www.totalrisksa.co.za

Total Risk Administrators (Pty) Ltd (TRA)
an authorised financial services provider
- FSP No 40815

Auto&General

Underwritten by:
Auto&General Insurance Company Limited, a licensed non-life
Insurer & Financial Services Provider
Reg No 1973/016880/06

TOTAL RISK CANCER COVER

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BENEFITS

The Policy will (subject to the limits shown below, and the full terms and conditions outlined in this whole Policy document), pay the cash value of the benefit resulting from a claim event.

PRODUCT	GRAND	SUPREME	ULTIMATE
LUMP SUM PAYOUT - A predetermined sum of money paid upon the confirmed diagnosis of one of the following female cancers (paid out only once per Cancer type): Cervical Cancer, Uterine Cancer, Cancer of the Fallopian tubes, Breast Cancer, Ovarian Cancer, Vaginal Cancer and Bladder Cancer.	**R50 000 per unrelated occurrence**	**R100 000 per unrelated occurrence**	**R150 000 per unrelated occurrence**
ACCIDENTAL DEATH BENEFIT - A predetermined sum of money is paid upon the death of the Policyholder, due to an accident.	**R5 000**	**R10 000**	**R15 000**
MONTHLY PREMIUM			
18 - 55 years old	R149	R258	R361
56 - 64 years old	R183	R366	R550
65+ years old	R287	R572	R859

The below benefits are only applicable where this optional benefit is in place. See your Policy Certificate and Schedule for more information. Where there is NONE in place, this is not applicable. If you wish to add this benefit, email: **membership@totalrisksa.co.za**, or call **011 372 1540**.

OPTIONAL FOR HIM BENEFIT **- conditional upon there being a Female Cancer Cover Policy in place. This is not a stand-alone product.**	SELECT	PRIME	PEAK
LUMP SUM PAYOUT - A predetermined sum of money paid upon the confirmed diagnosis of one of the following male cancers (paid out only once per Cancer type): Prostate cancer, Testicular cancer, Penile cancer, Bladder cancer, Male breast cancer.	R25 000 per unrelated occurrence	R50 000 per unrelated occurrence	R75 000 per unrelated occurrence
ACCIDENTAL DEATH BENEFIT - A predetermined sum of money is paid upon the death of the male dependant, due to an accident.	R5 000	R10 000	R15 000
Additional MONTHLY PREMIUM per Policy per month for Optional For Him Benefit			
18 - 55 years old	R 75	R125	R180
56 - 64 years old	R110	R170	R260
65+ years old	R180	R300	R480

TOTAL RISK CANCER COVER

THE POLICY

1. PARTIES

1.1 The parties to this Policy are: -

1.1.1 Auto & General Insurance Company Limited (Reg. No 1973/016880/06), a licensed Insurer and Financial Services Provider, with License number 16354.

1.1.2 Total Risk Administrators (Reg. No 1999/024507/07), the Product Supplier, a UMA underwritten by Auto & General Insurance Company Limited, an authorised Financial Services Provider, with Licence number 40815.

1.1.3 The Policyholder (who is also the Insured).

1.2 The Intermediary and Underwriting Management Agent / UMA have an agreement with the Insurer in terms of which administration fees are payable for the insurance business. If the Policy was sold to you by the Intermediary's telemarketer, the same details as those of the Intermediary are applicable. Recordings of the telephone discussion with the telemarketer can be made available to you on request.

1.3 The Intermediary receives commission (up to 20% of the premium contribution) and the Underwriting Management Agent receives administration fess which are equal to 14% of the premium contribution.

2. ELIGIBLITY

2.1 Female Cancer Cover: One female Policyholder per Policy only.

2.2 The Optional For Him Benefit is conditional upon there being a Female Cancer Cover Policy in place (it is not a stand-alone option), and the For Him option will also cover One male per Policy only - who is a dependant on the female's Female Cancer Cover Policy (this Policy) - she is the Policyholder.

2.3 The male dependant on the For Him option should be the female Policyholder's legal spouse or common law partner (common law partners need to provide an affidavit proving cohabitation of at least 12 months).

2.4 Both the female Policyholder and the male dependant must be at least 18 years old. Child dependants are not covered under this Policy.

3. BENEFITS

3.1 The Insurer will provide the benefits for cover, as specified herein, subject to compliance with the terms, exceptions and conditions herein specified. The entire contract i.e. the/this Policy, consists of this Policy Document, the Policy Certificate, the Policy Schedule (Page 2) and the Option Benefits (Page 3), together with any Personal Information which has been provided by this contract.

3.2 The Policy, its certificate, schedules, benefits and any annexures/ endorsements shall be read together as one contract.

3.3 The Insurer will issue an Amended Certificate and Schedule to reflect any changes to this Policy.

4. WAITING PERIODS

4.1 NO claim may be submitted for processing for 3 months from the Join Date of this Policy. In addition, the first diagnosis of any Cancer covered in this Policy cannot be within 3 months of the Join Date. Example: your Join Date specified on the Certificate is 1 June 2021 – the specialist you see who diagnoses you can only be documented from 1 September 2021 onwards. Then, even post September 2021, once a claim is submitted, all of the other terms and conditions throughout this Policy also applies e.g., see section 13 of this Policy.

4.2 If the male dependant starts cover at a date later than the female Policyholder, his waiting period will commence from his own personal Join Date e.g., if he starts 1 July 2021, he will then only have benefits from 1 October 2021.

5. THE CORRECTNESS OF ANY STATEMENTS MADE TO THE INSURER

5.1 The Insurer relies on the truth, completeness and correctness of all statements submitted. If the benefits 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.

5.2 Should any benefits have been paid out on the basis of the information provided by the Insured Person, Scheme, Service Provider/s or an Intermediary, or any other relevant third party acting on behalf of the Insured Person (where any third party acting on behalf of the Insured Person is deemed to be an agent of the Policyholder), to the Insurer, and such information subsequently proves to be incorrect in any material respect, the Insurer shall have the right to take such steps as may be required to put it in the position it would have been in if the correct information had been provided in the first instance.

