The PPS Provider™ Policy, Policy Document Version 1 which includes changes that became effective on 1 March 2012, is hereby amended by way of this endorsement in accordance with Section 6 of the said document. The changes will take effect on 1 November 2012.

1. **SECTION 1: DEFINITIONS**

The definition “Student Policyholder” is hereby repealed and replaced with the following definition:

“**Student Policyholder:** A policyholder who is registered with a university or other educational institution as a student in training for one of the professions eligible for membership of the Professional Provident Society Holdings Trust and who has satisfied the Professional Provident Society Holdings Trust that he has progressed sufficiently with his studies to be considered for such membership.”

The definition “PPS Limited” is hereby repealed and replaced with the following definition:

“**Professional Provident Society Holdings Trust:** Professional Provident Society Holdings Trust (Trust Number IT 312/2011).”

2. **SECTION 5: THE CONTRACT**

Section 5 is hereby repealed in its entirety and replaced with the following section:

“5. **THE CONTRACT**

The contract between the Policyholder and PPS Insurance is a long-term insurance policy.

Participation in the benefits under this contract is restricted to members of the Professional Provident Society Holdings Trust. The requirements for membership of the Professional Provident Society Holdings Trust are specified in the Trust Deed of the Professional Provident Society Holdings Trust. For the purposes of the Trust Deed of the Professional Provident Society Holdings Trust this contract shall, where applicable, be deemed to be the Master Contract.

For the purposes of the Trust Deed of the Professional Provident Society Holdings Trust, an Ordinary Member is a policyholder:

1. who has not exercised the Surplus Rebate Account Retention Option (Please refer to the section titled SURPLUS REBATE ACCOUNT for the requirements in this regard); and
2. with respect to whom PPS Insurance did not implement the Surplus Rebate Account Retention Option (Please refer to the section titled SURPLUS REBATE ACCOUNT for the requirements in this regard); and
3. with respect to whom the Surplus Rebate Account was not paid out for whatever reason (Please refer to the section titled SURPLUS REBATE ACCOUNT for the requirements in this regard).
A policyholder who does not meet the requirements of an Ordinary Member as set out above will be “any other participant in any product offered by PPS Insurance” and an Associate Member for the purpose of the Trust Deed of the Professional Provident Society Holdings Trust.

The latest Policy Certificate issued by PPS Insurance together with the PPS Provider™ Policy Document and any endorsement thereto, forms the contract between the Policyholder and PPS Insurance. The application form forms the basis of the contract between PPS Insurance and the Policyholder.

The PPS Provider™ Policy Document provides comprehensive information about all the products and benefits offered in terms of the PPS Provider™ Policy. Details of the products and benefits which are applicable to the Policyholder will be reflected on the latest Policy Certificate issued by PPS Insurance. The Policyholder must ensure that the information contained in the latest Policy Certificate issued by PPS Insurance correctly reflects the agreement between the Policyholder and PPS Insurance. If this is not the case the Policyholder must inform PPS Insurance in writing of the incorrect details. If a specific product and / or benefit is not reflected in the latest Policy Certificate issued by PPS Insurance, such product and / or benefit will not be applicable to the contract entered into between PPS Insurance and the Policyholder.

The version number of the PPS Provider™ Policy must correspond with the version number of the PPS Provider™ Policy as reflected on the latest Policy Certificate issued by PPS Insurance. It is possible that different versions of the PPS Provider™ Policy may be applicable to different products and / or benefits selected by the Policyholder.

3. **SECTION 9: DURATION OF THE PPS PROVIDER™ POLICY**

The references to “PPS Limited” in the wording of section 9 is hereby repealed and replaced with “The Professional Provident Society Holdings Trust”.

4. **SECTION 36: ACCELERATED CATCHALL COVER**

The following wording under the first bullet point of section 36 is hereby repealed: “Results in at least a class 4 rating in the American Medical Association “Guidelines to the Evaluation of Permanent Impairment” and results in a Whole Person Impairment (WPI) severity of at least 50%;”

The repealed section is hereby replaced with the following wording: “Results in a Whole Person Impairment (WPI) severity of at least 35%;”

5. **SECTION 42: CATCHALL COVER**

The following wording under the first bullet point of section 42 is hereby repealed: “Results in at least a class 4 rating in the American Medical Association “Guidelines to the Evaluation of Permanent Impairment” and results in a Whole Person Impairment (WPI) severity of at least 50%;”

The repealed section is hereby replaced with the following wording: “Results in a Whole Person Impairment (WPI) severity of at least 35%;”

6. **SECTION 46: SEVERE ILLNESS BENEFIT**
The following wording under the first bullet point of section 46 is hereby repealed: Results in at least a class 4 rating in the American Medical Association “Guidelines to the Evaluation of Permanent Impairment” and results in a Whole Person Impairment (WPI) severity of at least 50%.”

The repealed section is hereby replaced with the following wording: “Results in at least a class 4 rating in the American Medical Association “Guidelines to the Evaluation of Permanent Impairment” and results in a Whole Person Impairment (WPI) severity of at least 35%;”

7. SECTION 47: THE SICKNESS AND PERMANENT INCAPACITY BENEFIT

Section 47 is hereby repealed in its entirety and replaced with the following section:

“47. SICKNESS AND PERMANENT INCAPACITY

If the Policyholder is unable to attend to his usual professional duties due to sickness or permanent incapacity as defined in the PPS Provider™ Policy, PPS Insurance will pay a Sick Pay Benefit or Permanent Incapacity Benefit due in terms of the SICKNESS AND PERMANENT INCAPACITY BENEFIT, subject to the terms and conditions set out in the PPS Provider™ Policy.

The SICKNESS AND PERMANENT INCAPACITY BENEFIT will commence on the commencement date reflected on the latest Policy Certificate issued by PPS Insurance.

The SICKNESS AND PERMANENT INCAPACITY BENEFIT will end automatically on the first of the following events occurring:

- death of the Policyholder;
- cancellation by the Policyholder;
- termination of the PPS Provider™ Policy or cancellation of the SICKNESS AND PERMANENT INCAPACITY BENEFIT by PPS Insurance as provided for in the contract;
- on the day the Policyholder attains the age of 71 years, provided that in the absolute discretion of PPS Insurance he may, subject to certain terms and conditions as set out hereafter, be allowed to retain his units of benefit if, on this date, he continues in private practice for his own account;
- on the day on which the Policyholder attains the age of 66 years if, on this date, he is in receipt of Permanent Incapacity Benefit in terms of his contract;
- at the end of the month during which the Policyholder retires from practice or is, in the opinion of PPS Insurance, no longer substantially practicing his profession, provided that if he has attained the age of 66 years, he will be deemed to have retired from practice if he had been totally or partially unable, due to sickness, to perform his professional duties for a total continuous period of 182 days; or
- where he is a Student Policyholder in terms of his contract, on the day that he attains the age of 34 years, if, on the day before he attains this age, he had not yet qualified for the relevant degree or other tertiary qualification required by PPS Insurance.

The SICKNESS AND PERMANENT INCAPACITY BENEFIT consists of the SICK PAY BENEFIT and the PERMANENT INCAPACITY BENEFIT.

SICK PAY BENEFIT

The Policyholder will qualify for Total Sick Pay Benefit if he was totally unable to carry out his professional duties for at least seven consecutive days due to sickness. The Total Sick Pay Benefit will be paid retrospectively from the first day of his inability to carry out his professional duties due to sickness.
The Policyholder will only be deemed to be totally unable to carry out his professional duties where he is totally unable to carry out any of his professional duties due to sickness. If he is able to carry out some of his professional duties, even on a very limited scale, he does not qualify for Total Sick Pay Benefit.

If, however, after a period of qualifying for Total Sick Pay Benefit as set out above for at least seven consecutive days, the Policyholder recovered to such extent that he is able to carry out at least some of his professional duties, but due to the same sickness he is not able to carry out his normal duties or work his normal hours, he may qualify for Partial Sick Pay Benefit.

Total Sick Pay Benefit will not be payable for an amount greater than two-thirds of the amount of the Policyholder’s gross income derived from the practice of his profession as determined by PPS Insurance.

