FOR PROFESSIONALS

SINCE 1941

THE PROFESSIONAL PROVIDENT SOCIETY HOLDINGS TRUST (REGISTRATION NO IT312/2011)

FIRST AMENDED AND RESTATED TRUST DEED

WERKSMANS
ATTORNEYS

FIRST AMENDED AND RESTATED TRUST DEED

for

THE PROFESSIONAL PROVIDENT SOCIETY HOLDINGS TRUST

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FIRST AMENDED AND RESTATED TRUST DEED

for

THE PROFESSIONAL PROVIDENT SOCIETY HOLDINGS TRUST

PART A: INTRODUCTION

1 INTERPRETATION

In this Deed, clause headings are for convenience and shall not be used in its interpretation and, unless the context clearly indicates a contrary intention -

1.1 a word or an expression which denotes -

1.1.1 any gender includes the other genders;

1.1.2 a natural Person includes an artificial or juristic Person and vice versa; and

1.1.3 the singular includes the plural and vice versa;

1.2 the following words and expressions shall bear the meanings assigned to them below and cognate words and expressions bear corresponding meanings –

1.2.1 "**Affiliated Entities**" – the following Entities, funds and schemes which are, as at the Signature Date, Controlled, managed or administered by or otherwise affiliated with PPS Holdco and its Subsidiaries and provide or are involved in the provision of Products or other benefits and services to members of PPS Holdco -

1.2.1.1 Profmed Medical Scheme;

1.2.1.2 Professional Provident Society Retirement Annuity Fund;

1.2.1.3 Professional Provident Society Beneficiaries Trust;

1.2.1.4 Professional Provident Society Preservation Provident Fund;

1.2.1.5 Professional Provident Society Preservation Pension Fund;

1.2.1.6 Preservation Provident Society Personal Pension Retirement Annuity Fund;

as well as any additional Entities, funds or schemes which may in future (i) provide or be involved in the provision of Products or other benefits and services to Members and (ii) be designated as such by resolution of the Board;

1.2.2 "**AGM**" – an Annual General Meeting of Members;

1.2.3 "**Apportionment Account**" – in relation to each Ordinary Member means the positive balance, if any, from time to time reflected in his/her Apportionment Account which is described in the Master Contract (it being recorded that the Member's Apportionment Accounts are, as at the Signature Date, described in clause 48 of the Master Contract referred to in 1.2.25.1 that was applicable as at the Implementation Date and in annexure C of the Master Contract referred to in 1.2.25.2 which was applicable as at the Implementation Date);

1.2.4 "**Associate Member**" – an Associate Member referred to in 18.4;

1.2.5 "**Auditor**" – the Auditor of the Trust who holds office as such in terms of 25;

1.2.6 "**Audit Committee**" – the Audit Committee referred to in 26;

1.2.7 "**Beneficiaries**" – means –

1.2.7.1 PPS Insurance; and

1.2.7.2 any other member/s of the Group which the Board decides to appoint as a Beneficiary/ies;

on the basis provided for in this Deed;

1.2.8 "**Board**" – the Trustees of the Trust for the time being;

1.2.9 "**Business Day**" - any calendar day which is not a Saturday, a Sunday or an official public holiday in South Africa;

1.2.10 "**Chairman**" – the chairman of the Board elected in terms of 9.2;

1.2.11 "**Companies Act**" – the Companies Act No 71 of 2008;

1.2.12 "**Control**" – shall be construed in accordance with section 2(2) (as read with section 3(2)) of the Companies Act;

1.2.13 "**Corporate Member**" – a Member of the Trust that is a juristic Person, as contemplated in 17.2.2;

1.2.14 "**Deed**" – this document, together with its annexures, as amended or restated from time to time;

1.2.15 "**Deputy Chairman**" – the deputy chairman of the Board elected in terms of 9.2;

1.2.16 "**Dispose**" - sell, transfer, make over, give, donate, exchange, dispose of, unbundle, distribute or otherwise alienate;

1.2.17 "**Electronic Medium**" - any form or method of electronic communication, as defined in the Electronic Communications and Transactions Act No 25 of 2002, which includes, but is not limited to, telephone, facsimile, electronic data message (including, but not limited to, e-mail), bulletin board, internet website, CD ROM and computer network;

1.2.18 "**Encumbrance**" - includes any mortgage bond, notarial bond, pledge, lien, hypothecation, assignment, *cession-in-securitatem debiti*, deposit by way of security, and "**Encumber**" shall be mean the creation of any Encumbrance;

1.2.19 "**Entity**" or "**Person**" - includes any natural or juristic person, association, business, close corporation, company, concern, enterprise, firm, partnership, joint venture, trust, undertaking, voluntary association, body corporate, and any similar entity;

1.2.20 "**Existing Members**" – the members (being all ordinary members and associate members) of PPS Holdco immediately prior to the Implementation Date;

1.2.21 "**General Meeting**" – any general meeting of Members (including any resumption thereof pursuant to any adjournment);

1.2.22 "**Group**" – means, collectively, -

1.2.22.1 the Trust, PPS Insurance and the Subsidiaries of PPS Insurance as at the Implementation Date; and

1.2.22.2 such additional Subsidiaries of the Trust which the Trust may in future form or acquire for the purpose of or in connection with the provision of Products or other benefits and services to the Members, which additional Subsidiaries may be held by the Trust directly or indirectly through other members of the Group; and

1.2.22.3 the Affiliated Entities; provided that the Affiliated Entities shall be excluded from the Group for the purposes of 4.1 and 12.1.

A reference to a "**member of the Group**" shall mean any one of the Entities referred to in 1.2.22.1 and 1.2.22.2. Notwithstanding the foregoing, any Entity which ceases to be a Subsidiary of the Trust or an Affiliated Entity shall thereupon automatically cease to be a member of the Group;

1.2.23 "**Implementation Date**" – 13 April 2011, being the date on which the Trust took delivery of the entire issued share capital of PPS Insurance pursuant to the Sale;

1.2.24 "**Master**" – the Master of the High Court of South Africa;

1.2.25 "**Master Contract**" – means each of –

1.2.25.1 any PPS Provider Policy between, on the one hand, Members and, on the other hand, PPS Insurance; and

1.2.25.2 any master contract between, on the one hand, Members and, on the other hand, PPS Namibia,

as amended, restated or renamed from time to time. The currently applicable Master Contracts are attached as annexure C to this Deed;

1.2.26 "**Member**" – a Member referred to in 17, who shall be categorised as an Ordinary Member or an Associate Member. The term "**Membership**" shall be construed accordingly;

1.2.27 "**Member Information**" – all communications, information and documents that are provided to Members, including notices (including, notices of General Meetings and AGMs of the Trust, distribution notices and interest notices), forms of proxy, annual financial statements, reports, annual reports and interim reports, and any other document which is determined by the Trustees to be Member Information;

1.2.28 "**Nominating Professional Organisation**" – each of the following Professional organisations –

1.2.28.1 any organisation which represents Professionals if the members of that organisation include Ordinary Members constituting not less than twelve percent of the aggregate number of Ordinary Members; and

1.2.28.2 any Professional organisation which is not referred to in 1.2.28.1 but which represents Professionals and has been (and for so long as it remains) designated by the Board as a Nominating Professional Organisation, whereafter that Professional organisation may be invited by the Board (on such terms and conditions as may be determined by the Board) to appoint a Trustee; provided that the

Board shall not extend such an invitation, and such an invitation shall cease to be valid, to the extent that such appointment of a Trustee would cause the maximum number of Trustees referred to in 5.1 to be exceeded;

1.2.29 "**Nominations Closing Date**" – in relation to any General Meeting means the Nominations Closing Date for that General Meeting referred to in 5.4.2.2;

1.2.30 "**Office**" – the premises situated at 6 Anerley Road, Parktown, Johannesburg, 2193 or such other premises as may, from time to time, be designated by decision of the Board as the Office for the purposes of this Deed;

1.2.31 "**Old Companies Act**" – the Companies Act No. 61 of 1973;

1.2.32 "**Ordinary Member**" - an Ordinary Member referred to in 18.3;

1.2.33 "**PPS Holdco**" – Professional Provident Society (NPC) (formerly Professional Provident Society Limited (Limited by guarantee)) (registration number 2001/011016/09), a company duly incorporated in South Africa;

1.2.34 "**PPS Insurance**" – Professional Provident Society Insurance Company Limited (registration number 2001/017730/06), a public company duly incorporated in South Africa;

1.2.35 "**PPS Namibia**" – Professional Provident Society Insurance Company (Namibia) Limited (registration number 2003/122), a company incorporated in the Republic of Namibia;

1.2.36 "**Present**" – at a General Meeting, means present in person or represented by proxy appointed in terms of this Deed;

1.2.37 "**Product**" – any insurance, investment, retirement annuity fund, pension fund or medical aid product or service and any similar or other product or service;

1.2.38 "**Profession**" - any profession which is regulated by law or which is recognised as a profession by the Board for the purposes of this Deed, and the term "**Professional**" shall be construed accordingly;

1.2.39 "**Recognised Professional Organisations**" - any Professional organisation which represents Professionals and has been (and for so long as it remains) designated by the Board (on such terms and conditions as may be determined by the Board) as a Recognised Professional Organisation for the purposes of this Deed;

1.2.40 "**Sale**" – the Disposal referred to in 2.2;

1.2.41 "**Secretary**" - the secretary of the Trust appointed in terms of 27 or any Person authorised to act in his place and includes a Person authorised by the Board to carry out any of the duties of the Secretary;

1.2.42 "**Signature Date**" – means, provided that all signatories have signed this Deed, the date upon which this Deed is signed by the signatory who signs it last;

1.2.43 "**South Africa**" – the Republic of South Africa;

1.2.44 "**Subsidiary**" – shall have the meaning given to it in the Companies Act and shall, for the avoidance of doubt, include any Entity which would, in terms of the meaning given in the Companies Act, have been a subsidiary if it had been a company incorporated in terms of the Companies Act;

1.2.45 "**Trust**" – the trust constituted in terms of 3, consisting of the Trustees for the time being acting in their capacity as such;

1.2.46 "**Trust Assets**" – the amount to be donated to the Trust in terms of 3.1 together with all other rights and assets which may from time to time accrue to or be acquired by the Trust, whether by donation, contribution, purchase or otherwise;

1.2.47 "**Trustees**" – the Trustees of the Trust who are appointed and hold office as such from time to time;

1.2.48 "**Trust Objects**" – the objects of the Trust stipulated in 4;

1.2.49 "**Trust Property Control Act**" – the Trust Property Control Act No 57 of 1988;

1.2.50 "**Written Acceptance**" – an acceptance in writing, signed by any person who is eligible to become a Trustee in terms of 6, of his appointment as Trustee, which acceptance shall –

1.2.50.1 be unconditional;

1.2.50.2 confirm that that person is eligible to be a Trustee in terms of this Deed;

1.2.50.3 be accompanied by such documents as may be required in terms of the qualification criteria referred to in 6.2;

1.2.50.4 appoint a *Domicilium* in terms of 28 for delivery to that person of documents relating to the Trust; and

1.2.50.5 if the Board has prescribed a form for such Written Acceptance in a notice to Members, which notice may be given by posting on the website referred to in 28, be substantially in the form of that prescribed form;

provided that the Board may in its discretion accept a written acceptance which does not comply with this 1.2.50;

1.3 any reference to any statute, regulation or other legislation shall be a reference to that statute, regulation or other legislation as at the Signature Date, and as amended or substituted from time to time;

1.4 if any provision in a definition is a substantive provision conferring a right or imposing an obligation on any party then, notwithstanding that it is only in a

definition, effect shall be given to that provision as if it were a substantive provision in the body of this Deed;

1.5 where any term is defined within a particular clause other than 1.2, that term shall bear the meaning ascribed to it in that clause wherever it is used in this Deed;

1.6 where any number of days is to be calculated from a particular day, such number shall be calculated as excluding such particular day and commencing on the next day. If the last day of such number so calculated falls on a day which is not a Business Day, the last day shall be deemed to be the next succeeding day which is a Business Day;

1.7 any reference to days (other than a reference to Business Days), months or years shall be a reference to calendar days, calendar months or calendar years respectively;

1.8 any term which refers to a South African legal concept or process (for example, without limiting the foregoing, winding-up or curatorship) shall be deemed to include a reference to the equivalent or analogous concept or process in any other jurisdiction in which this Deed may apply or to the laws of which a party may be or become subject;

1.9 the use of the word "including" followed by a specific example/s shall not be construed as limiting the meaning of the general wording preceding it and the *eiusdem generis* rule shall not be applied in the interpretation of such general wording or such specific example/s; and

1.10 the annexures to this Deed form an integral part hereof and words and expressions defined in this Deed shall bear, unless the context otherwise requires, the same meaning in such annexures.

2 INTRODUCTION

2.1 After the commencement of the Companies Act, PPS Holdco was no longer able to continue to exist in its then current form, being a company limited by guarantee in terms of the Old Companies Act.

2.2 Accordingly, PPS Holdco formed the Trust and transferred Control of PPS Insurance to the Trust by Disposing of all its assets, including the entire issued share capital of PPS Insurance and all of PPS Holdco's intellectual property and any other assets, to the Trust, in order to give effect to the Trust Objects. PPS Holdco is now in the process of being, or has been, deregistered in terms of the provisions of the Companies Act.

2.3 Notwithstanding anything to the contrary contained in this Deed, it is recorded that PPS Holdco ceased to have any rights in terms of this Deed or in relation to the Trust with effect from the Implementation Date.

PART B: FORMATION OF THE TRUST

3 DONATION AND ESTABLISHMENT OF THE TRUST

3.1 PPS Holdco irrevocably donated R100 to the Trustees, to be held in trust for the Trust Objects on the terms of this Deed.

3.2 The Trust created in terms of 3.1 is known as "The Professional Provident Society Holdings Trust".

4 TRUST OBJECTS

The Sale having been implemented, the objects of the Trust shall be –

4.1 to hold shares in members of the Group for the purpose referred to in 4.2; provided that 4.1 shall not prevent the Trust from disposing of any such shares if such disposal is necessary or desirable for the purpose referred to in 4.2 or authorised in accordance with 12;

4.2 to maintain and facilitate the continued existence of the Group in such form as may be determined to be most desirable by the Trustees and enable the Group to continue operating, developing and expanding its business for the purpose of the Group providing Products or other benefits and services to the Members; provided that this 4.2 shall not prevent the Trust from allowing the Group to cease providing any particular Product, benefit or service. The Members shall participate in the control of the Group indirectly through the

entitlement of Members to vote on the election and removal of Trustees, reserved matters referred to in 12, termination of the Trust referred to in 29 and any other matters which are put to a vote of the Members. No Member shall have any right to receive any distributions nor any vested or contingent right in all or a portion of the receipts or accruals or the assets of the Trust and the Members are not Beneficiaries; and

4.3 to increase the number of Members in order to facilitate the object referred to in 4.2.

Notwithstanding the foregoing, it is recorded that these Trust Objects shall not exclude or prevent the conclusion and implementation by the Trust of, or the Trust allowing or authorising, any transaction or other matter referred to in 12, which shall be permitted if authorised in accordance with 12.

PART C: TRUSTEES

5 APPOINTMENT OF TRUSTEES

5.1 Number of Trustees

There shall at all times be a minimum of twelve and a maximum of twenty-five Trustees in office for the valid exercise of the powers and discharge of the duties of the Trustees in terms of this Deed; provided that even if the number of Trustees in office at any time falls below the required minimum, the remaining Trustee/s shall be authorised to exercise the powers of the Trustees to the extent necessary or desirable for the preservation and administration of the Trust and the Trust Assets, for co-opting additional Trustees in terms of the proviso to 5.3.1 or in terms of 5.3.3 and for convening any General Meeting.

5.2 Initial Trustees

5.2.1 Annexure A lists the Trustees who are in office as such on the date of adoption of this Deed and indicates whether they are elected by the Members, appointed by a Nominating Professional Organisation or co-opted.

5.2.2 It is recorded that each director of PPS Holdco who was elected by the members of PPS Holdco shall be deemed to have been elected as a Trustee by the Members in terms of 5.3.1 and shall be deemed to have been in office as a Trustee since the date on which he was last elected as a director of PPS Holdco.

5.3 **Composition of the Board**

The Board shall be composed of Trustees who have been appointed as follows –

5.3.1 a maximum of twelve Trustees may be appointed by the Members in General Meeting in accordance with the election procedure referred to in 5.4; provided that if any Trustee so elected ceases to hold office at any time then the Board may co-opt a replacement Trustee to serve in office as such until the end of the next AGM of the Trust;

5.3.2 one Trustee may be appointed by each Nominating Professional Organisation from time to time by giving written notice to that effect to the Trust and the Nominating Professional Organisation which appointed any such Trustee may at any time, by giving further written notice to that effect to the Trust, remove and replace that Trustee. Any such notice of appointment shall only be effective if accompanied by the Written Acceptance of that Trustee;

5.3.3 two Trustees may be co-opted by the Board if they have executed Written Acceptances; provided that the Board shall not be entitled to co-opt any Trustee to the extent that such co-option would cause the maximum number of Trustees referred to in 5.1 to be exceeded.

Any such appointment shall take effect from the date of such election, notice of appointment or co-option, as the case may be, or as soon thereafter as letters of authority are issued to the Trustee so appointed in terms of the Trust Property Control Act and the Board shall co-operate with any Trustee so appointed to obtain such letters of authority from the Master.

5.4 **Election of Trustees by the Members**

5.4.1 An individual shall be elected as a Trustee by the Members in General Meeting in terms of 5.3.1 in the following manner –

5.4.1.1 that individual ("**Nominee**") must have been nominated in writing ("**Written Nomination**") for election by at least two Ordinary Members and the Trust must have received that Written Nomination accompanied by a Written Acceptance by that individual by no later than the Nominations Closing Date for that General Meeting;

5.4.1.2 at the General Meeting there shall be a vote on a resolution to elect each such Nominee;

5.4.1.3 the Nominees whose election resolutions were adopted at the General Meeting shall be ranked from highest to lowest by the number of votes cast in favour of the resolutions to elect them;

5.4.1.4 such number of the highest ranked Nominees as does not exceed the number of vacancies that exist or arise at the end of that General Meeting pursuant to this Deed shall be elected as Trustees and the resolutions to elect the other Nominees shall, notwithstanding the votes cast in favour of those resolutions, be deemed to have been rejected.

5.4.2 The Board shall –

5.4.2.1 not be obliged to call for Nominees to be appointed to the Board. It shall be the responsibility of the Ordinary Members who are nominating a Nominee to be appointed to the Board to ensure that the Written Nomination and Written Acceptance is received by the Trust by not later than the Nominations Closing Date for that General Meeting, failing which such Nominee shall not be eligible for appointment as a Trustee;

5.4.2.2 for each General Meeting at which a Trustee may be elected, stipulate a "**Nominations Closing Date**", which shall be not later

than two weeks prior to the date on which that General Meeting has been convened; provided that, unless the Board determines otherwise, the Nominations Closing Date for each AGM shall be the last day of February preceding that AGM; and

5.4.2.3 notify members of the identity of the Nominees standing for election at any General Meeting in the notice convening that General Meeting.

6 ELIGIBILITY AND DISQUALIFICATION OF TRUSTEES

No person shall be eligible to become, or to continue in office as, a Trustee if -

6.1 he is not an Ordinary Member of the Trust; or

6.2 he does not meet the qualification criteria (which may include the provision of documents and proof of eligibility) which have been determined from time to time by the Board and have been recorded in a notice to Members, which notice may be given by publication on the internet website referred to in 28; or

6.3 his estate is finally sequestrated; or

6.4 he files a petition for the surrender of his estate as insolvent; or

6.5 he is placed under curatorship by any court of competent jurisdiction; or

6.6 he dies or becomes insane or incapacitated to the extent that he is unable to perform the functions of a Trustee, and is unlikely to regain that capacity within a reasonable time; or

6.7 he is convicted, whether in South Africa or elsewhere, for theft, fraud, forgery, uttering of a forged document or perjury or any other offence referred to in Section 69(8)(b) of the Companies Act; or

6.8 he is removed by a competent court from any office of trust on account of misconduct; or

6.9 he has -

6.9.1 taken personal advantage of information or an opportunity, contrary to 10.1 as read with section 76(2)(a) of the Companies Act; or

6.9.2 intentionally, or by gross negligence, inflicted harm upon the Trust or a Subsidiary of the Trust, contrary to 10.1 as read with section 76(2)(a) of the Companies Act; or

6.9.3 acted in a manner that –

6.9.3.1 amounted to gross negligence, wilful misconduct or breach of trust in relation to the performance of the Trustee's functions within, and duties to, the Trust; or

6.9.3.2 amount to gross abuse of the position of Trustee or was materially inconsistent with the duties of a Trustee; or

6.9.4 repeatedly been personally subject to a compliance notice or similar enforcement mechanism, for substantially similar conduct, in terms of any legislation; or

6.9.5 committed any conduct referred to in any of sections 162(5)(a), (b), (c), (d) or (f) or 162(7) of the Companies Act; or

6.10 he, on any grounds in addition to those mentioned above, becomes ineligible to be or disqualified from being a director in terms of the Companies Act; or

6.11 he has reached the age of seventy-two years; provided that any Trustee who is already in office when he reaches the age of seventy-two years shall remain in office until the time referred to in 7.1.2.2. In the light of the fact that clause 7.2 allows each elected Trustee to hold office for a period of three years, no person shall be elected as a Trustee if, at the time of his election as such, he has already reached the age of sixty-nine years.

7 REMOVAL AND RETIREMENT OF TRUSTEES

7.1 Ceasing to hold office as Trustee

A Trustee shall, without affecting the continuation in office of the other Trustees, automatically cease to hold office as such if –

7.1.1 he delivers a notice of his/her resignation to the Trust, in which event such resignation shall have effect from the date on which that notice is delivered; provided that, if that notice provides for that resignation to take effect on a later date and the Board approves that later date then such resignation shall have effect from that later date;

7.1.2 in terms of 6 he ceases to be eligible to continue in office as a Trustee, it being recorded that if he ceases to be so eligible as a result of an event referred to in –

7.1.2.1 clauses 6.1 to 6.10, then he shall cease to hold office with effect from the date of that event ; or

7.1.2.2 clause 6.11, he shall cease to hold office with effect from the end of the AGM immediately succeeding his seventy-second birthday;

7.1.3 he is removed from that office by a decision of a competent court or the Master, in which event such removal shall have effect from the date of that decision or such later date, if any, as may have been determined for this purpose by that court or the Master;

7.1.4 in the case of a Trustee elected by the Members in terms of 5.3.1, he is removed from that office by a resolution of the Members, in which event such removal shall have effect from the date of adoption of that resolution;

7.1.5 in the case of a Trustee appointed in terms of 5.3.2, he is removed by notice from the Professional Organisation which nominated him in terms of 5.3.2, in which event such removal shall have effect from the date on which the Trust receives that notice or such later date, if any, as may have been specified for this purpose in that notice;

7.1.6 in the case of a Trustee co-opted by the Board in terms of the proviso to 5.3.1 or in terms of 5.3.3, if he is not appointed as a Trustee in terms of 5.3.1 or 5.3.2 prior to the end of the AGM immediately succeeding the date on which he was co-opted, in which event that Trustee shall cease to hold office as such at the end of that AGM; or

7.1.7 he retires on rotation at the end of an AGM in accordance with 7.2 and he is not appointed as a Trustee in terms of 5.3.1 or 5.3.2 prior to the end of that AGM, in which event that Trustee shall cease to hold office as such at the end of that AGM.

7.2 **Retirement by rotation**

7.2.1 At every AGM, one-third of the Trustees appointed in terms of 5.3.1 for the time being or, if their number is not a multiple of three, then the number nearest to, but not less than, one-third of their aggregate number, shall retire from office.

7.2.2 The Trustees so to retire shall be those who have been longest in office since their last election, but in the case of persons who became Trustees on the same day, those to retire shall (unless they otherwise agree among themselves) be determined by lot.

