered.

2.6.3.16 Aptitude and intelligence / IQ tests and similar tests as well as treatment of learning problems are specifically excluded from this cover.

2.6.3.17 Scelotherapy, thermo-coagulation and radio frequency ablation for treatment of varicose veins is specifically excluded from this cover.

2.7 PRE-BIRTH COVER

2.7.1 Definition and Defined Events

The Insurer will indemnify the Insured Person up to the maximum cover amount as per the Schedule should the Insured consult a gynaecologist due to a positive pregnancy diagnosis by a registered general practitioner as contemplated in Section 2.1, subject to the limits specified on the Schedule. The amount will be paid directly to your Onecard, subject to the available annual limit and cover limit as per the limits specified on the Schedule. The policy holder will be responsible to pay the practitioner directly. You need to keep the Practitioner's account on record as the Underwriter may ask for a valid proof of payment in order to validate your claim. Cover is only active from month four of the confirmed pregnancy.

2.7.2 Waiting Period

The cover has a seven month (seven calendar months) waiting period from the Inception Date of the policy. Cover is only active from month four of the confirmed pregnancy.

2.7.3 Special Conditions

2.7.3.1 A general practitioner needs to refer the Insured after diagnosis to a registered gynaecologist but only after the first four months of the pregnancy.

2.7.3.2 An authorisation code needs to be requested and received from the Insurer.

2.7.3.3 Cover may only be activated four months from date of conception.

2.7.3.4 Cover extends to the Principal Insured, their spouse or partner only.

2.7.3.5 Only policies that specifically include this cover enjoy Pre-birth Cover as stated in the Schedule.

2.7.3.6 This cover includes all sonars performed in the practitioner's room. Separate radiology cover as per Section 2.4 will apply only for radiology completed a radiology department.

2.7.3.7 3D and 4D scans are not deemed to be clinically indicated and will not be covered.

2.7.3.8 Should the Insured elect to use the services of a midwife for natural birth, these costs will be covered under this section.

2.8 OPTOMETRY

2.8.1 Definition and Defined Events

The Insurer will indemnify the Insured Person up to the maximum cover amount as per the Schedule should the Insured visit a registered optometrist due to the occurrence of an unforeseen optical event, subject to the limits specified on the Schedule. The amount will be paid directly to your Onecard, subject to the available annual limit and cover limit as per the limits specified on the Schedule. The policy holder will be responsible to pay the practitioner directly. You need to keep the Practitioner's account on record as the Underwriter may ask for a valid proof of payment in order to validate your claim.

2.8.2 Waiting Period

The cover has a twelve calendar months waiting period from the Inception Date of the policy and the Insured Person may only claim again against this cover after twenty four months from the date of the previous claim.

2.8.3 Special Conditions

2.8.3.1 Spectacles will be covered if the following norms are met:

2.8.3.1.1 An unaided visual acuity of at least 6/12 or worse on the Snellen Scale for distance and near vision.

2.8.3.1.2 A refraction requirement of at least 0.75 dioptre sphere and/or 0.75 dioptre cylinder on distance vision for both eyes or

2.8.3.1.3 A refraction requirement of at least 1.25 dioptre sphere on near vision for both eyes.

2.8.3.2 PLEASE NOTE: Low prescription lenses and sunglasses are not covered.

2.8.3.3 Please refer to Appendix A for a list of practitioners not covered.

2.8.3.4 This cover includes either glasses or contact lenses.

2.8.3.5 The maximum cover limit covers the cost of the eye test and glasses / lenses.

SECTION 3

3 ONEPLAN HOSPITAL RISK COVER

3.1 EMERGENCY ILLNESS AND EMERGENCY ACCIDENT COVER

3.1.1 Definition and Defined Events

In the event that an Insured Person requires urgent medical attention in a situation that is deemed Life-threatening, by the Underwriters at their sole discretion, and authorised by the emergency call centre which cannot wait for a normal consultation at the Insured's doctor, the Insured may go to the nearest hospital casualty unit, where the Insurer will cover up to R 4 800 (four thousand eight hundred rand) for the treatment received. Please be aware that the casualty unit will require a Certificate of Insurance and the Insured will need to contact the Emergency Call Centre for assistance. For unforeseen emergency illness or accidents resulting in emergency medical care, the Insurer will indemnify the Insured Person medical expenses directly incurred due to the specific unforeseen event up to a maximum amount of R4 800 (four thousand eight hundred rand).

3.1.2 Excess

3.1.2.1 During the first three months of the policy, all claims will carry an excess of 15% of the total sum insured of R4 800.00 (four thousand eight hundred rand).

3.1.2.2 Thereafter an excess of R200 (two hundred rand) will be payable for each and every claim.

3.1.2.3 In the event of non-receipt of excess amounts due, the Insurer reserves the right collect the due amounts via debit order or NAEDO.

3.1.3 Waiting Period

There is a ninety day (three calendar months) waiting period from Inception Date of the policy before this cover is active for illness related events.

The cover is active from inception for accident or injury related events that are not related to a specific health event.

3.1.4 Special Conditions

3.1.4.1 The cover will only be payable in the event that the emergency medical care needed is regarded as an emergency Life-threatening event (based on triage) as determined by the Underwriters at their sole discretion.

3.1.4.2 In the event that the Underwriter, at their discretion, determine that the reason for visiting the emergency unit or casualty unit was not a life-threatening event, the maximum cover contemplated in Section 2 of this policy wording will be applicable to the claim.