5.3 These steps as per 5.1 and 5.2 are at the discretion of the Insurer and may include the repudiation of all claims, a refund from the Insured Person/Policyholder back to the Insurer for any covered claims, and the possible immediate cancellation of the Insured Person's Policy and all benefits therein.

6. INTERPRETATIONS

6.1 "Cancer" shall mean a disease manifested by the presence of a malignant tumour and characterised by the uncontrolled growth and spread of malignant cells with the invasion and destruction of normal surrounding tissue.

6.1.1 The cancer must be confirmed by histological evidence of malignancy by a qualified oncologist or pathologist.

6.1.2 Malignant cells diagnosed and treated by primary biopsy only, that is, not requiring any further surgical and medical procedures (chemotherapy or other recognised oncology medication), radiotherapy or other modalities are excluded from the definition of "Cancer".

6.1.3 The term "Cancer" excludes cancer-in-situ and all tumours that are histologically described as pre-malignant or showing early malignant changes. The Insurer will however consider payment when cancer-in-situ will require radical treatment such as total mastectomy or total hysterectomy, followed by chemo- and/or radiotherapy, at its own and sole discretion.

6.2 "Claim Event" shall refer to a diagnosis of cancer that belongs to one of the following types: -

6.2.1 Breast Cancer.

6.2.2 Cervical Cancer (excluding Cervical Intraepithelial Neoplasia).

6.2.3 Female cancers of an organ that is a part of the Genito-Urinary system **which are covered under this Policy:** Ovarian cancer, cancer of the Bladder, cancer of the Fallopian Tubes, Vaginal cancer, or Uterine cancer ONLY.

6.2.4 In the case where an Optional For Him Benefit is in place on this Policy, "Claim Event" shall refer to a diagnosis of cancer that belongs to one of the following types: -

6.2.4.1 Male Breast cancer.

6.2.4.2 Male cancers of an organ that is a part of the Genito-Urinary system which are covered under this Policy: Prostate cancer, Testicular cancer, Penile cancer and Bladder cancer ONLY.

6.2.5 Only the cancers as stipulated above will be considered for cover as part of the "claim events" as above.

6.2.6 A Claim Event for the Accidental Death Benefit is as defined under the Benefit Payment section 9 of this Policy, point 9.5, and under the Exclusions section of this Policy, point 13.7.

6.3 "Default of a premium payment" would occur if a premium has not been paid on its due date nor within the days of grace (as defined in Section 7 of this Policy) following such non-payment of premium.

6.4 "Diagnosis" shall refer to a diagnosis during the period of this Policy, by a registered medical practitioner supported by clinical, radiological, histological and laboratory evidence as required by the Insurer.

6.5 "Pre-existing conditions" shall mean a medical condition that existed prior to the commencement of this Policy with regards to which:

6.5.1 the Policyholder/male dependant has received treatment and/or advice; or

6.5.2 the manifestation of symptoms which would have caused a reasonable and prudent person to seek advice (even if they didn't); or

6.5.3 any condition known to the Policyholder/male dependant prior to the date of Policy purchase in respect of which the Policyholder/male dependant has been recommended to continue or commence any treatment or seek medical advice after the effective date of coverage.

7. PREMIUM

7.1 Premiums under this Policy are payable by monthly direct debit order from the Policyholder's bank account.

7.2 Premiums under this Policy shall be payable in South African Rands.

7.3 All premiums are payable monthly. The period of grace allowed for non-payment of premiums is 31 days after the month in which the premium was due. If the premiums are not paid within the period of grace, the Policy will lapse. If premiums in whole or in part are in arrears, then no claim shall be payable.

7.4 No claims will be paid if the monthly premiums are not fully up to date/fully paid, at the time of claiming.

7.5 **It is the Policyholder's responsibility to monitor that monthly premiums are received by the Insurer.**

7.6 The premium rate/s indicated in the Policy Schedule will be reviewed in January of each year, or when the age of the Insured (for both Policyholder and the male dependant if applicable) changes, whereby they move into the new premium based on their age bracket. The Insurer reserves the right to vary the premium/s payable under this Policy by giving the Policyholder at least 31 days written notice before any variation in premiums takes effect.

7.7 The premium will be paid as one total premium amount, even if there are different amounts payable for the Cancer Cover which may include the Optional for Him Benefit. The Female Cancer Cover amount and the Optional for Him Benefit amount (dependent on product choice for each), will be added together to make a total premium amount as stipulated on this Policy Schedule, and will be debited as one amount. There are no exceptions to this rule. If the Policyholder/ premium payer cannot afford the total premium, they cannot retain the Policy at all. If they can afford the premium without the extra male Optional for Him Benefit, they could cancel just the Optional For Him and retain the rest of the main Policy. They cannot retain the male Optional For Him Product option only, as this is not a stand-alone product, but rather just an additional benefit on the main Policy.

7.8 VAT at the prevailing regulated rate is included in the monthly premium payment. In terms of Binding General Ruling No. 14, this document constitutes a tax invoice, debit note, or credit note as contemplated in section 20(7)(a) and 21(5)(b) of the VAT Act respectively.

7.9 Where payment is to be made to the Insurer, proof of such payment must be submitted to TRA and the Policy number must be used as a reference. **(Email membership@totalrisksa.co.za or phone (011) 372 1540 for details)**.

8. COOLING OFF PERIOD

8.1 The Policyholder can decide, within 31 days of the commencement of this Policy, to cancel the Policy and receive a refund of the monthly premium with no further penalties.

9. BENEFIT PAYMENT

9.1 The Sum/s Assured as stipulated on the Schedule of this Policy document, based on product choice, shall be payable to the beneficiary.

9.2 The Beneficiary of the Policy is:

9.2.1 The Policyholder; or

9.2.2 The Beneficiary (a party defined by the Executor of the Policyholder's Estate and confirmed by a qualified Lawyer), or the Estate of the Policy-holder, should the Policyholder not survive until the date on which payment will be made in terms of the Policy.

9.3 Benefits payable in terms of the Policy shall be paid by the Insurer in South African Rand.

9.4 Benefits are payable upon receipt of confirmed histological evidence of malignancy, by a qualified oncologist or pathologist, and subject to all of the other terms and conditions outlined in this whole Policy document (refer to section 3 of this Policy).

