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

Underwritten by:
Auto & General Insurance Company Limited
an Authorised Insurer & Financial Services Provider
Registration No 1973/016880/06

THIS DOCUMENT DESCRIBES THE TERMS AND CONDITIONS APPLICABLE TO THE 2021 TRA GAP COVER PRODUCT AND IS AN EXCERPT OF THE FULL POLICY DOCUMENTATION SENT TO ALL NEW POLICYHOLDERS

TOTAL RISK GAP COVER

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 Policyholder for an insured incident occurring during the period of insurance up to the Maximum Benefit Insured stated for the Policyholder and the benefit as stated in the Policy.

To be covered by this Gap Cover Policy you and your dependants must belong to a medical aid scheme which is registered with the Council for Medical Schemes. Medical Insurance does not qualify for Gap Cover.

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.

The Intermediary receives commission (up to 20% of the premium contribution) and the Underwriting Manager receives remuneration which is equal to 14% of the premium contribution.

CONDITION PRECEDENT

Strict compliance by both the Policyholder and Total Risk Administrators (PTY) Ltd (referred to as "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 within 30 days 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, change in dependant status e.g. birth, death, divorce and banking details.

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:-

Join Date	The date on which cover commenced as per the certificate.
Insured Event	The admission of a Policyholder, stated on the Certificate, into hospital.
Insured Person	Any one of the following: Policyholder, Principal Insured, Child, Children or Spouse insured as stated in the Schedule.
Application Form	The form that the Policyholder completes and shall be the basis for the selection of benefits.
Benefit Date	The first date that benefits are available in terms of this Policy.
Expiry / Resign Date	The notified date of cancellation of benefits by either the Insurer, Insured or his legal representative.
Hospital	Hospital, unattached operating theatre or Day Clinic.
Policyholder / Principal Policyholder or Principal Insured	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.
Scheme	The Policyholder's authorised Medical Aid Scheme.
Maximum Benefit Insured	The amount insured in respect of a Policyholder, Spouse, Child or Dependant as stated on the Certificate.
Children (Child) / Dependant	The Policyholder's unmarried child, and who is still a registered dependant on the Policyholder's medical aid scheme. This includes children who are either mentally or physically incapacitated from maintaining themselves, provided that the children are wholly dependent on the Policyholder for support and maintenance. Child/ren shall mean the Policyholder's natural, legally adopted or stepchild/ren.
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.

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WHEN CAN YOU CLAIM?

WAITING PERIODS

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

If a membership certificate is provided to show proof of a previous membership on another legitimate Gap Cover provider (and this membership is for a period of at least 24 months with no break in cover to the benefit start date of this policy), the below waiting periods i.e. 10 months, 9 months and 6 months which run concurrently, may be waivered.

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. Where a claim relates to a condition that is described in more than one waiting period definition, the longer of the two definitions shall apply.

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
- Any renal, kidney and bladder conditions
- Cardiac (relating to the heart)
- Dentistry (unless due to accidental trauma or oncology)
- 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)
- Carpal Tunnel Syndrome
- 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 R171 000 PER INSURED PERSON PER ANNUM. (EXCEPT FOR THE ACCIDENTAL DEATH AND POLICY EXTENDER BENEFITS - THIS LIMIT IS SUBJECT TO REGULATORY AMENDMENT).
- WHERE YOU AND YOUR DEPENDANTS DO NOT BELONG TO A MEDICAL AID WHICH IS REGISTERED WITH THE COUNCIL FOR MEDICAL SCHEMES.
- Where you have reached any of your benefit limits according to the maximum benefit insured i.e. the amount insured in respect of a Policyholder, Spouse, Child or Dependant as stated in the Schedule.
- Where your medical aid scheme 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 OR where the treatment has been authorised and paid from your medical aid scheme's In-Hospital or Major Medical 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. Dependent on product choice.
- 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 E.G. 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.
- Where the treatment has NOT been authorised and paid from your medical aid scheme's In-Hospital or Major Medical benefit.

SUB-LIMIT BENEFIT (Excludes Oncology Benefit)

- Where your medical aid sub-limit applies to any items besides MRI, CT or PET scans, internal prostheses and colonoscopies and gastroscopies. 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.
- Where the treatment has NOT been authorised and paid from your medical aid scheme's In-Hospital or Major Medical benefit.

GLOBAL FEE BENEFIT:

- Where the fee is related to a tariff rate, co-payment or sub-limit.