For the purposes of his contract, the Policyholder will be deemed to be practicing his profession if, subject to the normal eligibility criteria of the Professional Provident Society Holdings Trust, he carries out such professional duties as his qualifications and experience enable him to carry out, irrespective of whether he carries out such duties in private practice or not.

**Pregnancy Related Sickness**

Where a sickness is directly or indirectly attributable to pregnancy, confinement or miscarriage, a Sick Pay benefit will be payable to the policyholder provided that, in addition to meeting the normal requirements for Sick Pay Claims listed in this contract, the specific sickness contracted by the policyholder is also one of the conditions listed in Appendix E, and provided further that such sickness meets the description and all of the claim criteria and benefit requirements listed in Appendix E. A sickness will be deemed to be directly or indirectly attributable to pregnancy, confinement or miscarriage if it is established that, in spite of one or more intervening events or conditions, such sickness would not have been contracted by the policyholder, had it not been for the pregnancy, confinement or miscarriage. Sick Pay Benefits are in all instances limited to illnesses contracted by the policyholder and no Sick Pay Benefit will be payable under any circumstances in respect of any sickness contracted by an unborn child or a new-born child.

Payment in respect of the conditions listed in Appendix E will in all instances be limited to the maximum periods or number of days specified in Appendix E. All Sick Pay Benefits paid in terms of Appendix E will cease automatically on the day of delivery of the unborn child or on termination of the pregnancy, unless expressly stated otherwise.

Where a sickness is directly or indirectly attributable to pregnancy, confinement or miscarriage, but the specific sickness contracted by the policyholder is not one of the conditions listed in Appendix E and/or the sickness does not meet all of the claim criteria and benefit requirements listed in Appendix E, the payment of a Sick Pay Benefit will be limited to the period that the policyholder was hospitalised, provided that this hospitalisation period was at least a period of 4 consecutive days.

**Requirements for Sick Pay Claims**

A Policyholder, who is totally or partially unable to attend to his usual professional duties on account of sickness and who complies with all the applicable requirements of his contract for valid claims, may receive Sick Pay Benefit in terms of his contract, provided that:
1. he submits to PPS Insurance without delay and not more than six months from the date of onset of the sickness, a claim for Sick Pay Benefit and a certificate from the medical or dental practitioner or any other practitioner who attended to him, which practitioner has to be both registered with the Health Professions Council of South Africa and approved by PPS Insurance (both the claim and the certificate must be on the prescribed form provided by PPS Insurance);

2. he makes on such claim form, a declaration setting out the precise nature of the professional duties that he was carrying out before his sickness and the periods for which he was totally or partially unable to carry out such usual professional duties as a result of such sickness; and

3. the medical or dental practitioner certifies on such certificate that he personally examined and attended to the Policyholder during his sickness, describes the nature and cause of such sickness and states that in his opinion the Policyholder was as a consequence of such sickness totally or partially unable to carry out the professional duties stated by the Policyholder for the periods stated by him.

4. In order to satisfy itself that the Policyholder is or continues to be unable to attend to his professional duties, PPS Insurance may at any time (and if the Policyholder has been in receipt of Sick Pay Benefit for a continuous period of 182 days, PPS Insurance shall) either:
   4.1. obtain a special report from; or
   4.2. require the Policyholder to submit himself to medical examination by such medical practitioner as PPS Insurance may determine.

5. The Policyholder will during the continuation of his sickness send to PPS Insurance at weekly intervals or other intervals as determined by PPS Insurance, a certificate from his usual medical attendant certifying that he is still suffering from sickness (the nature of which again has to be stated) and has been unable to carry out his professional duties since the date of the previous certificate issued by the medical attendant.

6. The Policyholder will on recovery from sickness submit a certificate from his usual medical attendant stating the date from which he was again able to attend to his professional duties. In lieu of such certificate the medical attendant may, on the last of the certificates issued by him as set out above, state the day from which in his opinion the Policyholder will be able to resume his professional duties.

7. PPS Insurance will have the right to ask any other member of the Professional Provident Society Holdings Trust to visit such sick Policyholder at such intervals as it may determine and to obtain from such visiting member a report in writing.

8. The Policyholder will only qualify for Sick Pay Benefit if he continues to pay premiums to PPS Insurance during such period of sickness.

9. The Policyholder will only qualify for Sick Pay Benefit if he provides to PPS Insurance such information as it may require in respect of his income from the practice of his profession.

10. The Policyholder will only qualify for a Sick Pay Benefit if he complies with the processes and procedures for claiming a Sick Pay Benefit, as determined by PPS Insurance from time to time.

PPS Insurance may waive all or any of the above requirements for a claim for Sick Pay Benefit where it is satisfied that any failure to comply with the prescribed procedure was unavoidable in the circumstances of the case.

PPS Insurance may examine any claim for Sick Pay Benefit and its supporting medical certificate and may, after giving the claimant an opportunity to make representations (a) reduce the period for which the Policyholder has claimed such benefit if in its opinion the nature of the sickness is such that the period of time claimed for is excessive or (b) change a claim for Total Sick Pay Benefit to a claim for Partial Sick Pay Benefit in respect of periods when the Policyholder carried out some of his professional duties.
In reaching its decision in this regard PPS Insurance will refer its enquiries to the medical or
dental attendant who signed the medical certificate in question and may thereafter have
recourse to its own medical experts or may call for such further medical evidence, reports or
opinions as it deems necessary.

If a Policyholder submits a claim for Sick Pay Benefit containing deliberate false statements,
PPS Insurance will refuse to pay such claim and will cancel his entire PPS Provider™ Policy
with effect from the day upon which the claim containing the false statement was submitted
to PPS Insurance and will claim a refund of any amounts already paid in respect of a claim.

Sick Pay Benefit, in respect of the same, a consequential or related sickness will be payable
for a maximum aggregate period of 728 days, irrespective of whether such Sick Pay Benefit
consisted of Total or Partial Sick Pay Benefit.

A Policyholder who is in receipt of Sick Pay Benefit, will continue to pay premiums during such
period of sickness for the units of benefit held by him.

The Sick Pay Benefit has been designed to support the professional Policyholder during the
initial sickness period so that any realignment of his usual professional duties within his
profession, or reasonable adaptations to his work methods / duties can be made whilst
receiving Total or Partial Sick Pay Benefits. At the end of this period the Policyholder is then
assessed for the Permanent Incapacity Benefit and any residual effects of the sickness on his
ability to perform his usual professional duties is evaluated and the appropriate award is
made to compensate the Policyholder for the loss of his ability to generate professional
earnings.

PERMANENT INCAPACITY BENEFIT

Permanent Incapacity shall mean that PPS Insurance deems, in accordance with the
Permanent Incapacity Assessment Process, that a Policyholder presents with an impairment
that affects his ability to perform his usual professional duties. Permanent Incapacity could be
awarded as either Total Permanent Incapacity or Partial Permanent Incapacity.

Total Permanent Incapacity shall mean that PPS Insurance deems, in accordance with the
Permanent Incapacity Assessment Process, that a Policyholder is totally unable to work and
to perform his usual professional duties, even with adaptations to his work methods/duties,
and the realignment of his professional duties within his profession is not feasible in view of the
significance of his condition and/or his age, experience and knowledge.

Partial Permanent Incapacity shall mean that PPS Insurance deems, in accordance with the
Permanent Incapacity Assessment Process, that a Policyholder is partially but not totally
unable to perform his usual professional duties.

Permanent Incapacity Assessment Process shall mean the process undertaken by PPS
Insurance to evaluate, determine and assess whether a policyholder is Permanently
Incapacitated and which process involves consideration of amongst other factors the
following:

a) the payment of a valid Sick Pay Claim of at least seven consecutive days of sickness
   according to the definition of sickness contained in this contract. If the Policyholder applies
   for a Permanent Incapacity Benefit prior to having exhausted a maximum period of 728 days
   of Sickness Benefits, PPS Insurance will only consider a Permanent Incapacity award if it can
   establish that the Policyholder’s impairment will permanently affect his ability to perform his
   usual professional duties and any further improvement in his functional/vocational capacity is
   unlikely;
b) usual professional duties shall mean the professional duties that the Policyholder was carrying out immediately before the onset of his sickness, as recorded by the Policyholder on his Sickness Benefit Claim Forms;
c) a Policyholder’s ability to apply his mental and decision making skills, required to perform his usual professional duties, as a primary consideration;
d) a Policyholder’s physical/cognitive/functional and vocational capacity vs. the physical/cognitive/functional and vocational demands of his usual professional duties;
e) the Policyholder’s ability, as assessed by PPS Insurance, to perform his usual professional duties with reasonable adaptations to his work methods/duties;
f) in determining the level of permanent incapacity awards, a Policyholder’s ability, as assessed by PPS Insurance, to realign his usual professional duties within his profession, taking into account his professional knowledge, skills, age and experience. For the purposes of this subsection, a Policyholder’s profession shall be limited to jobs, vocations, fields or trades for which the Policyholder’s professional qualification(s) is a requirement;
g) all medical reports and evidence furnished by the Policyholder to PPS Insurance;
h) all medical reports and evidence requested by PPS Insurance;
i) the completion of Claims Questionnaires; and
j) any other information that PPS Insurance may require or considers relevant for the purposes of assessment.