9.5 ACCIDENTAL DEATH BENEFIT: this benefit is payable, as a lump sum, as stipulated on page 3 of this Policy document, dependent on product choice, to: 1. A beneficiary appointed by the female Policyholder in the event she passes away due to accidental death or 2: The female Policyholder in the case that her male dependant on the Optional For Him Benefit passes away due to an accidental death. Benefits are payable upon all of the information being submitted as per 13.7 and 14 of this Policy document.

10. TERMINATION/RESIGNATION AND MATURITY OF THE POLICY

10.1 This Policy will terminate on the earlier of:

10.1.1 The cover termination date of the Policy (if any);

10.1.2 The death of the Policyholder (NB: even if the male dependant has not passed away unlike the Policyholder, the Optional For Him Benefit falls within this Policy, and is not a stand-alone product, so if the female Policyholder passes away, the Policy is null and void. Alternatively, if the male dependant passes away, the Policy with the female cancer cover benefits can still remain intact, subject to all other valid terms and conditions being applicable.

10.1.3 Failure to pay premiums in accordance with the terms of this Policy.

10.1.4 Once the Policyholder (or her legal representative) has given one (1) month's written notice to terminate this Policy, or once the Insurer has provided at least 31 day's written notice to the Insured/Policyholder of any such termination. Upon receipt of this notice, all the benefits will be cancelled forthwith, and all subsequent premiums paid will be refunded.

10.2 This Policy has no paid-up option or cash surrender value.

10.3 This Policy has no maturity benefits payable on the cover termination date (if there is a termination date specified).

10.4 The Policyholder may cancel/terminate/resign from just the Optional For Him Benefit and retain the rest of the main Policy. They cannot retain the male Optional For Him Product option only, as this is not a stand-alone product, but rather, just an additional benefit on the main Policy.

11. ALTERATION/VARIATION OF THIS POLICY

11.1 The Insurer must be advised of any changes to be made to this Policy, e.g., a change in any personal or contact details, a removal or addition of the Optional For Him Benefit etc.

11.2 These changes must be provided to the Insurer in writing and sent to **membership@totalrisksa.co.za**

11.3 The Policyholder must be aware that certain changes can be effective immediately e.g. the spelling of a name, where an amended Policy document can be provided to them. **However, some changes i.e., an addition or removal of the Optional For Him Benefit, must be provided 31 days prior, in order for debit orders to be processed correctly, and products to be loaded with new Join Dates.**

NB: AMENDMENT TO BANKING DETAILS:
Amendments to personal banking details which relate to debit orders or claim refunds must be received by TRA within 7 working days prior to the action date for such transaction.

11.4 Cover and premiums etc. may be altered by the Insurer upon giving at least 31 day's written notice of any possible changes to the Policy.

12. REINSTATEMENT; INCREASE IN COVER; OPTION CHANGES AND NEW POLICIES

12.1 This Policy cannot be reinstated, under any circumstances, after Policy termination described in section 10 of this Policy. Also, the level of cover cannot be increased. In the case that an exception has been made in terms of a reinstatement or increase in cover, the Insurer will administer full underwriting at the cost of the Policyholder. The costs of this underwriting shall be paid by the Policyholder at the time of applying for reinstatement or increase in cover.

12.2 Option changes/new Policies: A Policyholder or male dependant cannot change product option plans during the year. Policies are only renewable annually within a certain time frame which is stipulated in the year-end communication sent to the Policyholder. However, if the Policyholder is for some reason permitted by TRA Management to change product option plans at another time apart from this time frame, and if any amount is claimed for thereafter, OR, if they resign from this current Policy and join under a new plan and Policy number, the first claim made under the new Policy may be subject to an excess (the amount of this excess will be equivalent to the lower of 5% of the total value of the processed claim OR R10 000). Upon changing options or joining a new Policy after resigning from current Policy membership, Option Benefit limits as stipulated in the Schedule and Benefits Pages may be pro-rated.

13. EXCLUSIONS

13.1 No claim will be considered under this Policy, if the claim is related in the opinion of the Insurer, directly or indirectly, to any pre-existing condition (including for any Cancer) for which the Policyholder and/or male dependant sought or should have sought medical advice and/or treatment, during the 24 months prior to the commencement/Join Date of this Policy. The Insurer may determine conditions they felt would have likely been existing, even if they were not attended to i.e., 'should have sought treatment'. More documentation may be required from the Policyholder at the discretion of the Insurer to determine this.

13.2 No payment shall be made for any claims directly caused by, resulting from, or in connection with the use of nuclear, biological or chemical weapons, or any radioactive contamination, attacks on or sabotage of facilities (including but not limited to nuclear power plants, reprocessing plants, final repository sites and research reactors) and storage depots which lead to the release of radioactivity or nuclear, biological or chemical warfare agents, irrespective of whether any of the aforesaid has been performed with the specific use of information technology.

13.3 No payment shall be made for Breast cancer, if the Insured had a mastectomy or lumpectomy, or a positive diagnosis for Breast cancer, at any point prior to the commencement/Join Date of this Policy.

13.4 No payment shall be made for Cervical Intraepithelial Neoplasia defined by the World Health Organisation as CIN I, II III.

13.5 If a claim is made more than once, and a subsequent 'Claim Event' (see section 6.2 of this Policy) **is either for or in any way related to** the same cancer as a previous claim (one of the cancers on the defined list for this product - see section 6.2), no payment shall be made.

Example (for the same cancer): The Policyholder and/or male dependant is diagnosed with Breast cancer, claims and receives a lump sum payment benefit, recovers from the cancer and is in remission, but then the cancer returns, and they are diagnosed with Breast cancer again, they cannot claim for Breast cancer again.

Example (for a related cancer): The Policyholder and/or male dependant is diagnosed with one of the listed cancers e.g., in the case of a female, Cervical cancer is diagnosed, they received the lump sum payment benefit, and then the initially diagnosed cancer from the cervix spreads to the bladder, causing Bladder cancer, the second diagnosis i.e., Bladder cancer, is not covered.