ACCIDENTAL TRAUMA/CASUALTY UNIT BENEFIT (Excludes Oncology Benefit)

- Where the treatment was not caused by a sudden accident, and treated in a casualty unit immediately after this accident, unless the treatment provided was for a child under the age of 8 years old, and the treatment was provided at the times and days as specified in the Option Benefits.
- Where the Casualty Unit is not attached to a hospital.
- 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.
- For children under 8 years, where the treatment is not received within the hours of 19h00 to 07h00 from Monday to Friday, from 19h00 on a Friday until 07h00 on a Monday, and all public holidays.

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. 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 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).

ONCOLOGY GAP BENEFIT: BREAST RECONSTRUCTION SURGERY

- Where the procedure has not been approved by the medical aid (as part of an approved oncology related procedure).
- Where the scheme has not paid up to scheme tariff.
- Where the costs do not fall within the annual scheme limit.
- Where the medical aid has not paid their full portion first, as stipulated in the medical aid plan's annual benefits.
- Where the medical aid will not pay anything towards this surgery first.
- Where the Policyholder has not been diagnosed with medically defined breast cancer ((a MALIGNANT (not benign) growth)), in one or both breasts, by a qualified oncologist or pathologist, and submitted proof of such to TRA at the claims stage.

- Where the date of diagnosis is prior to membership (although this will be reviewed in line with the Cancer Diagnosis Waiting period - see: 'Cancer Diagnosis Waiting Period' in this policy document).
- Where the Policyholder fails to submit all medical and any other reports requested from TRA at the claims stage.
- Where the Policyholder withholds or fails to disclose any relevant information at any point.
- Where the Policyholder wants to do a partial or full mastectomy and then reconstruction on one or both breasts as a merely preventative measure i.e. no cancer is yet present.
- Where the reconstruction is for any cosmetic purposes.
- Where the claims involve or relate to any post-operative care, fixing or repairing anything from the initial first operation, or any follow-up treatments or operations.

MATERNITY PRIVATE WARD BENEFIT

- Where your medical aid has not paid their portion of the related General Ward Rate.
- Where the claim is not related to the shortfall between the General Ward Rate and the Private Ward Rate.
- Where the claim is not related to hospitalisation for childbirth.

COVID-19 ISOLATION HOTEL BENEFIT

- Where you have not been admitted into a designated Covid-19 isolation hotel.
- Where you have not tested positive for Covid-19.
- Where your medical aid has not paid their portion of the Covid-19 isolation hotel Daily Rate.
- Where no designated hotel rooms are available or the isolation hotel facilities are no longer in operation.

POLICY EXTENDER BENEFIT

- Where the benefit is not related to accidental death. All of the terms and conditions related to the Accidental Death Benefit below apply.
- Where the official documents i.e. the death certificate is not provided for.
- Where it is not related to the accidental 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 9 months.

ACCIDENTAL DEATH BENEFIT

- 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

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 Policyholders. There are, however, certain requirements that a Policyholder 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.
- Policyholders must use the scheme's designated healthcare service providers.

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PMB'S are covered, but for non-emergency PMB conditions only. The Medical Schemes Act (131 of 1998) clearly states that a medical scheme must cover all emergency PMB conditions in full / at cost and all non-emergency PMB conditions subject to the medical scheme's approved rules. TRA processes non-emergency PMB claims only once valid reasons for the scheme rejecting the above tariff portion of such claim is received by TRA, and the reason for the rejection is aligned to the definitions of PMB's per the Medical Schemes Act (131 of 1998). The PMB claims process, in certain circumstances, will require the Policyholder to liaise with their medical scheme to obtain the necessary information confirming the reasons as to why the scheme is not covering these types of claims in full / at cost. The required information must be submitted to TRA within 90 days from the date of the request or the claim will be rejected as late/stale in terms of the Policy and will not be paid. All other terms and conditions apply.

ELIGIBILITY

- Only the Policyholder, Spouse and dependants who are members on one policy of a registered medical aid scheme may be covered on one TRA Gap Cover policy. (Subject to proof of membership and the premium being based on the age of the oldest beneficiary.)
- Policyholders 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 at least 12 months of cohabitation.
- There is no entry age limit.
- Policyholder dependants may be added or removed from this Policy.
- If new and eligible Dependants are to be added to the Policy (for example: a newborn 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 CLAIMS ARE SUBMITTED TO AND ARE RECEIVED BY TRA WITHIN SIX (6) MONTHS FROM THE DATE OF TREATMENT, AS WELL AS ENSURING THAT TRA HAS 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 statement showing the payment of the Service Provider claim and reason for short payment.