Levels of Permanent Incapacity

If PPS Insurance deems, in accordance with the Permanent Incapacity Assessment Process, that the Policyholder is capable of performing more than 80% of his usual professional duties, with or without minor adaptations to his work methods/duties, he will not qualify for any Permanent Incapacity award.

A Partial Permanent Incapacity award will be either 20% or 60%. This percentage will be determined in accordance with the Permanent Incapacity Assessment Process.

A Policyholder who has been awarded a Partial Permanent Incapacity award of 20% or 60%:

- may elect to remain working within his profession. He will still be required to pay premiums and will be allowed to file claims for any sickness unrelated to that for which he is receiving a permanent incapacity award.
- may elect not to work within his profession. He will not be required to pay any further premiums and will not be entitled to make claims for any sickness unrelated to that for which he is receiving a permanent incapacity award. He will still be entitled to an upward review of his partial permanent incapacity award.

A Total Permanent Incapacity award will be 100%. A Policyholder who has been awarded a Total Permanent Incapacity award of 100% will not pay any further premiums and will also not be entitled to file any further sick pay claims.

Review of Permanent Incapacity Awards

A Policyholder may at any stage apply for a review of his existing Permanent Incapacity award provided that he submits new medical evidence to PPS Insurance. In addition PPS Insurance may at its sole discretion at any stage decide to review a Policyholder’s existing Permanent Incapacity award. Any review of an existing Permanent Incapacity award will be done in accordance with the Permanent Incapacity Assessment Process.

For the purpose of any review of an existing Permanent Incapacity award PPS Insurance may require a Policyholder to submit to medical examination by a medical practitioner appointed by PPS Insurance or may gather evidence concerning his state of health from any other source. If at any time PPS Insurance is of the opinion that:
1. The extent of the Policyholder’s permanent incapacity has changed, PPS Insurance may make a fresh determination in terms of this contract and the amount of his Permanent Incapacity Benefit shall be adjusted from the date of such change in the extent of his permanent incapacity;

2. The Policyholder is no longer permanently incapacitated, his Permanent Incapacity Benefit will cease to be paid and he will be regarded as having temporarily ceased to practise his profession from a date determined by PPS Insurance and be subject to the conditions under which PPS Insurance is prepared to allow a temporary cessation of payment of premiums unless he resumes fully his previous profession and, if he has ceased payment of premiums, resumes payment of premiums in respect of all units of benefit held by him immediately prior to cessation, at the rate at which he was paying immediately prior to cessation in terms of this contract, when he shall again become entitled to all the cover available in terms of such units of benefit;

3. The Policyholder remains permanently incapacitated except that he is endeavouring to resume his usual professional duties or to carry out such other professional duties as his professional qualifications and experience enable him to carry out, PPS Insurance may, in its discretion and on consideration of such additional evidence as it may require, continue to pay the Permanent Incapacity Benefit for a period not exceeding 182 days while he so endeavours; or

4. The Policyholder continues to be, or is again in the opinion of PPS Insurance permanently incapacitated, he shall continue to be entitled to a Permanent Incapacity Benefit in terms of this contract.

Where it is necessary for the purposes of determining any incapacity, or inability to carry out usual professional duties, or the extent thereof, the incapacity shall be determined on the basis of the medical reports and other medical evidence together with other reports, information or opinions, and submissions by the Policyholder obtained by PPS Insurance in the course of investigating the claim and for this purpose PPS Insurance will use its own medically qualified employees. The Policyholder acknowledges that the determination of incapacity or inability to work is a value judgment and he agrees to be bound by the decision of PPS Insurance unless he demonstrates that any decision taken by PPS Insurance was:

a. Clearly influenced by a material error of law; or
b. Taken for a reason not authorised by this contract; or
c. Taken for an ulterior motive or in bad faith or arbitrary or capriciously; or
d. Taken because irrelevant considerations were taken into account or relevant considerations were not considered.

**Maximum age for receipt of Permanent Incapacity Benefit**

No Permanent Incapacity Benefit will be payable from and including the day the Policyholder attains the age of 66 years.

**Benefit Options**

The Policyholder may qualify for the following benefit options:

**(a) Ordinary Benefit Option:** In order to acquire this benefit option, the Policyholder has to apply for Units of Ordinary Benefit. Units of Ordinary Benefit entitle him to either Sick Pay Benefit or Permanent Incapacity Benefit. Where he qualifies for Total Sick Pay Benefit, he will be paid 40 cents per unit for each day of sickness. Where he qualifies for Partial Sick Pay Benefit, he will be paid 20 cents per unit for each day of sickness. Where he qualifies for Total Permanent Incapacity Benefit, he will be paid 50 cents per unit for each day of permanent incapacity. Where he qualifies for Partial Permanent Incapacity Benefit, he will be paid 50 cents per unit multiplied by the benefit percentage awarded to him for each day of permanent incapacity.
Where the Policyholder has not yet attained the age of 30 years when Units of Ordinary Benefit are issued to him, he may elect to pay a reduced premium for each such Unit of Ordinary Benefit issued to him before the day he attains the age of 30 years. He will continue to pay such reduced rate until the day before he attains the age of 30 years. He will commence paying the full rate on the day that he attains the age of 30 years or on any earlier date chosen by him. A Policyholder who has commenced paying the full rate will not be permitted again to pay a reduced rate.

(b) **A Supplementary Benefit Option:** In order to acquire this benefit option, a Policyholder has to hold Units of Ordinary Benefit, and has to apply for Units of A Supplementary Benefit. Units of A Supplementary Benefit entitle him to Sick Pay Benefit. Where he qualifies for Total Sick Pay Benefit, he will be paid 35 cents per unit for each day of sickness. Where he qualifies for Partial Sick Pay Benefit, he will be paid 20 cents per day for each day of sickness.

(c) **B Supplementary Benefit Option:** In order to acquire this benefit option, a Policyholder has to hold Units of Ordinary Benefit, and has to apply for Units of B Supplementary Benefit. Units of B Supplementary Benefit entitle him to Sick Pay Benefit.

The Policyholder will not be entitled to receive Sick Pay Benefit in respect of Units of B Supplementary Benefit within the first 90 days immediately following the effective date of issue of such units of benefit. This waiting period does not apply to Units of B Supplementary Benefit issued to the Policyholder in terms of an annual increase of Units of Benefit declared by PPS Insurance.

Where he qualifies for Total Sick Pay Benefit, he will be paid 160 cents per unit for each day of sickness. Where he qualifies for Partial Sick Pay Benefit, he will be paid 40 cents per unit for each day of sickness.

Sick Pay Benefit in respect of Units of B Supplementary Benefit will be paid for periods of sickness totaling not more than 182 days in any one cycle of 364 days. The first such cycle will commence on the date from which the Policyholder becomes sick and entitled to Sick Pay Benefit and will expire 364 days later. If he is sick on the date of expiry of a cycle, a new cycle will commence immediately after such date. If he is not sick on the date of expiry of such cycle, a new cycle will commence on the day when he again becomes sick.

His Units of B Supplementary Benefit will be cancelled on the day that he attains the age of 66 years. No further premiums or benefits will thereafter be payable in respect of such cancelled units.

(d) **Deferred Benefit Option:** In order to acquire this benefit option, a Policyholder has to hold Units of Ordinary Benefit, and has to apply for Units of Deferred Benefit. Units of Deferred Benefit entitle him to Permanent Incapacity Benefit.