IN BOTH INSTANCES, IT DOES NOT MATTER HOW LONG THE TIME FRAME IS BETWEEN THE TWO DIAGNOSES.

13.6 **NB:** Only **ONE** lump sum is payable ever for one claim stipulating a diagnosis/diagnoses by a specialist, even if the Policyholder and/or male dependant is diagnosed with more than one type of cancer on the defined list at one time. e.g., the specialist diagnoses Breast cancer and Cervical Cancer after consultation and all results are received – but only one times the Sum Assured can be paid.

13.7 Accidental Death Benefit - you are not covered:

- Where death does not occur within 12 months of the incident.
- When claims are submitted and received after a period equal to 3 (three) months after the date of death.
- Where death is caused, complicated, or attributed to any of the following:

  - AIDS (Acquired Immune Deficiency Syndrome)
  - HIV (Human Immunodeficiency Virus) or any venereal diseases
  - Use or suspected use of drugs or intoxicating liquor
  - Any self-inflicted event, including suicide or attempted suicide
  - Any wrongful or illegal action by the Insured, including active participation in any riotous or such-like behaviour

- Death while:

  - engaged in any form of military or police duties including reservist duties
  - working in any mining or tunnelling operation
  - involved in any form of racing, other than by foot on solid ground
  - mountain climbing where the use of ropes is required, winter sport involving snow or ice, big game hunting, steeple chasing, potholing, surfing, bungee jumping, hang-gliding, aerial suspension, sky-diving, parachuting or any other pastime involving similar and exceptional high risk
  - participating in any form of professional sport
  - motorcycling, either as a rider or passenger
  - driver or passenger in any open-top type vehicle (including convertibles, trailers, and open-back vehicles) or fibre glass constructed vehicles; flying, other than as an ordinary passenger in a commercial aircraft licensed to carry passengers

- Non-compliance with Policy terms and obligations or not responding to our request for:

  - Medical examination
  - Release of medical records and information
  - Post-mortem examination or documents relating thereto, including death certificates
  - Identification certificates

13.8 No ex-gratia payments will be made by the Insurer.

14. PAYMENT OF BENEFITS

14.1 In order to claim against this Policy, a signed and completed claim form must be received by the Insurer within 90 days of the "Claim Event" (see section 6 of this Policy) giving rise to a claim, together with any additional information and medical evidence which the Insurer may require (as outlined on the claim form) in order to assess the claim. Email claims@totalrisksa.co.za or call 011 372 1540 to submit/request a claim form.

14.2 The Insurer must be satisfied that the claim is valid before accepting the claim. Only actual "Claim Events" as per section 6 of this Policy may be considered for payment.

14.3 The Policyholder/male dependant will be required to provide suitable medical evidence outlined on the initial claim form, as well as possibly required further clinical information, reports and/or letters etc. (at the discretion of what may be required by the Insurer based on the claim), in support of the claim, from practitioners who are:

14.3.1 recognised by the Insurer; and

14.3.2 resident and operating in the Republic of South Africa.

14.3.3 The qualified oncologist/s or pathologist/s should also be registered with the Health Professionals Council of South Africa (HPCSA) and have valid practice numbers linked to them for claims to be considered.

14.4 SHOULD A CLAIM BE REJECTED OR PENDING FOR NOT ALL OF THE INITIAL DOCUMENTS AS PER 14.1 BEING RECEIVED, OR, ANY ADDITIONAL INFORMATION WHICH IS REQUIRED, ALL OF THE ADDITIONAL INFORMATION MUST BE SUBMITTED TO TRA WITHIN 31 DAYS FROM THE DATE OF REQUEST, OR THE CLAIM WILL BE REJECTED AS LATE/STALE IN TERMS OF THIS POLICY AND WILL NOT BE PAID.

15. REJECTION OF LIABILITY AND TIME BAR

The liability of the Insurer, unless otherwise agreed with the Insured, shall be limited to the benefits actually purchased by the premiums received according to the rates in force in respect of benefits agreed on under this Policy at the time of purchase.

In accordance with the Policyholder Protection Rules, you will as a first step have 90 days, from the date of the claims decision communication sent to you, to dispute the outcome of your claim, by contacting our Complaints Department (complaints@totalrisksa.co.za) or 011 372 1540 (but the complaint must be in writing to be valid). Immediately following this 90-day period, you have a further 6 months to serve summons on us. If you do not do so within this time period, your right to challenge the decision will be forfeited.

16. FRAUDULENT CLAIM

16.1 If any claim made under this Policy is in any respect fraudulent, the benefit will not be payable and the Policy shall be cancelled, effective immediately, with no return of past paid premiums.

17. CURRENCY AND LAW

17.1 All Rand amounts stated in this contract are in the currency of the Republic of South Africa.

17.2 Any question of law arising under this contract will be decided according to the laws of the Republic of South Africa.

18. DECLARATION OF GOOD HEALTH

18.1 The following declarations need to be made by the Policyholder and the Insured male (if applicable – when taking out the Optional For Him Benefit), at the time of applying for cover and which form the basis of this contract:

18.1.1 The Policyholder and male Insured were in good health at the time of applying for cover and to the best of their knowledge there was nothing related to their health that could materially affect the application for cover under the Policy.

18.1.2 Specifically, the Policyholder and the Insured male declared that they did not suffer and had never suffered from Cancer and to the best of their knowledge none of their immediate family (biological parents and siblings) currently suffer or have suffered from Cancer.

18.1.3 The Policyholder/male dependant shall need to disclose any pre-existing conditions i.e. see 6.5 as a reference for what a pre-existing condition is. These conditions include undiagnosed or unattended to conditions e.g., the manifestation of symptoms which would have caused a reasonable and prudent person to seek advice (even if they didn't); relating to:

Section 13, point 13.1 of this Policy: No claim will be considered under this Policy, if the claim is related in the opinion of the Insurer, directly or indirectly, to any pre-existing condition (including for any Cancer) for which the Policyholder and/or male dependant sought or should have sought medical advice and/or treatment, during the 24 months prior to the commencement/Join Date of this Policy. The Insurer may determine conditions they felt would have likely been existing, even if they were not attended to i.e., 'should have sought treatment'. More documentation may be required from the Policyholder at the discretion of the Insurer to determine this.