3.1.4.3 This cover is not intended to replace cover contemplated in Section 2 of this policy wording.

3.1.4.4 Pre-existing conditions are excluded.

3.1.4.5 Authorisation is required and the Underwriters may request medical reports in order to authorise a claim.

3.1.4.6 Only events that require immediate cover (triaged as orange or red) will be deemed as life threatening. Please refer to the table below:

TRIAGE CATEGORIES	COVER
Green	Only covered under Section 2 for example general practitioners, medication, radiology or pathology.
Yellow	Only covered under Section 2 Emergency Illness Cover will only be considered based on the final diagnosis.
Orange	Cover under Emergency Illness Cover if not related to a pre-existing condition or exclusion.
Red	Cover under Emergency Illness Cover if not related to a pre-existing condition or exclusion.

3.1.4.7 In the event of an accident or injury event, an accident report needs to be submitted.

3.1.4.8 Should an event result in admission, the cost will be included under the applicable Illness or Accident Cover.

3.1.4.9 This cover will not be paid together with any other cover in this policy.

3.1.4.10 In the event of an accident or injury, any orthopaedic appliances, for example but not limited to braces, crutches and moonboots, will be included under the cover limit available for this section.

3.1.4.11 In the event that the Insured did not seek immediate medical attention / treatment for an accident or injury, such claims will be covered under Section 2.1, at the Underwriters discretion.

3.2 ACCIDENT COVER (HOSPITALISATION DUE TO AN ACCIDENT)

3.2.1 Definition and Defined Events

In the event of an accident ALWAYS phone the Emergency Call Centre to report the accident. The Insured may not need an ambulance and may be able to go to the hospital unaided, but the event must be reported. The Emergency Call Centre will do an immediate pre-authorization and will send the needed Certificate of Insurance to the specific medical institution. The Cover is available immediately after Inception Date of the policy and no waiting period is applicable. The Insurer will indemnify the Insured person up to the maximum cover amount for medical expenses related to an admission in a medical facility that was directly incurred from the date of the unforeseen accident for up to six months after the date of the accident, which is directly linked due to the specific insured accident event up to the cover amounts per chosen policy and as stipulated on the Schedule. Cover is limited as per the Schedule.

3.2.2 Excess

3.2.2.1 An amount of five hundred rand R600 (six hundred rand) excess is payable by the Insured Person for each and every claim submitted under this Cover.

3.2.2.2 For claims related to a Contact Sport, the excess amount will be 15% of the claim amount.(12 month waiting period)

3.2.2.3 In the event of non-receipt of excess amounts due, the Insurer reserves the right collect the due amounts via debit order or NAEDO.

3.2.3 Waiting Period

The cover is active from the Inception Date of the policy.

3.2.4 Special Conditions

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

3.2.4.2 Claims as a result of a medical condition will be covered under the Illness in Hospital Cover.

3.2.4.3 Injuries as result of a Contact Sport will be excluded for a period of twelve months.

3.2.4.4 The Insured is responsible for submission of an accident / injury report for each claim. The Underwriters, at their discretion, will determine if it is a valid claim and /or if more medical reports are required

3.2.4.5 For accidents that do not result in admission, an amount for R4 800.00 (four thousand eight hundred rand only) will be provided (by the Underwriters sole discretion) as per Section 3.1.

3.3 ILLNESS IN HOSPITAL (HOSPITALISATION DUE TO ILLNESS)

3.3.1 Definition and Defined Events

In the event that the Insured requires hospitalisation for illness or for an operation that is not a pre-existing or related condition / symptoms, it is essential to contact the Emergency Call Centre to obtain your pre-authorisation within fourteen days of the date of diagnosis of such illness. The Emergency Call Centre will send the required confirmations and Certificates of Insurance to the required medical facility. The Insurer will indemnify the Insured Person up to the maximum cover amount for medical expenses in a medical facility that is directly incurred from the date of the unforeseen illness for up to six months after the date of the illness was diagnosed, which is directly linked to the specific diagnosed illness event, that result in the Insured Person being admitted in a medical facility or hospital. The Insurer will indemnify the Insured Person up to the maximum cover per chosen policy as stated in the Schedule.

3.3.2 Excess

3.3.2.1 During month's four to six of the policy, all claims will be subject to an excess amount of 15% of the claim amount, not exceeding the total sum assured.

3.3.2.2 Any claims submitted after six months of the policy being in force will be subject to an excess of 5% of the claim amount, not exceeding the total sum assured.

3.3.2.3 The excess amount must be paid by the Insured to the Insurer after the claim has been settled and closed.

3.3.2.4 In the event of non-receipt of excess amounts due, the Insurer reserves the right collect the due amounts via debit order or NAEDO.

3.3.3 Waiting Period

There is a ninety day (three calendar months) waiting period from Inception Date of the policy before this cover is active. Please refer to Special Conditions for conditions that have a twelve month waiting period from the date of inception.

3.3.4 Special Conditions

3.3.4.1 The time periods stated above and cover payable will terminate immediately upon the Insured Person's discharge from the hospital.

3.3.4.2 Pre-existing conditions (known or unknown) and related and associated conditions / symptoms caused by the pre-existing conditions are excluded for the period contained in the Schedule. If not disclosed or known such conditions will be regarded as a pre-existing condition and will be excluded for at least twelve months from the Inception Date.