7.2.3 Notwithstanding anything herein contained, if at the date of any AGM any Trustee shall have held office for a period of three years since his last election or appointment, he shall retire at such AGM either as one of the Trustees to retire by rotation or in addition thereto.

7.2.4 The length of time a Trustee has been in office shall be computed from date of his last election or deemed election.

7.2.5 Trustees who are retiring at an AGM in terms of this 7.2 but are eligible in terms of 6 to continue in office as such and have been nominated for election at that AGM in accordance with 5.4, shall be capable of being re-elected at that AGM and shall be deemed to have been so re-elected, unless -

7.2.5.1 it is expressly resolved at such AGM not to fill such vacated office; or

7.2.5.2 a resolution for the re-election of such Trustee shall have been put to the AGM and rejected; or

7.2.5.3 the proviso to 5.4.1 applies and the resolution for the re-election of that Trustee is deemed to have been rejected in terms of 5.4.1.4.

8 SECURITY DISPENSED WITH

No Trustee shall be required by the Master or any other authority to furnish any security of any nature whatever, nor shall any security be required for the due performance of any duty under the Trust Property Control Act or under any other statutory provision of South Africa or elsewhere.

9 MEETINGS OF TRUSTEES

9.1 A quorum for a meeting of the Board shall not be less than one-half of the Trustees in office at the time of that meeting.

9.2 At its first meeting after each AGM, the Board shall elect from among the Trustees referred to in 5.3.1, a Chairman and a Deputy Chairman. Each of the Chairman and Deputy Chairman shall retain office as such until the earlier of the date on which he ceases to be a Trustee and the date of election of the new Chairman and Deputy Chairman, as the case may be, in terms of this 9.2.

9.3 The Chairman shall preside at all meetings of the Board and shall accordingly determine the procedure to be followed at any such meeting; provided that the powers of the Chairman to determine such procedures shall be subject to the provisions of this Deed and shall be subject to any decision that the Board may have adopted on that subject. In his absence or if he is unwilling or unable to preside then the Deputy Chairman shall so preside and exercise the Chairman's powers. In the absence of both the Chairman and the Deputy Chairman or if both are unable or unwilling to preside, then the Trustees present shall elect one of the Trustees who is present to preside over that meeting as its chairman and exercise the Chairman's powers.

9.4 The Board shall meet for the dispatch of its business, adjourn and otherwise regulate its meetings as it thinks fit. The Chairman may at any time, and shall on the written request of not less than six members of the Board, convene a meeting of the Board. Not less than forty-eight hours' notice shall be given of a meeting of the Board. It shall not be necessary to send notice of a meeting of the Board to a member of the Board for the time being outside South Africa.

9.5 Subject to 9.6 and 31, all decisions of the Board shall be taken at a meeting of the Board by a simple majority of the votes cast by the Trustees present at that meeting. Each Trustee shall have one vote and the Chairman shall not have a casting vote at meetings of the Board.

9.6 A resolution in writing which has been sent to all Trustees then in office and has been signed by a majority (or, in the case of a resolution referred to in 31, 75%) of the Trustees then in office, shall be as valid and effective as if it had been passed at a meeting of the Trustees duly called and constituted. Any such resolution may consist of several documents in a like form, each signed by one or more of the Trustees. A resolution of the Board passed in terms of this 9.6 shall be placed in a minute book of the Trust and shall be noted at the next succeeding meeting of the Trustees and shall also be signed by the chairman of that meeting.

9.7 All acts done by any meeting of the Trustees or a committee of Trustees or by any person acting as a Trustee shall, even if –

9.7.1 there was some defect in the appointment of any such Trustee or person acting as aforesaid; or

9.7.2 they are or any of them were not eligible or were disqualified; or

9.7.3 there was an immaterial defect in the form or manner of giving notice of the meeting of the Trustees; or

9.7.4 there was an accidental or inadvertent failure to give notice of the meeting to any Trustee or Trustees, provided that at least 75% of the Trustees then in office did in fact receive notice or attended the meeting

or have confirmed that they were aware of the meeting and agreed to the conduct of the meeting in their absence,

be as valid as if there had been no such defect, ineligibility or failure.

9.8 Without limiting the discretion of the Trustees to regulate their meetings, Trustees may participate in and act at any meeting of Trustees through the use of a conference telephone or other communications equipment by means of which all Persons participating in the meeting can at least speak and hear each other at approximately the same time and participate reasonably effectively in the meeting. A resolution passed at such a meeting shall, notwithstanding that the Trustees are not present together in one place at the time of the meeting, be deemed to have been passed at a meeting duly called and constituted on the day on which and at the time at which the meeting was so held.

10 **DUTIES OF TRUSTEES**

10.1 Sections 75 and 76 of the Companies Act (but excluding section 76(3)(c) of the Companies Act, for the reason set out in 10.2) shall be incorporated herein by reference on the basis that all references therein to –

10.1.1 a director or directors shall be deemed to be references to a Trustee or the Trustees; or

10.1.2 the company shall be deemed to be references to the Trust,

with the intention that those sections shall accordingly apply to the Trustees in relation to the Trust as if the Trust was a company and they were directors of that company.

10.2 It is recorded that section 76(3)(c) of the Companies Act –

10.2.1 deals with the duty of care, skill and diligence of a director of a company; and

10.2.2 has been excluded from the duties of Trustees referred to in 10.1 because section 9 of the Trust Property Control Act stipulates that -

10.2.2.1 each Trustee shall in the performance of his duties and the exercise of his powers act with the care, diligence and skill which can reasonably be expected of a person who manages the affairs of another; and

10.2.2.2 this Deed may not exempt a Trustee from the requirements referred to in 10.2.2.1.

11 POWERS OF TRUSTEES

Subject to 12 and the requirement that the Trustees shall act in a manner consistent with the Trust Objects -

11.1 the Trust shall have all of the powers and capacity that it would have had if it were an individual of full legal capacity (except to the extent that a juristic person is, of necessity as a result of its juristic nature, incapable of exercising any such power or having such capacity), it being intended that the Trust should have no limitations on its powers and capacity except for those specifically imposed in this Deed;

11.2 all powers to conduct, manage and control the business and all affairs of the Trust shall be vested in the Board which, in addition to the powers and authorities expressly conferred upon the Trust or the Board by this Deed, may exercise all powers and authorities and perform all acts which may be exercised or done by the Trust and may do all such other acts or things as, in the opinion of the Board, are conducive to the attainment of all or any of the Trust Objects. For the avoidance of doubt, it is recorded that the general powers given by this 11.2 shall not be limited or restricted by any specific authority or power given to the Board by any other provision of this Deed;

11.3 the Board shall be entitled to appoint such officers, employees, agents or other representatives as it may require or determine to be convenient in connection with the business and affairs of the Trust and on such terms and conditions

and with such restrictions as it may deem fit. Such appointments shall include the appointment of the Secretary;

11.4 the Board shall be entitled at any time to –

11.4.1 delegate to and confer upon any Trustee, officer, other individual or committee referred to in 15 such of the powers and authority vested in the Board as it may think fit (including the power to consider Membership applications and terminations in terms of 19 and 20 respectively), for such time, for such purposes, upon such terms (including full power of sub-delegation) and conditions and with such restrictions as the Board may think fit; and

11.4.2 revoke or vary all or any of such powers and authorities so delegated;

11.5 the Board shall be entitled at any time to –

11.5.1 admit and retain Members; and

11.5.2 extend an invitation or grant recognition to Professional organisations as referred to in 1.2.28 and 1.2.39,

on such terms and conditions as the Board may deem fit in order to facilitate the Trust Objects and representation of Members;

11.6 the Board shall be entitled at any time to resolve, on such terms and conditions as the Board may deem fit, that –

11.6.1 the Trust shall form or acquire a Subsidiary for the purpose of or in connection with the provision of Products or other benefits and services to the Members; or

11.6.2 an Entity shall be an Affiliated Entity or that any Affiliated Entity shall cease to be an Affiliated Entity;

11.7 the Trust shall be entitled, at any time and on such terms and conditions as the Board may deem fit, to contract with and/or pay fees or remuneration to

any Person for the purpose of and/or in connection with any introductions to possible Members or activities relating to increasing the number of Members;

11.8 the Trust shall be entitled to procure services from or provide services to any member of the Group or any other Person on such terms and conditions as the Board may deem fit; and

11.9 the Trustees shall furthermore be able to exercise all such additional powers as may be conferred upon them by law or which are referred to in annexure B to this Deed.

12 **RESERVED MATTERS**

12.1 Notwithstanding anything to the contrary in this Deed, the Trust shall not authorise, agree to or implement any of the following transactions unless such transaction has been authorised by at least seventy-five percent of the votes cast by Members Present at a General Meeting held in accordance with 22 or by written vote in accordance with 22.9 -

12.1.1 any transaction by the Trust or any other member of the Group which constitutes a Disposal to any Entity/ies other than a member of the Group of the whole or the greater part of the Trust Assets or of assets constituting the whole or the greater part of the assets of the Group. For the purposes of this 12.1.1, it is recorded that any reference to assets constituting the greater part of any group of assets shall mean assets having an aggregate value equal to 50% or more of the value of all the assets within that group, and all such values shall be calculated in accordance with section 112(4) of the Companies Act at a date determined for this purpose by the Trustees, which date shall not be more than thirty days prior to the date on which the written agreement providing for that Disposal is signed;

12.1.2 any transaction by the Trust or any other member of the Group which -

12.1.2.1 confers Control of the whole Group or of a member of the Group on any Entity other than the Trust or a member of the Group; or

12.1.2.2 causes the Trust to cease to own (directly and indirectly) more than 50% of the issued ordinary share capital of any member of the Group where, prior to that transaction, the Trust owned more than 50% of such issued ordinary share capital; provided that this shall not apply to a winding-up or deregistration of any member of the Group;

12.1.3 any amendment to this Deed or any termination of the Trust; and

12.1.4 the payment of remuneration to Trustees as referred to in 13.1 in respect of any period after the end of the month in which the first AGM occurs.

12.2 The Trust shall not authorise, agree to or implement any transaction which is not a transaction referred to in 12.1.2 but will result in any person other than the Trust acquiring any shares in the issued share capital of PPS Insurance, unless the Trust has given prior notice of such anticipated transaction to the Members and the Registrar of Long-term Insurance.

12.3 For the purposes of interpreting 12.1 and 12.2, it is recorded that the Trust may conclude any agreement which provides for any of the transactions referred to in 12.1 or 12.2 but which is subject to any condition which will ensure compliance with 12.1 and 12.2.

13 REMUNERATION AND EXPENSES OF TRUSTEES

Subject to 12.1.4, the Board shall be entitled to determine –

13.1 the remuneration, if any, to be paid to Trustees for attendance at meetings and any other work performed in connection with the Trust; and

13.2 the reimbursement, if any, to be paid to Trustees for expenses incurred in connection with the Trust,

and failing a determination of the Board entitling a Trustee to such remuneration or reimbursement, that Trustee shall have no right to any such remuneration or reimbursement.

14 PAYMENTS

14.1 All amounts received by the Trust may be applied by the Board as follows –

14.1.1 such amounts or any portion thereof may be paid to any one or more members of the Group if the Board determines that such payment is desirable, and in that event such payment may be made in such manner and on such terms and conditions as the Board may determine; or

14.1.2 such amounts or any portion thereof may be invested if the Board determines that such amount is not required for the purposes referred to in 14.1.1.

14.2 The Trust shall not make any distributions to its Members.

14.3 For the avoidance of doubt, it is recorded that PPS Insurance shall not, whether by way of distribution from the Trust or otherwise, be entitled to acquire any shares in its own share capital unless such acquisition complies with the Companies Act, the Long-term Insurance Act No. 52 of 1998 and any other applicable laws.

15 COMMITTEES OF TRUSTEES

The Board may –

15.1 appoint any number of committees of Trustees;

15.2 appoint a chairman and deputy chairman of any such committee;

15.3 appoint as members of any such committee persons who are not Trustees, but no such person shall have a right to vote on a matter to be decided by the committee;

15.4 authorise the Members of such committee, or any of them, to fill any vacancies on that board or committee;

15.5 specify how the meetings, procedures and acts of such committees shall be governed, failing which those meetings, procedures and acts shall, mutatis

mutandis and as if such committee were the Board, be governed by the provisions of this Deed relating to meetings, procedures and acts of Board;

15.6 without limiting 11.4, delegate to that committee any power and authority of the board (including the power to consult with or receive advice from any person) and that committee shall, to the extent of that delegation, have the full power and authority of the Board in respect of any matter referred to it.

Without limiting the foregoing, it is specifically recorded that the Board (i) may appoint a nominations committee in order to assist with and discharge any or all of the functions of the Board in relation to the appointment of Trustees; and (ii) shall appoint the Audit Committee referred to in 26.

16 LIMITATION OF TRUSTEES' LIABILITY AND INDEMNITY

Subject to the provisions of the Trust Property Control Act -

16.1 no Trustee shall be responsible for any loss caused by any act or omission of that Trustee in reliance on any document, unless the Trustee knew that such document was not in fact what it purported to be;

16.2 each Trustee shall be entitled, notwithstanding anything to the contrary herein contained, to use his discretion as to the manner and time in which he should exercise or perform any of the powers or obligations conferred or imposed on him in terms of this Deed and shall not be responsible for any loss caused as a result thereof, unless the Trustee has been negligent or wilfully dishonest; and

16.3 subject to 16.1, 16.2 and 13.2, each Trustee shall be indemnified out of the Trust Assets against any loss, liability, damage, cost or expense suffered or incurred by him as a result of acting as Trustee.

PART D: MEMBERS

17 ELIGIBILITY FOR MEMBERSHIP

17.1 All Existing Members shall automatically, and without any need for acceptance of benefits, become Members of the Trust on the Implementation Date.

17.2 Save as provided in 17.1, a Person shall only be entitled to become a Member of the Trust if such Person is, and continues to be, -

17.2.1 a Professional Person who is a member, or who is eligible for membership, of one of the Recognised Professional Organisations; and/or

17.2.2 a juristic Person which provides Professional services;

provided that the Board shall be entitled to admit such other Professional and/or juristic Persons as Members as it deems fit.

18 CLASSES OF MEMBERS

18.1 Existing Members who were –

18.1.1 ordinary members of PPS Holdco as at the Implementation Date shall, initially and subject to the further provisions of this Deed, be classified as Ordinary Members; or

18.1.2 associate members of PPS Holdco as at the Implementation Date shall, initially and subject to the further provisions of this Deed, be classified as Associate Members.

18.2 The Members of the Trust shall be divided into the following classes of Members, who will have distinct rights as set out this Deed –

18.2.1 Ordinary Members; and

18.2.2 Associate Members.

18.3 The following Members shall be Ordinary Members -

18.3.1 ordinary participants, from time to time, as defined in the Master Contract;

18.3.2 accident participants, from time to time, as defined in the Master Contract;

18.3.3 special participants, from time to time, as defined in the Master Contract;

18.4 The following Members shall be Associate Members -

18.4.1 members of the Professional Provident Society Retirement Annuity Fund;

18.4.2 members of the Profmed Medical Aid Scheme;

18.4.3 Members who have ceased to be ordinary participants, from time to time, as defined in the Master Contract and who have retired from a Professional Organisation or who have retired from their Profession; and

18.4.4 any other participant in any Product provided by the Group and any other Member who is not an Ordinary Member.

18.5 If a Member ceases to qualify as an Ordinary Member, but remains a Member then such Member shall *ipso facto* be reclassified as an Associate Member.

18.6 A Member who qualifies as an Ordinary Member and an Associate Member shall only be an Ordinary Member.

18.7 The Trust shall maintain a register of Members of the Trust, which shall reflect the class into which each Member falls.

19 APPLICATION FOR MEMBERSHIP

19.1 Any Person (excluding, for the avoidance of doubt, an Existing Member) wishing to apply to become a Member ("**Applicant**") shall apply to the Trust in such manner and on such application form as the Board shall from time to time prescribe.

19.2 An Applicant shall in all cases give all such information to the Board as the Board may require.

19.3 The decision to admit an Applicant to Membership or to reject the application shall be at the sole and absolute discretion of the Board.

19.4 Without derogating from 19.3, the Board shall be entitled, but not obliged (unless obliged by any applicable law which overrides this provision of this Deed), to furnish its reasons for rejecting an Applicant's application for Membership in terms of 19.3 to that Member in writing.

20 TERMINATION OF MEMBERSHIP

20.1 A Member shall cease to be a Member of the Trust –

20.1.1 when his membership is terminated in terms of 20.2; or

20.1.2 upon the date of receipt by the Trust of written notice of resignation from the Member or such later date as may be stipulated as the effective date of such resignation in that notice.

20.2 The Board shall, with effect from such date as the Board may determine for such purpose, be entitled to terminate a Member's membership of the Trust -

20.2.1 if such Member is not a participant in any Product provided by the Group; or

20.2.2 if such Member ceases to be a member, or ceases to be eligible for membership, of a Recognised Professional Organisation; or

20.2.3 if such Member ceases to be registered with, or ceases to be eligible for registration with, the statutory registering authority for his Profession; or

20.2.4 if such Member is in the opinion of the Board guilty of improper or unworthy or disgraceful conduct; or

20.2.5 upon his death; or

20.2.6 when a Member changes his Profession to one other than a Profession referred to in 17.2; or

20.2.7 if such Member is a Corporate Member and it ceases to provide Professional services; or

20.2.8 for any other reason which the Board deems sufficient to warrant such termination,

provided that the Board may, in its sole and absolute discretion, decide to allow any Member to continue as a Member notwithstanding the occurrence of an event referred to in this 20.1.

20.3 Without derogating from 20.1, the Board shall, as soon as reasonably possible in the circumstances, furnish its reasons for terminating a Member's Membership in terms of 20.1 to that Member in writing.

21 TRANSFER OF MEMBERSHIP

A Member shall not be entitled to Dispose of, Encumber or in any way transfer to any Person his Membership or any rights or obligations comprising or associated with his Membership.

22 MEETINGS OF MEMBERS

22.1 General Meetings

22.1.1 The Trust shall hold its first AGM within eighteen months after the Implementation Date and shall thereafter in each financial year of the Trust hold an AGM; provided that an AGM shall be held within six months after the end of each financial year of the Trust and the annual financial statements for that preceding financial year shall be submitted to such AGM.

22.1.2 An extraordinary General Meeting shall be convened –

22.1.2.1 on the instructions of the Board; or

22.1.2.2 by the Board on the requisition submitted in writing to the Board and signed by not less than one hundred Members or of Members having 10% of the total voting rights of all the Members entitled to be present and to vote at a General Meeting. If a General Meeting is convened on the requisition of any Members, all expenses in connection with such meeting shall be paid by the requisitioning

Members jointly and severally, unless otherwise decided by the Trust in General Meeting; or

22.1.2.3 if there are no Trustees then in office then any Member or the Master shall be entitled to convene a General Meeting for the purposes of electing new Trustees in terms of 5.3.1.

22.1.3 Other General Meetings may be held at any time.

22.1.4 General Meetings shall be held at such time and place as the Board shall determine.

22.1.5 There shall be no separate meetings for different classes of Members and all Members will attend and vote at the same meeting in accordance with the voting rights of each Member.

22.1.6 The Board may, on such terms and conditions as it may decide, provide for Members to participate in and act at any General Meeting through the use of a conference telephone or other communications equipment by means of which all Persons participating in the meeting can at least speak and hear each other at approximately the same time and participate reasonably effectively in the meeting. A resolution passed at such a General Meeting shall, notwithstanding that the Members are not present together in one place at the time of the General Meeting, be deemed to have been passed at a General Meeting duly called and constituted on the day on which and at the time at which the General Meeting was so held.

22.2 **Notice of General Meetings**

22.2.1 Any General Meeting shall be convened by giving notice thereof to Members in the following manner –

22.2.1.1 notice shall be given not less than ten clear Business Days prior to the date of that meeting. The notice period shall be exclusive of the day on which notice is given and of the date of the meeting;

22.2.1.2 the notice shall specify the place, the day and the hour of the meeting and shall be given in the manner hereinafter mentioned or

in such other manner, if any, as may be prescribed by the Members in General Meeting.

22.2.2 Notice of every General Meeting shall be given in any manner authorised by this Deed -

22.2.2.1 to every Member of the Trust except those Members in respect of whom the Trust does not have an address within South Africa for the giving of notices to them; and

22.2.2.2 to the Auditor as referred to in 25.7.2.2.

No other Person shall be entitled to receive notice of General Meetings.

22.2.3 Subject to compliance with 22.1.1, the Board may postpone any General Meeting (other than a General Meeting convened in terms of 22.1.2.2 or 22.1.2.3) at any time prior to the commencement of that General Meeting by giving notice to that effect to the Members.

22.3 **Proceedings at General Meetings**

22.3.1 The AGM shall deal with and dispose of –

22.3.1.1 the consideration of the annual financial statements;

22.3.1.2 the election of Trustees;

22.3.1.3 the appointment of Auditor as referred to in 25.2; and

22.3.1.4 any other business of which notice is given in the notice convening the AGM.

22.3.2 No business shall be transacted at any General Meeting unless a quorum of Members is Present throughout that General Meeting.

22.3.3 The Chairman shall preside at all General Meetings and shall accordingly determine the procedure to be followed in order to regulate access to any

such General Meeting, to verify the identity and authority of Persons wishing to attend any such General Meeting as well as the procedure to be followed at such General Meeting; provided that the powers of the Chairman to determine such procedures shall be subject to the provisions of this Deed. In his absence or if he is unwilling or unable to preside then the Deputy Chairman shall so preside and exercise the Chairman's powers. In the absence of both the Chairman and the Deputy Chairman or if both are unable or unwilling to preside, then the Members Present shall elect one of the Trustees who is present or, if no Trustee is present, any Ordinary Member, to preside over that meeting as its chairman and exercise the Chairman's powers.

22.3.4 All acts done by any General Meeting shall, even if there was –

22.3.4.1 an immaterial defect in the form or manner of giving notice of the General Meeting; or

22.3.4.2 an accidental or inadvertent failure to give notice of the General Meeting to any Person/s, provided that at least 75% of the Members did in fact receive notice or attended the meeting or have confirmed that they were aware of the meeting and agreed to the conduct of the meeting in their absence,

be as valid as if there had been no such defect or failure.

22.4 **Quorate General Meetings**

A quorum for a General Meeting shall be twenty-five Ordinary Members who are entitled to vote at that General Meeting; provided that if within thirty minutes after the time appointed for the commencement of a General Meeting (including the resumption of a General Meeting adjourned in terms of 22.5 but not the resumption of any meeting adjourned in terms of this 22.4) such quorum is not present or should there not be such quorum at any time after the General Meeting has commenced, then –

22.4.1 the General Meeting shall automatically stand adjourned to be resumed on the third Business Day after the date appointed for that General

Meeting, at the same time and place as was fixed for the adjourned General Meeting and if such place is not available at such other place as the Board may decide;

22.4.2 notice of such adjournment shall be given in accordance with 22.5.2.2; and

22.4.3 if such quorum is not Present within thirty minutes after the scheduled time for resumption of the adjourned General Meeting, then the Members then Present at such adjourned General Meeting shall constitute a quorum.

22.5 **Adjournment of General Meetings**

22.5.1 The chairman of a quorate General Meeting shall from time to time adjourn such General Meeting, in whole or in respect of the consideration of only some of the matters on the agenda for such General Meeting, if so directed by a resolution adopted by such General Meeting at the request of the chairman or any Ordinary Member.

22.5.2 If any General Meeting is so adjourned –

22.5.2.1 it shall be resumed at such time and place as may –

22.5.2.1.1 have been stipulated in the resolution directing such adjournment; or

22.5.2.1.2 be determined by the chairman of that General Meeting, or failing any such determination by the chairman, by the Board, but the time for the resumption of the adjourned General Meeting which is determined by the chairman or the Board shall not be earlier than the third Business Day after the date of the adjourned General Meeting;

22.5.2.2 the Board shall cause notice of such adjournment to be given to Members by Electronic Medium only or by Electronic Medium and such other means as the Board may deem fit.