18.1.4 If the Policyholder or the Insured male do declare that they were diagnosed with any form of cancer or a relevant pre-existing condition, prior to membership, the Insurer can: 1. Request more information, and has the right to decline cover for membership at its discretion, based upon medical evidence reviewed by an expert committee, who will remain fair and objective on the matter or 2. Accept cover, but subject to the terms and conditions as stipulated in this Policy document, particularly as outlined in section 13 of this Policy document.

19. CONSENT FOR COMMUNICATION

TRA has a duty to keep Policyholders updated about any offers and new products that are made available from time to time. TRA might communicate about these. As a Policyholder who has accepted this Policy, you accept this possible communication channel.

20. JURISDICTION

The Policy shall be subject to the laws of the Republic of South Africa, whose courts shall have sole jurisdiction to the exclusion of the courts of any other country.

20.1 TERRITORIAL LIMITATIONS

A Policyholder/male dependant shall be eligible, provided that they are resident in the Republic of South Africa. Should a a Policyholder/male dependant be temporarily absent from this territory, the following provisions shall apply:

20.1.1 Payment of claims shall only apply to treatment and events which occur within the borders of South Africa.

20.1.2 Payment of premiums shall be continued by the Policyholder and the Policyholder shall continue to be covered for the Assurance for a period of six months. If the Policyholder desires that the Assurance should continue for absence in excess of six months, then this must be advised to the Insurer by the Policyholder and must be accepted in writing by the Insurer.

20.1.3 After twelve consecutive months' absence from this territory, the Assurance in respect of that Policyholder shall automatically terminate, irrespective of any arrangements that may have been agreed to between the Policyholder and the Insurer in terms of clause 1 above.

20.1.4 Non-payment of premiums shall have the same effect as if the Policyholder were not temporarily absent from this territory and are subject to the provisions as per the PREMIUM and TERMINATION and ALTERATION clauses above.

21. USE OF PERSONAL INFORMATION

When you enter into this Policy you will be giving TRA your personal information that may be protected by data protection legislation, including but not only, the Protection of Personal Information Act, 2013 ("POPIA"). We will take all reasonable steps to protect your personal information. You authorise us to:

1. Process your personal information to:
   a. Communicate information to you that you ask us for.
   b. Provide you with insurance services.
   c. Verify the information you have given us against any source or database.
   d. Compile non-personal statistical information about you.
2. Transmit your personal information to any affiliate, subsidiary or re-insurer so that we can provide insurance services to you and to enable us to further our legitimate interests including statistical analysis, re-insurance and credit control.
3. Transmit your personal information to any third party service provider that we may appoint to perform functions relating to your Policy on your behalf.
4. Obtain access, make enquiries thereupon and request documentation in relation to your personal and medical information and that of any of your registered dependants, for the purposes of providing insurance services. You also give TRA full authority to perform these tasks as you would have done if you were personally present, with the required power of authority to perform the elected acts expressly granted in this Policy. You acknowledge that this consent will remain in force even if your Policy is cancelled or lapsed.

The TRA POPIA OVERVIEW can be found here: **www.totalrisksa.co.za/downloads/TRA-POPIA-Overview-2021.pdf**

22. TREATING CUSTOMERS FAIRLY

This product has been created to meet the requirements of our clients. We will at all times deliver on customer service and customer expectations by enforcing the principles of Treating Customers Fairly (TCF). The TCF principles ensure we apply fairness to all client experiences relating to new business, Policy terms, service and claims processes. The TCF framework has 6 outcomes which are:

1. You are confident that Your fair treatment is key to our culture.
2. Products and services are designed to meet Your needs.
3. We will communicate clearly, appropriately and on time during the lifespan of Your policy.
4. We provide advice that is suitable to Your needs and circumstances.
5. Our products and services meet Your standards and deliver to expectations.
6. There are no unreasonable barriers to access our services, or to lodge a claim or to lodge any complaints.

www.totalrisksa.co.za

23. COMPLAINTS RESOLUTION PROCESS

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 to complaints@totalrisksa.co.za or completed in the Complaints Section on the website www.totalrisksa.co.za. Alternatively, please ensure that where the complaint is delivered by hand or by any other means, that you retain proof of delivery.

Complaint has to be relevant

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

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

Procedures

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

1. Complaints can be submitted via email to complaints@totalrisksa.co.za or call us on (011) 372 1540.
2. The final complaint will be lodged (and has to be in writing) in our central complaints register on the same day that it is made and confirmation of receipt forwarded to you.
3. The complaint is immediately allocated to a trained and skilled person who specialises in that type of complaint.
4. The complaint will be investigated and we will revert to you with our findings within 5 working days.
5. In the event that you are not satisfied with our solution, you may refer the complaint to the Key Individual or the Chief Executive Officer (CEO) via email to Geoff@totalrisksa.co.za or Frank@totalrisksa.co.za respectively.

   The Key Individual or CEO may amend the solution or confirm it. Please be informed that certain decisions may have to be approved by the Board or Management Committee. In such a case, we will communicate that fact to you, as well as the date on which a decision will be taken.
6. If, after having referred the complaint to the Key Individual or the CEO, 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 Compliance Officer, ISS Compliance (Pty) Ltd, who is contactable on tel: +27 11 064 1672 and +27 31 832 0300 or email compliance@nfsgroup.co.za
7. If, after having referred your complaint to the Compliance Officer, you are still not satisfied with the outcome, you may approach the FAIS Ombud for complaints relating to services received from the administrator and any product related complaints can be submitted to the OSTI.
8. You must, if you wish to refer a matter to the Ombud, do so within a period of six months.
9. The Ombuds may be contacted as follows:

   FAIS Ombud:
   125 DALLAS AVENUE
   MENLYN CENTRAL
   WATERKLOOF GLEN
   PRETORIA, 0010

   P.O. BOX 74571
   LYNWOOD RIDGE
   0040
   TEL: +27 12 762 5000
   www.faisombud.co.za

   OMBUDSMAN FOR SHORT-TERM INSURANCE (OSTI):
   P O BOX 32334
   BRAAMFONTEIN, 2017
   Tel: +27 11 726 8900
   Fax: +27 11 726 5501
   www.osti.co.za

www.totalrisksa.co.za

GLOSSARY

This Glossary attempts to assist to provide definitions for certain terms/items and words which occur in this whole Policy document, in order for the Policyholder to better comprehend the said terms. However, not every single term requiring further understanding may be listed below. **These definitions do not imply cover under this Policy.**

It is the Policyholder's responsibility to query anything they do not understand clearly below or throughout this Policy document contract.