3.3.4.3 The section above is not related to Dread Diseases, and no cover will be payable to the Insured for the diagnoses of or hospitalisation due to a Dread Disease. Please see the Dread Disease Cover section.

3.3.4.4 Should the person be re admitted within six months of being discharged for the same illness it will be deemed under this section to form part of the same illness event and cover will carry on as if the stay were uninterrupted.

3.3.4.5 The following conditions are excluded for a period of twelve months (subject to the Underwriter's discretion):

3.3.4.5.1 Tonsillectomies

3.3.4.5.2 Grommets, ear surgery, adenoidectomies and sinus / nasal surgery

3.3.4.5.3 Hernias

3.3.4.5.4 Pregnancy, complications of pregnancy and deliveries

3.3.4.5.5 Gynaecological conditions and procedures including hysterectomies, CIN lesions, LLETZ, colposcopies, endometriosis treatment, ovarian cysts, polycystic ovaries, ablation of uterus, fibroids, hysteroscopies, myomectomies, entrocele and rectocele repairs

3.3.4.5.6 Kidney stones and removal of kidney stones and bladder / urethra surgery, including cystoscopies and circumcisions

3.3.4.5.7 Ulcers, gastritis, GERD, diverticulitis, irritable bowel syndrome, rectal bleeding and associated gastroscopies, colonoscopies and sigmoidoscopies

3.3.4.5.8 Gallstones and removal of gallbladder (cholecystectomy)

3.3.4.5.9 Spinal procedures and joint surgery, including carpal tunnel syndrome

3.3.5.6 This cover will not be paid together with any other cover in this policy

3.3.5.7 A minimum turnaround time of 48hrs is required for authorisation under this Cover. The Underwriter may require a twenty four month medical history or test results from all practitioners consulted before a claim may be considered.

3.3.5.8 Any type of dental conditions including specialised dentistry, operations or dental procedures in any type of hospital for example (but not limited to) wisdom teeth removal, jaw surgery, orthodontic procedures and treatment of dental abscesses are not covered.

3.3.5.9 Admission to a medical centre for the purposes of pain control will not be covered.

3.3.5.10 Arthroscopies and related procedures will not be covered under this section but under the Accident Cover subject to the conditions of that section.

3.3.5.11 Follow-up visits for illness events will be covered under Section 2.6.

3.4 DREAD DISEASE COVER

3.4.1 Definition

In the event that you need assistance due to a Dread Disease that was not pre-existing, you need to phone the Emergency Call Centre to get claim authorisation. The Emergency Call Centre will send the required confirmations and Certificates of Insurance to the required medical institution. The Insurer will indemnify the Insured Person up to the maximum cover amount for medical expenses in an approved medical facility and that is directly incurred from the date of the unforeseen Dread Disease is diagnosed for up to twelve months after the date of the of diagnoses which is directly linked due to the specific Insured Dread Disease illness up to an amount as per each specific plan as stipulated in the Schedule. The Insured can only claim again for a new event for the same disease after a six month “resting” period from the end of the previous incident.

3.4.2 Defined Events

3.4.2.1 Heart Attack: A heart attack occurs when the blood flow to the heart is blocked, by a blood clot or build-up of fat, cholesterol and other substances, which form a plaque in the arteries that feed the heart (coronary arteries). The interrupted blood flow damage or destroy part of the heart muscle. This is often a result of coronary heart disease. Related risk conditions include high blood pressure, high cholesterol, diabetes and a family history of heart attack. Dread Disease cover will be considered once the diagnosis is confirmed with results of new electrocardiogram changes and the elevation of cardiac enzymes. Diagnosis based on the elevation of Troponin T test alone shall not be considered. Angina is specifically excluded from this cover.

3.4.2.2 Coronary Artery Disease Requiring Surgery: Coronary artery disease develops when the coronary arteries, the major blood vessels that supply the heart with blood, oxygen and nutrients, become damaged or diseased. This develops over years. Dread Disease cover will be considered with a confirmed diagnosis, by coronary arteriography, that the three major arteries (Circumflex, Right Coronary Artery (RCA), Left Anterior Descending Artery (LAD) is narrowed by more than 60 percent and result in placement of a coronary stent or coronary artery by-pass surgery by way of a thoracotomy. An angiogram without placement of a stent is specifically excluded from Dread Disease cover.

3.4.2.3 Heart Valve Replacement: Heart valve defects or abnormalities that have occurred after the Inception Date of the policy that requires open-heart surgery to replace or to repair cardiac valves. The diagnosis of heart valve abnormality must be supported by cardiac catheterization or echocardiogram. Repair, via valvotomy, intra-arterial procedure, laparoscopic surgery or similar techniques are specifically excluded.

3.4.2.4 Surgery to Aorta / aneurysm: An aneurysm is a bulge or "ballooning" in the wall of an artery. Arteries are blood vessels that carry oxygen-rich blood from the heart to other parts of the body. If an aneurysm grows large, it can burst and cause dangerous bleeding or even death. Dread Disease cover will be considered when surgery is required to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen, excluding surgery of the branches of the thoracic and abdominal aorta.

3.4.2.5 Stroke: A stroke occurs when an artery to the brain is blocked or ruptures, resulting in death of an area of brain tissue due to loss of blood supply. This can be due to ischemia (lack of blood flow) caused by blockage (blood clot, cholesterol or fatty plaque), or a haemorrhage (leakage of blood). A stroke can be cause by hypertension, high cholesterol, a burst aneurysm. Dread Disease cover will be considered when the diagnosis is confirmed with a CT or MRI scan. Specifically excluded from Dread Disease cover is transient ischaemic attacks; brain damage due to an infection, vasculitis, and inflammatory disease; vascular disease affecting the eye or optic nerve; and ischaemic disorders of the vestibular system.

