

## TOTAL RISK GAP COVER

**THIS IS AN EXCERPT OF THE FULL POLICY DOCUMENT. REFER TO FULL POLICY DOCUMENT ON APPLICATION.**

### THE POLICY

In consideration of and conditional upon the prior payment of the premium by or on behalf of the Insured and the receipt thereof by or on behalf of the Insurer before the join date or renewal date (as the case may be) and subject to the terms, exceptions, conditions and provisions of the Policy, the Insurer agrees to pay the Principal Insured person for an insured incident occurring during the period of insurance up to the Maximum Benefit Insured stated for the insured person and the benefit as stated in the Policy.

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

The Intermediary and Underwriting Manager / UMA have an agreement with the Insurer in terms of which remuneration is 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.

### CONDITION PRECEDENT

Strict compliance by both the Member and TRA with all provisions, conditions and terms of the Policy shall be a condition precedent to liability on the part of TRA hereunder.

It remains the responsibility of the policyholder to inform TRA of any changes to their membership status i.e. change of medical aid scheme, change of physical address, change of email address, telephone contact numbers and change in dependant status e.g. birth, death and divorce etc.

### POLICY 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:-

<b>Join Date</b>	The date on which cover commenced as per the certificate.
<b>Insured Event</b>	The admission of an Insured Person, stated in the Schedule, into hospital.
<b>Application Form</b>	The form that the Principal Insured completes and shall be the basis for the selection of benefits.
<b>Benefit Date</b>	The first date that benefits are available in terms of this Policy.
<b>Expiry / Resign Date</b>	The notified date of cancellation of benefits by either the Insurer, Insured or his legal representative.
<b>Hospital</b>	Hospital, unattached operating theatre or Day Clinic.
<b>Principal Policyholder/ Member / Insured Person</b>	The person who took out the Policy, and who is to be insured under this Policy, and whose benefit(s) have not expired in terms of the Expiry Date.
<b>Scheme</b>	The Insured Person's authorised Medical Aid Scheme.
<b>Maximum Benefit Insured</b>	The amount insured in respect of a Member, Spouse, Child or Dependant as stated in the Schedule.
<b>Children (Child) / Dependant</b>	The Principal Member's unmarried minor child who has not yet attained the age of 21. This age may be extended to 25 in respect of an unmarried child who is a full-time student. There will be no age restriction for children who are either mentally or physically incapacitated from maintaining themselves, provided that the children are wholly dependent on the Principal Member for support and maintenance. Once a child has become independent of the Principal Member for support and maintenance, dependency definition of a child cannot be revived at a later date unless that child is still under the age of 21. Child/ren shall mean the Principal Member's natural, legally adopted or step child/ren.
<b>Spouse</b>	The legal or common law husband/wife of a Principal Member or such person residing with the Member (verified by submission of an affidavit confirming 12 months of cohabitation) who is normally regarded by the community as the Principal Member's husband or wife.

## WHEN CAN YOU CLAIM?

### WAITING PERIODS

There is no general three (3) month waiting period.

The following waiting periods are/were applicable from the 'Join Date' until such time as they are completed. The waiting periods all start on the same 'Join Date' as specified in the certificate.

### 10 MONTH CONDITION SPECIFIC WAITING PERIOD

No claims may be submitted within the first 10 months of membership for any Gap Cover policy if they relate to any of the following conditions:

- Head, neck and spinal procedures (including stimulators) e.g. Laminectomy
- All types of hernia procedures
- Endoscopic procedures e.g. Colonoscopy, Gastroscopy
- Pregnancy and childbirth (including caesarean delivery)
- Gynaecological conditions e.g. Hysterectomy
- Joint replacement (including Arthroplasty, Arthroscopy, Metatarsal Osteotomy) but excluding treatment due to accidental trauma.
- Inability to walk / move without pain
- Renal Failure
- Cardiac (relating to the heart)
- Dentistry (unless due to accidental trauma)
- Cataracts and / or eye laser surgery (including all eye and lens procedures)
- Neurological conditions and procedures (including stimulators)
- Organ transplants (including cochlear implants)
- Reconstructive surgery as a result of an incident or condition that occurred prior to membership (including skin grafts)
- Mental health or psychiatric conditions (including depression)
- Varicose veins
- Oesophagitis, Gastroenteritis and Gastro-Intestinal Disorders
- Male genital system (including prostatectomy/robotic prostatectomy)
- All robotic type surgery
- Any Ear, Nose and Throat procedures (including nasal, sinus, tonsil and adenoid procedures)
- Diabetes and related complications