An email can be sent to our membership (membership@totalrisksa.co.za) or customer services (claims@totalrisksa.co.za) regarding this.

Alternatively, call 011 371 1540 for more information.

(Terms and Conditions Apply. Errors and Omissions Excepted).

ADVICE

Recommending an appropriate choice of action.

BENEFIT DATE

The first date that benefits are available in terms of this Policy.

BIOLOGICAL WARFARE / BIOLOGICAL WEAPON

Biological warfare is also known as germ warfare. It is the use of any organism (bacteria, virus or other disease-causing organism) or toxin found in nature, as a weapon of war. It is meant to incapacitate or kill an adversary. Biological weapons are the weapons used in biological warfare.

BLADDER CANCER

Malignant growths of the urinary bladder in females or males.

BREAST CANCER

Malignant growth in one or both breasts. This can affect both males and females.

CANCER

A disease manifested by the presence of a malignant tumour and characterised by the uncontrolled growth and spread of malignant cells with the invasion and destruction of normal surrounding tissue.

CANCER OF THE FALLOPIAN TUBES

Malignant growths on either of a pair of slender ducts through which ova pass from the ovaries to the uterus in the female reproductive system.

CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN I; CIN II; CIN III)

The abnormal growth of precancerous cells in the cervix. It is classified as mild (CIN I), moderate (CIN II) and severe (CIN III). This severity can be evaluated by special investigations involving taking a small sample for microscopic study. CIN is not cancer and is usually curable.

CERVICAL CANCER (CANCER OF THE CERVIX)

Malignant growths of the entrance to the womb (uterus). The cervix is the lower, narrow part of the uterus (womb).

CHEMICAL WARFARE / CHEMICAL WEAPONS

Chemical warfare (and associated military operations) is one using the toxic properties of chemical substances to kill, injure or incapacitate an enemy. Chemical weapons are the weapons used in chemical warfare.

DECLARATION

A firm statement made as an act of good faith in an insurance contract.

DIAGNOSIS

Refers to the diagnosis of cancer which is the discovery and identification of malignant cells (cells which are abnormal and have uncontrollable growth) within the body.

EXCLUSION

Situation under which the sum assured will not be paid out to the Insured, even if the claim event has occurred.

FAMILY HISTORY

In this context, the above refers to the health conditions of one's close relatives such as one's siblings, parents, grandparents, uncles, aunts and cousins.

GENITO-URINARY SYSTEM

The group of organs that are involved in reproduction and production and elimination of urine. These include: Breasts, adrenal gland, kidneys, ureter, bladder, genital tract, genital organs.

HISTOLOGY

The study of organic tissues.

INFORMATION TECHNOLOGY

The development, installation and implementation of computer systems and applications.

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INSURED/INSURED PERSON

The Policyholder and male dependant (if the Policyholder added the Optional For Him Benefit on their Policy), who are insured under this Policy, as outlined on the Policy Certificate and Schedule of this Policy document.

JOIN DATE

The date on which cover commenced as per the certificate.

LUMP SUM PAYOUT/LUMP SUM PAYMENT BENEFIT

The amount as stipulated on the schedule to be paid out, dependent on product choice, and subject to all of the terms and conditions in this Policy, as one payout, paid all at once, versus smaller amounts paid in installments.

MALE DEPENDANT

The female Policyholder of this Policy's Spouse or common law partner, proved by a legal South African marriage certificate or via an affidavit confirming 12 months of cohabitation or more, who is potentially Insured under this Policy, as stipulated with their Name on the Certificate of this Policy, under the Optional For Him Benefit which they applied for, where the female main Policyholder also signed off on this.

NUCLEAR POWER PLANT

A thermal power station in which the heat source is one or more nuclear reactors generating nuclear power. Nuclear power plants are base load stations, which work best when the power output is constant (although boiling water reactors can come down to half power at night).

NUCLEAR WARFARE / NUCLEAR WEAPON

A nuclear weapon is one that derives its destructive force from the nuclear reactions of nuclear fission and/or fusion. A nuclear warfare is one that involves the use of nuclear weapons.

OVARIAN CANCER

Malignant growth within the ovary/ovaries.

PAID-UP POLICY OPTION

An option that allows the Policyholder to stop paying premiums and still retain cover, only with reduced benefits. This option is not applicable to this Policy.

PENILE CANCER

A disease in which cancer cells form in the tissues of the penis.

POISON

A substance that causes injury, illness, or death, especially by chemical means.

POLICYHOLDER

The person who took out the Policy, and who is to be insured under this Policy, and whose benefit(s) are still valid under this Policy - in this case the female Policyholder who originally took out one of the female cancer product options.

PREMIUM INCREASE

Premiums will be reviewed in January of each year irrespective of when they were incepted.

PROSPECTIVE POLICYHOLDERS

A person who potentially can buy the product and become a Policyholder.

PROSTATE CANCER

Prostate cancer is cancer that occurs in the prostate. The prostate is a small walnut-shaped gland in males that produces the seminal fluid that nourishes and transports sperm.

RADIOACTIVE CONTAMINATION

It is typically the result of a loss of control of radioactive materials during the production or use of radioisotopes. For example, if a radioisotope used in medical imaging is accidentally spilled, the material could be spread by people as they walk around. Radioactive contamination may also be an inevitable result of certain processes, such as the release of radioactive xenon in nuclear fuel reprocessing. In cases that radioactive material cannot be contained, it may be diluted to safe concentrations. Nuclear fallout is the distribution of radioactive contamination by a nuclear explosion. Containment is what differentiates radioactive material from radioactive contamination. Therefore, radioactive material in sealed and designated containers is not properly referred to as contamination, although the units of measurement might be the same.