Where he qualifies for Total Permanent Incapacity Benefit, he will be paid 30 cents per unit for each day of permanent incapacity.

Where he qualifies for Partial Permanent Incapacity Benefit, he will be paid 30 cents per unit multiplied by the benefit percentage awarded to him for each day of permanent incapacity.

His Units of Deferred Benefit will be cancelled on the day that he attains the age of 66 years. No further premiums or benefits will thereafter be payable in respect of such cancelled units.
(e) **Accident Benefit Option:** In order to acquire this benefit option, the Policyholder has to apply for Units of Accident Benefit. Where he did not apply for Units of Accident Benefit, but his application for Units of Ordinary, A Supplementary, B Supplementary or Deferred Benefit has been rejected by PPS Insurance due to the state of his health, PPS Insurance may issue Units of Accident Benefit to him. Provided that he complies with the terms and conditions of this contract, Units of Accident Benefit entitle him to either Sick Pay Benefit or Permanent Incapacity Benefit.

Sick Pay Benefit or Permanent Incapacity Benefit will only be paid in respect of Units of Accident Benefit if such sickness or permanent incapacity is the result only of a visible bodily injury, solely caused violently and accidentally by external and visible means and (a) the disability suffered by the Policyholder is not one that is ordinarily considered to be an illness, (b) the sickness has occurred within six months of the date of the injury that caused the sickness, and (c) the injury has not occurred before the effective date of issue of such Units of Accident Benefit.

Where he qualifies for Total Sick Pay Benefit, he will be paid 35 cents per unit for each day of sickness. Where he qualifies for Partial Sick Pay Benefit, he will be paid 20 cents per unit for each day of sickness. Where he qualifies for Total Permanent Incapacity Benefit, he will be paid 35 cents per unit for each day of permanent incapacity. Where he qualifies for Partial Permanent Incapacity Benefit, he will be paid 35 cents per unit multiplied by the benefit percentage awarded to him for each day of permanent incapacity.

His Units of Accident Benefit will be cancelled on the day that he attains the age of 71 years. No further premiums or benefits will thereafter be payable in respect of such units.

**Rider Benefits**

The Policyholder may qualify for the following rider benefits:

(a) **Hospital Rider Benefit:** In order to acquire this rider benefit, the Policyholder has to apply for the Hospital Rider Benefit. The Hospital Rider Benefit is available as a rider benefit in respect of Units of Ordinary, A Supplementary, B Supplementary and Accident Benefit. Provided that he complies with the requirements of his contract for Hospital Rider Benefit, it entitles him to a daily Hospital Benefit that shall be equal to the daily Total Sick Pay Benefit in respect of those units in respect of which the Hospital Rider Benefit was issued to him for each day that he is hospitalised.

He will not be entitled to receive benefits in terms of the Hospital Rider Benefit within the first 30 days after the effective date of issue of the Hospital Rider Benefit. After such initial waiting period, he will qualify for payment of benefits provided that he was hospitalised for at least four consecutive days.

If, in addition to qualifying for benefits in terms of the Hospital Rider Benefit, he also complies with the requirements of this contract for Sick Pay Benefit, such Sick Pay Benefit will be paid simultaneously with, and in addition to, the Hospital Rider Benefit.

Benefits in terms of the Hospital Rider Benefit will be paid for periods of hospitalisation totaling not more than 182 days in any one cycle of 364 days. The first such cycle will commence on the date from which the Policyholder is hospitalised and entitled to benefits in respect of the Hospital Rider Benefit and will expire 364 days later. If he is hospitalised on the date of expiry of a cycle, a new cycle will commence immediately after such date. If he is not hospitalised on the date of expiry of a cycle, a new cycle will commence on the day when he again becomes hospitalised.

His Hospital Rider Benefit will be cancelled on the day that he attains the age of 66 years.
(b) **Occupation Specific Rider Benefit™**: In order to acquire this Rider Benefit, the Policyholder has to apply for the Occupation Specific Rider Benefit™. It is available as a rider benefit in respect of Units of Ordinary and Deferred Benefit. Provided that he complies with the requirements set out in his contract for benefits in terms of this rider benefit, he will be entitled to payment of an Occupation Specific Permanent Incapacity Benefit on a monthly basis in substitution for any Partial Permanent Incapacity Benefit being paid in terms of this contract. The monthly benefit payable to him will be equivalent to the maximum Permanent Incapacity Benefit payable in respect of all Units of Ordinary and Deferred Benefit held by him. No further benefits in terms of Sick Pay Benefit and/or Permanent Incapacity Benefit are available once the Occupation Specific Rider Benefit™ award has been made and all premiums for these benefits will cease accordingly.

**Requirements for acquiring the Occupation Specific Rider Benefit™**: The Policyholder will only qualify for this rider benefit if he, at the time of applying for this rider benefit:

(i) holds Units of Ordinary and/or Deferred Benefit;
(ii) has not yet attained the age of 60 years;
(iii) is not in receipt of Sick Pay Benefit or Permanent Incapacity Benefit;
(iv) is not a Student Policyholder as defined in this contract; and
(v) has included the required comprehensive description of the exact nature of his Nominated Specific Occupation which will be used as basis for determining permanent incapacity in terms of this rider benefit.

The Occupation Specific Rider Benefit™ will only be issued by PPS Insurance as a rider benefit in respect of all Units of Ordinary and Deferred Benefit held by the Policyholder. It will be applicable to both categories of units of benefit and the Policyholder will not be entitled to this rider benefit on only the Units of Ordinary or Units of Deferred Benefit.

Should his Units of Ordinary or Deferred Benefit be increased or reduced in terms of this contract, the Occupation Specific Rider Benefit™ will be increased or reduced accordingly by PPS Insurance.

The Policyholder will qualify for payment of benefits in terms of this rider benefit if:

(i) he suffers a disability due to a disease, injury, accident or other cause;
(ii) he has received Sick Pay Benefit for a maximum aggregate period of 728 days for the same, a consequential or related sickness; and
(iii) he has been assessed as qualifying for a Partial Permanent Incapacity award in terms of the Permanent Incapacity Assessment Process.

**Change of occupation**: If the Policyholder changes his nominated specific occupation or the tasks undertaken by him in the course of practicing such nominated specific occupation, he must deliver to PPS Insurance, within six months of any such change, a new comprehensive description in the form required by PPS Insurance of the exact nature of his changed nominated specific occupation. PPS Insurance will, when assessing whether his functioning and ability to practice the nominated specific occupation is continuously, permanently and significantly restricted, take into account only those details of his nominated specific occupation which are contained in the original application form or any amendment thereof provided within six months of any such change. Upon receipt of information with respect to a change of occupation, PPS Insurance will be entitled to review the terms of this rider benefit.

**Exclusions**: In addition to all standard exclusions imposed under the contract and any specific exclusions imposed as a result of application of the underwriting criteria of PPS
Insurance and reflected on the latest Policy Certificate issued to the Policyholder, no benefit will be payable in terms of the Occupation Specific Rider Benefit™ in respect of:

(i) Chronic fatigue syndrome (also known as yeppie flu or myalgic encephalomyelitis (ME);
(ii) Fibromyalgia; and
(iii) Mental Illness.

The exclusions listed in (i) to (iii) above apply only to the Occupation Specific Rider Benefit™ and do not impact on any award made in terms of the Permanent Incapacity Assessment Process.

Duration of benefits: Irrespective of any change in the Policyholder’s functioning and ability to practice his nominated specific occupation, his benefits in terms of the Occupation Specific Rider Benefit™, once awarded by PPS Insurance, will not be reviewed.

The benefits will cease and no further payments will be made to him on the day on which he attains the age of 66 years.

Student Policyholders

A Policyholder who is a Student Policyholder as defined in his contract, will qualify for Sick Pay Benefit provided that, subject to all the other requirements of this contract for Sick Pay Benefit, he is totally unable to attend to his normal duties or activities as determined by PPS Insurance, due to sickness. The quantum of Sick Pay Benefit payable to him will not be limited due to the fact that he is not earning any income from the practice of any profession.

A Student Policyholder may hold such number of Units of Ordinary Benefit as is determined by PPS Insurance from time to time irrespective of whether he earns an income from the practice of any profession or not.