**All claims for these conditions received within the waiting period will be reviewed by medical management to identify pre-existing conditions.**

### CANCER DIAGNOSIS WAITING PERIOD

If a Policyholder is diagnosed with any form of cancer prior to membership, all related claims will be subject to a nine (9) month waiting period. If a Policyholder has previously been diagnosed with cancer and is currently in remission, the Policyholder needs to advise the Insurer by way of medical evidence that the remission period has been for two (2) or more consecutive years.

## PRE-EXISTING MEDICAL CONDITION/S WAITING PERIOD

NO claims relating to any pre-existing condition/s that may lead to hospitalisation (excluding cancer: see above) will be covered within the first six (6) months of membership. The Insurer reserves the right to request any clinical information from a Policyholder's doctor should a claim in this period indicate, and/or relate to, a pre-existing condition.

**All claims for these conditions received within the waiting period will be reviewed by medical management to identify pre-existing conditions.**

## WHEN ARE YOU NOT COVERED UNDER YOUR GAP POLICY?

- WHEN YOU HAVE REACHED THE ANNUAL AGGREGATE LIMIT OF R158 000 PER INSURED PERSON PER ANNUM. (EXCEPT FOR THE ACCIDENTAL DEATH AND POLICY EXTENDER BENEFITS - THIS LIMIT IS SUBJECT TO REGULATORY AMENDMENT).
- Where you have reached any of your benefit limits according to the maximum benefit insured i.e. the amount insured in respect of a Member, Spouse, Child or Dependant as stated in the Schedule.
- Where your medical aid does not pay their portion of an account first from the Risk or Major Medical benefit. No claims processed from your Scheme's day to day benefit will be covered - except for the Casualty benefit. (Please check your option benefits in the Schedule).
- Where you have not been admitted into hospital - except for the Casualty benefit.
- Where the dates of a claim are before or after the period you were admitted to hospital.
- Where your hospital charges theatre and ward fees over and above medical aid rates.
- MRI, CT and PET scans where your medical aid does not pay any portion of the account.
- Where the hospital charges for medication that is not part of an authorised procedure or that is taken home when being discharged.
- Where you have been charged a co-payment or deductible by your medical aid because you did not adhere to your medical aid rules OR you chose to see a doctor or hospital that is not on your Scheme's network. This is dependent on product option choice.
- Where the claim is below R100.
- Where your claim is not related to Oncology, but you want to claim from the benefits which fall under the Oncology benefit e.g. Oncology Co- Payments - see the Schedule for your option benefits.
- Where your claim is related to Oncology, but you want to claim from benefits which do not fall under the Oncology Benefit - see the Schedule for your option benefits.
- Where you want to claim twice for one unique medical expense/item from two benefits e.g. claiming a co-payment expense from the co-payment benefit as well as from the gap cover/shortfall benefit.

- NB: WHERE YOU HAVE BEEN CHARGED ANY PENALTY BY YOUR MEDICAL AID BECAUSE YOU DID NOT ADHERE TO YOUR MEDICAL AID RULES or YOU CHOSE A DOCTOR OR HOSPITAL THAT IS NOT ON YOUR SCHEME'S NETWORK.

#### CO-PAYMENT COVER (Excludes Oncology Benefit)

- Where you have been charged a co-payment or deductible by your medical aid because you did not adhere to your medical aid rules OR you chose to see a doctor or hospital that is not on your Scheme's network. This is dependent on product choice.
- Where your provider charges a separate fee (split billing) which you need to pay upfront and which cannot be claimed back from your medical aid.
- Where your treatment is related to Oncology, this co-payment does not apply at all. See Oncology Benefit in the Schedule and/or Oncology Benefit hereafter.