22.5.3 No business shall be transacted at the resumption of any adjourned General Meeting other than the business left unfinished at the General Meeting at which the adjournment took place. When a General Meeting is adjourned, the provisions of 22.3 shall *mutatis mutandis* apply to such adjournment.

22.5.4 The chairman may allow any General Meeting to be interrupted for any reason if the General Meeting continues in the same place at a later time on the same day and in that event such interruption shall not be regarded as an adjournment.

22.6 **Voting at meetings**

22.6.1 Subject to 12 and 22.9, all decisions of the Members shall be taken at a General Meeting by a simple majority of the votes cast by the Members Present at that meeting and any casting vote exercised by the chairman as referred to in 22.6.2.3.

22.6.2 For the purposes of any vote at a General Meeting on any resolution during any financial year of the Trust -

22.6.2.1 Associate Members shall not have any vote; and

22.6.2.2 each Ordinary Member shall have one hundred votes plus one additional vote for each completed R200,00 in his/her Apportionment Account at the most recent date prior to that General Meeting when the Apportionment Accounts of Ordinary Members were adjusted; provided that an Ordinary Member who is, as at the date of that vote, three months or more in arrear with the payment of his premiums (payable in terms of the Master Contract) shall only have one vote at a General Meeting; and

22.6.2.3 the chairman of the General Meeting shall have a casting vote in addition to any deliberative votes he may have.

22.6.3 A Member who has more than one vote, may not split votes to exercise his votes in voting on any particular resolution but shall exercise votes either for or against the resolution or the Member may abstain from voting on it.

22.6.4 The Trust shall keep a record of the votes that each Member is entitled to exercise at each meeting of the Trust.

22.6.5 At any General Meeting, a resolution put to the vote of the meeting shall be decided on a show of hands, unless a poll is (before or on the declaration of the result of the show of hands) demanded by the chairman of the meeting or by any five or more Ordinary Members or by any Ordinary Members who are entitled in terms of 22.6.2 to cast votes comprising 10% or more of the aggregate number of votes which may be cast by all Members at a General Meeting, and unless a poll is so demanded, a declaration by the chairman of the meeting that a resolution has, on a show of hands, been carried either unanimously or by a particular majority and an entry to that effect in the book containing the minutes of the proceedings of General Meetings shall be conclusive evidence of the fact, without proof of the number or proportion of the votes recorded in favour of or against such resolution. Any demand for a poll may be withdrawn.

22.6.6 If a poll is duly demanded it shall be taken in such a manner as the chairman of the meeting directs and the result of the poll shall be deemed to be the resolution of the meeting on the matter on which the poll was demanded. The chairman of the meeting may appoint scrutineers to determine the result of the poll.

22.6.7 A poll demanded by the chairman of the meeting or a poll demanded on the question of adjournment by any Ordinary Member shall be taken forthwith. A poll demanded on any other question shall be taken at such time as the chairman of the meeting directs. The demand for a poll shall not prevent the continuation of a meeting for the transaction of any business not affected by the question upon which the poll has been demanded.

22.7 **Proxies**

22.7.1 The appointment of a proxy shall be in writing and signed by the appointer or by his agent duly authorised in writing. A proxy need not be a Member. Subject to compliance with the provisions of this Deed relating to proxies which shall apply equally to the holder of a general or special power of attorney given by a Member, such holder shall, whether he is himself a Member or not, if and to the extent that he is duly authorised under that power, be entitled to attend any General Meeting and to speak and to vote on behalf of that Member.

22.7.2 Unless otherwise indicated in the instrument appointing a proxy to vote on behalf of a Member at a General Meeting, that instrument shall be deemed to confer authority to exercise all rights which that Member could have exercised at that General Meeting and shall accordingly include authority to speak at that General Meeting and to demand or join in demanding a poll or an adjournment.

22.7.3 The instrument appointing a proxy –

22.7.3.1 and the power of attorney or other authority, if any, under which it is signed, or a certified copy of such power or authority, shall be deposited at the Office not less than two clear Business Days prior to the date for holding the General Meeting (or any resumption of an adjourned General Meeting) at which the person named in the instrument proposes to vote;

22.7.3.2 may, if the Trustees so decide and then subject to such terms and conditions as the Trustees may decide, be completed and lodged by Electronic Medium;

22.7.3.3 shall be substantially in the following form or in such other form as the Trustees may approve, in either case under the heading of or referring to the Trust's name, and shall be completed in accordance with the instructions contained therein -

"Professional Provident Society Holdings Trust
("the Trust")

I/We,_____
of _____
being a Member of the Trust, hereby appoint
_____
of _____
or failing him _____
of _____

as my to attend and speak and vote on a poll for me and on my behalf at the annual general meeting or general meeting (as the case may be) of the Trust to be held on the _____ day of _____ 20__ and at any adjournment thereof, as follows:

	In favour of	**Against**	**Abstain**
Resolution No.			
Resolution No.			
Resolution No.			

(Indicate instruction to proxy in respect of a resolution by way of a tick or a cross in one of the columns above alongside the reference to that resolution. If no tick or cross is inserted in any column, then the proxy may vote or abstain from voting as he deems fit.)

SIGNED this _____ day of _____20__.

_____
Signature

(Note: A Member entitled to attend and vote is entitled to appoint a proxy to attend, speak and vote in his stead, and such proxy need not also be a Member of the Trust.)"

provided that the chairman of the General Meeting to which an instrument purporting to appoint a proxy relates shall be entitled, if he is satisfied in his discretion that the proxy was intended by a Member to be authorised to represent that Member at that General Meeting, to relax the requirements of this 22.7.3 and to allow that proxy to represent that Member at that General Meeting in accordance with that intention.

22.8 **Representation of corporate members**

The board of directors of a Corporate Member may authorize any person to act as its representative and to exercise all of the rights of that Corporate Member in terms of this Deed, whether at a meeting of Members or otherwise. Any person so authorised to represent a Corporate Member may, subject to any

limitations within that authority and to the Trust having first been provided with reasonably satisfactory proof as to the extent of that authority, exercise those rights without restriction. This 22.8 does not prevent a Corporate Member or any representative referred to in this 22.8 from appointing a proxy for the Corporate Member in accordance with this Deed.

22.9 **Written resolutions**

22.9.1 Subject to 22.9.3, any resolution of Members that could be voted on at a General Meeting may instead be adopted by written vote of the Members conducted in accordance with 22.9.2, if it is supported by Members entitled to exercise a sufficient majority of the votes cast in accordance with 22.9.2 for it to have been adopted at a properly constituted General Meeting. Any such resolution shall be deemed to have been adopted on the last day of the period referred to in 22.9.2.

22.9.2 Any written resolution to be voted on in accordance with 22.9.1 shall be given to Members in accordance with 28.5 along with a voting paper for completion by Members. In order to vote on any such written resolution, Members shall be required to complete the voting paper in respect of that written resolution and return it to the Trust in accordance with 28.4 on or before the date stipulated for this purpose in the voting paper, which shall not be earlier than ten Business Days after the submission date on which that voting paper is given to the Members.

22.9.3 The items of business referred to in 22.3.1.1 and 22.3.1.3 which are required to be dealt with at an AGM may not be dealt with by written resolutions in terms of this 22.9.

PART E: ADMINISTRATION OF THE TRUST

23 MINUTES AND RECORDS OF MEETINGS

23.1 The Board shall cause minutes to be made of -

23.1.1 all appointments of officers made by the Board;

23.1.2 the names of the Trustees present at each meeting of the Board;

23.1.3 all resolutions and proceedings at each meeting of the Board;

23.1.4 all resolutions passed by the Board in terms of 9.6;

23.1.5 the names of the Members present at each General Meeting;

23.1.6 all resolutions and proceedings at each General Meeting.

23.2 Minutes mentioned in 23.1 of any resolutions and proceedings at a meeting which appear in one of the minute books of the Trust shall be evidence of the facts therein stated if signed by -

23.2.1 any person purporting to be the chairman of the meeting to which it relates; or

23.2.2 any person present at the meeting and appointed by the Board to sign in the place of the chairman of that meeting; or

23.2.3 the chairman of a subsequent General Meeting (if the minutes relate to a General Meeting) or the chairman of a subsequent meeting of Trustees (if the minutes relate to a meeting of Trustees).

23.3 Any extracts from or copy of minutes purporting to be signed by –

23.3.1 any person referred to in 23.2 if the minutes relate to a meeting; or

23.3.2 any Trustee or the Secretary if those minutes relate to a meeting or any other matter referred to in 23.2,

shall be prima facie proof of the facts therein stated.

24 FINANCIAL YEAR, AUDITORS AND FINANCIAL STATEMENTS

24.1 The Trust shall have a financial year which shall, unless the Board determines otherwise, end on 31 December of each year.

24.2 The Board shall –

24.2.1 make arrangements for the retention and safe-keeping of all instruments of title and other documents relating to the Trust and the Trust Assets in the same manner as the Trust would be obliged to do if the Trust were a company;

24.2.2 be obliged to open and maintain at least one bank account for the Trust with any bank or similar institution;

24.2.3 keep or cause to be kept true and correct records and books of account of the affairs of the Trust in the same manner as would be required if the Trust were a company;

24.2.4 prepare or cause to be prepared annual financial statements reflecting the affairs of the Trust during and as at the end of each financial year of the Trust with the same content that would be required if the Trust were a company. Such annual financial statements shall –

24.2.4.1 be approved by the Board, signed by an authorised Trustee and submitted to an AGM in accordance with 22.1.1; and

24.2.4.2 be accompanied by a report by the Board on the extent to which the King Code on Corporate Governance for South Africa, as amended or replaced from time to time, has been applied in the affairs of the Trust and the rest of the Group; and

24.2.5 cause the books of account and the annual financial statements certified by it to be audited by the Auditor, who shall report on the financial statements.

24.3 A certificate issued by a Trustee or by a director or officer of a member of the Group relating to –

24.3.1 the size of any Ordinary Members' Apportionment Account; or

24.3.2 the aggregate of all Members' Apportionment Accounts; or

24.3.3 the number of votes which an Ordinary Member is entitled to cast at any meeting of Members,

shall constitute *prima facie* proof of the contents thereof for all purposes relating to this Deed.

25 **AUDITOR**

25.1 The initial Auditor of the Trust shall be PricewaterhouseCoopers Inc.

25.2 At each AGM, the Members shall appoint an Auditor; provided that –

25.2.1 the Members may not appoint as Auditor any Person who has not been approved by the Audit Committee for this purpose after that Person has submitted to the Audit Committee proof of that Person's qualification to hold office in terms of 25.4 and the terms and conditions on which that Person is prepared to serve as Auditor; and

25.2.2 if a General Meeting does not replace the existing Auditor, the existing Auditor remains in office subject to the provisions of 25.5.

25.3 If at any time the Auditor ceases to serve as such for any reason other than his replacement at a General Meeting, the Board shall fill the resultant vacancy with another Auditor.

25.4 The Members and the Board shall not appoint as Auditor (or allow to remain in office as Auditor) any Person who, if the Trust was a company, could not be appointed as its auditor in terms of the Companies Act.

25.5 The Auditor shall hold office as such until –

25.5.1 he resigns as such; or

25.5.2 he ceases to be qualified to hold office as such in terms of 25.4; or

25.5.3 his appointment as such is terminated by the Trustees, who may terminate the appointment of the Auditor on account of any misconduct on the part of the Auditor or his firm or any breach of the contract between the Trust and the Auditor; or

25.5.4 he is replaced by the appointment of another Auditor at a General Meeting.

25.6 Subject to the provisions of this Deed, the Audit Committee shall determine the terms and conditions on which the Auditor shall be appointed.

25.7 The Auditor –

25.7.1 has the right of access at all times to the accounting records and all books and documents of the Trust and its Subsidiaries, and is entitled to require from the Trustees, the Secretary and any directors, officers or employees of any such Subsidiary any information and explanations necessary for the performance of the Auditor's duties; and

25.7.2 is entitled to –

25.7.2.1 attend any General Meeting;

25.7.2.2 receive all notices of and other communications relating to any General Meeting; and

25.7.2.3 be heard at any General Meeting on any part of the business of the General Meeting that concerns the Auditor's duties or functions.

25.8 An Auditor may apply to a court for an appropriate order to enforce the rights set out in 25.7, and a court may –

25.8.1 make any order that is just and reasonable to prevent frustration of the Auditor's duties by the Trust or any of its Trustees or employees; and

25.8.2 make an order of costs personally against any Trustee whom the court has found to have wilfully and knowingly frustrated, or attempted to frustrate, the performance of the Auditor's functions.

26 **AUDIT COMMITTEE**

26.1 At each AGM, the Members shall elect an Audit Committee comprising at least three Trustees. A Trustee shall not be appointed to the Audit Committee if he -

26.1.1 is involved in the day-to-day management of the Group's business or has been so involved at any time during the previous financial year; or

26.1.2 is a prescribed officer, or full-time employee, of any member of the Group, or has been such an officer or employee at any time during the previous three financial years; or

26.1.3 is a material supplier or customer of the Group, such that a reasonable and informed third party would conclude in the circumstances that the integrity, impartiality or objectivity of that Trustee is compromised by that relationship. However, the fact that any Trustee participates in any Product or other benefit or service provided by the Group, and the value or extent of that participation and that Trustee's Apportionment Account, shall be disregarded for the purpose of determining whether that Trustee is disqualified from membership of the Audit Committee by this 26.1.3; or

26.1.4 is related (as defined in the Companies Act) to any Person who meets the criteria set out in 26.1.1, 26.1.2 or 26.1.3; or

26.1.5 does not satisfy any minimum qualification criteria prescribed for the members of Audit Committees of companies in terms of section 94(5) of the Companies Act.

26.2 If any member of the Audit Committee ceases to serve as such for any reason, the Board shall fill the resultant vacancy in the Audit Committee with another Trustee who meets the requirements of 26.1.

26.3 The Board shall delegate to the Audit Committee –

26.3.1 the duty and power to assess the independence of the Auditor and to determine the terms and conditions of appointment of the Auditor; and

26.3.2 such of its other duties and powers as the Board may deem fit, taking into account –

26.3.2.1 the nature of the Trust and its affairs;

26.3.2.2 the extent to which any Subsidiary of the Trust has an Audit Committee performing such functions; and

26.3.2.3 the functions which are assigned to an audit committee of a company in section 94(7) of the Companies Act.

27 SECRETARY

27.1 The Board shall appoint a Secretary who may be charged with all secretarial and administrative functions relating to the Trust, including those functions that could be performed by a company secretary if the Trust were a company.

27.2 The Board shall not appoint as Secretary any Person who, if the Trust was a company, could not be appointed as its secretary in terms of the Companies Act.

28 DOMICILIUM, NOTICES AND COMMUNICATION

28.1 Each Trustee chooses *domicilium citandi et executandi* ("***Domicilium***") for the purposes of the giving of any notice, the payment of any sum, the serving of any process and for any other purpose arising from this Deed, as appointed by that Trustee in his Written Acceptance.

28.2 Each Member who appointed a physical address, postal address, facsimile number or e-mail address for the purposes of communications with or his membership of PPS Holdco shall be deemed to have appointed that same physical address, postal address, facsimile number or e-mail address for the

purposes of communications relating to the Trust and in particular the receipt of Member Information. The Trust shall, to the extent it deems fit, obtain one or more of such addresses/numbers from any new Member before that Person becomes a Member.

28.3 Each Trustee and each Member shall be entitled from time to time, by giving written notice to the Trust, to vary any physical address appointed by him to any other physical address (not being a post office box or *poste restante*) within South Africa and to vary any facsimile number and/or e-mail address appointed by him to any other facsimile number and/or e-mail address respectively. Any such variation notice shall be effective as of the day after receipt thereof by the Trust.

28.4 Any Trustee or Member may give any notice to the Trust by giving it to the Secretary at the following physical address, postal address, e-mail address or facsimile number –

physical	-	6 Anerley Road Parktown Johannesburg 2193
postal	-	PO Box 1089 Houghton 2041
e-mail	-	vbarnard@pps.co.za
facsimile	-	(011) 644-4641
attention	-	the Secretary

or such other physical address, postal address, facsimile number or e-mail address as may be stipulated for this purpose by the Trust, whether on its internet website or otherwise.

28.5 Any notice given by the Trust or any Trustee, Member or other Entity to the Trust or any Trustee or Member ("**Addressee**") which is –

28.5.1 delivered by hand between the hours of 09:00 and 17:00 on any Business Day to the Addressee's physical address for the time being shall

be deemed to have been received by the Addressee at the time of delivery;

28.5.2 successfully transmitted by facsimile or e-mail to the Addressee's facsimile number or e-mail address respectively for the time being shall be deemed to have been received by the Addressee on the date of successful transmission thereof; or

28.5.3 posted to the Addressee's postal address for the time being shall be deemed to have been received by the Addressee on the date of posting. A notice or other document shall be deemed to have been posted if it is proved that it was properly addressed and delivered to a postal authority.

28.6 In addition to the abovementioned methods of providing Member Information to Members, the Trust may –

28.6.1 give Member Information to all Members by giving to Members a notice of the availability of such Member Information from an internet website or other source (which notice shall contain instructions for obtaining such Member Information from that internet website or other source), and any such Member Information shall be deemed to have been received by all Members on the date on which that notice is given; and

28.6.2 provide Member Information to all Members by advertisement in any newspaper/s which circulate in at least Johannesburg, Cape Town and Durban, and any such Member Information shall be deemed to have been received by all Members on the date on which it is so advertised.

28.7 For the avoidance of doubt, it is recorded that the Trust is authorised to send Member Information to all Members in electronic format or through Electronic Medium; provided that if any Member specifically requests delivery to him/her of Member Information in paper format, the Trust shall as soon as practicable thereafter make such Member Information available (or, if practicable, send such Member Information) to that Member in paper format, but no such request shall detract from the validity of the giving of that Member Information in electronic format or through Electronic Medium.

28.8 Any notice actually received by a Trustee or a Member will constitute adequate notice to that Trustee or Member notwithstanding that it is not sent or delivered to an appointed address or facsimile number of that Trustee or Member.

28.9 Any notice in terms of or in connection with this Deed shall be valid and effective only if in writing and if received or deemed to be received by the Addressee.

PART F: TERMINATION OF THE TRUST

29 TERMINATION OF THE TRUST

The Trust shall endure in perpetuity unless –

29.1 terminated by a resolution of the Trustees to that effect which has been adopted by at least seventy-five percent of the Trustees and has been approved by the Members in accordance with 12 (but the approval of any other Beneficiary shall not be required); provided that no such resolution shall become effective while the Trust still holds any Trust Assets;

29.2 the Trust is wound up.

PART G: LEGAL MATTERS

30 DISPUTES

For all purposes relating to the Trust and this Deed, each Trustee and each Member submits itself/himself/herself to the non-exclusive jurisdiction of the South Gauteng High Court, Johannesburg.

31 AMENDMENT

31.1 Any provision of this Deed, including the Trust Objects, may be amended at any time; provided that any such amendment shall not be effective unless -

31.1.1 reduced to writing;

31.1.2 approved by a resolution adopted by at least seventy-five percent of the Trustees;

31.1.3 approved by the Members in accordance with 12 (but the approval of any other Beneficiary shall not be required); and

31.1.4 the Registrar of Long-term Insurance has confirmed that it does not object to the proposed amendment.

31.2 For the avoidance of doubt, it is recorded that because PPS Holdco ceased to have any rights in terms of this Deed or in relation to the Trust with effect from the Implementation Date, this Deed may be amended without any reference to, or the approval of, PPS Holdco.

32 **GENERAL**

32.1 This Deed constitutes the sole record of terms of the Trust.

32.2 No indulgence or extension of time which the Trustees may grant to any Person shall constitute a waiver of or, whether by estoppel or otherwise, limit any of the existing or future rights of the Trust in terms hereof, save in the event and to the extent that the Board has signed a written document expressly waiving or limiting such right.

32.3 Each provision of this Deed is, notwithstanding the grammatical relationship between that provision and the other provisions of this Deed, severable from the other provisions of this Deed. Any provision of this Deed which is or becomes invalid, unenforceable or unlawful shall be treated as *pro non scripto* to the extent that it is so invalid, unenforceable or unlawful, without invalidating or affecting the remaining provisions of this Deed which shall remain of full force and effect. It is the intention that this Deed would be adopted without such invalid, unenforceable or unlawful provision if they were aware of such invalidity, unenforceability or unlawfulness at the time of adoption of this Deed.

ANNEXURE A – PARTIES TO THE DEED

NAME		Method of appointment
1	David Guy Compton Presbury	Elected
2	Ebrahim Aboobaker Moolla	Elected
3	David Randle Anderson	Elected
4	Tayob Nazeer Aboobaker	Nominated by the General Council of the Bar of South Africa
5	Verash Kumar Shantilal Bhagwandas	Elected
6	Neil Gordon Campbell	Elected
7	James Allon Balfour Downie	Co-opted by the Board
8	Yaswant Narotham Gordhan	Elected
9	Umesh Dhanjee Jivan	Elected
10	Ivan Kotzé	Nominated by the Pharmaceutical Society of South Africa
11	Christian Martin Krüger	Elected
12	Mphata Norman Mabasa	Nominated by the South African Medical Association
13	Jayant Patel	Nominated by the South African Dental Association
14	Sybil Nomathonya Elizabeth Seoka	Co-opted by the Board
15	Brandon Rodney Topham	Elected
16	Shaylen Trikamjee	Elected
17	Ursula Botha	Elected
18	Pankajkumar Ranchod	Elected
19	Doris Liana Theresia Dondur	Nominated by The South African Institute of Chartered Accountants
20	Vaughn Patrick Rimbault	Nominated by the Engineering Voluntary Associations

ANNEXURE B – POWERS OF TRUSTEES

Without in any way limiting the generality of any of the provisions of the Deed, the Trustees shall have the following rights and powers which they may exercise in their discretion -

1 to open and operate any banking account and/or building society account and to draw and issue cheques and to receive cheques, promissory notes and/or bills of exchange, and to endorse any of the same for collection by the bank and/or building society at which the said account was opened. Save as otherwise expressly provided by the Deed, all cheques, promissory notes, bills of exchange and other negotiable or transferable instruments and all documents to be executed by the Trust, shall be signed, drawn, accepted, endorsed or executed, as the case may be, in such manner as the Board shall from time to time determine;

2 to buy or sell movable, immovable or incorporeal property of whatsoever nature, and to sign and execute any agreement or deed of sale in relation thereto, and to sign and execute all requisite documents and to do all things necessary for the purpose of effecting and registering, if needs be, transfer according to law of any such property, whether movable, immovable or incorporeal, bought or sold by the Trustees;

3 to buy, sell and/or exchange shares, stocks, debentures, debenture stock, units, promissory notes, bills of exchange and other negotiable instruments and documents of any kind, and to do all things and sign all documents requisite to acquire or, as the case may be, to transfer title thereto;

4 to lend money on such terms and conditions and at such interest (or without interest) and to such Persons as the Trustees may (in their discretion) determine, and either with or without security or upon such security of movable or immovable property or such personal suretyships and/or guarantees, as the Trustees may (in their discretion) determine, and to sign and execute all requisite documents and to do all things necessary for the effecting and registration of any such security; provided that the Trust may not lend money to any Trustee;

5 from time to time to determine what moneys, not immediately required to meet the current charges upon the Trust, are available for investment and to vary any investment made by realising the same and/or by substituting therefor any other investment which the Trustees are empowered in terms hereof to make;

6 to borrow money on such terms and conditions and at such interest and from such Persons as the Trustees may (in their discretion) determine, and either without security or upon such security of movable or immovable property or such personal suretyship and/or guarantees as the Trustees may (in their discretion) determine, and to sign and execute all requisite documents and to do all things necessary for the effecting and registration of any requisite instrument of debt and of any such security;

7 to Encumber, as security for any liability of the Trust or any member of the Group (including, without limitation, any liability of the Trustees as surety for or guarantor of any other Person's obligations), any movable, immovable or incorporeal property forming part of the Trust Assets, and for the purpose of any such Encumbrance to sign and execute all requisite documents and do all things necessary for effecting and registering the same;

8 to let, either by written agreement of lease or otherwise, improve, alter or maintain any immovable property belonging to the Trust or any improvements thereon;