Restrictions on number of Units of Benefit held by the Policyholder

PPS Insurance will determine the minimum and maximum number of units of benefit that a Policyholder may hold. Subject to such minimums and maximums, a Policyholder may hold any number of units of benefit provided that the number of units of benefit held by him at no stage confers Sick Pay Benefit of an amount exceeding two-thirds of his gross income derived from the practice of his profession as determined by PPS Insurance.

Annual increase of Units of Benefit declared by PPS Insurance

PPS Insurance may annually issue units of benefit to the Policyholder if in its opinion the value of the Policyholder’s benefits has during the year under consideration for any reason been eroded or diminished, provided that at no stage will such issue of units of benefit cause the Policyholder’s unit holding to exceed the maximums as determined by PPS Insurance from time to time or as determined by reference to the Policyholder’s gross income derived from the practice of his profession.

The following conditions will apply to such an issue of units of benefit:

1. Each year PPS Insurance will consider the economic factors and indicators which it believes relevant or applicable to Policyholders’ holding of units of benefit in terms of this contract, including but not limited to the consumer price index, and if PPS Insurance is of the opinion that inflation and/or any other circumstances have resulted in the value of the benefits enjoyed by Policyholders in respect of their benefits being eroded or diminished, then PPS Insurance may in its entire discretion, decide upon percentages by which the unit holdings of all Policyholders in each
benefit option will be increased on 1 January of the following year.

2. The percentage increase so determined for each benefit option will be calculated on each Policyholder’s existing unit holding in every option as at 31 December of the immediately preceding year and if a fraction of a unit results from such a calculation, the Policyholder’s unit holding in each option will be rounded up or down to the nearest whole number.

3. The Policyholder will pay a premium for the additional units so issued to him at the applicable rate for his age at the date of issue.

4. The units so issued will in each benefit option be subject to the premium loadings and/or exclusions that applied to the immediately preceding issue of units to the Policyholder in each respective benefit option.

5. Subject to the rights of Policyholders who are in receipt of Partial Permanent Incapacity Benefit and elect to remain working, Policyholders who have been declared permanently incapacitated will not be issued with these additional units of benefit.

6. Policyholders who attained the age of 66 on or before 31 of December in any year, will not be issued with additional units of benefit in terms of this declared annual issue.

7. Policyholders who are in receipt of Sick Pay Benefit or Partial Permanent Incapacity Benefit and elect to remain working, shall be issued with these additional units of benefit and subject to payment of the premiums in respect thereof shall be entitled to benefits on these units from the date on which they are issued.

**Bonus units of benefit for permanently incapacitated Policyholders**

PPS Insurance may annually issue bonus Units of Ordinary, Deferred or Accident Benefit to those Policyholder’s who have been declared permanently incapacitated (excluding Policyholders who have been declared partially permanently incapacitated and elect to remain working) subject to the following conditions:

1. The number of bonus units of benefit to be issued in any year shall be determined in the entire discretion of PPS Insurance after it has considered and approved its annual audited accounts. These bonus units of benefit shall then be issued from a date to be determined by PPS Insurance.

2. The bonus Units of Ordinary, Deferred or Accident Benefit will respectively rank for benefits in the same way as Units of Ordinary, Deferred or Accident Benefit and the permanently incapacitated Policyholder will not be required to pay any premiums in respect of such bonus units of benefit. The bonus units of benefit will respectively qualify for bonus allocations in respect of the Policyholder’s apportionment account as described hereafter, in the same way as Units of Ordinary, Deferred or Accident Benefit.

3. In the event that a Policyholder for any reason ceases to be deemed permanently incapacitated in terms of this contract, he will retain the bonus units of benefit issued to him in the past. He will pay a premium for each of these retained bonus units of benefit as calculated by PPS Insurance from the first day of the month following the month in which he so ceased to be deemed to be permanently incapacitated. These bonus units of benefit will be deemed to be units of benefit for all purposes under his contract.

**Applying for Additional Units of Benefit**

A Policyholder may apply for additional units of benefit provided that the number of units of benefit held by him after issue of such additional units of benefit will not exceed the maximums as determined by PPS Insurance from time to time or as determined by reference to his gross income derived from the practice of his profession.
He will only qualify for such additional units of benefit if, at the time of issue of such units of benefit, he has not yet attained the age of 62 years.

The issue of such additional units of benefit will be subject to the underwriting policy as determined by PPS Insurance from time to time.

A Policyholder who is in receipt of a Permanent Incapacity Benefit in terms of this contract will not be entitled to apply for additional units of benefit.

Guaranteed right to additional Units of Benefit
Notwithstanding the other provisions of this contract, all Policyholders, excluding Policyholders who are Student Policyholders, may take up additional Units of Ordinary and/or A Supplementary and/or Deferred Benefit without further proof of insurability on the following conditions:

1. The Guaranteed Right may only be claimed by a Policyholder who:
   (a) had the SICKNESS AND PERMANENT INCAPACITY BENEFIT continuously from 1 June 2005; and
   (b) is under 40 years of age at the time that he applies for Units of Benefit in terms of this section; and
   (c) held at least 100 Units of Ordinary Benefit immediately after applying for cover under this contract or after last applying for additional Units of Benefit otherwise than under this section; and
   (d) has satisfied PPS Insurance that he has no reason to suppose that he might be infected with the human immunodeficiency virus; and
   (e) at the time of applying for cover under the SICKNESS AND PERMANENT INCAPACITY BENEFIT or when last applying for additional Units of Benefit was granted cover or additional units without the imposition of an additional premium of more than 5 cents per unit per month.

2. The units issued in terms of this section shall in each option be subject to the payment of the additional premiums and/or the limitation of benefits that applied to the immediately preceding issue of units to the Policyholder in each respective benefit option.

3. In addition to the additional premium and/or limitation of benefits imposed as aforementioned, PPS Insurance shall be entitled to impose any further premium or limitation of benefits required in order to satisfy its statutory actuary that the premiums, benefits and other values are actuarially sound having regard to the additional units applied for.

4. The number of Units of Benefit that a Policyholder shall be entitled to take up in terms of this Guaranteed Right shall be limited to and by the following provisions:
   (a) if a Policyholder is under the age of 32 at the time that he first claims Units of Benefit in terms of this section then:
      (i) the maximum number of Units of Benefit that he is entitled to take up shall be the difference between the number of units (in each option) held by him at the date when he was last issued with units (of whatsoever benefit option) by PPS Insurance and the maximum number of Units of Benefit (in each benefit option) offered by PPS Insurance at the time that the Policyholder first claims Units of Benefit in terms of this section; and
      (ii) he shall be entitled to take up one-fifth of the maximum number of Units of Benefit calculated in accordance with sub-paragraph (i) above, in each benefit option, at the time that he first claims Units of Benefit in terms of this section, and thereafter only on each of the 2nd, 4th, 6th and 8th anniversaries of the date on which he first claimed Units of Benefit in terms of this section;
   (b) if a Policyholder is 32 years of age or older at the time that he first claims Units of Benefit in terms of this section then:
      (i) the number of Units of Benefit that he is entitled to take up shall be the maximum number of units calculated, in accordance with paragraph (a)(i) above, but reduced by one-fifth for each completed two-year period, or part thereof, that the age of the Policyholder exceeds 32 years;
(ii) he may take up the units to which he is entitled (in each benefit option) only as to one-fifth of the maximum number of units calculated in accordance with paragraph (a)(i) above at the time that he first claims Units of Benefit in terms of this section and thereafter only on each of the anniversaries of this date, referred to in paragraph (a)(ii) above, that falls before his fortieth birthday.

5. After a Policyholder has taken up his first one-fifth entitlement calculated in accordance with paragraph (4) above, the Policyholder shall be required to give notice of his intention to take up any subsequent one-fifth entitlement, within 60 days prior to the relevant anniversary date referred to in paragraph (4) above, failing which his right to take up that entitlement shall lapse. This notice must be in writing and must reach PPS Insurance within the said 60-day period.

6. Fractions of units will not be issued and accordingly if a fraction of a unit results from the calculation of the abovementioned one-fifth entitlement then the number of Units of Benefits to be issued (in each or any benefit option) shall in respect of the first issue of units to a Policyholder in terms of this section, be increased to the nearest whole number and the Policyholder's remaining entitlement/s (if any) shall be reduced to the nearest whole number so that the Policyholder's total entitlement in terms of this section is issued to him in tranches consisting of whole numbers of units, which tranches are as near as possible equal to one another and which tranches together do not exceed the Policyholder's total entitlement.