#### SUB-LIMIT BENEFIT (Excludes Oncology Benefit)

- Where your medical aid sub-limit applies to any items besides MRI, CT or PET scans and internal prostheses. See the Schedule to see what your product option provides regarding this benefit.
- Where your medical aid sub-limit is used up and your medical aid does not contribute any amount towards this account.
- Where your treatment is related to Oncology, this sub-limit benefit does not apply at all. See Oncology Benefit in the Schedule or Oncology Benefit hereafter.

#### CASUALTY BENEFIT (Excludes Oncology Benefit)

- Where the treatment is not an emergency / immediately required, is of an internal nature or did not come about due to an external force and/or impact with something or someone.
- Where the hospital charges for medication that is not part of an authorised procedure or that is taken home when being discharged.
- Where your medical aid covers casualty costs as part of a hospital benefit.
- Where your treatment is related to Oncology, this casualty benefit does not apply at all.

#### ONCOLOGY BENEFIT

- Where you want to claim for anything not related to Oncology under this benefit.
- Where your claim is related to Oncology treatment and you have reached any of your Oncology limits (see the Schedule), so you want to claim from the benefits which do not fall under the Oncology benefit e.g. Co-Payments.
- Where you have been charged a co-payment or deductible by your medical aid because you did not adhere to your medical aid rules OR you chose to see a doctor or hospital that is not on your Scheme's designated network.
- Where your provider charges a separate fee (split billing) which you need to pay upfront and which cannot be claimed back from your medical aid.

- Where your medical aid does not authorise treatment and/or biological medication as part of an approved oncology treatment plan.
- Where the Oncology costs are above scheme tariff (for the Oncology Gap Benefit applicable to all options) and the medical aid has not covered up to scheme tariff.
- Where the Oncology costs are above scheme tariff (for the Oncology Gap Benefit), or the Oncology costs are related to Oncology co-payments, and the treatment costs are not within the annual scheme oncology limit.
- Where the Oncology costs are above scheme limit (for the Oncology Extender Benefit) but the scheme has not covered up to this limit.

(This is dependent on product choice).

#### POLICY EXTENDER BENEFIT

- Where the benefit is not related to death.
- Where the official documents i.e. the death certificate is not provided for.
- Where it is not related to the death of the Principal Policyholder who was paying the premium contributions for the Gap Cover Policy.
- Where the premiums are to be provided for by TRA for a period of longer than 6 months.

#### ACCIDENTAL DEATH BENEFIT

- Where death does not occur within 12 months of the incident.
- 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 and 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.

#### PRESCRIBED MINIMUM BENEFIT CONDITIONS (PMB'S)

In terms of the Medical Aid Schemes Act of 1998 (Act number 131 of 1998) and its regulations, all medical schemes have to cover the costs related to diagnosis, treatments and care of:

- any life-threatening emergency medical condition.
- a defined set of 270 diagnoses and
- 27 chronic conditions.

These conditions and their treatments are known as the Prescribed Minimum Benefits (PMB's). All medical schemes in South Africa have to include PMB's in the health plans they offer to their members. There are, however, certain requirements that a member must meet before he or she can benefit from the PMB's, as follows:

- The condition must be part of the list of defined PMB conditions.
- The treatment needed must match the treatments in the defined benefits on the PMB list.
- Members must use the scheme's designated healthcare service providers.

**PMB's, regardless of how they are classified by a medical scheme, are covered on certain product options only, and for non-emergencies only.**

Please check your product options in the Schedule of this policy document to establish your cover.

#### ELIGIBILITY

- A dependant registered under this Policy must also be a dependant of the Policyholder and covered by a registered medical aid scheme that may or may not be the same scheme. Members and their dependants can only be on two different medical aids and one Gap Cover Policy if they are legally married or common law partners verified by submission of an affidavit confirming 12 months of cohabitation.
- There is no entry age limit.
- Policyholder dependants may be added or removed from this Policy.
- Dependants (excluding 'Spouse') need to take out their own Gap Policy if 21 years of age or older (25 in the case of an unmarried full-time student). A student needs to prove that they are a student by means of an official acceptance letter (the original or certified copy to be provided for) into the registered tertiary institution for the current calendar year.
- Only the Principal Policyholder, Spouse and Child Dependants, 21 years old or younger (or 25 in the case of an unmarried, full-time student), may be on the same Policy as the Principal Policyholder. Even if the Principal Policyholder

has other Dependants, for example, their parents who are on their Medical Aid Policy, these Dependants are not permitted to be on the same Gap Cover Policy as the Principal Policyholder and should take out their own Gap Cover Policy, separate to that of the Principal Policyholder.