9 to collect and receive rents, and, if necessary, cancel any lease or other tenancy and take all legal proceedings for ejectment or otherwise in connection with such lease or other tenancy or the cancellation thereof;

10 to sue for, recover and receive all debts or sums of money, goods, effects and things whatsoever, which may become due, owing, payable or belonging to the Trust and to bring sequestration, liquidation and judicial management proceedings against any party;

11 to defend, oppose, adjust, settle, compromise or submit to arbitration all accounts, debts, claims, demands, disputes, legal proceedings and matters which may subsist or arise between the Trust and any Person or Persons whatsoever, and for the purposes aforesaid to do and execute all necessary acts and documents;

12 to attend all meetings of creditors of any Person or Persons whatsoever indebted to the Trust whether in insolvency, liquidation, judicial management or otherwise, and to vote for the election of a trustee or trustees and/or liquidators and/or judicial managers as also to vote on all questions submitted to any such meeting of creditors and generally to exercise all rights accruing to a creditor;

13 to exercise the voting power attached to any shares, stocks, debentures, units or other instruments held by the Trust, in such manner as they may deem fit;

14 to take such steps or enter into such agreements with other Persons as they may deem fit, for the purpose of any amalgamation, or merger of, or compromise in, or alteration of the capital of any company in which the Trust holds shares, stocks, debentures or units;

15 to guarantee the obligations of any Person (other than a Trustee) whatsoever and to bind the Trust as surety for and co-principal debtor *in solidum* with any Person whatsoever;

16 to give receipts, releases or other effectual discharges for any sum of money or thing recovered;

17 to engage the services of professional practitioners of whatsoever nature and tradesmen of whatsoever nature for the performance of work and rendering of services necessary for or incidental to the affairs of the Trust;

18 to pay out of the funds of the Trust all debts incurred on behalf of the Trust by the Trustees in the exercise of their powers in terms hereof;

19 to make donations for charitable or other purposes from the income of the Trust Assets;

20 to accept on behalf of the Trust all or any donations from any Person whatsoever;

21 to enter into any of the transactions aforesaid (including the purchase or sale of any movable, immovable or incorporeal property, the lending or borrowing of money and/or the furnishing or obtaining of suretyships and/or guarantees) with or in favour of or from or for the benefit of the Members or any of them and/or any company, firm, business, partnership or venture with or in which they or any of them are associated and without any necessity for any court order to sanction or approve any such transaction;

22 to enter into any partnership, joint venture or other association, with any other Person for the doing or performance of any transaction or series of transactions within the powers of the Trustees in terms hereof;

23 to do all or any of the foregoing things and to exercise all or any of the foregoing rights and powers in South Africa or in any other part of the world;

24 to exercise, at any time, any rights of conversion to or subscription for any shares in the capital of any company which are held as Trust Assets or, at their discretion, to sell or realise any such rights;

25 from time to time to use any voting rights attached to any shares held by the Trust in such manner as they in their discretion may determine, including to cause changes to be made to the board of directors or in the other offices of any of the companies involved and they shall be entitled to appoint or cause to be appointed any one or more of themselves as directors or officers or cause some other person or persons to be so appointed on the basis that such director or officer will have the right to retain remuneration for his services as director or other officer;

26 to enter into any shareholders, voting pool or similar agreement in respect of any shares held by the Trust even if such agreement relates to or restricts the Disposal of those shares or grants rights of pre-emption to any other Person;

27 to agree to any alteration or conversion of the capital of any company if shares of the company form part of the Trust Assets;

28 to enter into contracts on behalf of the Trust and to adopt and accept for the Trust benefits under contracts entered into for the benefit of the Trust, whether before or after its creation;

29 to authorise any one or more Trustees, Trust officers or any other person as it may determine, upon such terms and conditions as it may determine, to negotiate, finalise and/or sign any contract or other document binding the Trust or any document authorising the performance of any act on behalf of the Trust;

30 to register the Trust with all such bodies and for all such purposes as the Trustees in their discretion deem appropriate;

31 to –

31.1 establish any contributory or non-contributory pension, retirement, provident, medical or other funds for the benefit of; and

31.2 pay on behalf of the Trust a gratuity or pension or allowance on retirement or other benefit to,

any Trustee or ex-Trustee or other officer or employee of the Trust, its holding or Subsidiary (if any), whether or not he has held any other salaried office with the Trust, or to his widow or dependents, and may make contributions to any fund and pay premiums for the purchase or provision of any such gratuity, pension or allowance or life assurance or other benefits;

32 to exercise such further rights, powers and authorities as may from time to time be conferred upon them by a majority of Members or be required or convenient for achieving the Trust Objects;

33 generally, to do all such things as may be expedient to further the interests, aims or objectives of the Trust or which are incumbent or necessary or conducive thereto or to the exercise of any powers of the Trustees.

ANNEXURE C – MASTER CONTRACT
PPS PROVIDER™ POLICY
Policy Document
Version 1
Changes to the Policy Document which became effective on 1 March 2015 are included in this document

1. DEFINITIONS

In the PPS ProviderÊ Policy the following words have the following meaning unless the context clearly indicates a contrary intention:

Contract	The agreement between the Policyholder and PPS Insurance, constituting a long-term policy as defined in the Long-term Insurance Act, in terms of which PPS Insurance agrees to provide benefits against payment of premiums. The latest Policy Certificate issued by PPS Insurance together with the PPS ProviderÊ Policy Document and any endorsement thereto, forms the contract between the Policyholder and PPS Insurance.
Policy	Has the same meaning as ñcontractò
Declared Annual Increases	Annual increases in benefits declared at the sole discretion of PPS Insurance to reduce the eroding effects of inflation.
Sickness	Any significant inability to carry out the life insuredôs usual professional duties due to disease, injury, accident or other cause or condition, requiring optimal medical or dental treatment or supervision in the form of hospitalisation, surgery, rehabilitation or medication.
Life insured	The person to whose life, or to the functional ability or health of whose mind or body, this long-term policy relates. The name of the Life insured is reflected on the latest policy certificate issued by PPS Insurance. The Life insured is the same person as the Policyholder.
Policyholder	The person who owns the policy and who is, subject to the terms and conditions of the PPS ProviderÊ Policy, entitled to be provided with the policy benefits under this long-term policy. The name of the Policyholder is reflected on the latest Policy Certificate issued by PPS Insurance. The Life insured is the same person as the Policyholder.
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.
Sum Assured	The Sum Assured applicable to the particular benefit as set out in the Policy Certificate including any reductions or increases in the Sum Assured as allowed for in the Policy Document regardless of whether a new Policy Certificate was issued to reflect such increased or reduced Sum Assured.
Premium(s)	The amount of money, which must be paid for policy benefits, including premium increases, if applicable.
PPS Insurance	Professional Provident Society Insurance Company Limited (Registration Number 2001/017730/06).
Professional Provident Society Holdings Trust	Professional Provident Society Holdings Trust (Trust Number IT 312/2011).

In the PPS ProviderÊ Policy, unless the context clearly indicates a contrary intention:

1. the words importing only one gender shall include the other gender;
2. the singular shall include the plural and vice versa.

2. PPS INSURANCE

PPS Insurance means PROFESSIONAL PROVIDENT SOCIETY INSURANCE COMPANY LIMITED (Registration Number 2001/017730/06). PPS Insurance is a Long-term Insurer, registered in terms of the Long-term Insurance Act, 1998 and regulated by the Financial Services

Board. PPS Insurance is registered as a Financial Services Provider in terms of the Financial Advisory and Intermediary Services Act, 2002 ï license number 1044.

PPS Insurance is a member of the Association for Savings and Investment in South Africa (ASISA) and is subject to the Codes of Conduct prescribed by the association.

The Policyholder can contact PPS Insurance if any information or assistance is required. PPS Insurance cannot assist the Policyholder with financial advice. For financial advice the Policyholder must contact his Financial Adviser.

3. FINANCIAL ADVISER

The Financial Adviser has a duty to furnish the policyholder with his personal details in the form of a Provider and Representative Disclosure Letter.

PPS Insurance is only responsible for the financial advice or intermediary services provided by a Financial Adviser that is an authorised representative of PPS Insurance if that Financial Adviser acts in terms of his contract with PPS Insurance.

4. COMMUNICATING WITH THE POLICYHOLDER

PPS Insurance can deal with the Policyholder and his affairs electronically and all parties must treat electronic communication (E-mail, fax, telephone etc.) as being the same as written communication, authority and confirmation. Where the Policyholder chooses to use such electronic methods to transact with PPS Insurance, the Policyholder will carry the risk of such use.

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 Vested PPS Profit-Share Account option (Please refer to the section titled THE PPS PROFIT-SHARE ACCOUNT™ for the requirements in this regard); and
2. with respect to whom PPS Insurance did not implement the Vested PPS Profit-Share Account option (Please refer to the section titled THE PPS PROFIT-SHARE ACCOUNT™ for the requirements in this regard); and
3. with respect to whom the PPS Profit-Share Account™ was not paid out for whatever reason (Please refer to the section titled THE PPS PROFIT-SHARE 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 ñany other participant in any product offered by PPS Insuranceò 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 ProviderÊ 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 ProviderÊ Policy Document provides comprehensive information about all the products and benefits offered in terms of the PPS ProviderÊ 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 ProviderÊ Policy must correspond with the version number of the PPS ProviderÊ Policy as reflected on the latest Policy Certificate issued by PPS Insurance. It is possible that different versions of the PPS ProviderÊ Policy may be applicable to different products and / or benefits selected by the Policyholder.

6. AMENDING THE TERMS OF THE PPS PROVIDER™ POLICY

The Policyholder may from time to time require changes to the products, benefits or terms of the PPS ProviderÊ Policy as the Policyholderôs circumstances change.

The PPS ProviderÊ Policy Document reflects the products, benefits or terms that can be changed and the circumstances under which such changes will be effected subject to the approval and / or conditions imposed by PPS Insurance.

Requests for changes should be in writing and in the manner prescribed by PPS Insurance from time to time, signed by the Policyholder and sent to PPS Insurance.

No changes to the initial contract will be valid unless PPS Insurance issues a new Policy Certificate reflecting the new products, benefits or terms. The latest Policy Certificate issued by PPS Insurance will always replace all previously issued Policy Certificates with respect to this policy.

If the policyholder applies to PPS Insurance for the reduction of the Sum Assured of any product or benefit, PPS Insurance can allow the reduction in its sole discretion and upon terms and conditions, including minimum Sum Assured as determined by PPS Insurance from time to time. Upon the reduction of the Sum Assured the last additional cover taken out will be reduced first. This will lead to the removal of loadings and exclusions relating solely to the portion of the Sum Assured being cancelled.

Please refer to the sections titled BENEFICIARIES and CESSIONS for the requirements regarding cession notifications and beneficiary nominations.

PPS Insurance may change the contractual terms of the policy, without compensating the Policyholder, if any laws or practices affecting this policy are changed.

PPS Insurance may in its sole discretion, by way of endorsement:

- amend or rescind any of the provisions contained in this policy; and
- make new provisions in addition to or in substitution of any of the provisions contained in this policy.

Policyholders will be informed in advance of such endorsements to the contract in writing.

7. COOLING OFF PERIOD

The Policyholder may:

a) where no claims have been made with respect to the insurance transaction or an event insured against has not yet occurred; and

b) within a period of 30 days of receipt of a Policy Summary,

cancel the insurance transaction in respect of which the Policy Summary is sent, by sending a written cancellation notice to PPS Insurance.

All premiums paid by the Policyholder to PPS Insurance in terms of the cancelled insurance transaction shall be refunded to the Policyholder subject to the deduction of the cost of any risk cover actually enjoyed by the Policyholder.

An ñinsurance transactionò means the entering into or amendment of a policy and includes variations of such policy, for example the purchase of additional products or benefits or cancellation of products or benefits, resulting in a change to the premium, products and / or benefits in terms of the policy. The cooling off period is not applicable to any contractually pre-determined or determinable variation.

8. CANCELLING THE PPS PROVIDER™ POLICY OR PRODUCTS OR BENEFITS IN TERMS OF THE PPS PROVIDER™ POLICY

The Policyholder has the right to cancel the PPS ProviderÊ Policy or any products or benefits in terms of the PPS ProviderÊ Policy by written cancellation notice to PPS Insurance. The effective date of the cancellation will be the last day of the calendar month during which PPS Insurance received the written cancellation notice from the Policyholder. Please refer to the specific products or benefits in this PPS ProviderÊ Policy Document to determine whether any benefits will be payable to the Policyholder upon such cancellation.

The Policyholder acknowledges being aware that a cancellation as aforementioned or the replacement of a policy may, for various reasons, not be in the interest of the Policyholder. When a policy is replaced by another insurance policy the Policyholder must complete the appropriate replacement form and annex it to the application form for the replacement policy.

If the Policyholder cancels the PPS ProviderÊ Policy or products or benefits in terms of the PPS ProviderÊ Policy, PPS Insurance will not be liable for the payment of any Sum Assured or portion thereof in respect of the products or benefits that were cancelled, after the last day of the calendar month during which PPS Insurance received the written cancellation notice from the Policyholder.

9. THE DURATION OF THE PPS PROVIDER™ POLICY

Commencement

The commencement date of the contract between the Policyholder and PPS Insurance is reflected on the latest Policy Certificate issued by PPS Insurance.

The commencement date of the Policyholderôs entitlement to the products or benefits is reflected on the latest Policy Certificate issued by PPS Insurance, subject to the provisions of paragraphs 24.1 and 24.2 of this Policy Document.

The Benefit Term

The benefit terms of the respective products or benefits are reflected on the latest Policy Certificate issued by PPS Insurance.

Termination

The PPS ProviderÊ Policy will terminate upon the first of the following events occurring:

1. on the day when the life insured no longer is eligible for membership of the Professional Provident Society Holdings Trust; or
2. on cancellation of the PPS ProviderÊ Policy by the Policyholder; or
3. on cancellation of the PPS ProviderÊ Policy by PPS Insurance; or
4. when PPS Insurance has performed all its contractual obligations; or
5. on the death of the life insured.

Where the Policyholder is a Student Policyholder, all products and benefits in terms of the PPS ProviderÊ Policy will terminate on the last day of the month during which the Student Policyholder attains the age of 34 years, if, on that day he has not yet qualified for the relevant degree or other tertiary qualification required by PPS Insurance for membership of the Professional Provident Society Holdings Trust.

10. THE POLICYHOLDER'S CONTRACTUAL RIGHTS

If the Policyholder meets his contractual obligations, the Policyholder will be entitled to:

1. the products or benefits reflected on the latest Policy Certificate issued by PPS Insurance, unless there is a valid and enforceable beneficiary nomination or a valid and enforceable cession in place in respect of that benefit, and subject to the terms of the PPS ProviderÊ Policy.
2. information regarding the contract between the Policyholder and PPS Insurance, unless the information is protected from disclosure.
3. personal information being kept confidential, subject to the limitations contained in the application form signed by the Policyholder, the terms of the Promotion of Access to Information Act, 2000, the terms of the Financial Intelligence Centre Act, 2001, or any other relevant legislation.
4. appoint or change a beneficiary, subject to the conditions contained under BENEFICIARIES in this PPS ProviderÊ Policy Document.
5. cede this policy, subject to the conditions contained under CESSIONS in this PPS ProviderÊ Policy Document.

11. THE POLICYHOLDER'S CONTRACTUAL OBLIGATIONS

The Policyholder is obliged to:

1. ensure that PPS Insurance underwriting and claims requirements are complied with within a reasonable time.
2. ensure that full and honest disclosure of all material factors concerning the assessment of risk and any claim have been made to PPS Insurance.
3. comply with the terms and conditions contained in this PPS ProviderÊ Policy Document.

12. THE LAW

The laws of the Republic of South Africa govern this policy.

13. CURRENCY

All amounts payable in terms of this policy must be paid in the currency of the Republic of South Africa in South Africa.

14. JURISDICTION and LEGAL ADDRESS

The courts having jurisdiction over Johannesburg will have jurisdiction in all legal proceedings that may arise between the Policyholder and PPS Insurance. Process in any legal proceedings against PPS Insurance may be served at the Head Office located at:

PPS Insurance
6 Anerley Road
Parktown

The physical address of the Policyholder as reflected on the latest Policy Certificate Issued by PPS Insurance shall be the chosen *domicilium citandi et executandi* and address for all purposes under this PPS ProviderÊ Policy.

15. BENEFICIARIES

Subject to the rights of any cessionary, the Policyholder is entitled to nominate beneficiaries with respect to products or benefits. Beneficiaries must be nominated in writing in the manner

prescribed by PPS Insurance from time to time. Beneficiaries will be reflected in the latest Policy Certificate issued by PPS Insurance.

Beneficiaries will be entitled to the percentage of the Sum Assured as reflected on the **PPS Insurance Beneficiary Nomination Form** and Policy Certificate, payable in terms of specific benefits upon the death of the life insured.

If no beneficiaries are nominated with respect to a benefit or a percentage of that benefit, that benefit will be paid to the Policyholderõs estate to be dealt with by the Executor in terms of the laws governing testate or intestate succession.

Revocation of existing beneficiary nominations and beneficiary nominations will not be valid, unless a **PPS Insurance Beneficiary Nomination Form** is duly completed, signed by the Policyholder, and reached the head office of PPS Insurance before the insured event occurred.

In the event of a valid cession, the beneficiary nomination will not be cancelled or otherwise affected, but the cession will take precedence over the beneficiary nomination. Please refer to the section titled CESSIONS.

16. CESSIONS

The Policyholder may not cede the PPS ProviderÊ Policy in any way except as provided for in the PPS ProviderÊ Policy Document under the headings **Partial Security Cessions** and **Complete Security Cessions.**

The Policyholder cannot cede products or benefits during a period when PPS Insurance agreed to a temporary cessation of payment of premiums. PPS Insurance will not allow a temporary cessation of payment of premiums when any products or benefits are ceded.

PPS Insurance is not a party to any cession agreement between the Policyholder and the third party and PPS Insurance is not responsible for the wording of or the appropriateness or efficacy of the cession in relation to the Policyholderõs requirements. PPS Insurance will not interpret the agreement between the Policyholder and the third party in respect of the cession. PPS Insurance will act in terms of the information contained in the relevant PPS Insurance **Cession Notification Form.**

Notwithstanding notification of the cession, PPS Insurance bears no responsibility for the validity, enforceability or any other matter arising from the cession. PPS Insurance will not act on a cession unless PPS Insurance received the relevant duly completed PPS Insurance **Cession Notification Form** signed by the Policyholder and submitted to PPS Insurance before the insured event occurred.

Partial Security Cessions

The Policyholder is entitled to cede a part of his rights to the following products, including all the benefits under that product, to a third party as security:

- THE PPS PROFESSIONAL LIFE PROVIDERÊ PRODUCT
- THE PPS PROFESSIONAL HEALTH PROVIDERÊ PRODUCT
- THE PPS ACCIDENTAL DEATH PRODUCT

The Policyholder may only part cede a product in its entirety as aforementioned. The Policyholder cannot part cede only certain benefits under a product. Where a product is part ceded the amount ceded will be paid from the first valid claim under any one of the benefits under the ceded product.

Where the PPS PROFESSIONAL LIFE PROVIDERÊ PRODUCT is part ceded for security, the amount ceded to the cessionary/ies will be paid to the security cessionary/ies by PPS Insurance from the proceeds of the:

- TERM LIFE COVER benefit and / or the WHOLE LIFE COVER benefit in the event of a valid claim; and / or
- TERMINAL ILLNESS BENEFIT in the event of a valid claim; and / or
- PROFESSIONAL DISABILITY BENEFIT in the event of a valid claim; and / or
- OSRB PROFESSIONAL DISABILITY BENEFIT in the event of a valid claim; and / or
- TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT and / or the WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT in the event of a valid claim; and / or
- TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER and / or the WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER in the event of a valid claim; and / or ACCIDENTAL DEATH BENEFIT in the event of a valid claim; and / or
- ACCELERATED CatchAll Cover in the event of a valid claim.
- The IMMEDIATE NEEDS BENEFIT will be suspended until the cancellation of the Partial Security Cession.

Where the PPS ACCIDENTAL DEATH PRODUCT is part ceded for security, the amount ceded to the cessionary/ies will be paid to the security cessionary/ies by PPS Insurance from the proceeds of the:

- ACCIDENTAL DEATH BENEFIT in the event of a valid claim.

Where the PPS PROFESSIONAL HEALTH PROVIDERÊ PRODUCT is part ceded for security the amount ceded to the cessionary/ies will be paid to the security cessionary/ies by PPS Insurance from the proceeds of the:

- TERM PPS PROFESSIONAL HEALTH PROVIDERÊ BENEFIT and / or the WHOLE LIFE PPS PROFESSIONAL HEALTH PROVIDERÊ BENEFIT in the event of a valid claim; and / or
- TERM PPS PROFESSIONAL HEALTH PROVIDERÊ BENEFIT with CORE 100% COVER and / or the WHOLE LIFE PPS PROFESSIONAL HEALTH PROVIDERÊ BENEFIT with CORE 100% COVER in the event of a valid claim; and / or
- CATCHALL COVER in the event of a valid claim; and / or
- MATERNITY COVER in the event of a valid claim.

Upon payment of the amount ceded to the security cessionary by PPS Insurance, the partial security cession will be cancelled.

The aforementioned products may not be part ceded as security for an amount of less than R250 000 or such other amount that PPS Insurance, in its sole discretion may decide on from time to time.

The aforementioned products may be part ceded to more than one security cessionary, but it may never be part ceded to more than 4 different security cessionaries at the same time.

If the Policyholder informs PPS Insurance of the fact that he part ceded his rights to the aforementioned products for security to a third party by completing a PPS Insurance **Part Security Cession Notification Form**, signed by the Policyholder, and such form is submitted to PPS Insurance before the insured event occurred:

1. PPS Insurance will issue a new Policy Certificate reflecting the security cessionary;
2. The amount ceded as security will be reflected on the Policy Certificate and PPS Insurance will pay that amount to the security cessionary in the event of a valid claim.
3. If the Policyholder informs PPS Insurance on the PPS Insurance **Part Security Cession Notification Form** that his rights as aforesaid are ceded to more than one security cessionary, all the security cessionaries will be reflected on the Policy Certificate.
4. A part security cession will not cancel or otherwise affect the nomination of beneficiaries by the Policyholder, but the part security cession will take precedence over the nomination of beneficiaries. Any benefits payable in excess of the amounts payable to

the part security cessionaries will be paid by PPS Insurance to the nominated beneficiaries. Accordingly, all amounts ceded to the part cessionary/ies will be a first charge against the insurance benefits, and the beneficiaries will be entitled to only the balance, if any, after discharge of the Policyholderõs liability to the cessionary/ies secured by the cession.

Complete Security Cessions

The Policyholder is entitled to cede his rights to the following products to a third party as security:

- THE PPS PROFESSIONAL LIFE PROVIDERÊ PRODUCT
- THE PPS PROFESSIONAL HEALTH PROVIDERÊ PRODUCT
- THE PPS ACCIDENTAL DEATH PRODUCT

Where the PPS PROFESSIONAL LIFE PROVIDERÊ PRODUCT is ceded for security all the proceeds of the:

- TERM LIFE COVER benefit and the WHOLE LIFE COVER benefit will be paid to the security cessionary in the event of a valid claim;
- TERMINAL ILLNESS BENEFIT will be paid to the security cessionary in the event of a valid claim;
- PROFESSIONAL DISABILITY BENEFIT will be paid to the security cessionary in the event of a valid claim;
- OSRB PROFESSIONAL DISABILITY BENEFIT will be paid to the security cessionary in the event of a valid claim;
- TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT and the WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT will be paid to the security cessionary in the event of a valid claim;
- TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER and the WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER will be paid to the security cessionary in the event of a valid claim;
- ACCELERATED CATCHALL COVER will be paid to the security cessionary in the event of a valid claim;
- The ACCIDENTAL DEATH BENEFIT will be paid to the security cessionary in the event of a valid claim.
- The IMMEDIATE NEEDS BENEFIT will be suspended until the cancellation of the Complete Security Cession.