7. If a Policyholder reaches 40 years of age before having exercised his right to take up all or any Units of Benefit in terms of this section, his Guaranteed Right shall lapse.

8. The Guaranteed Right to Units of Benefit may only be exercised by a Policyholder who is in good standing and who has fully paid all premiums due to PPS Insurance.

9. If a Policyholder is in receipt of sick pay benefits from PPS Insurance at the time that he becomes entitled to take up any portion of Units of Benefit in terms of this section, he shall nevertheless be entitled to take up such units and to be paid sick pay in respect of these Units of Benefit.

10. From the date that a Policyholder is declared Permanently Incapacitated his right to take up any Units of Benefit in terms of this section, shall lapse.

11. The Guaranteed Right shall lapse when for any reason a Policyholder ceases to have a SICKNESS AND PERMANENT INCAPACITY BENEFIT.

12. A policyholder cannot take up Units of Benefit (or any portion thereof) in terms of this section, whilst in a period of temporary cessation of payment of premiums.

13. The Guaranteed Right may not be claimed in respect of Units of Accident or Hospital Benefit.

14. Except insofar as has been provided in this section, the terms of this contract shall apply to all Units of Benefit issued to Policyholders in terms of this section.

Reduction of Units of Benefit

A Policyholder may, subject to the approval of PPS Insurance, reduce the number of units of benefit held by him. From the date upon which such reduction is approved, he shall receive Sick Pay Benefit or Permanent Incapacity Benefit only in respect of such reduced number of units of benefit.

The units of benefit to be cancelled will be the units last issued to him in each benefit category. If the number of units to be cancelled exceeds the number last issued, the balance to be cancelled shall be units issued on the last occasion but one, and so on.

The reduction of premiums will be the cost of the specific units so cancelled.

If a Policyholder’s gross income derived from the practice of his profession is reduced at any stage, he is obliged to request PPS Insurance to reduce the number of units held by him in order to ensure that at no stage the number of units held by him will entitle him to Sick Pay Benefit of an amount greater than two-thirds of such income.
Temporary cessation of payment of premiums

The policyholder can apply to PPS Insurance for a temporary cessation of payment of premiums. Please refer to the section titled PREMIUMS.

The policyholder will receive no Sick Pay Benefit or Permanent Incapacity Benefit in respect of sickness or injury during such period or during an interval of three months following the expiry of such period; and no bonus allocations will be credited to his apportionment account as described hereafter in respect of such period.

Participation after age 71

A Policyholder who has attained the age of 71 years may be allowed, in the absolute discretion of PPS Insurance, to retain his units of benefit held in terms of his contract, without additional medical examination, subject to the conditions that:

1. he must be and will remain in private practice for his own account;
2. his units of benefit will not be subject to any maximum age restriction but his continued participation will at all times remain in the absolute discretion of PPS Insurance and may be terminated at any time;
3. if he is unable to carry out his professional duties for a continuous period of 90 days (or for periods which aggregate 90 days in any one cycle of 360 days) due to sickness, his units of benefit will be cancelled on the day after such 90-day period of sickness;
4. the premium that he will pay in respect of the units of benefit that he retains will be double the rate per unit that he paid up to the day before he attained the age of 71 years and the increased premiums will be payable
   (a) in the case of a Policyholder who attains the age of 71 years on the first day of the month, from the first day of that month; or
   (b) in the case of any other Policyholder, from the first day of the month following the month in which he attains the age of 71 years;
5. he will qualify for Total Sick Pay Benefit only if he was totally unable to carry out his professional duties for at least 14 consecutive days due to sickness;
6. he will not be entitled to claim Partial Sick Pay Benefit; and
7. he will not be entitled to request a temporary cessation of payment of premiums.

Exclusions

In addition to (a) any specific underwriting exclusions reflected on the latest Policy Certificate issued to the Policyholder by PPS Insurance and (b) the exclusions set out hereafter, no Sick Pay or Permanent Incapacity Benefit will be payable in respect of sickness or permanent incapacity directly or indirectly attributable to any event included in the Standard Exclusions set out in the PPS Provider™ Policy.

No Sick Pay or Permanent Incapacity Benefit will be payable in respect of sickness or permanent incapacity directly or indirectly attributable to surgery or other procedures of a cosmetic nature.

No Sick Pay Benefit will be paid in terms of the Hospital Rider Benefit in respect of any sickness arising out of a condition or injury which predates the issue of the Hospital Rider Benefit by twelve months or less.

Benefit limitations applicable to the Sickness and Permanent Incapacity Benefit

The Sickness and Permanent Incapacity Benefit carries an automatic benefit limitation of R1.2 Million Rand (Gross Professional Income), which is equivalent to 5454 Ordinary Units of Benefit, and which shall apply under the following circumstances:
1. Any form of chronic fatigue syndrome, myalgic encephalitis, ‘Yuppie Flu’, or Fibromyalgia or any related or similar disorder as it may become known, or direct or indirect result thereof as well as co-morbid conditions arising from this, including the treatment or complications; and

2. Any mental illness or stress related mental disorder, or direct or indirect result thereof, as well as co-morbid conditions arising from this, including any treatment or complications.

This automatic benefit limitation does not apply:

a) where there is a demonstrable cause of cognitive deficit; or
b) to any cause of dementia; or

c) any physical conditions which are a secondary effect of stress.”

8. APPENDIX A

8.1 Section 11: PARALYSIS (Quadriplegia/Paraplegia)

The following wording in Section 11 is hereby repealed: "Severity A – 100%
Total and permanent loss of function of two or more limbs after 6 months as a result of injury to or disease of the spinal cord. Limb is defined as the complete arm or the complete leg. The 6-month waiting period may be waived at the discretion of PPS Insurance."

The repealed section is hereby replaced with the following wording: "Severity A – 100%
Total and permanent loss of function of two or more limbs as a result of injury to or disease of the spinal cord. Limb is defined as the complete arm or the complete leg."

8.2 Section 12: LOSS OF USE OF LIMBS

The following wording in Section 12 is hereby repealed: "Total, permanent and irreversible loss of or loss of use of any of the limbs listed either due to injury or disease. For loss of use of limbs, maximum medical improvement must have been reached with little or no chance of further improvement as approved by a specialist nominated by PPS Insurance after a period of 6 months. The 6-month waiting period may be waived at the discretion of PPS Insurance."

The repealed section is hereby replaced with the following wording: "Total, permanent and irreversible loss of or loss of use of any of the limbs listed either due to injury or disease. For loss of use of limbs, maximum medical improvement must have been reached with little or no chance of further improvement as approved by a specialist nominated by PPS Insurance."

The following section is hereby inserted in the table in section 12:

| One arm and one leg | GPI Sum Assured | A |

8.3 Section 30: LOSS OF SPEECH

The following wording in Section 30 is hereby repealed: "Severity B – 75%
Means the complete and irrecoverable loss of speech as a result of sickness or injury. The loss of the ability to speak must be established after a period of 12 months. No benefits will be payable if in general specialist opinion any aid, device, treatment or implant could result in the partial or total restoration of speech."
There is a 12 month waiting period for this benefit. This may be waived at the discretion of PPS Insurance for certain medical conditions only."

The repealed section is hereby replaced with the following wording: “Severity B – 75%
Means the complete and irrecoverable loss of speech as a result of sickness or injury. No benefits will be payable if in general specialist opinion any aid, device, treatment or implant could result in the partial or total restoration of speech.”

9. **APPENDIX B**

9.1 **Section 12: PARALYSIS (Quadriplegia/Paraplegia)**

The following wording in Section 12 is hereby repealed: “Severity A – 100%
Total and permanent loss of function of two or more limbs after 6 months as a result of injury to or disease of the spinal cord. Limb is defined as the complete arm or the complete leg. The 6-month waiting period may be waived at the discretion of PPS Insurance.”

The repealed section is hereby replaced with the following wording: “Severity A – 100%
Total and permanent loss of function of two or more limbs as a result of injury to or disease of the spinal cord. Limb is defined as the complete arm or the complete leg.”