3.4.2.6 Cancer: Cancer is defined as the uncontrollable growth and spread of malignant cells and the invasion and destruction of normal tissue. All skin cancers except malignant melanoma, Stage 1 Hodgkin's disease and tumours manifesting as complications of Acquired Immune Deficiency Syndrome are specifically excluded from Dread Disease cover.

3.4.2.7 Acute Kidney Failure: Acute kidney failure, that developed in less than two days, due to the kidney's ability to remove waste and help balance fluids and electrolytes in the body, that requires short term dialysis. The causes for the acute dialysis will include septic shock (septicaemia) or disorders that cause clotting of the kidney's blood vessel. Chronic diseases causing renal failure that require permanent dialysis is specifically excluded.

3.4.2.8 Major Organ Transplant: Organ transplantation is the moving of an organ from one body to another, or from a donor site including bone marrow on the patient's own body, for the purpose of replacing the recipient's damaged or absent organ. Transplant of parts of organs and other tissue are excluded. Organ transplant will only be considered for conditions that developed after the Inception Date of the policy.

3.4.2.9 Brain Tumours: A brain tumour is an intracranial solid neoplasm, a tumour (defined as an abnormal growth of cells) within the brain or the central spinal canal. Dread Disease cover will be considered when the tumour is confirmed by a CT scan or MR. Cysts, granulomas, malformations in or of the arteries or veins of the brain, haematomas, tumours in the pituitary gland or spine and tumours of the acoustic nerve are excluded from Dread Disease Cover.

3.4.3 Waiting Period

The cover has a six month (six calendar months) waiting period from date of inception.

3.4.4 Special Conditions

3.4.4.1 Pre-existing conditions, symptoms and newly diagnosed conditions within first six months from the date of inception are excluded for twelve months.

3.4.4.2 As a general rule all pre-existing conditions that existed twenty four months prior to the Inception Date and diagnosed within the first six months of the policy, will have a minimum of twelve month general exclusion or may be totally excluded from cover.

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

3.4.4.4 The Insurer will not pay the cover under any other cover together with this section.

3.4.4.5 The Insurer agrees to cover certain procedures that are directly linked to the specific health (Dread Disease) event. These procedures are to be approved by the Insurer or Underwriter and medical evidence needs to be supplied by the client.

3.4.4.6 In the lifetime of a policy, up to three Dread Disease claims for the same Dread Disease per dependant will be allowed.

3.5 NATURAL BIRTH AND EMERGENCY CAESAREAN COVER

3.5.1 Definition and Defined Events

In the event that the Insured requires hospitalisation for natural birth or an emergency caesarean procedure, it is essential to contact the Emergency Call Centre to obtain your pre-authorisation. The Emergency Call Centre will send the required confirmations and Certificates of Insurance to the required medical facility. The Insurer will indemnify the Insured Person up to the maximum cover amount for medical expenses in a medical facility that is directly incurred. The Insurer will indemnify the Insured Person up to the maximum cover per chosen policy as stated in the Schedule and is subject to the overall annual limit for Illness in Hospital Cover.

3.5.2 Excess

3.5.2.1 Any claims related to birth or pregnancy will be subject to an excess amount of 10% of the claim amount.

3.5.3 Waiting Period

There is a twelve month (twelve calendar months) waiting period from Inception Date of the policy before this cover is active.

3.5.4 Special Conditions for Delivery

3.5.4.1 To book a bed for delivery, a letter of confirmation of cover needs to be requested from the Underwriter.

3.5.4.2 Authorisation for the delivery will be provided two weeks prior to the delivery date or once payment of the Premium for the month in which the delivery will occur is received.

3.5.4.3 Natural birth, water birth and midwife deliveries in a hospital, maternity facility or at home will be covered.

3.5.4.4 Caesarean sections must be clinically indicated and a motivation letter must be sent to the Underwriters for approval.

3.5.4.5 Elective caesareans will only be covered up to the applicable cover limit for natural birth.

3.5.4.6 In the event of sterilisation or tubal ligation procedures performed together with a caesarean section, the costs of these procedures will be for the Insured Person's liability.

3.5.4.7 In the event that the birth of the new born is born within the first twelve months from the inception of the policy, the Insurer will not cover the birth nor any complications related to the birth.

3.5.4.8 In the event that there are complications regarding the new born baby during the birth (for births after the twelve months waiting period) expenses will be met up to the Insured's cover limit.

3.5.4.9 The cover may only be utilised once during the lifetime of the policy for dependants other than a spouse or partner.

3.5.4.10 Follow-up visits will be covered under Section 2.6.

3.5.5 Special Conditions for New Born Babies

3.5.5.1 After the birth the new born baby will only be covered once he has been discharged from the hospital with a clean bill of health, subject to the baby being registered and accepted as an Insured child within thirty days of the date of birth. This excludes any conditions related to a delivery that was not covered by the policy for a period of six months from the date of birth.

3.5.5.2 In the event that the next month's debit order is returned, the Insurer will have the right to claim back any cover paid towards the new born baby.