Where the PPS ACCIDENTAL DEATH PRODUCT is ceded for security all the proceeds of the:

- ACCIDENTAL DEATH BENEFIT COVER will be paid to the security cessionary in the event of a valid claim.

Where the PPS PROFESSIONAL HEALTH PROVIDERÊ PRODUCT is ceded for security all the proceeds of the:

- TERM PPS PROFESSIONAL HEALTH PROVIDERÊ BENEFIT and the WHOLE LIFE PPS PROFESSIONAL HEALTH PROVIDERÊ BENEFIT will be paid to the security cessionary in the event of a valid claim;
- TERM PPS PROFESSIONAL HEALTH PROVIDERÊ BENEFIT with CORE 100% COVER and the WHOLE LIFE PPS PROFESSIONAL HEALTH PROVIDERÊ BENEFIT with CORE 100% COVER will be paid to the security cessionary in the event of a valid claim;
- CATCHALL COVER will be paid to the security cessionary in the event of a valid claim;
- MATERNITY COVER will be paid to the security cessionary in the event of a valid claim.

If the Policyholder informs PPS Insurance of the fact that he complete ceded his rights to the aforementioned products for security to a third party by completing a PPS Insurance **Complete**

Security Cession Notification Form, signed by the Policyholder, and such form is submitted to PPS Insurance before the insured event occurred:

1. PPS Insurance will issue a new Policy Certificate reflecting the security cessionary;
2. The complete security cession will not cancel or otherwise affect the nomination of beneficiaries by the Policyholder, but the complete security cession will take precedence over the nomination of beneficiaries;
3. Until the cancellation of the complete security cession by the cessionary, no changes may be made to the benefits or products. Declared annual increases in products or benefits will however continue, unless the policyholder specifically requested declared annual increases to cease when the **Complete Security Cession Notification Form** was completed.

If the security cessionary informs PPS Insurance of the cancellation of a security cession in writing and PPS Insurance is informed as aforesaid before the insured event occurred:

1. PPS Insurance will issue a new Policy Certificate on which the security cessionary will no longer be reflected as a security cessionary.
2. The rights of the security cessionary will terminate.

17. CHANGE OF OCCUPATION

The Policyholder will inform PPS Insurance in writing of a change in the life insuredôs occupation; or if the life insured is no longer substantially practising the occupation reflected on the latest Policy Certificate issued by PPS Insurance, within 30 days from the date on which the life insured changed his occupation or no longer substantially practices the occupation reflected on the latest Policy Certificate issued by PPS Insurance.

PPS Insurance is entitled, in its sole discretion:

- to cancel the PPS ProviderÊ Policy or products or benefits there under from the end of the month during which the life insuredôs occupation changed or the life insured no longer substantially practices the occupation reflected on the latest Policy Certificate issued by PPS Insurance. If PPS Insurance cancels the PPS ProviderÊ Policy or benefits there under, PPS Insurance will return all premiums paid from the date of cancellation, but PPS Insurance will be entitled to deduct all costs incurred as a result of the Policyholderôs failure to inform PPS Insurance as aforesaid before refunding the premiums.
- to review the terms of the products or benefits granted from the end of the month during which the life insuredôs occupation changed or the life insured no longer substantially practices the occupation reflected on the latest Policy Certificate issued by PPS Insurance. If PPS Insurance changes the terms or the benefits, PPS Insurance will inform the Policyholder of the new terms and a new Policy Certificate reflecting the new terms will be issued.

18. CHANGES IN SMOKING STATUS

Premiums may be paid on smoking or non-smoking rates depending on the smoking status of the life insured. The smoking status of the life insured is reflected on the latest Policy Certificate issued by PPS Insurance.

A Policyholder who is paying a premium based on smoking rates may apply to PPS Insurance to pay a premium as a non-smoker provided that:

- The life insured undergoes a cotinine test at the time of applying for any cover or increased cover confirming his status as a non-smoker; and
- After a waiting period of twelve months a further cotinine test performed on the life insured confirms his status as a non-smoker.
- The life insured may be obliged to undergo a further cotinine test at the time of making any claim.
- The premium will revert to smoker rates from the beginning of any month in which the life insured starts smoking again.

PPS Insurance may allow the change of the premium based on smoking rates to a premium based on non-smoking rates in its sole discretion and upon terms and conditions as determined by PPS Insurance from time to time.

The Policyholder must inform PPS Insurance in writing if the life insured starts smoking.

The Policyholder warrants that the life insured will be a non-smoker as long as premiums are paid on non-smoking rates.

PPS Insurance is entitled to review the terms of the policy if the life insured starts smoking.

19. MATERIAL NON-DISCLOSURES and MISREPRESENTATIONS

If the Policyholder made any representation to PPS Insurance which representation is not true in all respects; or if the Policyholder failed to disclose any information to PPS Insurance, which information materially affected the assessment of the risk by PPS Insurance at the time of the issue or at the time of any variation of the policy, PPS Insurance may in its discretion:

- terminate from the date of such misrepresentation or from any date thereafter, this PPS ProviderÊ Policy or terminate the products or benefits to which such misrepresentation relates or exclude from such cover any product or benefit to which the misrepresentation relates; or
- impose any additional premium, limitation or condition which it could have imposed had such misrepresentation not been made with effect from such date as PPS Insurance may determine.

The Policyholder has an obligation to disclose all material information. If there has been a deterioration in the state of health of the life insured between the date of his application for any products or benefits in terms of the PPS ProviderÊ Policy and the date on which the entitlement to the product or benefit commences, the policyholder must advise PPS Insurance in writing of such a deterioration of health, upon which PPS Insurance will be entitled in its absolute discretion, to re-assess the risk and the conditions upon which the cover was granted.

A representation or non-disclosure shall be regarded as material if a reasonable, prudent person would consider that the particular information constituting the representation or which was not disclosed, as the case may be, should have been correctly disclosed to PPS Insurance so that PPS Insurance could form its own view as to the effect of such information on the assessment of the relevant risk.

PPS Insurance will adjust the product and / or benefit if the life insuredôs date of birth was misrepresented to PPS Insurance. The adjusted product and / or benefit will be equal to that which could have been secured by the premiums paid, if the correct age was disclosed. If the product and / or benefit would not have been granted had the life insuredôs correct age been disclosed, PPS Insurance will cancel the product and / or benefit from inception. Upon cancellation as aforesaid, PPS Insurance will return the premiums from the date of cancellation after deducting all costs and expenses incurred by PPS Insurance.

The Policyholder has a continuous duty of good faith whenever dealing with PPS Insurance for the duration of this policy. PPS Insurance will be entitled to cancel the policy, products or benefits from inception if the policyholder breaches this duty of good faith in any way.

20. PREMIUMS

The premium initially payable by the Policyholder in respect of the products and benefits selected by the Policyholder is reflected in the latest Policy Certificate issued by PPS Insurance.

The premium pattern can be:

- **Age Related:** the premiums increase each year on the 1st of the month following the life insuredôs birthday or on such a date or intervals as determined by PPS. The increases may follow the underlying risk curve applicable to the benefits as determined by PPS Insurance in its sole discretion or may be a pre-determined percentage increase. The pre-determined increases are reflected on the latest Policy Certificate issued by PPS Insurance.

- **PPS Whole Life:** the premiums increase each year on the 1st of the month following the life insuredôs birthday. The percentage increases pre-retirement are based on PPS Insurancecôs expectation of a typical professionalôs likely earnings progression pre-retirement, and for post-retirement are based on current expectations of inflation. The percentage increases combine initial affordability (where earnings increases at younger ages are low) with subsequent increases in the professionalôs significant earning years, which allows PPS Insurance to restrict post-retirement premium increases to be more closely aligned to current expectations of inflation, rather than the underlying risk curve increases. The percentage increases are determined by PPS Insurance in its sole discretion. This premium pattern is applicable to whole life benefits.

- **Level:** a level premium pattern may be selected on certain products. The premium pattern selected is reflected on the latest Policy Certificate issued by PPS Insurance.

The premium pattern applicable to the respective products or benefits is reflected on the latest Policy Certificate issued by PPS Insurance.

At the sole discretion of PPS Insurance, annual increases in benefits may be declared to reduce the eroding effects of inflation. Benefits will increase by the declared percentage for effective cover on the 1st of January each year. The premium for additional benefits will be based on the life insuredôs age next birthday at the time of the increase.

The premium rates are not guaranteed and may be revised from time to time at the discretion of PPS Insurance. Policyholders will be given notice in advance of any changes to the premiums.

Premiums are payable monthly, quarterly, semi-annually or annually in advance. For products and / or benefits that the policyholder had on or before 1 June 2010, a discount of 5% will be granted on premiums paid twelve months in advance and a discount of 2.5% will be granted on premiums paid six months in advance.

A premium will be regarded as being paid once PPS Insurancecôs bank account has been credited and provided that payment is not subsequently reversed.

Subject to the provisions of paragraphs 24.1 and 24.2 of this Policy Document, all products and benefits in terms of this PPS ProviderÊ Policy are suspended until PPS Insurance receives the first premium payable in respect of that benefit.

Premiums shall be paid on or before the fifteenth day of the month in which the premium is payable.

PPS Insurance will inform the Policyholder of a premium default if the premiums are not paid on the due date. If the premiums are not paid within sixty days from the due date PPS Insurance will cancel the policy, product or benefit in respect of which the premium is outstanding and no further benefits in terms of the cancelled policy, product or benefit will be available to the Policyholder.

If, within three calendar months after the date of cancellation of the policy, product or benefit by PPS Insurance due to the non-payment of premiums, the Policyholder applies to PPS Insurance in the manner prescribed by PPS Insurance for the policy, product or benefit to be reinstated, PPS Insurance may at its discretion and on receipt of such medical evidence as it may require,

reinstate the policy, product or benefit from the date of cancellation or any subsequent date subject to such conditions as it may determine.

Premiums may be paid on smoking or non-smoking rates depending on the smoking status of the life insured. Please refer to the section titled CHANGES IN SMOKING STATUS.

Premiums are payable until the termination of the policy, product or benefit in respect of that premium. Premiums will remain payable even in the event of a claim being admitted in respect of a benefit, unless the PPS ProviderÊ Policy specifically states that no further premiums will be payable by the policyholder or PPS Insurance informs the policyholder in writing that no further premiums are payable.

Temporary Cessation of Payment of Premiums
The Policyholder may be entitled to a temporary cessation of payment of premiums in respect of premiums for the SICKNESS AND PERMANENT INCAPACITY BENEFIT; TERM PROFESSIONAL HEALTH PROVIDER BENEFIT (which includes CATCHALL and MATERNITY COVER), WHOLE LIFE PROFESSIONAL HEALTH PROVIDER BENEFIT (which includes CATCHALL and MATERNITY COVER), TERM PPS PROFESSIONAL HEALTH PROVIDERÊ BENEFIT with CORE 100% COVER (which includes CATCHALL and MATERNITY COVER), WHOLE LIFE PPS PROFESSIONAL HEALTH PROVIDERÊ BENEFIT with CORE 100% COVER (which includes CATCHALL and MATERNITY COVER), DISABILITY COVER and / or the OSRB DISABILITY COVER.

A policyholder who has paid premiums for at least three months can apply to PPS Insurance in writing in the manner prescribed by PPS Insurance for a temporary cessation of payment of premiums prior to the cessation of premiums. PPS Insurance will inform the policyholder in writing whether it will allow a temporary cessation of premiums. PPS Insurance will not allow a temporary cessation of premiums during any period when the policy is ceded.

A policyholder can apply to PPS Insurance in writing in the manner prescribed by PPS Insurance for an extension of the abovementioned period at least 2 months before the end of the expiry of the period. PPS Insurance will inform the policyholder in writing whether it will allow an extension of the temporary cessation of payment of premiums.

In exercising its discretion, PPS Insurance may from time to time impose and amend the conditions upon which any temporary cessation of payment of premiums will be granted or extended including conditions relating to the period or maximum period or any extension thereof, the manner of application for such indulgence, the requirements of PPS Insurance as to medical and financial underwriting prior to resumption of payment of premiums, the amount of premiums to be paid on resumption thereof, the total number of periods of temporary cessation permitted during the period of the policy and the premiums to which the indulgence applies.

The policyholder may in the absolute discretion of PPS Insurance retain his benefit for a period not exceeding 12 months without payment of premiums in respect of such period provided that all premiums due up to the commencement of the period have been paid. An insured event that occurs during this period, and the three months following the expiry of such period, will be excluded.

If the policyholder wishes to reduce the period of the cessation of premiums after PPS Insurance agreed to the temporary cessation in writing, PPS Insurance may at its discretion and on receipt of such medical evidence as it may require, reduce the period of cessation of premiums subject to such conditions and terms as it may determine. The aforementioned conditions and terms may include loadings or exclusions.

21. THE CLAIMS PROCESS

The benefits in terms of the PPS ProviderÊ Policy will be paid once the Policyholder has complied with PPS Insurance's claims requirements, PPS Insurance are in receipt of all the information requested by PPS Insurance to assess the claim, PPS Insurance is satisfied that the insured event occurred and PPS Insurance has established that the person claiming the benefits is entitled thereto. PPS Insurance may request all information and evidence which it considers necessary to determine the admissibility and amount of the claim. This may include but is not limited to the completion of forms and obtaining of reports.

Claims for benefits in terms of the PPS ProviderÊ Policy must be submitted to PPS Insurance in writing on a PPS Insurance claim form. Claim forms can be obtained from PPS Insurance. Please refer to the section titled LATE SUBMISSION OF CLAIMS.

PPS Insurance reserves the right to have the life insured medically examined, by medical advisers or other suitably qualified persons appointed by PPS Insurance, to determine the validity of the claim. If the life insured fails to undergo the medical examination PPS Insurance will not pay benefits in respect of the claim.

PPS Insurance is entitled to deduct from any benefits payable in terms of this policy any sum or sums owing by the Policyholder to PPS Insurance.

Unclaimed Benefits

In the event that the policyholder becomes entitled to payment of any benefits in terms of the PPS Provider Policy PPS Insurance will attempt to contact the policyholder in order to obtain instructions in respect of the bank account into which the benefits should be paid, should the bank account details not have been provided. In the event that PPS Insurance, despite its reasonable efforts to contact the policyholder, is unsuccessful in obtaining instructions from the policyholder as aforesaid any PPS Profit-Share Account benefits will be paid into the bank account from which the premiums in respect of the PPS Provider benefits were being paid at the time that the PPS Profit-Share Account benefits first became due to the policyholder (the premium paying account). All other benefits will be deemed to be unclaimed benefits and will not be paid out until PPS received clear instructions on payment from the policyholder or beneficiaries, as the case may be. PPS will comply with the Association for Savings and Investment SA (ASISA's) prescribed tracing process in its attempts to procure instructions from the policyholder or beneficiaries, as the case may be.

ASISA's prescribed tracing process for unclaimed benefits involves, amongst other things, the following:

- PPS Insurance will attempt to contact the policyholder in order to advise him of the available benefits;
- In the event that PPS Insurance is unsuccessful in its initial efforts to contact the policyholder PPS Insurance will use reasonable efforts to determine the last known contact information and address of the policyholder by utilising the PPS Insurance internal database. Where appropriate PPS Insurance will also use reasonable efforts to compare the policyholder's contact information as it appears on the PPS Insurance database with information on an external database or databases;
- In the event that PPS Insurance is still unsuccessful in its efforts to contact the policyholder an external tracing company will be employed to trace the policyholder;
- Any direct administrative-, tracing- and management costs Incurred by PPS Insurance after a period of 6 months from the date on which the benefits first became due to the policyholder will be charged against the remaining value of the unclaimed benefits.

These costs may change from time to time and will be published in the annual correspondence that PPS Insurance sends to all of its policyholders every year;

- PPS Insurance will cease all attempts to trace the policyholder in the event that the remaining value of the unclaimed benefits is less than the minimum value prescribed by ASISA from time to time (R 1000. 00 as at 1 June 2013) and the costs of tracing exceed the benefits of tracing.

It is the policyholderÕs responsibility to ensure that his personal- and contact particulars, as reflected on the latest Policy Certificate issued by PPS Insurance, is correct. If this is not the case, or in the event that the policyholderÕs personal- and/or contact particulars change, it is the policyholderÕs responsibility to inform PPS Insurance in writing of the incorrect particulars or the change in particulars, as the case may be. PPS Insurance will not accept any responsibility for any loss, damages or inconvenience suffered by the policyholder, howsoever caused, as a direct or indirect result of incorrect personal- and/or contact particulars.

22. LATE SUBMISSION OF CLAIMS

Claims for benefits in terms of the PPS ProviderÊ Policy should be submitted as soon as possible after the occurrence of the event that gave rise to the claim in order to ensure efficient claims processing. A claim is submitted when PPS Insurance is in receipt of a duly completed PPS Insurance Claim Form. Claims submitted to PPS Insurance after the expiry of six months from the occurrence of the event giving rise to the claim will not be paid by PPS Insurance unless PPS Insurance is satisfied that the failure to submit the claim within the prescribed 6 months were unavoidable in the circumstances of the case.

23. LOADINGS AND EXCLUSIONS

Specific Underwriting Exclusions and Loadings

On application for any benefit or additional benefits in terms of the PPS ProviderÊ Policy, PPS Insurance will be entitled to add premium loadings and / or exclude any benefits.

PPS Insurance will not pay a claim for any benefit, if the claim falls within one of the excluded events.

Specific underwriting exclusions are reflected on the latest Policy Certificate issued by PPS Insurance.

Standard Exclusions

No benefits will be paid in terms of the PROFESSIONAL DISABILITY BENEFIT, OSRB PROFESSIONAL DISABILITY BENEFIT, DISABILITY COVER, SEVERE ILLNESS BENEFIT, OSRB DISABILITY COVER, TERM PROFESSIONAL HEALTH PROVIDER BENEFIT, WHOLE LIFE PROFESSIONAL HEALTH PROVIDER BENEFIT, TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT, WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT, TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER, WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER, ACCELERATED CATCHALL COVER, TERM PPS PROFESSIONAL HEALTH PROVIDERÊ BENEFIT with CORE 100% COVER, WHOLE LIFE PPS PROFESSIONAL HEALTH PROVIDERÊ BENEFIT with CORE 100% COVER, ACCIDENTAL DEATH BENEFIT, MATERNITY COVER, CATCHALL COVER, TERMINAL ILLNESS BENEFIT, SICKNESS BENEFIT, PERMANENT INCAPACITY BENEFIT, HOSPITAL RIDER BENEFIT, FAMILY HOSPITAL BENEFIT AND PERMANENT INCAPACITY BOOSTER BENEFIT if a claim for benefits arose directly or indirectly from any of the following events:

1. deliberate involvement of the life insured in war, invasion, hostility, civil war, rebellion, act of foreign enemy, warlike operations and accidental or deliberate explosion of weapons of war, during war or as a result of previous war;

2. deliberate involvement of the life insured in terrorism, sabotage, or other acts involving violence or the use of force or not, which acts, from its nature or context are done in connection with political, social, religious, ideological or similar causes or objectives;
3. deliberate involvement in strikes, labour disturbances, riots and civil commotion;
4. atomic energy, nuclear fission or reaction;
5. directly or indirectly attributable to, continued by or aggravated by excessive indulgence in liquour or drugs, immorality or disorderly conduct;
6. directly or indirectly attributable to, continued by or aggravated by intentionally self-inflicted or intentionally self-induced events, circumstances, disease, illness, injury or disability.
7. the result of the consumption of a poisonous substance that would be known by a reasonable person to be harmful;
8. due to an act committed by the life insured that constitutes a breach of any law.

No benefits will be paid in terms of the TERM LIFE COVER or WHOLE LIFE COVER (which includes the IMMEDIATE NEEDS BENEFIT) if the death of the life insured is the result of suicide, while sane or insane, committed within 24 months after either the date of commencement or, where applicable, the date of reinstatement of cover or in the event of the execution of the death sentence on account of an offence committed before or within 24 months after commencement or reinstatement of cover.

No benefits for the increased Sum Assured will be paid in terms of the TERM LIFE COVER or WHOLE LIFE COVER (which includes the IMMEDIATE NEEDS BENEFIT) if the death of the life insured is the result of suicide, while sane or insane, committed within 24 months after the commencement of the increase of the Sum Assured, or in the event of the execution of the death sentence on account of an offence committed before or within 24 months after commencement of the increase of the Sum Assured.

No benefits will be paid in respect of any products or benefits if the insured event occurred during a period of Temporary Cessation of Payment of Premiums and the three months following the expiry of such period (Please refer to the section titled PREMIUMS).

There may be other exclusions applicable to specific products or benefits in terms of the PPS ProviderÊ Policy. Please refer to the specific products and benefits in this regard.

The life insured is not restricted in regard to travel or residence or participating in hazardous pursuits.

BENEFITS IN TERMS OF THE PPS PROVIDER™ POLICY

24. OVERVIEW

This PPS ProviderÊ Policy contains comprehensive information regarding all the products and benefits available in terms of the PPS ProviderÊ Policy. Details of the products and benefits applicable to the Policyholder are reflected in the latest Policy Certificate issued by PPS Insurance. Subject to the provisions of paragraphs 24.1 and 24.2 of this Policy Document, the Policyholder is only entitled to the products and benefits reflected in the latest Policy Certificate issued by PPS Insurance. If a product or benefit is not reflected in the latest Policy Certificate issued by PPS Insurance, the Policyholder will not be entitled to such product or benefit.

The following PRODUCTS are available in terms of the PPS ProviderÊ Policy:

- THE PPS PROFESSIONAL LIFE PROVIDERÊ PRODUCT
- THE PPS ACCIDENTAL DEATH PRODUCT
- THE PPS PROFESSIONAL HEALTH PROVIDERÊ PRODUCT
- THE PPS PROFESSIONAL DISABILITY PROVIDERÊ PRODUCT
- THE SICKNESS AND PERMANENT INCAPACITY BENEFIT
- THE PPS KICKSTART PACKAGE
- Automatically included in the PPS ProviderÊ Policy: THE PPS PROFIT-SHARE ACCOUNT™

The following BENEFITS are available in terms of the PPS PROFESSIONAL LIFE PROVIDERÊ PRODUCT:

- TERM LIFE COVER, which automatically includes:
    - TERMINAL ILLNESS BENEFIT
    - IMMEDIATE NEEDS BENEFIT
- WHOLE LIFE COVER, which automatically includes:
    - TERMINAL ILLNESS BENEFIT
    - IMMEDIATE NEEDS BENEFIT
- Optional rider: ACCIDENTAL DEATH BENEFIT
- Optional rider: PROFESSIONAL DISABILITY BENEFIT
- Optional rider: PROFESSIONAL DISABILITY BENEFIT with Occupation Specific Rider BenefitÊ (OSRB PROFESSIONAL DISABILITY BENEFIT)
- Optional rider: TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT
- Optional rider: WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT Optional rider: TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER
- Optional rider: WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER
- Optional rider: ACCELERATED CATCHALL COVER

The following BENEFITS are available in terms of the PPS ACCIDENTAL DEATH PRODUCT:

- ACCIDENTAL DEATH BENEFIT

The following BENEFITS are available in terms of the PPS PROFESSIONAL HEALTH PROVIDERÊ PRODUCT:

- TERM PROFESSIONAL HEALTH PROVIDER BENEFIT
- WHOLE LIFE PROFESSIONAL HEALTH PROVIDER BENEFIT
- TERM PPS PROFESSIONAL HEALTH PROVIDERÊ BENEFIT with CORE 100% COVER
- WHOLE LIFE PPS PROFESSIONAL HEALTH PROVIDERÊ BENEFIT with CORE 100% COVER
- Optional rider: CATCHALL COVER

- Optional rider: MATERNITY COVER

The following BENEFITS are available in terms of the PPS PROFESSIONAL DISABILITY PROVIDERÊ PRODUCT:

- DISABILITY COVER
- DISABILITY COVER with Occupation Specific Rider BenefitÊ (OSRB DISABILITY COVER)
- SEVERE ILLNESS BENEFIT

The PPS KICKSTART PACKAGE consists of the following BENEFITS:

- ACCIDENTAL DEATH BENEFIT
- SICKNESS BENEFIT

24.1 THE IMMEDIATE COVER BENEFIT

Notwithstanding anything else contained in this Policy Document PPS shall, where a policyholder (the term ñpolicyholderò shall for the purpose of this clause 24.1 also include a prospective policyholder) has applied for life cover under the PPS Professional Life Provider product or the PPS Accidental Death product, pay the life cover sum assured to the policyholdersônominated beneficiaries in the event of a valid claim even though PPS has not yet granted the benefits applied for or issued a Policy Certificate in respect of such benefits.