Claim documents can be emailed to claims@totalrisksa.co.za, submitted online via our website www.totalrisksa.co.za or submitted via our mobile app, TRA Assist. 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 scheme 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. (IN ADDITION TO ALL THE REQUIRED CLAIMS DOCUMENTATION PLEASE ALSO PROVIDE PROOF OF ANY DIRECT PAYMENT/S MADE TO THESE SERVICE PROVIDERS).

SHOULD A CLAIM BE REJECTED FOR ADDITIONAL INFORMATION (E.G. PRE-AUTHORISATION LETTER, MEDICAL AID STATEMENT, DOCTOR'S ACCOUNT OR FIRST 2 PAGES OF THE HOSPITAL ACCOUNT) NOT RECEIVED, ALL THE ADDITIONAL INFORMATION MUST BE SUBMITTED TO TRA WITHIN 30 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.

SHOULD A DISCOUNT BE RECEIVED BY A SERVICE PROVIDER AFTER THE GAP CLAIMS PAYMENT IS RECEIVED, PLEASE REFUND THE DISCOUNTED AMOUNT TO TRA. PLEASE CONTACT CLAIMS@TOTALRISKSA.CO.ZA OR CALL (011) 372 1540 TO RECEIVE OUR BANKING DETAILS.

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 or Insured Person 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. 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. Should a backdated termination arise due to non-payment of premiums, any claims paid between the last date of receipt of a premium and the termination date will be reversed and the policyholder will be liable to pay these claims amounts to the Insurer. It is the policyholder's responsibility to monitor that monthly premiums are received by the insurer.

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).

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.

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. 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 (2) month's 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.
3. Upon the death of the Policyholder, the Policy may be terminated. A new Policyholder who will be responsible for payment of premiums can be nominated or the Policy can be terminated.

ALTERATION: -

4. 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 newborn or a Spouse), TRA must be informed, in writing, within 30 days 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.
5. Failure to advise TRA of resignation from a medical aid does not constitute a valid claim for a refund of premiums collected.
6. 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. 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. Insurrection, rebellion or revolution.

4. Hospitalised psychiatric care is limited to 14 days per annum.
5. Costs 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 infertility or hormone treatment.
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).
20. **All** reconstructive surgeries, including but not limited to, breast, jaw, maxillofacial and nasal construction, are limited to R1000.00 per case ((Unless the surgery is the result of oncology treatment (also see Cancer Diagnosis Waiting Period)), or due to an accident which occurred after the 'Join Date' of this policy.
21. Expenses incurred by a Policyholder or Dependants 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. Surgical equipment, e.g. scopes.
22. All external appliances, e.g. wheelchairs, crutches, knee/back braces.
23. Claims for external prosthesis/ses.
24. Benefits for spectacles, lenses and contact lenses.
25. Dental implants and any preparation for dental implants and ANY other related costs, including any aftercare treatment and any co-payments, **irrespective** of medical aid approval.
26. Any benefits and dental treatment in hospital (**unless**, it is for children under the age of 18, or was authorised by the medical scheme and is for the treatment of impacted wisdom teeth, extractions, apicectomies or loss of teeth due to oncology or trauma). No other treatments for adults over the age of 18 are covered.
27 Any ex-gratia payment approved by the medical aid scheme. (Including medical aid exceptions).
28. Biological medicine. (except on approved oncology treatment - see benefit).
29. Transportation and harvesting costs for/related to organ transplant/s.
30. Any general transportation costs, including ambulances.
31. Robotic Surgery (except for the shortfall covered if paid as a global fee by the medical aid - covered from the gap cover global fee benefit- see product option benefits on page 3 of this Policy document).

TRA ASSIST powered by ITUASSIST

HOME DRIVE

- Access to 6 free trips per annum.
- Available to each Policyholder 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.
- The service can only be utilised from 18h00 until 03h00. The last available booking time is 01h00 (peak periods) or 02h00 (off peak periods).
- 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, and need to be determined with the service provider.

UBER 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.
- When making use of an Uber X or Uber XL, 1 trip will be deducted per one-way ride.
- When making use of an Uber Black, 2 trips will be deducted per one-way ride.
- When making use of an Uber Van, 3 trips will be deducted per one-way ride.

OTHER BENEFITS

All **TRA ASSIST** benefits are subject to the standard ituASSIST 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 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 Ombud.
8. You must, if you wish to refer a matter to the Ombud, do so within a period of six months.
9. The Ombud may be contacted at the following address:

Please note that the FAIS Ombud has recently moved. Their new address is as follows:

KASTEEL PARK OFFICE PARK,
ORANGE BUILDING, 2ND FLOOR,
546 JOCHEMUS STREET,
ERASMUS KLOOF,
PRETORIA, 0048

FAIS OMBUD
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