3.5.5.3 Phototherapy for jaundice (in hospital or at home) will be included in the cover amount for the delivery.

3.5.5.4 Audiology, dietician consultations and PCA pumps for pain control are specifically excluded from cover.

3.6 AMBULANCE AND EMERGENCY SERVICES COVER

3.6.1 Definition and Defined Events

In the event of a medically justifiable life-threatening medical emergency, the Insured Person will be covered for transport by ambulance or air transport to the appropriate medical facility. There is a 24 hour dedicated emergency line via the call centre.

3.6.2 Waiting Period

The cover is active from the Inception Date of the policy.

3.6.3 Special Conditions

3.6.3.1 Voluntary transfers will not be covered.

3.6.3.2 Transport from a hospital / medical facility to a residence will not be covered.

3.6.3.3 Transport to a consulting room where an event is not related to an admission will not be covered.

3.6.3.4 Transport in the event that no other means of transport is available to the Insured Person will not be covered.

3.6.3.5 In the event that ambulance services have been utilised for non-life-threatening events or events not approved by the Underwriters, will be for the Insured Person's own account.

3.6.3.6 Transport for events excluded from the policy and Schedule will not be covered.

SECTION 4

4 ONEPLAN DISABILITY COVER

4.1 ACCIDENT PERMANENT DISABILITY COVER

4.1.1 Definition and Defined Events

In the event that the Principal Insured sustains a bodily injury due to an accident in the borders of South Africa, which results within twelve calendar months from the date of the accident in permanent disability or loss of the use of limbs the Insurer agrees to compensate the Insured person or their Estate or mandated nominee the compensation stated in the percentage of permanent disablement table of cover (see below). The Insurer will compensate the Insured Person such percentage of the amount as specified in the Schedule and as specified in the percentage of permanent disablement table of cover.

Injury		Percentage of permanent disablement
Loss of two Limbs		100%
Loss of both hands, or of all fingers and both thumbs		100%
Total loss of sight / blindness		100%
Total paralysis including paraplegia and quadriplegia		100%
Injuries resulting in employee being permanent bedridden		100%
Any other injury causing permanent total disablement		100%
Loss of arm at shoulder		65%
Loss of arm between elbow and shoulder		65%
Loss of arm at elbow		55%
Loss of arm between wrist and elbow		55%
Loss of hand at wrist		50%
Loss of four fingers and thumb of one hand		50%
Loss of four fingers		40%
Loss of thumb	Both phalanges	25%

	One phalanx	15%
Loss of index finger	Three phalanges	10%
	Two phalanges	8%
	One phalanx	5%
Loss of middle finger	Three phalanges	8%
	Two phalanges	6%
	One phalanx	4%
Loss of ring finger	Three phalanges	6%
	Two phalanges	5%
	One phalanx	3%
Loss of little finger	Three phalanges	4%
	Two phalanges	3%
	One phalanx	2%
Loss of metacarpals	First, second and third (additional)	4%
	Fourth or fifth (additional)	2%
Loss of leg	At hip	70%
	Between knee and hip	70%
	Below knee	45%
Loss of toes	All	15%
	Big, both phalanges	7%
	Big, one phalanx	3%
	Toes other than big toes	
	Four toes	7%
	Three toes	5%
	Two toes	3%
	One toe	1%
Loss of eye	Whole eye	50% / 100%
	Sight	100%
	Sight except perception of light	100%
Loss of hearing	Both ears	100%
	One ear	50% / 100%

4.1.1.1 Paraplegia / quadriplegia are defined as loss of motor, sensory or automatic function of the extremities as a result of a spinal cord injury which affects the neutral elements of the spinal cord.

4.1.1.2 Blindness is defined the loss of sight that is permanent and irreversible to the extent that vision is measured 3/60, even with the use of visual aids and must be confirmed by an ophthalmologist.

4.1.1.3 Loss of hearing is defined as the total and irreversible loss of hearing in one or both ears as a result of an accident. The diagnosis must be supported by an audiometric and sound threshold test provided and certified by an Ear, Nose, Throat (ENT) specialist. The total loss must be at least 95 decibels in all frequencies of hearing.

4.1.2 Waiting Period

The cover is active from the Inception Date of the policy.

4.1.3 Special conditions

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

SECTION 5

5 ONEPLAN DEATH COVER

5.1 NATURAL DEATH COVER, ACCIDENTAL DEATH COVER AND FAMILY DEATH COVER

5.1.1 Description

In the event that the Insured Person dies, the Insurer will make compensation stated under cover payable, in terms of the policy cover schedule. In the event that any Insured Person under this policy dies due to an unforeseen event, the policy will pay the Principal Insured or his Estate or nominated account the death cover per deceased Insured Person as stated in the Schedule as a stated lump sum amount.

5.1.2 Waiting Period

5.1.2.1 Death of any Insured due to an accident is covered from the Inception Date of the policy.

5.1.2.2 Death of any Insured due to natural unforeseen causes (such as disease, age or operation) is covered only after three months (three calendar months) from the Inception Date of the policy.

5.1.3 Death Cover Claims Procedure

5.1.3.1 Upon the death of any person, the Insurer or Underwriter needs to be informed as soon as possible and the necessary supporting documentation must be sent to the Underwriter.