The benefit will be paid to the beneficiaries nominated by the policyholder on his application form, or failing this to his estate.

Commencement

Cover in terms of the Immediate Cover Benefit will commence on the date that the policyholder submits a duly completed and signed application form for the PPS Professional Life Provider product or the PPS Accidental Death product to PPS Insurance, and the application form is recorded by the PPS Insurance Head Office in its records.

Termination

The Immediate Cover Benefit will end automatically on the first of the following events occurring:

- The date on which PPS communicates its underwriting decision in respect of the PPS Professional Life Provider product or the PPS Accidental Death product to the policyholder; or
- After a period of 30 (thirty) days has elapsed from the date on which the PPS Insurance Head Office recorded the duly completed and signed application form in its records.

Sum Assured

The sum assured in terms of the Immediate Cover Benefit shall in all instances be limited to the lesser amount of the life cover applied for in terms of the PPS Professional Life Provider product or the PPS Accidental Death product, and the maximum Accidental Death benefit sum assured as determined and published by PPS from time to time (R 2 528 731 as at 1 September 2013).

Conditions

A policyholder will only qualify for the Immediate Cover Benefit if **all** of the following conditions are met:

- The policyholder (life insured) is under the age of 62 (actual age) at the date when the application for the PPS Professional Life Provider product or the PPS Accidental Death product is recorded by the PPS Insurance Head Office in its records; and
- Provision is made by the policyholder, to the satisfaction of PPS, for the payment of the first premium in respect of the PPS Professional Life Provider product or the PPS Accidental Death product. The first premium will be deducted from the sum assured

before any payment is made to a deceased policyholdersô beneficiaries or to his estate; and

- PPS will only make payment in respect of the Immediate Cover Benefit if the death of the policyholder (life insured) was as a result of an accident as defined in paragraphs 29 and 37 of this Policy Document.

Exclusions
All of the standard exclusions listed in paragraph 23 of this Policy Document shall apply in respect of the Immediate Cover Benefit. In addition any exclusions applicable to the Accidental Death Benefit in paragraphs 29 and 37 of this Policy Document shall also apply to the Immediate Cover Benefit.

24.2 THE FREE COVER BENEFIT

Notwithstanding anything else contained in this Policy Document PPS shall, where a policyholder (the term ñpolicyholderò shall for the purpose of this clause 24.2 also include a prospective policyholder) has applied for any of the products or benefits in terms of this PPS Provider Policy (with the exception of products or benefits with an initial waiting period) pay the sum assured in terms of the relevant product or benefit to the policyholder or his nominated beneficiaries, whichever is applicable, in the event of a valid claim even though PPS has not yet received the first premium in respect of the relevant product or benefit.

Commencement
Cover in terms of the Free Cover Benefit will commence on the latest of the following dates:

- The date of underwriting acceptance by PPS; or
- 30 (thirty) days prior to the inception date selected by the policyholder in the relevant application form for the product or benefit, provided that underwriting acceptance has taken place.

For the purpose of this paragraph 24.2 the term ñunderwriting acceptanceò shall mean one of the following:

- The date on which PPS communicates its decision to accept the product or benefit applied for, free from any encumbrances (premium loadings and/or cover exclusions), to the policyholder; or
- The date on which PPS communicates its counter-offer in respect of the products or benefits applied for to the policyholder. The Free Cover Benefit will cease in the event that the policyholder rejects PPSôcounter-offer.

Termination
The Free Cover Benefit will end automatically on the inception date of the relevant product or benefit as indicated in the latest Policy Certificate issued by PPS. In the event that the policyholder requests PPS to move the inception date to a later date, the Free Cover Benefit will cease immediately.

Sum Assured
The sum assured in terms of the Free Cover Benefit shall be the sum assured of the product or benefit to which the Free Cover Benefit applies.

Conditions
A policyholder will only qualify for the Free Cover Benefit if **all** of the following conditions are met:

- The policyholder (life insured) is under the age of 62 (actual age) at the date when the application for the relevant product or benefit is recorded by the PPS Insurance Head Office in its records; and
- Provision is made by the policyholder, to the satisfaction of PPS, for the payment of the first premium in respect of the relevant product or benefit. The first premium will be

deducted from the sum assured of the relevant product or benefit before any payment is made to the policyholder, a deceased policyholdersôbeneficiaries or to his estate; and

- The policyholder has a duty to inform PPS of any deterioration in the state of health of the policyholder (life insured) between the date of his application for the relevant product or benefit and the date of underwriting acceptance; and
- The normal requirements applicable to the particular product or benefit, as outlined in this Policy Document, shall apply to any claim submitted in terms of the Free Cover Benefit.

Exclusions
All of the standard exclusions listed in paragraph 23 of this Policy Document, as well as any standard exclusions applicable to the specific product or benefit, shall apply in respect of the Free Cover Benefit. In addition any specific underwriting exclusions imposed by PPS underwriting on the relevant product or benefit shall apply in respect of the Free Cover Benefit.

24.3 THE PPS KICKSTART PACKAGE

Notwithstanding anything else contained in this Policy Document, anyone under the age of 33 who is eligible for PPS Membership or Student Membership may apply for cover under the PPS KickStart Package.

Commencement and Termination
The benefits will commence on the date of application (free cover applicable) and the Sickness benefit (described in the Sick Pay Benefit section in 47. SICKNESS AND PERMANENT INCAPACITY) will end at the end of the month in which the member turns 34 actual age (35 next). Members who are claiming Sickness at this time will only be paid up to the end of the month in which they turn 34 actual age (35 next).

The Accidental Death Benefit (described in 37. ACCIDENTAL DEATH BENEFIT) will continue to actual age 79 (80 next). If a Student Member fails to complete their four year degree before the age of 34, their student membership together with all benefits in force will automatically be cancelled at the end of the month in which they turn 34.

Sum Assured
Accidental Death Cover of R200 000,00 which may be increased up to the normal maximum cover amount, but may not be reduced to below R200 000,00 and Monthly Sickness Benefit Cover of R2 000,00 based on 187 Supplementary A Units of Benefit.

Members or Student Members who purchase the PPS KickStart Package will qualify for Annual Automatic Benefit Increases, but will not otherwise be able to increase Sickness cover.

Conditions
All of the standard exclusions listed in paragraph 23 of this Policy Document, as well as any standard exclusions applicable to the specific product or benefit shall apply and although no medical underwriting is required for the PPS KickStart Package, a pre-existing condition exclusion will be applied to the Sickness Benefit.

A member or student member may not have the PPS KickStart Package together with any other PPS benefits. In order to apply for other PPS Benefits the PPS KickStart Package will have to be cancelled.

THE PPS PROFESSIONAL LIFE PROVIDER™ PRODUCT

25. TERM LIFE COVER

If the life insured dies during the benefit term, PPS Insurance will pay the Sum Assured due in respect of the TERM LIFE COVER.

The Sum Assured will be reduced by the amount for which PPS Insurance has admitted liability with respect to the following benefits:

- TERMINAL ILLNESS BENEFIT automatically included in the TERM LIFE COVER; and
- IMMEDIATE NEEDS BENEFIT automatically included in the TERM LIFE COVER; and
- PROFESSIONAL DISABILITY BENEFIT that is linked to the TERM LIFE COVER; and
- OSRB PROFESSIONAL DISABILITY BENEFIT that is linked to the TERM LIFE COVER; and
- TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT that is linked to the TERM LIFE COVER; and
- TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER that is linked to the TERM LIFE COVER; and
- ACCELERATED CATCH ALL COVER that is linked to the TERM LIFE COVER.

After the reduction of the Sum Assured of the TERM LIFE COVER as aforesaid, the premium payable in respect of the reduced TERM LIFE COVER will be reduced or, where the Sum Assured is reduced to R0, TERM LIFE COVER will automatically end.

The TERM LIFE COVER will commence on the commencement date reflected on the Policy Certificate.

The TERM LIFE COVER will end automatically on the first of the following events occurring:

- Death of the life insured; or
- Cancellation by the Policyholder; or
- Cancellation of the benefit by PPS Insurance; or
- On the last day of the month during which the life insured attains the age of 66 years; or
- The date selected by the Policyholder for termination of the TERM LIFE COVER, which date is reflected in the latest Policy Certificate issued by PPS Insurance; or
- Reduction of the Sum Assured to R0 due to payment of the abovementioned linked or included benefits.

The Policyholder can at any time, but at least 2 months prior to the date selected by the Policyholder for termination of the TERM LIFE COVER, which date is reflected in the latest Policy Certificate issued by PPS Insurance, apply to PPS Insurance in writing in the manner prescribed by PPS Insurance for the TERM LIFE COVER to be changed to WHOLE LIFE COVER. The conversion of the TERM LIFE COVER to WHOLE LIFE COVER will be at the discretion of PPS Insurance and if granted will be on the conditions and terms imposed by PPS Insurance.

Sum Assured

The Sum Assured in respect of the TERM LIFE COVER is reflected on the latest Policy Certificate issued by PPS Insurance.

Declared annual increases will increase the Sum Assured on the 1st of January each year at the discretion of PPS Insurance, without proof of insurability. Upon such an increase, the premium will increase accordingly.

The Policyholder is entitled to apply to PPS Insurance for the Sum Assured to be increased. The Sum Assured will be increased subject to the acceptance of the application to increase the Sum Assured by PPS Insurance and subject to the requirements and conditions imposed by PPS

Insurance. An application to increase the Sum Assured must be made in writing in the manner prescribed by PPS Insurance.

Exclusions
Please refer to the section titled LOADINGS AND EXCLUSIONS.

Waiting period
There is no waiting period in respect of TERM LIFE COVER.

Increase in premiums
The premium pattern is reflected on the latest Policy Certificate issued by PPS Insurance.

At the sole discretion of PPS Insurance, annual increases in benefits may be declared to reduce the eroding effects of inflation. Benefits will increase by the declared percentage for effective cover on the 1st of January each year. The premium for additional benefits will be based on the life insured's age next birthday at the time of the increase.

26. WHOLE LIFE COVER

If the life insured dies during the benefit term, PPS Insurance will pay the Sum Assured due in respect of the WHOLE LIFE COVER.

The Sum Assured will be reduced by any amount for which PPS Insurance has admitted liability with respect to the following benefits:

- TERMINAL ILLNESS BENEFIT automatically included in the WHOLE LIFE COVER; and
- IMMEDIATE NEEDS BENEFIT automatically included in the WHOLE LIFE COVER; and
- PROFESSIONAL DISABILITY BENEFIT that is linked to the WHOLE LIFE COVER; and
- OSRB PROFESSIONAL DISABILITY BENEFIT that is linked to the WHOLE LIFE COVER; and
- WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT that is linked to the WHOLE LIFE COVER; and
- WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% Cover that is linked to the WHOLE LIFE COVER; and
  ACCELERATED CATCHALL COVER that is linked to the WHOLE LIFE COVER.

After the reduction of the Sum Assured of the WHOLE LIFE COVER as aforesaid, the premium payable in respect of the reduced WHOLE LIFE COVER will be reduced or, where the Sum Assured is reduced to R0, WHOLE LIFE COVER will automatically end.

The WHOLE LIFE COVER will commence on the commencement date reflected on the Policy Certificate.

The WHOLE LIFE COVER will cease automatically on the first of the following events occurring;

- Death of the life insured; or
- Cancellation by the Policyholder; or
- Cancellation of the benefit by PPS Insurance; or
- Reduction of the Sum Assured to R0 due to payment of the abovementioned linked or included benefits.

Sum Assured
The Sum Assured in respect of the WHOLE LIFE COVER is reflected on the latest Policy Certificate issued by PPS Insurance.

Declared annual increases will increase the Sum Assured on the 1st of January each year at the discretion of PPS Insurance, without proof of insurability. Upon such an increase, the premium will increase accordingly.

The Policyholder is entitled to apply to PPS Insurance for the Sum Assured to be increased. The Sum Assured will be increased subject to the acceptance of the application to increase the Sum Assured by PPS Insurance and subject to the requirements of and conditions imposed by PPS Insurance. An application to increase the Sum Assured must be made in writing in the manner prescribed by PPS Insurance.

Exclusions
Please refer to the section titled LOADINGS AND EXCLUSIONS.

Waiting period
There is no waiting period in respect of WHOLE LIFE COVER.

Increase in premiums
The premium pattern is reflected on the latest Policy Certificate issued by PPS Insurance.

At the sole discretion of PPS Insurance, annual increases in benefits may be declared to reduce the eroding effects of inflation. Benefits will increase by the declared percentage for effective cover on the 1st of January each year. The premium for additional benefits will be based on the life insured's age next birthday at the time of the increase.

27. TERMINAL ILLNESS BENEFIT

The TERMINAL ILLNESS BENEFIT is part of the TERM LIFE COVER and / or WHOLE LIFE COVER ("LIFE COVER"). The TERMINAL ILLNESS BENEFIT is automatically included in the LIFE COVER and no premium is payable in respect of the TERMINAL ILLNESS BENEFIT.

The TERMINAL ILLNESS BENEFIT will commence and cease on the same date as the LIFE COVER which it forms part of.

If the life insured is diagnosed with a terminal illness which results in the life insured being likely, in the opinion of PPS Insurance, to have less than 12 months to live, PPS Insurance will pay the Sum Assured in respect of the TERMINAL ILLNESS BENEFIT.

Following one successful claim for a TERMINAL ILLNESS BENEFIT no further claims for a TERMINAL ILLNESS BENEFIT will be allowed.

The LIFE COVER will be reduced by the amount paid in terms of the TERMINAL ILLNESS BENEFIT. After the reduction of the Sum Assured of the LIFE COVER as aforesaid, the premium payable in respect of the reduced LIFE COVER will be reduced.

Sum Assured
The Sum Assured is 50% of the LIFE COVER benefit.

Exclusions
Please refer to the section titled LOADINGS AND EXCLUSIONS.

Waiting Period
There is no waiting period in respect of the TERMINAL ILLNESS BENEFIT.

28. IMMEDIATE NEEDS BENEFIT

The IMMEDIATE NEEDS BENEFIT is part of the TERM LIFE COVER and / or WHOLE LIFE COVER ("LIFE COVER"). The IMMEDIATE NEEDS BENEFIT is automatically included in the LIFE COVER and no premium is payable in respect of the IMMEDIATE NEEDS BENEFIT.

The IMMEDIATE NEEDS BENEFIT will commence and cease on the same date as the LIFE COVER which it forms part of as reflected on the latest Policy Certificate issued by PPS Insurance.

In terms of the IMMEDIATE NEEDS BENEFIT the Sum Assured will be paid to the person entitled to receive the proceeds of the LIFE COVER on the death of the life insured. If more than one person is entitled to receive the LIFE COVER, the Sum Assured will be paid to those persons in such proportions as per their entitlement to the LIFE COVER. The Sum Assured will be paid within 2 working days from the time when PPS Insurance received a valid death certificate with respect to the life insured at its Head Office.

The LIFE COVER will be reduced by the amount paid in terms of the IMMEDIATE NEEDS BENEFIT even if the person to whom PPS Insurance, in good faith, made payment of the IMMEDIATE NEEDS BENEFIT was not in fact entitled to receive the IMMEDIATE NEEDS BENEFIT.

The payment of the IMMEDIATE NEEDS BENEFIT is no indication of the validity of the claim for LIFE COVER or the entitlement of the person to whom the IMMEDIATE NEEDS BENEFIT is paid to receive any further amounts with respect to the LIFE COVER.

If, for whatever reason, the claim for LIFE COVER is not valid, PPS Insurance will be entitled to reclaim the amount paid in respect of the IMMEDIATE NEEDS BENEFIT.

Cession
Where LIFE COVER is ceded, the IMMEDIATE NEEDS BENEFIT will be suspended until the cancellation of the cession.

Sum Assured
The Sum Assured will be the lesser of the remaining LIFE COVER Sum Assured and R50 000. The R50 000 may change from time to time at the discretion of PPS Insurance.

Exclusions
Please refer to the section titled LOADINGS AND EXCLUSIONS.

Waiting Period
There is no waiting period in respect of the IMMEDIATE NEEDS BENEFIT.

29. ACCIDENTAL DEATH BENEFIT

The ACCIDENTAL DEATH BENEFIT is only available to Policyholders who have either TERM LIFE COVER and / or WHOLE LIFE COVER (ñLIFE COVERò). Each ACCIDENTAL DEATH BENEFIT will be linked to one specific LIFE COVER benefit as reflected on the latest Policy Certificate issued by PPS Insurance.

If the life insured dies during the benefit term, and the death of the life insured results directly, and independently of all other causes, from:

- Bodily injury caused solely by external, violent and accidental means; or
- From accidental drowning

where:

- the death occurs less than 90 days after the bodily injury or accidental drowning occurred and
- the bodily injury or accidental drowning is not traceable, even indirectly, to the life insuredôs state of mental or physical health before the bodily injury or accidental drowning occurred.

PPS Insurance will pay the Sum Assured due in respect of the ACCIDENTAL DEATH BENEFIT.

The ACCIDENTAL DEATH BENEFIT will commence on the commencement date reflected on the Policy Certificate.

The ACCIDENTAL DEATH BENEFIT will end automatically on the first of the following events occurring:

- Death of the life insured; or
- Cancellation by the Policyholder; or
- Cancellation of the benefit by PPS Insurance; or
- On the last day of the month during which the life insured attains the age of 66 years if the ACCIDENTAL DEATH BENEFIT is linked to TERM LIFE COVER and on the last day of the month during which the life insured attains the age of 79 years if the ACCIDENTAL DEATH BENEFIT is linked to WHOLE LIFE COVER; or
- When the Policyholder no longer has the LIFE COVER to which the ACCIDENTAL DEATH BENEFIT is linked; or
- The date selected by the Policyholder for termination of the ACCIDENTAL DEATH BENEFIT, which date is reflected in the latest Policy Certificate issued by PPS Insurance.

Sum Assured
The Sum Assured in respect of the ACCIDENTAL DEATH BENEFIT is reflected on the latest Policy Certificate issued by PPS Insurance. The Sum Assured will, subject to minimum and maximum Sums Assured allowed by PPS Insurance from time to time, be the same as the Sum Assured of the LIFE COVER to which the ACCIDENTAL DEATH BENEFIT is linked. The Sum Assured will, subject to minimum and maximum Sums Assured allowed by PPS Insurance from time to time, automatically change when the Sum Assured of the LIFE COVER to which the ACCIDENTAL DEATH BENEFIT is linked, is changed. This will result in a change to the premium.

Declared annual increases will increase the Sum Assured on the 1st of January each year at the discretion of PPS Insurance, without proof of insurability. Upon such an increase, the premium will increase accordingly.

Exclusions
Please refer to the section titled LOADINGS AND EXCLUSIONS.

Waiting period
There is no waiting period in respect of ACCIDENTAL DEATH BENEFIT.

Increase in premiums
The premium pattern is age related. Premiums will increase annually on the 1st of the month following the life insuredÕs birthday.

At the sole discretion of PPS Insurance, annual increases in benefits may be declared to reduce the eroding effects of inflation. Benefits will increase by the declared percentage for effective cover on the 1st of January each year. The premium for additional benefits will be based on the life insuredÕs age next birthday at the time of the increase.

30. PROFESSIONAL DISABILITY BENEFIT

The PROFESSIONAL DISABILITY BENEFIT is only available to Policyholders who have either TERM LIFE COVER and / or WHOLE LIFE COVER (ñLIFE COVERÒ). Each PROFESSIONAL DISABILITY BENEFIT will be linked to one specific LIFE COVER benefit as reflected on the latest Policy Certificate issued by PPS Insurance.

The PROFESSIONAL DISABILITY BENEFIT will commence on the commencement date reflected in the latest Policy Certificate issued by PPS Insurance.

The PROFESSIONAL DISABILITY BENEFIT will cease automatically on the first of the following events occurring:

- On the last day of the month during which the life insured reaches the age of 66 years; or
- When the Policyholder no longer has the LIFE COVER to which the PROFESSIONAL DISABILITY BENEFIT is linked; or
- Cancellation by the Policyholder; or
- Cancellation of the benefit by PPS Insurance; or
- A successful claim for a PROFESSIONAL DISABILITY BENEFIT.

The Policyholder will inform PPS Insurance in writing of a change in the life insuredôs occupation. Please refer to the section titled CHANGE OF OCCUPATION.

If the life insured is disabled during the benefit term, PPS Insurance will pay the Sum Assured in respect of the PROFESSIONAL DISABILITY BENEFIT. The PROFESSIONAL DISABILITY BENEFIT will only be payable if:

- the life insured is in the opinion of PPS Insurance significantly unable to use his professional training and knowledge to carry out his own profession as well as any other profession that could be carried out by persons with similar or comparable qualifications as a result of a disease, injury or accident; and
- the disability is in the opinion of PPS Insurance permanent, significant and severe.

The LIFE COVER to which the PROFESSIONAL DISABILITY BENEFIT is linked will be reduced with the amount paid in terms of the PROFESSIONAL DISABILITY BENEFIT. After the reduction of the Sum Assured of the LIFE COVER as aforesaid, the premium payable in respect of the reduced LIFE COVER will be reduced or, where the LIFE COVER Sum Assured is reduced to R0, the LIFE COVER will automatically end.

Sum Assured
The initial Sum Assured in respect of the PROFESSIONAL DISABILITY BENEFIT is reflected on the latest Policy Certificate issued by PPS Insurance.

Declared annual increases will increase the Sum Assured on the 1st of January each year at the discretion of PPS Insurance, without proof of insurability. Upon such an increase, the premium will increase accordingly.

The Policyholder is entitled to apply to PPS Insurance for the Sum Assured to be increased. The Sum Assured will be increased subject to the acceptance of the application to increase the Sum Assured by PPS Insurance and subject to the requirements and conditions imposed by PPS Insurance. An application to increase the Sum Assured must be made in writing in the manner prescribed by PPS Insurance.

The Sum Assured can never be more than the Sum Assured in respect of the LIFE COVER to which the PROFESSIONAL DISABILITY BENEFIT is linked. If the LIFE COVER to which the PROFESSIONAL DISABILITY BENEFIT is linked is reduced for any reason, and such reduction has the effect that the Sum Assured in respect of the PROFESSIONAL DISABILITY BENEFIT is more than the Sum Assured in respect of the LIFE COVER, the Sum Assured for the PROFESSIONAL DISABILITY BENEFIT will automatically be reduced to an amount equal to the Sum Assured in respect to the LIFE COVER and the premium payable in respect of the reduced PROFESSIONAL DISABILITY BENEFIT will be reduced.

Exclusions
Please refer to the section titled LOADINGS AND EXCLUSIONS.

Waiting Period
There is no waiting period in respect of the PROFESSIONAL DISABILITY BENEFIT.

Increase in premiums
The premium pattern is reflected on the latest Policy Certificate issued by PPS Insurance.

At the sole discretion of PPS Insurance, annual increases in benefits may be declared to reduce the eroding effects of inflation. Benefits will increase by the declared percentage for effective cover on the 1st of January each year. The premium for additional benefits will be based on the life insured's age next birthday at the time of the increase.

31. OSRB PROFESSIONAL DISABILITY BENEFIT

The PROFESSIONAL DISABILITY BENEFIT with Occupation Specific Rider Benefit" (OSRB PROFESSIONAL DISABILITY BENEFIT) is only available to Policyholders who have either TERM LIFE COVER and / or WHOLE LIFE COVER ("LIFE COVER"). Each OSRB PROFESSIONAL DISABILITY BENEFIT will be linked to one specific LIFE COVER benefit as reflected on the latest Policy Certificate issued by PPS Insurance.