9.2 **Section 13: LOSS OF USE OF LIMBS**

The following wording in Section 13 is hereby repealed: “Total, permanent and irreversible loss of or loss of use of any of the limbs listed either due to injury or disease. For loss of use of limbs, maximum medical improvement must have been reached with little or no chance of further improvement as approved by a specialist nominated by PPS Insurance after a period of 6 months.
The 6-month waiting period may be waived at the discretion of PPS Insurance.”

The repealed section is hereby replaced with the following wording: “Total, permanent and irreversible loss of or loss of use of any of the limbs listed either due to injury or disease. For loss of use of limbs, maximum medical improvement must have been reached with little or no chance of further improvement as approved by a specialist nominated by PPS Insurance.”

The following section is hereby inserted in the table in section 13:

| One arm and one leg | GPI Sum Assured | A |

9.3 **Section 31: LOSS OF SPEECH**

The following wording in Section 31 is hereby repealed: “Means the complete and irrecoverable loss of speech as a result of sickness or injury. The loss of the ability to speak must be established after a period of 12 months. No benefits will be payable if in general specialist opinion any aid, device, treatment or implant could result in the partial or total restoration of speech.

There is a 12 month waiting period for this benefit. This may be waived at the discretion of PPS Insurance for certain medical conditions only.”

The repealed section is hereby replaced with the following wording: “Means the complete and irrecoverable loss of speech as a result of sickness or injury. No benefits will be payable if
in general specialist opinion any aid, device, treatment or implant could result in the partial or total restoration of speech.”

10. **APPENDIX D**

10.1 **Section 11: PARALYSIS (Quadriplegia/Paraplegia)**

The following wording in Section 11 is hereby repealed: “Severity A – 100%
Total and permanent loss of function of two or more limbs after 6 months as a result of injury to or disease of the spinal cord. Limb is defined as the complete arm or the complete leg. The 6-month waiting period may be waived at the discretion of PPS Insurance.”

The repealed section is hereby replaced with the following wording: “Severity A – 100%
Total and permanent loss of function of two or more limbs as a result of injury to or disease of the spinal cord. Limb is defined as the complete arm or the complete leg.”

10.2 **Section 12: LOSS OF USE OF LIMBS**

The following wording in Section 12 is hereby repealed: “Total, permanent and irreversible loss of or loss of use of any of the limbs listed either due to injury or disease. For loss of use of limbs, maximum medical improvement must have been reached with little or no chance of further improvement as approved by a Specialist nominated by PPS after a period of 6 months. The 6-month waiting period may be waived at the discretion of PPS Insurance.”

The repealed section is hereby replaced with the following wording: “Total, permanent and irreversible loss of or loss of use of any of the limbs listed either due to injury or disease. For loss of use of limbs, maximum medical improvement must have been reached with little or no chance of further improvement as approved by a Specialist nominated by PPS.”

10.3 **Section 27: LOSS OF SPEECH**

The following wording in Section 27 is hereby repealed: “Severity A – 100%
Means the complete and irrecoverable loss of speech as a result of sickness or injury. The loss of the ability to speak must be established after a period of 12 months. No benefits will be payable if in general specialist opinion any aid, device, treatment or implant could result in the partial or total restoration of speech.

There is a 12 month waiting period for this benefit. This may be waived at the discretion of PPS Insurance for certain medical conditions only.”

The repealed section is hereby replaced with the following wording: “Severity A – 100%
Means the complete and irrecoverable loss of speech as a result of sickness or injury. No benefits will be payable if in general specialist opinion any aid, device, treatment or implant could result in the partial or total restoration of speech.”

11. **APPENDIX E**

The following Appendix is hereby inserted after Appendix D:

“APPENDIX E

* NOTE: All Sick Pay Benefits paid in terms of Appendix E will cease automatically on the day
of delivery of the unborn child or on termination of the pregnancy, unless expressly stated otherwise.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Minimum Claim Criteria</th>
<th>Benefit Requirements</th>
<th>Maximum Payment Periods*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ectopic Pregnancy</td>
<td>A pregnancy developing outside the normal lining of the uterus.</td>
<td>• Proof of admission to hospital; and</td>
<td>• For a Laparoscopic procedure: 10 days, which shall include any period of hospitalisation;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A report from the policyholders’ treating obstetrician; and</td>
<td>• For a Laparotomy: 42 days in total unless the policyholder was booked-off from work for a shorter period, in which event payment will be made for the period for which the policyholder was booked-off from work.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A claim form (Declaration by Doctor Form) completed by the policyholders’ treating obstetrician; and</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A claim form (Declaration by Member Form) completed by the policyholder.</td>
<td></td>
</tr>
<tr>
<td>Severe Abruptio Placenta</td>
<td>Placenta separates from the uterus wall.</td>
<td>• Proof of admission to hospital; and</td>
<td>Duration of hospitalisation plus the remainder of the pregnancy, unless the policyholder was booked-off from work for a shorter period, in which event payment will be made for the period for which the policyholder was booked-off from work.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A report from the policyholders’ treating obstetrician; and</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A claim form (Declaration by Doctor Form) completed by the policyholders’ treating obstetrician; and</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A claim form (Declaration by Member Form) completed by the policyholder; and</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ultrasound evidence of significant retroplacental blood clot; and</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Evidence of maternal complications related to blood loss as evidenced by low haematocrit, or hypovolaemic shock, or acute renal failure.</td>
<td></td>
</tr>
</tbody>
</table>
| Major Placenta Praevia | The placenta totally covers the internal cervical os. | • Proof of admission to hospital; and  
• A report from the policyholders’ treating obstetrician; and  
• A claim form (Declaration by Doctor Form) completed by the policyholders’ treating obstetrician; and  
• A claim form (Declaration by Member Form) completed by the policyholder; and  
• Evidence of active bleeding which results in the policyholder requiring total bed rest. | • This benefit will only pay during the third trimester of the pregnancy; and  
• For the duration of hospitalisation plus the remainder of the pregnancy (in the third trimester only), unless the policyholder was booked-off from work for a shorter period, in which event payment will be made for the period for which the policyholder was booked-off from work. |
|------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| Uterine Rupture        | • May occur either prior to or during labour; and  
• Requires a hysterectomy. | • Proof of admission to hospital; and  
• A report from the policyholders’ treating obstetrician; and  
• A claim form (Declaration by Doctor Form) completed by the policyholders’ treating obstetrician; and  
• A claim form (Declaration by Member Form) completed by the policyholder. | For a hysterectomy: 42 days in total unless the policyholder was booked-off from work for a shorter period, in which event payment will be made for the period for which the policyholder was booked-off from work. |
| Severe Hyperemesis Gravidarum | Severe vomiting and nausea during pregnancy. | • Proof of admission to hospital; and  
• A report from the policyholders’ treating obstetrician; and  
• A claim form (Declaration by Doctor Form) completed by the policyholders’ treating obstetrician; and  
• A claim form (Declaration by Member Form) completed by the policyholder. | 7 days, which shall include any period of hospitalisation. |
<table>
<thead>
<tr>
<th>Primary Post Partum Haemorrhage</th>
<th>treating obstetrician; and</th>
<th>A claim form (Declaration by Member Form) completed by the policyholder; and</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood loss &gt;500 ml at vaginal delivery or &gt;1 litre at caesarean section; or</td>
<td>In addition to the above at least 3 of the following requirements must be met, as confirmed by the policyholders’ treating obstetrician:</td>
<td>Weight loss; and/or Dehydration indicated by blood tests; and/or Hyponatraemia; and/or Hypokalaemia; and/or Hyponatraemic Acidosis; and/or Abnormalities in liver function indicated by liver function tests; and/or Ketonuria; and/or Haemoconcentration indicated by full blood count.</td>
</tr>
<tr>
<td>Bleeding associated with hypotension and tachycardia, or</td>
<td>• Weight loss; and/or • Dehydration indicated by blood tests; and/or • Hyponatraemia; and/or • Hypokalaemia; and/or • Hyponatraemic Acidosis; and/or • Abnormalities in liver function indicated by liver function tests; and/or • Ketonuria; and/or • Haemoconcentration indicated by full blood count.</td>
<td>• Proof of admission to hospital; and • A report from the policyholders’ treating obstetrician; and • A claim form (Declaration by Doctor Form) completed by the policyholders’ treating obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder.</td>
</tr>
<tr>
<td>Drop in haematocrit of 10 or more %; or</td>
<td></td>
<td>If no hysterectomy is required: period of hospitalisation plus 7 days, unless the policyholder was booked-off from work for a shorter period, in which event payment will be made for the period for which the policyholder was booked-off from work.</td>
</tr>
<tr>
<td>Bleeding requiring blood transfusion.</td>
<td></td>
<td>If a hysterectomy is required: 42 days in total unless the policyholder was booked-off from work for a shorter period, in which event payment will be made for the period for which the policyholder was booked-off from work.</td>
</tr>
</tbody>
</table>
| **Pre-eclampsia** | Newly diagnosed hypertension on two occasions measured at least 6 hours apart, after 20 weeks gestation, with one or more of the following:  
- Generalised oedema as measured by weight gain >0.5kg per week, or pitting oedema of trunk or hands, or worsening of ankle oedema, or facial or sacral oedema; or  
- proteinuria >300mg/day; or  
- Impaired liver function with AST >40IU/l; or  
- Impaired renal function with plasma creatinine >100 micromol/l; or  
- Neurological problems including hyperreflexia (with clonus or severe headaches); or  
- Haematological disorders, thrombocytopaenia, and orhaemolysis.  
| **Proof of admission to hospital; and**  
| **A report from the policyholders’ treating obstetrician; and**  
| **A claim form (Declaration by Doctor Form) completed by the policyholders’ treating obstetrician; and**  
| **A claim form (Declaration by Member Form) completed by the policyholder.**  
| **14 days in total, which shall include any period of hospitalisation, for the initial/first claim period, unless the policyholder was booked-off from work for a shorter period, in which event payment will be made for the period for which the policyholder was booked-off from work.**  
| **Any further claims after the initial/first claim period will be assessed on receipt of the policyholders’ treating obstetricians’ motivational report and Declaration by Doctor form, and must include blood pressure readings and biochemical test results for the total further period claimed. Any further claims after the initial/first claim period will in all instances be assessed on a 14 day basis. Claims will be assessed on receipt of two-weekly declaration by doctor forms including aforementioned medical information for the duration of the claim period. The benefit will pay only if total bed rest is required as indicated by the obstetrician.**  