5.1.3.2 Claim documentation need to be submitted within six months of the date of death.

5.1.3.3 No claim where documentation is submitted after six months of the date of death will be paid.

5.1.4 Claim Documentation

5.1.4.1 A claim notification document duly completed and signed by the Insured or the beneficiary.

5.1.4.2 The duly certified final death certificate signed, stamped and dated by a Commissioner of Oaths.

5.1.4.3 A fully completed BI1663 Form.

5.1.4.4 A Certified copy of the Principal Insured person's Identity Document.

5.1.4.5 A Certified copy of the deceased's identity document.

5.1.4.6 Proof of relationship and/or validity of cover where applicable.

5.1.4.7 The Underwriter and or Claims Manager reserves the right to request further documentation from the claimant in order to properly assess a claim and such documentation must be submitted within six months after the date of death.

5.1.4 Payment of Cover

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

5.1.4.2 Claims will be paid within one calendar month of approval of such claims.

SECTION 6

6 TRAUMA, ASSAULT AND ACCIDENTAL HIV

This service is provided by Oneplan Underwriting Managers(Pty) Ltd. This is a 24 hour emergency assistance helpline which will arrange for the necessary help an Insured may require in a situation where assault, accidental exposure to HIV or any other trauma occurs.

6.1 Trauma and Assault Counselling

In the case of trauma, the Insured will receive psychological counselling from a public trauma centre or a private institution in the event of the following:

- Rape
- Fire
- Woman abuse
- Hi-jacking
- Motor Vehicle Accident
- Kidnapping /abduction
- Child abuse
- Death of next-to-kin
- Suicide of close family members
- Domestic violence and/or abuse

6.2 Accidental HIV Infection

The HIV protection service provides Insured Persons with peace of mind because in the event of a violent assault such as rape or any other accidental exposure such as a needle prick with a contaminated needle, the Insured Person or his/her family has access to hospital care, treatment and diagnostic regimes for the management of the consequences. The imminence of HIV/Aids will often cause the trauma to be of a more intense nature; therefore the Insured Person will also receive psychological counselling.

In the event of accidental exposure to HIV as confirmed by a general practitioner and providing that the Insured Person is HIV negative (as per a rapid test), he will be provided with access to the following per event:

- Three HIV blood tests: one test immediately after the event, the second test at six weeks and the third test at three months.
- 30 day starter pack of antiretroviral medication
- A 7-day course of STI (Sexually Transmitted Infections) medication
- A ‘morning-after pill’ to prevent pregnancy (for women who are raped)
- Registration for an HIV management treatment, where applicable
- Three counselling sessions with either a general practitioner, trauma trained nurse or trauma counsellor

Should the rapid test indicate that the Insured Person is HIV positive, he will have access to the following:

- 24-hours-a-day, 365-days-a-year telephonic trauma counselling
- 24-hours-a-day, 365-days-a-year telephonic HIV counselling
- One counselling sessions with either a general practitioner, trauma trained nurse or trauma counsellor
- A 7-day course of STI medication
- A ‘morning-after pill’ to prevent pregnancy

6.3 Accidental HIV Infection Treatment

The Underwriter will provide the Insured Person up to a limit of R10 000.00 per event for the Insured Person that requires antiretroviral treatment as a result of accidental HIV exposure event. Pre-authorisation must be obtained within fourteen days of the diagnosis and treatment will not be provided for pre-existing or related conditions. General Practitioner / Specialist consultations and pathology related to the accidental exposure will be covered up to a limit of R5000.00 per event.

6.4 Exclusions

Cover will not be payable in the event of:

- Should a HIV infection claim not be reported within 48 hours (up to a maximum of 72 hours), the Underwriter cannot accept the claim for the HIV protection medication, although Insured Persons can still make use of our telephonic advice and trauma counselling. This exclusion pertains to the fact that the antiretroviral medication (Starter pack) will no longer be effective after expiry of 72 hours.
- Any claim which is in any respect fraudulent.
- Loss, damage or bodily injury deliberately caused by the Insured Person or any person acting in collusion with the Insured Person, consequential loss or damage except as specifically provided.

SECTION 7 REPATRIATION

The Insurer will indemnify the Insured Person for repatriation costs up to a limit of R10 000.00 per event. Repatriation as defined in this policy wording is the repatriation of the mortal remains of an Insured Person to the funeral home of the Insured Person's choice, closest to the place of burial. The place of death must fall within the Territory and the place of burial must fall within the Republic of South Africa.

SECTION 8 COMPLAINTS RESOLUTION POLICY

The purpose of the Complaint Resolution Policy is to ensure compliance with the Short-Term Insurance Act, Financial Advisory and Intermediary Services Act (FAIS), the Policy Holder Protection Rules for Short-Term Insurance and any other applicable legislation. We have embedded the Principals of TCF (Treating Customers Fairly) into our culture and it forms the foundation of our commitment to our policyholders.

1 OUR COMMITMENT TO YOU

Our complaints policy is available to you on request, published on our website and contained in our policy documentation. All complaints will be dealt with timeously and fairly and all the relevant staff receive training on a regular basis with regards to our complaints policy in accordance with the provisions of FAIS. All our records are kept for a minimum period of 5 years and this is a statutory requirement in terms of FAIS.

All your personal information (as per the Protection of Personal Information ACT –POPI) will be held for this period. The information submitted by you will be made available to and processed by our staff where required, as well as our external compliance practice for audit purposes, the Regulator (FSB) and any Ombud /Ombudsman who has jurisdiction. It is our business practice to retain records indefinitely so that we can identify possible trends and avoid similar complaints going forward.

This information is kept in accordance with our personal policies. Corrective measures are taken to ensure that problems and shortcomings are identified and that the same complaint will not occur again. Our staff and representatives adhere to the requirements of FAIS at all times.