- **If new and eligible Dependants are to be added to the Policy (for example: a new born baby or a new spouse), TRA must be informed within 30 days and provided with written notice of such an addition to the Policy. If TRA is not notified within this time frame, for example, from the date of birth/ adoption/ adjustment/ marriage, and then a claim is made for this 'Dependant' thereafter, this claim will under no circumstances be valid and will not be paid. If the dependant/s are registered after the 30-day period mentioned above, waiting periods and exclusions will apply.**

#### ALL CLAIMS - MANUAL AND AUTOMATIC PROCESSES

**IT REMAINS THE POLICYHOLDER'S RESPONSIBILITY TO ENSURE THAT TRA RECEIVES CLAIMS WITHIN THREE (3) MONTHS FROM THE DATE THE CLAIM WAS PROCESSED AND PAID BY THE MEDICAL AID SCHEME. PLEASE ALSO ENSURE THAT WE HAVE THE CORRECT BANKING DETAILS INTO WHICH THE CLAIM MUST BE PAID.**

#### CLAIMS - MANUAL PROCESS

Policyholders need to submit the following:

- Claim from the Service Provider.
- First TWO (2) pages of the hospital account showing the admission and discharge dates of the hospital event.
- The Medical Aid statements showing the payment of the Service Provider claim and reason for short payment.

Claim documents can be emailed to [claims@totalrisksa.co.za](mailto:claims@totalrisksa.co.za) or submitted online via our website [www.totalrisksa.co.za](http://www.totalrisksa.co.za). Alternatively, TRA may be contacted directly on +27 (11) 372 1540. One of our highly qualified and friendly claims specialists will gladly assist.

#### CLAIMS - AUTOMATIC PROCESS

TRA receives claims submitted by selected medical aid schemes on behalf of the Policyholder. Should your medical aid company have such an agreement with TRA, it is not necessary for the Policyholder to submit their claim to TRA. TRA will receive an electronic version of the claim and will process said claim within seven (7) working days of receipt thereof.

**CO-PAYMENT AND SUB-LIMIT CLAIMS MUST ALWAYS BE SUBMITTED MANUALLY BY THE POLICYHOLDER.**

#### THE CORRECTNESS OF STATEMENTS MADE TO THE INSURER

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.

Should any benefits have been paid out on the basis of the information provided by the Scheme 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.

#### PREMIUM PAYMENT

All premiums are payable monthly in advance. The period of grace allowed for non-payment of premiums is 30 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.

Where payment is to be made to or by the Insurer it shall be made in the currency of the Republic of South Africa.

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. (Phone (011) 372-1540 for details).

#### LIABILITY OF THE INSURER

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.

#### TERMINATION OR ALTERATION

##### COVER SHALL CEASE: -

1. At 24h00 hours on the last day of cover on which the premium has been paid. If a premium is not paid when due or if a premium debit is dishonoured, unless the Insured can prove to the satisfaction of the Insurer that this was an error by his paying agent.
2. In respect of minor children at the end of the calendar month in which he/she gets married or attains the age of twenty-one years, twenty-five if full-time student.
3. Once the Insured (or his legal representative) has given one (1) month's written notice to terminate this Policy, or once the Insurer has provided at least two months written notice to the Insured of any such alteration or termination. Upon receipt of this notice, all the benefits will be cancelled forthwith and all subsequent premiums paid will be refunded.
4. Upon the death of the main member, the Policy may be terminated. A new main-member who will be responsible for payment of premiums can be nominated or the Policy can be terminated.
5. The Insurer must be advised of any new dependants to be added to the Policy. The Insurer must be supplied with a current medical aid certificate showing the new dependant. If new and eligible Dependants are to be added to the Policy (for example: a new born or a Spouse), TRA must be informed within 30 days and provided with written notice of such an addition to the Policy. If TRA is not notified within this time frame, for example from the

date of birth/adoption/adjustment/marriage, and a claim is submitted for this 'Dependant' thereafter, this claim will under no circumstances be valid and will not be paid. If the dependant/s are registered after the 30-day period mentioned above, waiting periods and exclusions will apply.