RADIOACTIVITY

The emission of ionising radiation or particles caused by the spontaneous disintegration of atomic nuclei.

REINSTATE / REINSTATEMENT

Restoration of a formal Contract/Policy after it has previously been terminated.

REPOSITORY SITE

A storage facility for spent nuclear fuel and other radioactive waste. Spent nuclear fuel is the radioactive by-product of electric power generation at commercial nuclear power plants, and high-level radioactive waste is the by-product from production at defense facilities.

REPROCESSING PLANTS

Plants that undergo special or additional processing of nuclear fuels before reusing. Reprocessing is a process that separates any usable elements (e.g. uranium and plutonium) from fission products and other materials in used nuclear reactor fuels. Usually the goal is to place these elements in new mixed oxide fuel (MOX), but some reprocessing is done to obtain plutonium for weapons. A reprocessing plant is a facility where nuclear reprocessing takes place.

TESTICULAR CANCER

Testicular cancer occurs in the testicles (testes), which are located inside the scrotum, a loose bag of skin underneath the penis. The testicles produce male sex hormones and sperm for reproduction.

WAITING PERIOD

Means a period during which an Insured is not entitled to Policy benefits and is the period commencing from the Join Date, during which no cover will be provided for any Claim Event.

RESEARCH REACTORS

It comprises a wide range of civil and commercial nuclear reactors which are generally not used for power generation. The primary purpose of research reactors is to provide a neutron source for non-destructive testing, analysis and testing of materials, production of radioisotopes, research and public outreach and education. They are small relative to commercial power reactors whose primary function is to produce heat to make electricity (typically 10 kW - 10 MW, ~1/1000 the size of commercial reactors). Research reactors are simpler than power reactors and operate at lower temperatures. They need far less fuel, and far less fission products build up as the fuel is used. On the other hand, their fuel requires more highly enriched uranium, typically up to 20% U235, although some older ones use 93% U-235. They also have a very high power density in the core, which requires special design features. Like power reactors, the core needs cooling (typically natural or forced convection with water), and a moderator is required to slow down the neutrons and enhance fission. As neutron production is their main function, most research reactors benefit from reflectors to reduce neutron loss from the core.

RESIGNATION/TERMINATION/SURRENDER

The voluntary cancellation of the Policy or Optional For Him Benefit by the Policyholder, or the cancellation of the Policy by the Insurer.

SURRENDER VALUE

This shall mean any cash benefit payable upon surrender of the Policy. This is not applicable in the case of this Policy.

SPOUSE

The legal or common law husband/wife of a Policyholder or such person residing with the Policyholder (verified by submission of an affidavit confirming 12 months of cohabitation) who is normally regarded by the community as the Policyholder's husband or wife.

TREATMENT

Medical or surgical care given to a patient.

UTERINE CANCER

Malignant growths of the uterus.

VAGINAL CANCER

Vaginal cancer is a cancer that occurs in your vagina - the muscular tube that connects your uterus with your outer genitals. Vaginal cancer most commonly occurs in the cells that line the surface of your vagina, which is sometimes called the birth canal.

WARFARE AGENT (NUCLEAR, BIOLOGICAL OR CHEMICAL)

A substance which is intended for use in military operations to kill, seriously injure or incapacitate people because of its physiological effects. Excluded from this definition are riot control agents, herbicides, smoke and flame.

STATUTORY DISCLOSURE NOTICE TO NON-LIFE INSURANCE POLICYHOLDERS IMPORTANT

PLEASE READ CAREFULLY

DISCLOSURE AND OTHER LEGAL REQUIREMENTS

(This notice does not form part of the Insurance Contract or any other document)

As a non-life insurance policyholder, or prospective policyholder, you have the right to the following information:

Financial Advisory & Intermediary Services Act No.37 2002 "FAIS Act"

The FAIS Act requires compliance by Product Suppliers (insurers) and Financial Services Providers (UMA or intermediary) with a General Code of Conduct that was introduced to assist you in making informed decisions about the insurance products that you purchase. It also aims to ensure that your Product Supplier, Underwriting Management Agent (if applicable) and Financial Services Provider (if applicable) render financial services honestly, fairly, with due skill and diligence, in your interests and to uphold the integrity of the financial services industry.

You will receive a Disclosure Notice at the inception of your policy and at each subsequent Renewal (or Anniversary) date. The Disclosure Notice contains certain information about your Product Supplier and Financial Services Provider that you are entitled to together with information about the Ombudsman. Should you experience difficulties in obtaining the required details, please contact your Financial Services Provider for further assistance.

1. About the Product Supplier (Insurer)

Name: Auto&General Insurance Company Limited, a licensed non-life Insurer & Financial Services Provider
Registration No: 1973/016880/06
FSP No: 16354
Physical address: Auto&General Park, 1 Telesure Lane, Riverglen, Dainfern, 2191
Tel: +27 11 489 4000
Website: www.autogen.co.za
Compliance: Auto&General has appointed Telesure Group Services (Pty) Ltd as their compliance officer and they may be contacted on:
Email: compliance@tihsa.co.za
Tel: 0860 999 954

Claims: The claims process is detailed in the insurance contract. The claims specialist is contactable at the numbers provided in your policy schedule.

Complaints: All complaints must be reduced to writing and sent to the claims specialist at the numbers above or email disputeresolution@autogen.co.za.

Auto&General is a licensed non-life Insurer and Financial Services Provider in terms of the FAIS Act and may render advice and intermediary services in respect of Short-Term Insurance Personal Lines and Commercial Lines.

Auto&General holds professional indemnity insurance and fidelity guarantee cover.