2 COMPLAINT HAS TO BE IN WRITING

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

Please address your written complaints to: The Complaints Officer

complaints@oneplan.co.za

The following information must be provided in order for us to assist you:

1 Your name, surname, contact details and confirmation of where communication must be sent to

2 A complete and detailed description of your complaint. Please include any supporting documentation.

3 Expected outcome / resolution

3 COMPLAINT HAS TO BE RELEVANT

The financial services environment is complex. We will endeavour to address all reasonable requests from our clients, but may also refer you to a more appropriate facility. Where the complaint pertains to any aspect of our service, rejected claims or any disclosures that ought to be made by us, we will endeavour to address those complaints in writing, within 21 days.

4 PROCEDURE

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

1. The complaint will acknowledged within one business day of receipt.

2. The complaint will be assessed and, if a valid complaint, will be logged into our central complaints register.

3. The complaint will be allocated to a trained and skilled person who specialises in that type of complaint. This may not necessarily be the person to whom you addressed the complaint.

4. The complaint will be investigated and we will revert to you with our findings within 21 (twenty one) days. You may be requested to provide additional information before we provide you with a final resolution. If we require further time to investigate the complaint, this will be communicated to you in writing.

5. You will receive a response in writing with full reasons.

6. In the event that you are not satisfied with our solution, you may refer the complaint to the Managing Director of our business. The Managing Director may amend the solution or confirm it. Please be informed that certain decisions may have to be approved by the Board or Management committee of the company. In such a case, we will communicate that fact to you, as well as the date on which a decision will be taken.

7. If, after having referred the complaint to the Managing Director, you are still not satisfied with the outcome, we will regard the complaint as being unsatisfactorily resolved. In such a case, you may approach the office of the FAIS Ombud for Financial Services Providers, Ombudsman for Short Term Insurance or take such other steps as may be advised by your legal representatives.

8. For rejected claims, you will be provided with the reasons in writing and the external complaints avenues available. If a claim is rejected, representation must be made within 90 (ninety) days of the date of the letter of rejection. If a dispute is not satisfactorily resolved after following the above steps, legal action may be instituted. Summons must be served within 180 (one hundred and eighty) days from the date of original letter of rejection.

9. You must, if you wish to refer a matter to the Ombud or Ombudsman, do so within a period of six months. The Ombud will not adjudicate in matters exceeding a value of R800 000.00 and the Ombudsman will not adjudicate matters exceeding R2 000 000.00.

10. The Ombud / Ombudsman Offices may be contacted as follows:

Ombudsman for Short-Term Insurance
Sunnyside Office Park
5th Floor, Building D
32 Princess of Wales Terrace
Parktown, JHB

Tel: 011 726 8900
0860 726 890 (Sharecall)
Email: info@osti.co.za

FAIS Ombud
Celtis House,
Eastwood Office Park
Lynwood, Pretoria

Tel: 0860 324 766
Email: info@faisombud.co.za

Council for Medical Schemes

Block A
Eco Glades 2 Office Park
420 Witch - Hazel Avenue
Eco Park, Centurion

Tel: 012 431 0500

Email: information@medicalschemes.com

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

SECTION 9 STATUTORY DISCLOSURES

STATUS OF THE FINANCIAL SERVICES PROVIDER IN TERMS OF THE FAIS ACT

Oneplan Underwriting Managers (Pty) Ltd (FSP 43628) and Oneplan Brokers (Pty) Ltd (FSP 43627) are authorised Financial Services Providers, The Key Individuals approved by the Financial Services Board are:

Michael Robert Otten (ID 8312275036086)

Sven Laurencik (ID 8008265186085)

The company registration for Oneplan Underwriting Managers (Pty) Ltd is 2009/017597/07 and for Oneplan Brokers (Pty) Ltd is 2009/017561/07. The FSP's regularly monitor the Fit and Proper Status of the representatives and confirm that according to their knowledge the representatives are Fit and Proper.

LEGAL STATUS AND INTERESTS OF THE REPRESENTATIVE

Oneplan Underwriting Managers (Pty) Ltd is the underwriter and administrator and has written mandates with the Insurer, Bryte Insurance Company Limited. Oneplan Brokers (Pty) Ltd markets Oneplan products and has written mandates to act on behalf of the Insurer. The company has no shareholding with the Insurer. Oneplan Underwriting Managers (Pty) Ltd and Oneplan Brokers (Pty) Ltd have common shareholders.

REMUNERATION, FEES AND COMMISSION

Oneplan Brokers (Pty) Ltd receives commission from the Insurer as per the maximum permissible in addition to any fees contracted directly with any client and agreed to in writing. Oneplan Underwriting Managers (Pty) Ltd collects an underwriting and administration fee for each policy sold on behalf of the Insurer. A breakdown of the premium can be found on the policy schedule. Included in the breakdown of the fees are the commission amounts, administration fees, third party fees and any other additional fees applicable to the policyholder.

QUALIFICATIONS AND MEMBERSHIP

The FSP's have been in the Financial Services Industry since 2010.

INDEPENDENT STATUS OF THE FSP AND PROFESSIONAL INDEMNITY INSURANCE

In the past 12 months the FSP's earned more than 30% of its income from the Insurer. The FSP and Representatives have no financial interest in any other Insurer or product supplier. The Representatives and FSP carry Professional Indemnity Insurance as required.