6. Failure to advise TRA of resignation from a medical aid does not constitute a valid claim for a refund of premiums collected.

Cover may be altered by the Insurer upon giving at least one month's written notice of any possible changes to the policy.

**This Policy cannot be reinstated, under any circumstances, after Policy termination as described above.**

#### OPTION CHANGES/NEW POLICIES:

A Policyholder 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 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 this Policy may be subject to an excess (the amount of this excess will be stipulated at the time of claiming and is at the discretion of the TRA Management Committee). Upon changing options or joining a new Policy after resigning from current Policy membership, Option Benefit limits as stipulated in the Schedule may be pro-rated.

#### 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.

#### 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 six (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.

## 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.

## GENERAL GAP COVER POLICY LIMITATIONS

Notwithstanding all exclusions, including pre-existing conditions and waiting periods applicable to the Policyholder and/or his Medical Aid Scheme or Employer Scheme, TRA shall not be liable for hospitalisation, bodily injury, sickness or disease, directly or indirectly caused by, related to or in the consequence of:

1. War, invasion, act of foreign enemy, hostilities or warlike operations (whether war be declared or not) or civil war.
2. 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.
3.
  - a. Mutiny, military or usurped power, martial law or state of siege or any other event or cause which determines the proclamation or maintenance of martial law or state of siege.
  - b. Insurrection, rebellion or revolution.
4. Hospitalised psychiatric care is limited to 14 days per annum.
5. Cost of operations, treatments and procedures for cosmetic purposes.
6. Costs incurred for the treatment of obesity and health holidays.
7. The purchase of bandages, aids, patent foods (including baby foods), contraceptives, slimming preparations as advertised to the public, domestic and bio-chemical remedies.
8. Investigations, treatments, surgery for obesity or its sequelae or cosmetic surgery other than as a result of an insured event otherwise insured.
9. Participation in civil commotion, labour disturbances, riot, strike or the activities of locked out workers.
10. Participation in any form of race or speed test (other than on foot or in non-mechanically propelled watercraft on inland or coastal waters).
11. The cost of any treatment which is recoverable from another party.
12. Expenses incurred by a Policyholder or Dependant in the case of wilfully self-inflicted injuries, professional sport, speed contests and speed trials.
13. Travelling expenses.
14. Cost of treatment for infertility.
15. Cost of artificial insemination.
16. Services rendered by persons not registered with the SA Medical and Dental Council, SA Nursing Council or the Health Professions Council of South Africa.
17. Benefits for the following shall be limited to R200.00 per annum - alcoholism, narcotism, venereal disease, AIDS, breast reduction/augmentation, otoplasty and surgery performed at the same time as cosmetic surgery - for each of the seven (7) prescribed services.

18. In illness of a protracted nature, the committee may nominate a specialist of its choice in consultation with the attending practitioner.
19. Bionic ear implants (cochlear implants), breast reconstruction and nasal reconstruction are limited to R1000.00 per case.
20. Expenses incurred by a Policyholder or Dependents charged by either hospital, nursing home, unattached operating theatres and day-clinics for :
  - a. Accommodation (general / private ward); or
  - b. Theatre Fees; or
  - c. Drugs medicines and materials; or
  - d. Intensive care
  - e. Equipment (scope, robotic surgery etc.)
21. Benefits for spectacles, lenses and contact lenses.
22. Dental implants.
23. Any benefits and dental treatment in hospital for individuals over the age of 18 years unless authorised by the medical aid scheme.
24. Any ex-gratia payment approved by the medical aid scheme. (Including medical aid exceptions).
25. Any procedure performed without a Policyholder being admitted to hospital unless specified in the policy document.
26. Claims for external prosthesis/ses that are not approved by the Scheme unless specified in the policy document.
27. Biological medicine. (except on approved oncology treatment - see benefit).