2. About the Underwriting Management Agent (UMA)

Name: Total Risk Administrators (Pty) Ltd (TRA), an authorised financial services provider
Registration No: 1999/024507/07
FSP No: 40815
Physical address: 16 Jersey Drive, Longmeadow Business Estate (East), Longmeadow, Edenvale, 1609
Postal address: PO Box 8012, Greenstone, 1616
Tel: +27 11 372 1540
Fax: +27 11 372 1579
Website: www.totalrisksa.co.za
Email: info@totalrisksa.co.za
Public Officer and Key Individual: G Du Preez
Tel: +27 11 372 1540

Compliance: ISS Compliance (Pty) Ltd, Practice No. 28
Tel: +27 11 064 1672
Email: compliance@nfsgroup.co.za

In terms of the FSP license, TRA is authorised to render Intermediary Services for products under: CATEGORY 1: Long-Term Insurance subcategory A, Short Term Insurance Personal Lines, A1, and Commercial Lines.

Claims: The claims process is detailed in the insurance contract. Claims must be submitted to claims@totalrisksa.co.za

Complaints: All complaints must be reduced to writing and sent to complaints@totalrisksa.co.za

Should we not be able to address the concerns to your satisfaction, you may wish to lodge a complaint with any of the Ombudsmen whose details appear below, but in particular with the FAIS Ombud. You are entitled to request a copy of our complaints policy and procedure.

TRA holds a written mandate in an underwriting capacity to provide binder functions on behalf of the insurer and earns a binder fee for performance of certain binder functions including claims settlement. TRA holds Professional Indemnity Insurance Cover.

3. Particulars of the FAIS Ombudsman

Name: The FAIS Ombud
Tel: +27 12 762 5000
Email: info@faisombud.co.za
Website: www.faisombud.co.za

4. National Financial Ombud details for all shortterm and long-term insurance complaints

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

5. Name, Class or type of Policy

Full details about the name, class and type of policy involved are reflected on your policy schedules and are also contained in the policy wording. Should you require any explanation about the terms, conditions, exclusions, provisions, premiums, excess (or deductibles) or any other information, please contact your broker or TRA for assistance.

6. Extent and Nature of Premium Obligations Premium

The premium and all accompanying charges are detailed on your policy schedule. Method of payment: Monthly premiums are to be paid on the designated day of each calendar month (due date). Consequence of Non-Payment: Should you fail to make payment on or before the due date, you have a period of grace for the payment of premiums of not less than 31 days after the relevant due date. In the case of a monthly policy, this provision will apply with effect from the second month of the currency of the policy.

7. Warning

Do not sign any blank or partially completed application forms. Complete all forms in ink. Keep all documents handed to you. Make notes as to what is said to you. Ask for a letter of representation from your advisor. Do not be pressurised into buying the product. Failure to provide correct or full relevant information may influence an insurer on any claims arising from your contract of insurance.

8. Conflict of Interest Policy

We have considered the conflict of interest provisions in terms of the FAIS Act 37 of 2002 and have not identified any actual or potential conflicts of interest, either ownership interest, financial interest, third party relationships associates or distribution channels as defined. We adopt a values based approach where the spirit of the legislation is embraced. This is reviewed at least annually and reported on to the Financial Sector Conduct Authority. A conflict of interest management policy is available to clients upon request.

In the past financial year, the UMA received more than 30% of its income from the Insurer. The UMA has a written mandate (Binder agreement) to act on behalf of the Insurer.

Auto&General Insurance Company Limited, Hippo Advisory Services (Pty) Ltd and Total Risk Administrators (Pty) Ltd are wholly owned subsidiaries of Telesure Investment Holdings (Pty) Ltd and therefore are associates. The entities operate independently to ensure that any potential conflicts of interests are mitigated and to ensure an optimal customer experience. Auto&General Insurance Company Limited has contracted with both Hippo Advisory Services (Pty) Ltd and Total Risk Administrators (Pty) Ltd and remunerates each entity for the services rendered. Auto&General Insurance Company Limited has applied to the Financial Sector Conduct Authority for an exemption in relation to this relationship.

9. Other Matters of Importance

You will be informed in the event of any material changes to the information referred to in paragraphs 1, 2 and 3. If the information in paragraphs 1 and 2 was given orally, you will receive this information in writing. A Polygraph or lie detector test is not obligatory in the event of a claim and the failure thereof may not be the sole reason for repudiating a claim. If the insurer wishes to cancel your policy, this will be given in writing to your last known email address. If your premium is paid by debit order, the debit order must be in favour of the Product Supplier (Insurer) and may not be transferred to any other party without your approval.

10. How to institute a Claim

Claims must be submitted to TRA. TRA may assist in the electronic identification and submission of qualifying claims. However, the onus remains on the Insured to ensure that relevant claims are submitted. If you receive a summons or notice of impending legal action with regards to a claim in terms of your policy, notify TRA or the product Supplier (insurer) immediately and forward any documentation to them.

11. Sharing of Information

Insurers may share information with each other regarding policies and claims with a view to preventing fraudulent claims and obtaining material information regarding the 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 and in the interest of all current and potential policyholders. 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 agent. You also similarly give consent to the sharing of information regarding past insurance policies and claims that you have made and you also acknowledge that information provided 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 regarding underwriting or claims 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, may be included on the system and made available to other insurers participating in the Information Data Sharing System.

12. Use of Personal Information

When you enter into this policy you will be giving us your personal information that may be protected by data protection legislation, including but not only, the Protection of Personal Information Act, 2013 ("POPIA"). We will take all reasonable steps to protect your personal information. You authorise us to:

a. Process your personal information to:
   i. Communicate information to you that you ask us for.
   ii. Provide you with insurance services.
   iii. Verify the information you have given us against any source or database.
   iv. Compile non-personal statistical information about you.
b. Transmit your personal information to any affiliate, subsidiary or re-insurer so that we can provide insurance services to you and to enable us to further our legitimate interests including statistical analysis, re-insurance and credit control.
c. Transmit your personal information to any third party service provider that we may appoint to perform functions relating to your policy on your behalf. You acknowledge that this consent clause will remain in force even if your policy is cancelled or lapsed.

13. Waiver of Rights

The General Code of Conduct stipulates that no financial services provider may request or induce in any manner a client to waiver any right or benefit conferred on the client by or in terms of any provisions of the said Code, or recognise, accept or act on any such waiver by a client. Any such waiver is null and void.