The OSRB PROFESSIONAL DISABILITY BENEFIT will commence on the commencement date reflected in the latest Policy Certificate issued by PPS Insurance.

The OSRB PROFESSIONAL DISABILITY BENEFIT will cease automatically on the first of the following events occurring:

- On the last day of the month during which the life insured reaches the age of 66 years; or
- When the Policyholder no longer has the LIFE COVER to which the OSRB PROFESSIONAL DISABILITY BENEFIT is linked; or
- Cancellation by the Policyholder; or
- Cancellation of the benefit by PPS Insurance; or
- A successful claim for an OSRB PROFESSIONAL DISABILITY BENEFIT.

The Policyholder will inform PPS Insurance in writing of a change in the life insured's occupation within 30 days from the date on which the life insured changed his occupation or no longer substantially practices the occupation reflected on the latest Policy Certificate issued by PPS Insurance. Please refer to the section titled CHANGE OF OCCUPATION.

If the life insured is disabled during the benefit term, PPS Insurance will pay the Sum Assured in respect of the OSRB PROFESSIONAL DISABILITY BENEFIT. The OSRB PROFESSIONAL DISABILITY BENEFIT will only be payable if:

- the life insured is in the opinion of PPS Insurance significantly unable to perform his own specifically nominated occupation as a result of a disease, injury or accident. The occupation nominated for this purpose is reflected in the latest Policy Certificate issued by PPS Insurance; and
- the disability is in the opinion of PPS Insurance permanent, significant and severe.

The LIFE COVER to which the OSRB PROFESSIONAL DISABILITY BENEFIT is linked will be reduced with the amount paid in terms of the OSRB PROFESSIONAL DISABILITY BENEFIT. After the reduction of the Sum Assured of the LIFE COVER as aforesaid, the premium payable in respect of the reduced LIFE COVER will be reduced or, where the LIFE COVER Sum Assured is reduced to R0, the LIFE COVER will automatically end.

Sum Assured
The initial Sum Assured in respect of the OSRB PROFESSIONAL DISABILITY BENEFIT is reflected on the latest Policy Certificate issued by PPS Insurance.

Declared annual increases will increase the Sum Assured on the 1st of January each year at the discretion of PPS Insurance, without proof of insurability. Upon such an increase, the premium will increase accordingly.

The Policyholder is entitled to apply to PPS Insurance for the Sum Assured to be increased. The Sum Assured will be increased subject to the acceptance of the application to increase the Sum Assured by PPS Insurance and subject to the requirements and conditions imposed by PPS Insurance. An application to increase the Sum Assured must be made in writing in the manner prescribed by PPS Insurance.

The Sum Assured can never be more than the Sum Assured in respect of the LIFE COVER to which the OSRB PROFESSIONAL DISABILITY BENEFIT is linked. If the LIFE COVER to which the OSRB PROFESSIONAL DISABILITY BENEFIT is linked is reduced for any reason, and such reduction has the effect that the Sum Assured in respect of the OSRB PROFESSIONAL DISABILITY BENEFIT is more than the Sum Assured in respect of the LIFE COVER, the Sum Assured for the OSRB PROFESSIONAL DISABILITY BENEFIT will automatically be reduced to an amount equal to the Sum Assured in respect to the LIFE COVER and the premium payable in respect of the reduced OSRB PROFESSIONAL DISABILITY BENEFIT will be reduced.

Exclusions
Please refer to the section titled LOADINGS AND EXCLUSIONS.

Waiting Period
There is no waiting period in respect of the OSRB PROFESSIONAL DISABILITY BENEFIT.

Increase in premiums
The premium pattern is reflected on the latest Policy Certificate issued by PPS Insurance.

At the sole discretion of PPS Insurance, annual increases in benefits may be declared to reduce the eroding effects of inflation. Benefits will increase by the declared percentage for effective cover on the 1st of January each year. The premium for additional benefits will be based on the life insured's age next birthday at the time of the increase.

32. TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT

The TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT is only available to Policyholders who have TERM LIFE COVER (i.e. LIFE COVER). Each TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT will be linked to one specific LIFE COVER benefit as reflected on the latest Policy Certificate issued by PPS Insurance.

If the life insured suffers any of the dread diseases, trauma and physical impairments listed in Appendix A, PPS Insurance will pay a percentage of the Sum Assured in respect of the TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT according to the Severity Level thereof.

The TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT will commence on the commencement date reflected on the latest Policy Certificate issued by PPS Insurance.

The TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT will end automatically on the first of the following events occurring:

- Death of the life insured; or
- Cancellation by the Policyholder; or
- Cancellation of the benefit by PPS Insurance; or
- On the last day of the month during which the life insured reaches the age of 66 years; or
- When the Policyholder no longer has the LIFE COVER to which the TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT is linked; or
- The date selected by the Policyholder for termination of the TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT, which date is reflected in the latest Policy Certificate issued by PPS Insurance.

The Benefits due in terms of the TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT are a proportion of the Sum Assured calculated according to the Severity Level of the event as defined in Appendix A of which there shall be four severity levels namely:

Severity Level A for which the Benefit shall be 100% of the Sum Assured.
Severity Level B for which the Benefit shall be 75% of the Sum Assured.
Severity Level C for which the Benefit shall be 50% of the Sum Assured.
Severity Level D for which the Benefit shall be 25% of the Sum Assured.

More than 1 valid claim can be paid from the same or different benefit category. The benefit paid will be the Sum Assured according to the Severity Level thereof less any claims, from the same or different benefit category, previously paid.

The LIFE COVER to which the TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT is linked will be reduced with the amount paid in terms of the TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT. After the reduction of the Sum Assured of the LIFE COVER as aforesaid, the premium payable in respect of the reduced LIFE COVER will be reduced or, where the LIFE COVER Sum Assured is reduced to R0, the LIFE COVER will automatically end.

Sum Assured
The initial Sum Assured in respect of the TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT is reflected on the latest Policy Certificate issued by PPS Insurance.

Declared annual increases will increase the Sum Assured on the 1st of January each year at the discretion of PPS Insurance, without proof of insurability. Upon such an increase, the premium will increase accordingly.

The Sum Assured can never be more than the Sum Assured in respect of the LIFE COVER to which the TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT is linked. If the LIFE COVER to which the TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT is linked is reduced for any reason, and such reduction has the effect that the Sum Assured in respect of the TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT is more than the Sum Assured in respect of the LIFE COVER, the Sum Assured for the TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT will automatically be reduced to an amount equal to the Sum Assured in respect to the LIFE COVER and the premium payable in respect of the reduced TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT will be reduced.

Exclusions
Please refer to the section titled LOADINGS AND EXCLUSIONS.

Please note the specific exclusions in Appendix A.

Waiting Period
There is no initial waiting period applicable to a claim for a TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT.

Survival Period
The TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT is paid subject to a general survival period of 14 days together with any further survival period reflected in Appendix A. The life insured must survive for a period of 14 days after the event occurs or the condition is diagnosed.

Increase in premiums
The premium pattern is age related. Premiums will increase annually on the 1st of the month following the life insuredõs birthday.

At the sole discretion of PPS Insurance, annual increases in benefits may be declared to reduce the eroding effects of inflation. Benefits will increase by the declared percentage for effective cover on the 1st of January each year. The premium for additional benefits will be based on the life insured's age next birthday at the time of the increase.

33. WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT

The WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT is only available to Policyholders who have WHOLE LIFE COVER (ñLIFE COVERò). Each WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT will be linked to one specific LIFE COVER benefit as reflected on the latest Policy Certificate issued by PPS Insurance.

If the life insured suffers any of the dread diseases, trauma and physical impairments listed in Appendix A, PPS Insurance will pay a percentage of the Sum Assured in respect of the WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT according to the Severity Level thereof.

The WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT will commence on the commencement date reflected on the latest Policy Certificate issued by PPS Insurance.

The WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT will end automatically on the first of the following events occurring:

- Death of the life insured; or
- Cancellation by the Policyholder; or
- Cancellation of the benefit by PPS Insurance; or
- When the Policyholder no longer has the LIFE COVER to which the WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT is linked.

The Benefits due in terms of the WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT are a proportion of the Sum Assured calculated according to the Severity Level of the event as defined in Appendix A of which there shall be four severity levels namely:

Severity Level A for which the Benefit shall be 100% of the Sum Assured.
Severity Level B for which the Benefit shall be 75% of the Sum Assured.
Severity Level C for which the Benefit shall be 50% of the Sum Assured.
Severity Level D for which the Benefit shall be 25% of the Sum Assured.

More than 1 valid claim can be paid from the same or different benefit category. The benefit paid will be the Sum Assured according to the Severity Level thereof less any claims, from the same or different benefit category, previously paid.

The LIFE COVER to which the WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT is linked will be reduced with the amount paid in terms of the WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT. After the reduction of the Sum Assured of the LIFE COVER as aforesaid, the premium payable in respect of the reduced LIFE COVER will be reduced or, where the LIFE COVER Sum Assured is reduced to R0, the LIFE COVER will automatically end.

Sum Assured

The initial Sum Assured in respect of the WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT is reflected on the latest Policy Certificate issued by PPS Insurance.

Declared annual increases will increase the Sum Assured on the 1st of January each year at the discretion of PPS Insurance, without proof of insurability. Upon such an increase, the premium will increase accordingly.

The Sum Assured can never be more than the Sum Assured in respect of the LIFE COVER to which the WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT is linked. If the LIFE COVER to which the WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT is linked is reduced for any reason, and such reduction has the effect that the Sum Assured in respect of the WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT is more than the Sum Assured in respect of the LIFE COVER, the Sum Assured for the WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT will automatically be reduced to an amount equal to the Sum Assured in respect to the LIFE COVER and the premium payable in respect of the reduced WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT will be reduced.

Exclusions
Please refer to the section titled LOADINGS AND EXCLUSIONS.

Please note the specific exclusions in Appendix A.

Waiting period
There is no initial waiting period applicable to a claim for a WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT.

Survival Period
The WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT is paid subject to a general survival period of 14 days together with any further survival period reflected in Appendix A. The life insured must survive for a period of 14 days after the event occurs or the condition is diagnosed.

Increase in premiums
The premium pattern is the PPS Whole Life premium pattern. Premiums will increase annually by a percentage on the 1st of the month following the life insured's birthday. The percentage increases are determined by PPS Insurance in its sole discretion from time to time and are based on the life insured's age next birthday.

At the sole discretion of PPS Insurance, annual increases in benefits may be declared to reduce the eroding effects of inflation. Benefits will increase by the declared percentage for effective cover on the 1st of January each year. The premium for additional benefits will be based on the life insured's age next birthday at the time of the increase.

34. TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER

The TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER is only available to Policyholders who have TERM LIFE COVER ("LIFE COVER"). Each TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER will be linked to one specific LIFE COVER benefit as reflected on the latest Policy Certificate issued by PPS Insurance.

If the life insured suffers any of the dread diseases, trauma and physical impairments listed in Appendix B, PPS Insurance will pay a percentage of the Sum Assured in respect of the TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER according to the Severity Level thereof.

The TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER will commence on the commencement date reflected on the latest Policy Certificate issued by PPS Insurance.

The TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER will end automatically on the first of the following events occurring:

- Death of the life insured; or
- Cancellation by the Policyholder; or
- Cancellation of the benefit by PPS Insurance; or
- On the last day of the month during which the life insured reaches the age of 66 years; or
- When the Policyholder no longer has the LIFE COVER to which the TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER is linked; or
- The date selected by the Policyholder for termination of the TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER, which date is reflected in the latest Policy Certificate issued by PPS Insurance.

The Benefits due in terms of the TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT are a proportion of the Sum Assured calculated according to the Severity Level of the event as defined in Appendix B of which there shall be four severity levels namely:

Severity Level A for which the Benefit shall be 100% of the Sum Assured.
Severity Level B for which the Benefit shall be 75% of the Sum Assured.
Severity Level C for which the Benefit shall be 50% of the Sum Assured.
Severity Level D for which the Benefit shall be 25% of the Sum Assured.

More than 1 valid claim can be paid from the same or different benefit category. The benefit paid will be the Sum Assured according to the Severity Level thereof less any claims, from the same or different benefit category, previously paid.

The LIFE COVER to which the TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER is linked will be reduced with the amount paid in terms of the TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER. After the reduction of the Sum Assured of the LIFE COVER as aforesaid, the premium payable in respect of the reduced LIFE COVER will be reduced or, where the LIFE COVER Sum Assured is reduced to R0, the LIFE COVER will automatically end.

Sum Assured

The initial Sum Assured in respect of the TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER is reflected on the latest Policy Certificate issued by PPS Insurance.

Declared annual increases will increase the Sum Assured on the 1st of January each year at the discretion of PPS Insurance, without proof of insurability. Upon such an increase, the premium will increase accordingly.

The Sum Assured can never be more than the Sum Assured in respect of the LIFE COVER to which the TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER is linked. If the LIFE COVER to which the TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER is linked is reduced for any reason, and such reduction has the effect that the Sum Assured in respect of the TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER is more than the Sum Assured in respect of the LIFE COVER, the Sum Assured for the TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER will automatically be reduced to an amount equal to the Sum Assured in respect to the LIFE COVER and the premium payable in respect of the reduced TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER will be reduced.

Exclusions

Please refer to the section titled LOADINGS AND EXCLUSIONS.

Please note the specific exclusions in Appendix B.

Waiting Period
There is no initial waiting period applicable to a claim for a TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER.

Survival Period
The TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER is paid subject to a general survival period of 14 days together with any further survival period reflected in Appendix B. The life insured must survive for a period of 14 days after the event occurs or the condition is diagnosed.

Increase in premiums
The premium pattern is age related. Premiums will increase annually on the 1st of the month following the life insuredôs birthday.

At the sole discretion of PPS Insurance, annual increases in benefits may be declared to reduce the eroding effects of inflation. Benefits will increase by the declared percentage for effective cover on the 1st of January each year. The premium for additional benefits will be based on the life insuredôs age next birthday at the time of the increase.

35. WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER

The WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER is only available to Policyholders who have WHOLE LIFE COVER (ñLIFE COVERò). Each WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER will be linked to one specific LIFE COVER benefit as reflected on the latest Policy Certificate issued by PPS Insurance.

If the life insured suffers any of the dread diseases, trauma and physical impairments listed in Appendix B, PPS Insurance will pay a percentage of the Sum Assured in respect of the WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER according to the Severity Level thereof.

The WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER will commence on the commencement date reflected on the latest Policy Certificate issued by PPS Insurance.

The WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER will end automatically on the first of the following events occurring:

- Death of the life insured; or
- Cancellation by the Policyholder; or
- Cancellation of the benefit by PPS Insurance; or
- When the Policyholder no longer has the LIFE COVER to which the WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER is linked.

The Benefits due in terms of the WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER are a proportion of the Sum Assured calculated according to the Severity Level of the event as defined in Appendix B of which there shall be four severity levels namely:

Severity Level A for which the Benefit shall be 100% of the Sum Assured.
Severity Level B for which the Benefit shall be 75% of the Sum Assured.
Severity Level C for which the Benefit shall be 50% of the Sum Assured.
Severity Level D for which the Benefit shall be 25% of the Sum Assured.

More than 1 valid claim can be paid from the same or different benefit category. The benefit paid will be the Sum Assured according to the Severity Level thereof less any claims, from the same or different benefit category, previously paid.

The LIFE COVER to which the WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER is linked will be reduced with the amount paid in terms of the WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER. After the reduction of the Sum Assured of the LIFE COVER as aforesaid, the premium payable in respect of the reduced LIFE COVER will be reduced or, where the LIFE COVER Sum Assured is reduced to R0, the LIFE COVER will automatically end.

Sum Assured
The initial Sum Assured in respect of the WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER is reflected on the latest Policy Certificate issued by PPS Insurance.

Declared annual increases will increase the Sum Assured on the 1st of January each year at the discretion of PPS Insurance, without proof of insurability. Upon such an increase, the premium will increase accordingly.

The Sum Assured can never be more than the Sum Assured in respect of the LIFE COVER to which the WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER is linked. If the LIFE COVER to which the WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER is linked is reduced for any reason, and such reduction has the effect that the Sum Assured in respect of the WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER is more than the Sum Assured in respect of the LIFE COVER, the Sum Assured for the WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER will automatically be reduced to an amount equal to the Sum Assured in respect to the LIFE COVER and the premium payable in respect of the reduced WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER will be reduced.

Exclusions
Please refer to the section titled LOADINGS AND EXCLUSIONS.

Please note the specific exclusions in Appendix B.

Waiting Period
There is no initial waiting period applicable to a claim for a WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER.

Survival Period
The WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER is paid subject to a general survival period of 14 days together with any further survival period reflected in Appendix B. The life insured must survive for a period of 14 days after the event occurs or the condition is diagnosed.

Increase in premiums
The premium pattern is age related. Premiums will increase annually on the 1st of the month following the life insuredõs birthday.

At the sole discretion of PPS Insurance, annual increases in benefits may be declared to reduce the eroding effects of inflation. Benefits will increase by the declared percentage for effective cover on the 1st of January each year. The premium for additional benefits will be based on the life insuredõs age next birthday at the time of the increase.

36. ACCELERATED CATCHALL COVER

The ACCELERATED CATCHALL COVER is only available to Policyholders who have either a TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT and / or a WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT and / or a TERM ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER and / or a WHOLE LIFE ACCELERATED PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER (the "BASIC BENEFIT"). Each ACCELERATED CATCHALL COVER benefit will then be a rider benefit on one specific BASIC BENEFIT as reflected on the latest Policy Certificate issued by PPS Insurance.

Claims will only be paid under the ACCELERATED CATCHALL COVER BENEFIT if the life insured suffers a dread disease, trauma or physical impairment that is not covered in terms of the BASIC BENEFIT, including all severity levels, regardless of whether the claim was admitted under the BASIC BENEFIT or not.

PPS Insurance will pay the Sum Assured in respect of the ACCELERATED CATCHALL COVER BENEFIT if the life insured suffers a dread disease, trauma or physical impairment pursuant to the occurrence of a serious medical or physical condition that:

- Results in a Whole Person Impairment (WPI) severity of at least 35%; and
- results in confinement to a bed or wheelchair, for lives assured older than 75; and
- is permanent and unlikely to change in spite of further medical or surgical treatment.

The ACCELERATED CATCHALL COVER will commence on the commencement date reflected on the latest Policy Certificate issued by PPS Insurance.

The ACCELERATED CATCHALL COVER will end automatically on the first of the following events occurring:

- Death of the life insured; or
- Cancellation by the Policyholder; or
- Cancellation of the benefit by PPS Insurance; or
- If the Policyholder is no longer entitled to the BASIC BENEFIT; or
- Once a claim has been paid in terms of this benefit.

If a valid claim is submitted under this benefit, the benefit paid will be 100% less any percentage benefit already paid under the BASIC BENEFIT.

Sum Assured
The Sum Assured of the ACCELERATED CATCHALL COVER benefit will always be the same as the Sum Assured in respect of the BASIC BENEFIT.

Exclusions
Please refer to the section titled LOADINGS AND EXCLUSIONS.

Waiting period
There is no initial waiting period applicable to a claim for an ACCELERATED CATCHALL COVER.

Survival Period
The ACCELERATED CATCHALL COVER is paid subject to a general survival period of 14 days. The life insured must survive for a period of 14 days after the event occurs or the condition is diagnosed.

Increase in Premiums
The premium pattern applicable to the BASIC BENEFIT will be applicable to the ACCELERATED CATCHALL BENEFIT.

The premium will increase when the Sum Assured with respect to the BASIC BENEFIT is increased.

THE PPS ACCIDENTAL DEATH PRODUCT

37. ACCIDENTAL DEATH BENEFIT

If the life insured dies during the benefit term, and the death of the life insured results directly, and independently of all other causes, from:

- Bodily injury caused solely by external, violent and accidental means; or
- From accidental drowning

where:

- the death occurs less than 90 days after the bodily injury or accidental drowning occurred and
- the bodily injury or accidental drowning is not traceable, even indirectly, to the life insuredôs state of mental or physical health before the bodily injury or accidental drowning occurred.

PPS Insurance will pay the Sum Assured due in respect of the ACCIDENTAL DEATH BENEFIT.

The ACCIDENTAL DEATH BENEFIT will commence on the commencement date reflected on the Policy Certificate.

The ACCIDENTAL DEATH BENEFIT will end automatically on the first of the following events occurring:

- Death of the life insured; or
- Cancellation by the Policyholder; or
- Cancellation of the benefit by PPS Insurance; or
- On the last day of the month during which the life insured attains the age of 79 years.

Sum Assured

The Sum Assured in respect of the ACCIDENTAL DEATH BENEFIT is reflected on the latest Policy Certificate issued by PPS Insurance.

Declared annual increases will increase the Sum Assured on the 1st of January each year at the discretion of PPS Insurance, without proof of insurability. Upon such an increase, the premium will increase accordingly.

Exclusions

Please refer to the section titled LOADINGS AND EXCLUSIONS.

Waiting period

There is no waiting period in respect of ACCIDENTAL DEATH BENEFIT.

Increase in premiums

The premiums are level up to age 34 whereafter premiums will escalate every 5 to 10 years in the month directly following the policyholderôs birthday.

THE PPS PROFESSIONAL HEALTH PROVIDER™ PRODUCT

38. TERM PROFESSIONAL HEALTH PROVIDER BENEFIT

If the life insured suffers any of the dread diseases, trauma and physical impairments listed in Appendix A, PPS Insurance will pay a percentage of the Sum Assured in respect of the TERM PROFESSIONAL HEALTH PROVIDER BENEFIT according to the Severity Level thereof.

The TERM PROFESSIONAL HEALTH PROVIDER BENEFIT will commence on the commencement date reflected on the latest Policy Certificate issued by PPS Insurance.

The TERM PROFESSIONAL HEALTH PROVIDER BENEFIT will end automatically on the first of the following events occurring:

- Death of the life insured; or
- Cancellation by the Policyholder; or
- Cancellation of the benefit by PPS Insurance; or
- On the last day of the month during which the life insured reaches the age of 66 years; or
- The date selected by the Policyholder for termination of the TERM PROFESSIONAL HEALTH PROVIDER BENEFIT, which date is reflected in the latest Policy Certificate issued by PPS Insurance.

The Benefits due in terms of the TERM PROFESSIONAL HEALTH PROVIDER BENEFIT are a proportion of the Sum Assured calculated according to the Severity Level of the event as defined in Appendix A of which there shall be four severity levels namely:

Severity Level A for which the Benefit shall be 100% of the Sum Assured.
Severity Level B for which the Benefit shall be 75% of the Sum Assured.
Severity Level C for which the Benefit shall be 50% of the Sum Assured.
Severity Level D for which the Benefit shall be 25% of the Sum Assured.

There are 32 benefit categories including a Cardiovascular benefit category listed in Appendix A.

The Cardiovascular benefit category includes the conditions Heart attack, Cardiac Surgery and Procedures, Cardiomyopathy and Aortic surgery. Once 100% has been claimed from the Cardiovascular benefit category no further claims will be paid from this benefit category. Benefits for the Cardiovascular benefit category can be claimed at any severity until 100% of the sum assured has been paid.

Claims for the other 31 benefit categories never exhaust these benefit categories and claims for unrelated events qualifying for a claim under the same benefit category will be paid, regardless of previous payments from that benefit category.

More than 1 valid claim can therefore be paid from the same or different benefit category. The benefit paid will then differ for Related Claims and Unrelated Claims.

- Related Claims:
  A related claim is a condition or illness which is directly or indirectly related to a past claim where, in the opinion of PPS Insurance, the subsequent condition is either a complication of, outcome of, or treatment for, any previous illness or condition resulting in an existing payment under this policy; or an event that shares a common cause or effect with any previous illness or condition resulting in a claim under this benefit.
  The benefit paid will be the Sum Assured according to the Severity Level thereof less any Related Claims, from the same or different benefit category, previously paid.