## TRA ASSIST powered by ER24 ASSIST

### HOME DRIVE

- Access to 6 free trips per annum.
- Available to each member and up to a maximum of two of their guests that can be collected from a single pick-up point and transported to a single drop-off point.
- One way is equal to one trip
- Cancellations - Bookings can be cancelled up until 60 minutes before the arranged collection time. Any booking cancelled within 60 minutes of the collection time will be deducted from your total covered trips or billed at the full rate.
- The service is not available in every city in South Africa. Check at the time of booking if the service can be used in your area. Clients can be transported within a 50km radius of certain major city centres in South Africa.

### OWN VEHICLE

- In the event where you own a larger vehicle and can seat more than 2 guests, additional passengers will be accommodated for provided there are seatbelts for all the passengers in your car.
- Operating hours - Bookings are open until 02h00. The service can only be utilised from 17h30 until 03h00. Available 7 days a week.
- Bookings need to be made 48 hours in advance (especially for peak periods) and no less than 2 hours in advance in case of last minute arrangements. Drivers being available are not guaranteed.

- Peak periods are Thursday evenings to Sunday mornings as well as public holidays (the night before and on the day) and in some instances major public events that occur within the service area, for example sporting events and concerts.
- Additional Charges - if you exceed the number of total covered trips, you may continue to use the service at your own expense, If your trip exceeds 50km, payment for the additional distance will be per km. These payments need to be made by the user prior to the trip being used.

#### TAXI SERVICE

- The total radius allowed for a single trip is 50 kms.
- After 6 trips are used under the Home Drive service, the user may use the Own Vehicle service at their own expense (see Additional Charges above). or will need to make other arrangements themselves.
- The Taxi Service can be utilised at any time, seven days a week.

#### OTHER BENEFITS

All TRA ASSIST benefits are subject to the standard ER24 Assist terms and conditions.

#### TRA ASSIST DISCLAIMER

The use of TRA Assist does not imply or represent a commitment, in any way, to cover costs associated with medical (or any other) claims arising from the use of this app.

These services may be subject to change. Please double check when you utilise the services, that you are getting what you may require at the time.

#### COMPLAINTS 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](mailto:complaints@totalrisksa.co.za) or completed in the Complaints Section on the website [www.totalrisksa.co.za](http://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. The complaint will be lodged in our central complaints register on the same day that it is made and confirmation of receipt forwarded to you.
2. The complaint is immediately brought to the attention of the Key Individual of this provider for allocation to a trained and skilled person who specialises in that type of complaint.
3. The complaint will be investigated and we will revert to you with our findings within 5 working days.
4. In the event that you are not satisfied with our solution, you may refer the complaint to the Chief Executive Officer (CEO) of our business. The 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 of the organisation. In such a case, we will communicate that fact to you, as well as the date on which a decision will be taken.
5. If, after having referred the complaint to 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 Office of the Ombud for Financial Services Providers or take such other steps as may be advised by your legal representatives. The referral to the Office of the Ombud must be done in accordance with the provisions of section 21 of the FAIS Act and the rules promulgated in terms of that section. In instances where we have not been able to arrive at a resolution within six weeks after you have lodged your complaint, the matter may automatically be referred to the Ombud.
6. You must, if you wish to refer a matter to the Ombud, do so within a period of six months. The Ombud will not adjudicate in matters exceeding a value of R800 000.00.
7. The Ombud may be contacted at the following address:

**FAIS OMBUD**  
**P O BOX 74571**  
**LYNWOOD RIDGE**  
**0040**  
**TEL: 012 470 9080**  
**FAX: 012 348 3447**  
**WWW.FAISOMBUD.CO.ZA**

**OMBUDSMAN FOR SHORT-TERM INSURANCE (OSTI)**  
**P O BOX 32334**  
**BRAAMFONTEIN**  
**2017**  
**TEL: 011 726 8900**  
**FAX: 011 726 5501**  
**WWW.OSTI.CO.ZA**