| **Eclampsia** | Progression of pre-eclampsia leading to seizures and coma, occurring with pregnancy and having no other cause.  
| **Proof of admission to hospital; and**  
| **A report from the policyholders’ treating obstetrician; and**  
| **A claim form (Declaration by Doctor Form) completed by the policyholders’ treating obstetrician; and**  
| **A claim form (Declaration by**  
| **Duration of the pregnancy plus 14 days post-delivery, unless the policyholder was booked-off from work for a shorter period, in which event payment will be made for the period for which the policyholder was booked-off from work.**  


<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
<th>Member Form) completed by the policyholder.</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hydatidiform Mole</td>
<td>Benign form of gestational trophoblastic disease.</td>
<td></td>
<td>• Proof of admission to hospital; and • A report from the policyholders’ treating obstetrician; and • A claim form (Declaration by Doctor Form) completed by the policyholders’ treating obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder. • For treatment by suction curettage: Period of hospitalisation plus 7 days, unless the policyholder was booked-off from work for a shorter period, in which event payment will be made for the period for which the policyholder was booked-off from work. • For treatment by hysterectomy: 42 days in total unless the policyholder was booked-off from work for a shorter period, in which event payment will be made for the period for which the policyholder was booked-off from work.</td>
</tr>
<tr>
<td>Premature Rupture of Membranes</td>
<td>Membranes rupture before 37 weeks of pregnancy in the absence of uterine contractions.</td>
<td></td>
<td>• Proof of admission to hospital; and • A report from the policyholders’ treating obstetrician; and • A claim form (Declaration by Doctor Form) completed by the policyholders’ treating obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder. For the duration of hospitalisation plus the remainder of the pregnancy, unless the policyholder was booked-off from work for a shorter period, in which event payment will be made for the period for which the policyholder was booked-off from work.</td>
</tr>
<tr>
<td>Premature Labour</td>
<td>Labour which begins prior to 37 weeks pregnancy or foetal mass estimated at &lt;2500g.</td>
<td></td>
<td>• Proof of admission to hospital; and • A report from the policyholders’ treating obstetrician; and • A claim form (Declaration by Doctor Form) completed by the policyholder. For the duration of hospitalisation plus the remainder of the pregnancy, unless the policyholder was booked-off from work for a shorter period, in which event payment will be made for the period for which the policyholder was booked-off from work.</td>
</tr>
</tbody>
</table>
| High Risk Pregnancy | An underlying pathological condition aggravated by pregnancy; e.g. Cardiac disorders/blood disorders/endocrine disorders/ uncontrolled diabetes mellitus/ thyroid crisis. | • Proof of admission to hospital; and
• A report from the policyholders’ treating obstetrician; and
• A claim form (Declaration by Doctor Form) completed by the policyholders’ treating obstetrician; and
• A claim form (Declaration by Member Form) completed by the policyholder. | • For the duration of hospitalisation, plus 7 days post discharge, for the initial/first claim period, unless the policyholder was booked-off from work for a shorter period, in which event payment will be made for the period for which the policyholder was booked-off from work.
• Any further claims after the initial/first claim period will be assessed on receipt of the policyholders’ treating obstetricians’ motivational report and Declaration by Doctor form, and must include clinical evidence to support the fact that time off work is still required. |
| --- | --- | --- | --- |
| Treatment of mother for Congenital Foetal Abnormalities/ foetal death | Treatment of mother for foetal abnormalities/foetal death in pregnancy requiring management by caesarean section/ hysterectomy/ hysterotomy/ vaginal | • Proof of admission to hospital; and
• A report from the policyholders’ treating obstetrician; and
• A claim form (Declaration by Doctor Form) | • For caesarian section/ hysterotomy/vaginal extraction or evacuation: Duration of hospitalisation plus 7 days, unless the policyholder was booked-off from work for a shorter period, in which event payment will be made for |
<table>
<thead>
<tr>
<th><strong>Extraction</strong> or evacuation of uterus.</th>
<th>completed by the policyholders’ treating obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder.</th>
<th>the period for which the policyholder was booked-off from work. • For treatment by hysterectomy: 42 days in total unless the policyholder was booked-off from work for a shorter period, in which event payment will be made for the period for which the policyholder was booked-off from work.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miscarriage: threatened/incomplete/inevitable/complete/missed/abortion due to amniocentesis.</td>
<td>Terminated pregnancy before the foetus is viable or up until 28 weeks pregnancy. • Proof of admission to hospital; and • A report from the policyholders’ treating obstetrician; and • A claim form (Declaration by Doctor Form) completed by the policyholders’ treating obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder.</td>
<td>7 days, which shall include any period of hospitalisation.</td>
</tr>
<tr>
<td>Amniotic Fluid Embolism</td>
<td>Amniotic fluid in the general circulation. • Proof of admission to hospital; and • A report from the policyholders’ treating obstetrician; and • A claim form (Declaration by Doctor Form) completed by the policyholders’ treating obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder.</td>
<td>Duration of hospitalisation plus 14 days, unless the policyholder was booked-off from work for a shorter period, in which event payment will be made for the period for which the policyholder was booked-off from work.</td>
</tr>
<tr>
<td>Sheehan’s Syndrome</td>
<td>Pituitary necrosis causing hypopituitarism. • Proof of admission to hospital; and • A report from the</td>
<td>Duration of hospitalisation plus 14 days, unless the policyholder was booked-off from work.</td>
</tr>
</tbody>
</table>
| Deep Vein Thrombosis or Pulmonary Embolism | Blood clot obstruction of a vein or pulmonary artery. | • Proof of admission to hospital; and  
• Treatment with heparin; and  
• A report from the policyholders’ treating obstetrician; and  
• A claim form (Declaration by Doctor Form) completed by the policyholders’ treating obstetrician; and  
• A claim form (Declaration by Member Form) completed by the policyholder. | Duration of hospitalisation plus 7 days."

| | | | from work for a shorter period, in which event payment will be made for the period for which the policyholder was booked-off from work. |