AUTHORISATION

The FSP accepts responsibility for the actions of the Representatives acting in the scope and course of their employment. The FSP is authorised to give advice and render intermediary services in the following categories:

Long Term Category A

Long Term Category B1

Short-Term Insurance Personal and Commercial Lines

Our representatives may only provide information and intermediary services in respect of Short Term Personal lines.

The FSP will not be held liable in terms of prejudice in respect of services or advice provided by a Representative which falls outside the scope of authorisation, and any complaint in respect of any product which falls outside the definition of financial product of the FAIS Act, cannot be forwarded to the FAIS Ombud or Short-Term Insurance Ombudsman.

COMPLAINTS PROCEDURES AND CONFLICT OF INTEREST

If you have a complaint, please contact the FSP Key Individual or the Complaints Officer. He/She will assist you to address the concerns you have.

Please note that in terms of the FAIS Act, all complaints must be addressed to us in writing. Should we not be able to address the concerns to your satisfaction, you may wish to lodge a complaint with any of the Ombud and/or Ombudsman whose details appear below. If you wish to learn more about our complaints policy and procedure, please contact our complaints officer via email (complaints@oneplan.co.za) or consult our websites for a copy of the complaints policy. FSP 43627 and 43628 subscribes to the highest ethical code and we require all our representatives to adopt this in their dealings. A copy of our conflict of interest policy can be found on our website at www.oneplan.co.za

SHARING OF INSURANCE INFORMATION

Insurers share information with each other regarding policies and claims with a view to prevent fraudulent claims and to obtain material information regarding assessment of risks proposed for insurance. By reducing the incidents of fraud and assessing risks fairly, future premium increases may be limited. This is done in the public interest of all current and potential policy holders. The sharing of information includes, but is not limited to information sharing via the information Data Sharing System operated by TransUnion ITC on behalf of the South African Insurance Association. By the insurer accepting or renewing this insurance, you or any other person that is represented herein, gives consent to the said information being disclosed to any other insurance company or its agents.

You also similarly give consent to the sharing of information in regard to past insurance policies and claims that you have made. You also acknowledge that information by yourself or your representative may be verified against any legally recognised sources or databases.

By insuring or renewing your insurance, you hereby not only consent to such information sharing but also waive any rights of confidentiality with regard to underwriting or claim information

that you have provided or that has been provided by another person on your behalf.

In the event of a claim, the information you have supplied with your application together with the information you supply in relation to the claim, will be included on the system and made available to other insurer's participating in the Data Sharing System.

SECTION 21 OF THE GENERAL CODE OF CONDUCT

Section 21 of the General Code of Conduct states that no provider may request or induce, in any manner a client waive any right or benefit conferred on the client by, or in terms of, any provisions of this code, or recognise, accept or act on any such waiver by the client and such waiver is null of void.

CONTACT DETAILS

FSP Office Details	54 Maxwell Drive, North Office Park, Ground Floor, Woodmead, Gauteng, RSA Tel: 010 001 0141 Fax: 086 610 3918 Email: care@onegrp.co.za complaints@oneplan.co.za (complaints) Website: www.oneplan.co.za
Key Individual	Michael Robert Otten michael.o@onegrp.co.za Sven Laurencik Sven.l@onegrp.co.za
Insurer	Bryte Insurance Company Limited Company registration number 1965/006764/06 P.O. Box 61489, Marshalltown, 2107 15 Marshall Street, Ferreirasdorp, Johannesburg, 2001 Tel: 011 370 9111 Fax: 011 370 9910 Website:www.Bryte.co.za
Insurer Compliance Officer	The Compliance Officer (AIC) fais@Bryte.co.za
FSP Compliance Officer	Dawn Julyan Simply Comply (PTY) Ltd 012 998 7938
Ombudsman for Short-Term Insurance	Sunnyside Office Park 5th Floor, Building D, 32 Princess of Wales Terrace, Parktown, JHB Tel: 011 726 8900 Email: info@osti.co.za
FAIS Ombud Lynwood, Pretoria	Celtis House, Eastwood Office Park Tel: 0860 324 766 Email: info@faisombud.co.za
Fraud Reporting	If you become aware of irregularity on any policy you can contact the Insurer where your call will be treated in confidence. Free call: 0800 16 7464 Free fax: 0800 00 7788 Email: Bryte@tip-offs.com Free post: Tip-offs Anonymous, Freepost KZN 138 Umhlanga Rocks, 4320

Alternatively contact the Insurance Fraudline on 0860 002526 or email insurance@fraudline.co.za.

The policy wording and schedule must be read as one document. Please contact our offices should you require any information on any aspect of your policy. A copy of the policy wording can be viewed via our website at www.oneplan.co.za or may be obtained through our Customer Care Call Centre on 010 001 0141.

SECTION 10

APPENDIX A MEDICAL PRACTITIONERS NOT COVERED

The following are not covered under the Health Cover Section of the policy:

1 Audiologists and Acousticians

2 Biokineticist

3 Chiropractors

4 Clinical / Medical Technologists

5 Dietician

6 Genetic Counsellors

7 Homeopaths, Herbalists, Naturopaths and Osteopaths

8 Occupational Therapists

9 Orthodontist

10 Physiotherapists

11 Podiatrist

12 Psychologist

13 Speech Therapists

14 Maxillofacial Specialist

15 Ophthalmologist

16 Orthodontist

17 Plastic Surgeons

18 Counsellors including Genetic and Psychologist, Psychiatric Nurses and Social Workers

19 Acupuncturists

20 Traditional Healers