- Unrelated Claims:
  The benefit paid will be the Sum Assured according to the Severity Level thereof (regardless of any previous claims).

The Policyholder can at any time, but at least 2 months prior to the date selected by the Policyholder for termination of the TERM PROFESSIONAL HEALTH PROVIDER BENEFIT, which date is reflected in the latest Policy Certificate issued by PPS Insurance, apply to PPS Insurance in writing in the manner prescribed by PPS Insurance for the TERM PROFESSIONAL HEALTH PROVIDER BENEFIT to be changed to WHOLE LIFE PROFESSIONAL HEALTH PROVIDER BENEFIT. The conversion of the TERM PROFESSIONAL HEALTH PROVIDER BENEFIT to WHOLE LIFE PROFESSIONAL HEALTH PROVIDER BENEFIT will be at the discretion of PPS Insurance and if granted will be on the conditions and terms imposed by PPS Insurance, which terms will include an increase in the premiums.

Sum Assured
The Sum Assured in respect of the TERM PROFESSIONAL HEALTH PROVIDER BENEFIT is reflected on the latest Policy Certificate issued by PPS Insurance.

Declared annual increases will increase the Sum Assured on the 1st of January each year at the discretion of PPS Insurance, without proof of insurability. Upon such an increase, the premium will increase accordingly.

The Policyholder is entitled to apply to PPS Insurance for the Sum Assured to be increased. The Sum Assured will be increased subject to the acceptance of the application to increase the Sum Assured by PPS Insurance and subject to the requirements of and conditions imposed by PPS Insurance. An application to increase the Sum Assured must be made in writing in the manner prescribed by PPS Insurance.

Exclusions
Please refer to the section titled LOADINGS AND EXCLUSIONS.

Please note the specific exclusions in Appendix A.

Waiting Period
There is no initial waiting period applicable to a claim for a TERM PROFESSIONAL HEALTH PROVIDER BENEFIT.

Survival Period
The TERM PROFESSIONAL HEALTH PROVIDER BENEFIT is paid subject to a general survival period of 14 days together with any further survival period reflected in Appendix A. The life insured must survive for a period of 14 days after the event occurs or the condition is diagnosed.

Increase in premiums
The premium pattern is age related. Premiums will increase annually on the 1st of the month following the life insuredÕs birthday.

At the sole discretion of PPS Insurance, annual increases in benefits may be declared to reduce the eroding effects of inflation. Benefits will increase by the declared percentage for effective cover on the 1st of January each year. The premium for additional benefits will be based on the life insuredÕs age next birthday at the time of the increase.

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.

39. WHOLE LIFE PROFESSIONAL HEALTH PROVIDER BENEFIT

If the life insured suffers any of the dread diseases, trauma and physical impairments listed in Appendix A, PPS Insurance will pay a percentage of the Sum Assured in respect of the WHOLE LIFE PROFESSIONAL HEALTH PROVIDER BENEFIT according to the Severity Level thereof.

The WHOLE LIFE PROFESSIONAL HEALTH PROVIDER BENEFIT will commence on the commencement date reflected on the latest Policy Certificate issued by PPS Insurance.

The WHOLE LIFE PROFESSIONAL HEALTH PROVIDER BENEFIT will end automatically on the first of the following events occurring:

- Death of the life insured; or
- Cancellation by the Policyholder; or
- Cancellation of the benefit by PPS Insurance.

The Benefits due in terms of the WHOLE LIFE PROFESSIONAL HEALTH PROVIDER BENEFIT are a proportion of the Sum Assured calculated according to the Severity Level of the event as defined in Appendix A of which there shall be four severity levels namely:

Severity Level A for which the Benefit shall be 100% of the Sum Assured.
Severity Level B for which the Benefit shall be 75% of the Sum Assured.
Severity Level C for which the Benefit shall be 50% of the Sum Assured.
Severity Level D for which the Benefit shall be 25% of the Sum Assured.

There are 32 benefit categories including a Cardiovascular benefit category listed in Appendix A.

The Cardiovascular benefit category includes the conditions Heart attack, Cardiac Surgery and Procedures, Cardiomyopathy and Aortic surgery. Once 100% has been claimed from the Cardiovascular benefit category no further claims will be paid from this benefit category. Benefits for the Cardiovascular benefit category can be claimed at any severity until 100% of the sum assured has been paid.

Claims for the other 31 benefit categories never exhaust these benefit categories and claims for unrelated events qualifying for a claim under the same benefit category will be paid, regardless of previous payments from that benefit category.

More than 1 valid claim can therefore be paid from the same or different benefit category. The benefit paid will then differ for Related Claims and Unrelated Claims.

- Related Claims:
  A related claim is a condition or illness which is directly or indirectly related to a past claim where, in the opinion of PPS Insurance, the subsequent condition is either a complication of, outcome of, or treatment for, any previous illness or condition resulting in an existing payment under this policy; or an event that shares a common cause or effect with any previous illness or condition resulting in a claim under this benefit.
  The benefit paid will be the Sum Assured according to the Severity Level thereof less any Related Claims, from the same or different benefit category, previously paid.

- Unrelated Claims:
  The benefit paid will be the Sum Assured according to the Severity Level thereof (regardless of any previous claims).

The Sum Assured

The Sum Assured in respect of the WHOLE LIFE PROFESSIONAL HEALTH PROVIDER BENEFIT is reflected on the latest Policy Certificate issued by PPS Insurance.

Declared annual increases will increase the Sum Assured on the 1st of January each year at the discretion of PPS Insurance, without proof of insurability. Upon such an increase, the premium will increase accordingly.

The Policyholder is entitled to apply to PPS Insurance for the Sum Assured to be increased. The Sum Assured will be increased subject to the acceptance of the application to increase the Sum Assured by PPS Insurance and subject to the requirements of and conditions imposed by PPS Insurance.

Exclusions
Please refer to the section titled LOADINGS AND EXCLUSIONS.

Please note the specific exclusions in Appendix A.

Waiting period
There is no initial waiting period applicable to a claim for a WHOLE LIFE PROFESSIONAL HEALTH PROVIDER BENEFIT.

Survival Period
The WHOLE LIFE PROFESSIONAL HEALTH PROVIDER BENEFIT is paid subject to a general survival period of 14 days together with any further survival period reflected in Appendix A. The life insured must survive for a period of 14 days after the event occurs or the condition is diagnosed.

Increase in premiums
The premium pattern is the PPS Whole Life premium pattern. Premiums will increase annually by a percentage on the 1st of the month following the life insuredôs birthday. The percentage increases are determined by PPS Insurance in its sole discretion from time to time and are based on the life insuredôs age next birthday.

At the sole discretion of PPS Insurance, annual increases in benefits may be declared to reduce the eroding effects of inflation. Benefits will increase by the declared percentage for effective cover on the 1st of January each year. The premium for additional benefits will be based on the life insuredôs age next birthday at the time of the increase.

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.

40. TERM PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER

If the life insured suffers any of the dread diseases, trauma and physical impairments listed in Appendix B, PPS Insurance will pay a percentage of the Sum Assured in respect of the TERM PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER according to the Severity Level thereof.

The TERM PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER will commence on the commencement date reflected on the latest Policy Certificate issued by PPS Insurance.

The TERM PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER will end automatically on the first of the following events occurring:

- Death of the life insured; or
- Cancellation by the Policyholder; or
- Cancellation of the benefit by PPS Insurance; or
- On the last day of the month during which the life insured reaches the age of 66 years; or
- The date selected by the Policyholder for termination of the TERM PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER, which date is reflected in the latest Policy Certificate issued by PPS Insurance.

The Benefits due in terms of the TERM PROFESSIONAL HEALTH PROVIDER BENEFIT are a proportion of the Sum Assured calculated according to the Severity Level of the event as defined in Appendix B of which there shall be four severity levels namely:

Severity Level A for which the Benefit shall be 100% of the Sum Assured.
Severity Level B for which the Benefit shall be 75% of the Sum Assured.
Severity Level C for which the Benefit shall be 50% of the Sum Assured.
Severity Level D for which the Benefit shall be 25% of the Sum Assured.

There are 32 benefit categories including a Cardiovascular benefit category listed in Appendix B.

The Cardiovascular benefit category includes the conditions Heart attack, Cardiac Surgery and Procedures, Cardiomyopathy and Aortic surgery. Once 100% has been claimed from the Cardiovascular benefit category no further claims will be paid from this benefit category.

Claims for the other 31 benefit categories never exhaust these benefit categories and claims for unrelated events qualifying for a claim under the same benefit category will be paid, regardless of previous payments from that benefit category.

More than 1 valid claim can therefore be paid from the same or different benefit category. The benefit paid will then differ for Related Claims and Unrelated Claims.

- Related Claims:
  A related claim is a condition or illness which is directly or indirectly related to a past claim where, in the opinion of PPS Insurance, the subsequent condition is either a complication of, outcome of, or treatment for, any previous illness or condition resulting in an existing payment under this policy; or an event that shares a common cause or effect with any previous illness or condition resulting in a claim under this benefit.
  The benefit paid will be the Sum Assured according to the Severity Level thereof less any Related Claims, from the same or different benefit category, previously paid.
- Unrelated Claims:
  The benefit paid will be the Sum Assured according to the Severity Level thereof (regardless of any previous claims).

The Policyholder can at any time, but at least 2 months prior to the date selected by the Policyholder for termination of the TERM PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER, which date is reflected in the latest Policy Certificate issued by PPS Insurance, apply to PPS Insurance in writing in the manner prescribed by PPS Insurance for the TERM PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER to be changed to WHOLE LIFE PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER. The conversion of the TERM PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER to WHOLE LIFE PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER will be at the discretion of PPS Insurance and if granted will be on the conditions and terms imposed by PPS Insurance, which terms will include an increase in the premiums.

Sum Assured
The Sum Assured in respect of the TERM PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER is reflected on the latest Policy Certificate issued by PPS Insurance.

Declared annual increases will increase the Sum Assured on the 1st of January each year at the discretion of PPS Insurance, without proof of insurability. Upon such an increase, the premium will increase accordingly.

Exclusions
Please refer to the section titled LOADINGS AND EXCLUSIONS.

Please note the specific exclusions in Appendix B.

Waiting Period
There is no initial waiting period applicable to a claim for a TERM PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER.

Survival Period
The TERM PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER is paid subject to a general survival period of 14 days together with any further survival period reflected in Appendix B. The life insured must survive for a period of 14 days after the event occurs or the condition is diagnosed.

Increase in premiums
The premium pattern is age related. Premiums will increase annually on the 1st of the month following the life insured's birthday.

At the sole discretion of PPS Insurance, annual increases in benefits may be declared to reduce the eroding effects of inflation. Benefits will increase by the declared percentage for effective cover on the 1st of January each year. The premium for additional benefits will be based on the life insured's age next birthday at the time of the increase.

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.

41. WHOLE LIFE PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER

If the life insured suffers any of the dread diseases, trauma and physical impairments listed in Appendix B, PPS Insurance will pay a percentage of the Sum Assured in respect of the WHOLE LIFE PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER according to the Severity Level thereof.

The WHOLE LIFE PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER will commence on the commencement date reflected on the latest Policy Certificate issued by PPS Insurance.

The WHOLE LIFE PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER will end automatically on the first of the following events occurring:

- Death of the life insured; or
- Cancellation by the Policyholder; or
- Cancellation of the benefit by PPS Insurance.

The Benefits due in terms of the WHOLE LIFE PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER are a proportion of the Sum Assured calculated according to the Severity Level of the event as defined in Appendix B of which there shall be four severity levels namely:

Severity Level A for which the Benefit shall be 100% of the Sum Assured.
Severity Level B for which the Benefit shall be 75% of the Sum Assured.
Severity Level C for which the Benefit shall be 50% of the Sum Assured.
Severity Level D for which the Benefit shall be 25% of the Sum Assured.

There are 32 benefit categories including a Cardiovascular benefit category listed in Appendix B.

The Cardiovascular benefit category includes the conditions Heart attack, Cardiac Surgery and Procedures, Cardiomyopathy and Aortic surgery. Once 100% has been claimed from the Cardiovascular benefit category no further claims will be paid from this benefit category.

Claims for the other 31 benefit categories never exhaust these benefit categories and claims for unrelated events qualifying for a claim under the same benefit category will be paid, regardless of previous payments from that benefit category.

More than 1 valid claim can therefore be paid from the same or different benefit category. The benefit paid will then differ for Related Claims and Unrelated Claims.

- Related Claims:
  A related claim is a condition or illness which is directly or indirectly related to a past claim where, in the opinion of PPS Insurance, the subsequent condition is either a complication of, outcome of, or treatment for, any previous illness or condition resulting in an existing payment under this policy; or an event that shares a common cause or effect with any previous illness or condition resulting in a claim under this benefit.
  The benefit paid will be the Sum Assured according to the Severity Level thereof less any Related Claims, from the same or different benefit category, previously paid.
- Unrelated Claims:
  The benefit paid will be the Sum Assured according to the Severity Level thereof (regardless of any previous claims).

The Sum Assured
The Sum Assured in respect of the WHOLE LIFE PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER is reflected on the latest Policy Certificate issued by PPS Insurance.

Declared annual increases will increase the Sum Assured on the 1st of January each year at the discretion of PPS Insurance, without proof of insurability. Upon such an increase, the premium will increase accordingly.

Exclusions
Please refer to the section titled LOADINGS AND EXCLUSIONS.

Please note the specific exclusions in Appendix B.

Waiting period
There is no initial waiting period applicable to a claim for a WHOLE LIFE PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER.

Survival Period
The WHOLE LIFE PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER is paid subject to a general survival period of 14 days together with any further survival period reflected in Appendix B. The life insured must survive for a period of 14 days after the event occurs or the condition is diagnosed.

Increase in premiums
The premium pattern is the PPS Whole Life premium pattern. Premiums will increase annually by a percentage on the 1st of the month following the life insured's birthday. The percentage increases are determined by PPS Insurance in its sole discretion from time to time and are based on the life insured's age next birthday.

At the sole discretion of PPS Insurance, annual increases in benefits may be declared to reduce the eroding effects of inflation. Benefits will increase by the declared percentage for effective cover on the 1st of January each year. The premium for additional benefits will be based on the life insured's age next birthday at the time of the increase.

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.

42. CATCHALL COVER

The CATCHALL COVER is only available to Policyholders who have either a TERM PROFESSIONAL HEALTH PROVIDER BENEFIT and / or a WHOLE LIFE PROFESSIONAL HEALTH PROVIDER BENEFIT and / or a TERM PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER and / or a WHOLE LIFE PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER (the ñBASIC BENEFITò). Each CATCHALL COVER benefit will then be a rider benefit on one specific BASIC BENEFIT as reflected on the latest Policy Certificate issued by PPS Insurance.

Claims will only be paid under the CATCHALL COVER BENEFIT if the life insured suffers a dread disease, trauma or physical impairment that is not covered in terms of the BASIC BENEFIT or MATERNITY COVER (even where the policyholder does not have MATERNITY COVER), including all severity levels, regardless of whether the claim was admitted under the BASIC BENEFIT or not.

PPS Insurance will pay the Sum Assured in respect of the CATCHALL COVER BENEFIT if the life insured suffers a dread diseases, trauma or physical impairment pursuant to the occurrence of a serious medical or physical condition that:

- Results in a Whole Person Impairment (WPI) severity of at least 35%; and
- results in confinement to a bed or wheelchair, for lives assured older than 75; and
- is permanent and unlikely to change in spite of further medical or surgical treatment.

The CATCHALL COVER will commence on the commencement date reflected on the latest Policy Certificate issued by PPS Insurance.

The CATCHALL COVER will end automatically on the first of the following events occurring:

- Death of the life insured; or
- Cancellation by the Policyholder; or
- Cancellation of the benefit by PPS Insurance; or
- If the Policyholder is no longer entitled to the BASIC BENEFIT; or
- Once a claim has been paid in terms of this benefit.

If a valid claim is submitted under this benefit for a condition that is related to a condition already claimed under the BASIC BENEFIT or MATERNITY COVER the benefit paid will be 100% less the percentage benefit already paid.

A related claim is a condition or illness which is directly or indirectly related to a past claim where, in the opinion of PPS Insurance, the subsequent condition is either a complication of, outcome of, or treatment for, any previous illness or condition resulting in an existing payment under this policy; or an event that shares a common cause or effect with any previous illness or condition resulting in a claim under this benefit.

Sum Assured
The Sum Assured of the CATCHALL COVER benefit will always be the same as the Sum Assured in respect of the BASIC BENEFIT.

Exclusions
Please refer to the section titled LOADINGS AND EXCLUSIONS.

Waiting period
There is no initial waiting period applicable to a claim for a CATCHALL COVER.

Survival Period
The CATCHALL COVER is paid subject to a general survival period of 14 days. The life insured must survive for a period of 14 days after the event occurs or the condition is diagnosed.

Increase in Premiums
The premium pattern applicable to the BASIC BENEFIT will be applicable to the CATCHALL BENEFIT.

The premium will increase when the Sum Assured with respect to the BASIC BENEFIT is increased.

43. MATERNITY COVER

The MATERNITY COVER is only available to Policyholders who have either a TERM PROFESSIONAL HEALTH PROVIDER BENEFIT and / or a WHOLE LIFE PROFESSIONAL HEALTH PROVIDER BENEFIT and / or a TERM PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER and / or a WHOLE LIFE PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER. The Policyholder can only apply for the MATERNITY COVER simultaneously with an application for TERM PROFESSIONAL HEALTH PROVIDER BENEFIT and / or a WHOLE LIFE PROFESSIONAL HEALTH PROVIDER BENEFIT and / or a TERM PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER and / or a WHOLE LIFE PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER. The MATERNITY COVER benefit will then be a rider benefit on the TERM PROFESSIONAL HEALTH PROVIDER BENEFIT and / or a WHOLE LIFE PROFESSIONAL HEALTH PROVIDER BENEFIT and / or a TERM PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER and / or a WHOLE LIFE PROFESSIONAL HEALTH PROVIDER BENEFIT with CORE 100% COVER (the "BASIC BENEFIT").

If the life insured suffers any of the pregnancy complications listed in Appendix C, PPS Insurance will pay a percentage of the Sum Assured in respect of the MATERNITY COVER according to the Severity Level thereof.

The MATERNITY COVER will commence on the commencement date reflected on the latest Policy Certificate issued by PPS Insurance.

The MATERNITY COVER will end automatically on the first of the following events occurring:

- On the last day of the month during which the life insured reaches the age of 44 years; or
- Death of the life insured; or
- Cancellation by the Policyholder; or
- Cancellation of the benefit by PPS Insurance; or
- It the Policyholder is no longer entitled to the BASIC BENEFIT; or
- When an aggregate of 100% of the Sum Assured has been paid to the policyholder.

The Benefits due in terms of the MATERNITY COVER are a proportion of the Sum Assured calculated according to the Severity Level of the event as defined in Appendix C of which there shall be four severity levels namely:

Severity Level A for which the Benefit shall be 100% of the Sum Assured.
Severity Level B for which the Benefit shall be 75% of the Sum Assured.
Severity Level C for which the Benefit shall be 50% of the Sum Assured.
Severity Level D for which the Benefit shall be 25% of the Sum Assured.

Sum Assured
The Sum Assured in respect of the MATERNITY COVER is reflected on the latest Policy Certificate issued by PPS Insurance.

Declared annual increases will increase the Sum Assured on the 1st of January each year at the discretion of PPS Insurance, without proof of insurability. Upon such an increase, the premium will increase accordingly.

The Policyholder is not entitled to apply to PPS Insurance for the Sum Assured to be increased.

The Policyholder will be entitled to claim more than once but will not be entitled to a benefit exceeding an aggregate of 100% of the Sum Assured.

Exclusions
Please refer to the section titled LOADINGS AND EXCLUSIONS.

Please note the specific exclusions in Appendix C.

Waiting Period
No claim will be paid in respect of pregnancy related conditions occurring within 12 months after either the date of commencement or, where applicable, the date of reinstatement of cover.

Survival Period
The MATERNITY COVER is paid subject to a general survival period of 14 days together with any further survival period reflected in Appendix C. The life insured must survive for a period of 14 days after the event occurs or the condition is diagnosed.

Increase in Premiums
The premium pattern is age related. Premiums will increase annually on the 1st of the month following the life insured's birthday.

At the sole discretion of PPS Insurance, annual increases in benefits may be declared to reduce the eroding effects of inflation. Benefits will increase by the declared percentage for effective cover on the 1st of January each year. The premium for additional benefits will be based on the life insured's age next birthday at the time of the increase.

THE PPS PROFESSIONAL DISABILITY PROVIDER™ PRODUCT

44. DISABILITY COVER

The DISABILITY COVER will commence on the commencement date reflected in the latest Policy Certificate issued by PPS Insurance.

The DISABILITY COVER will cease automatically on the first of the following events occurring:

- On the last day of the month during which the life insured reaches the age of 66 years (upon which the SEVERE ILLNESS BENEFIT will automatically commence); or
- The date selected by the Policyholder for termination of the DISABILITY COVER, which date is reflected in the latest Policy Certificate issued by PPS Insurance; or
- Cancellation by the Policyholder; or
- Cancellation of the benefit by PPS Insurance; or
- A successful claim for a DISABILITY COVER.

The DISABILITY COVER will automatically convert into the SEVERE ILLNESS BENEFIT if the terms and conditions set out in the section titled SEVERE ILLNESS BENEFIT are met.

The Policyholder will inform PPS Insurance in writing of a change in the life insured's occupation within 30 days from the date on which the life insured changed his occupation or no longer substantially practices the occupation reflected on the latest Policy Certificate issued by PPS Insurance. Please refer to the section titled CHANGE OF OCCUPATION

If the life insured is disabled during the benefit term, PPS Insurance will pay the Sum Assured in respect of the DISABILITY COVER. The DISABILITY COVER will only be payable if:

- the life insured is in the opinion of PPS Insurance significantly unable to use his professional training and knowledge to carry out his own profession as well as any other profession that could be carried out by persons with similar or comparable qualifications as a result of a disease, injury or accident; and
- the disability is in the opinion of PPS Insurance permanent, significant and severe.

Sum Assured
The initial Sum Assured in respect of the DISABILITY COVER is reflected on the latest Policy Certificate issued by PPS Insurance.

Declared annual increases will increase the Sum Assured on the 1st of January each year at the discretion of PPS Insurance, without proof of insurability. Upon such an increase, the premium will increase accordingly.

The Policyholder is entitled to apply to PPS Insurance for the Sum Assured to be increased. The Sum Assured will be increased subject to the acceptance of the application to increase the Sum Assured by PPS Insurance and subject to the requirements and conditions imposed by PPS Insurance. An application to increase the Sum Assured must be made in writing in the manner prescribed by PPS Insurance.

Exclusions
Please refer to the section titled LOADINGS AND EXCLUSIONS.

Waiting Period
There is no waiting period in respect of the DISABILITY COVER.

Increase in premiums
The premium pattern is reflected on the latest Policy Certificate issued by PPS Insurance,

At the sole discretion of PPS Insurance, annual increases in benefits may be declared to reduce the eroding effects of inflation. Benefits will increase by the declared percentage for effective cover on the 1st of January each year. The premium for additional benefits will be based on the life insured's age next birthday at the time of the increase.

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.

45. OSRB DISABILITY COVER

The OSRB DISABILITY COVER will commence on the commencement date reflected in the latest Policy Certificate issued by PPS Insurance.

The OSRB DISABILITY COVER will cease automatically on the first of the following events occurring:

- On the last day of the month during which the life insured reaches the age of 66 years (upon which the SEVERE ILLNESS BENEFIT will automatically commence); or
- The date selected by the Policyholder for termination of the OSRB DISABILITY COVER, which date is reflected in the latest Policy Certificate issued by PPS Insurance; or
- Cancellation by the Policyholder; or
- Cancellation of the benefit by PPS Insurance; or
- A successful claim for an OSRB DISABILITY COVER.

The OSRB DISABILITY COVER will automatically convert into the SEVERE ILLNESS BENEFIT if the terms and conditions set out in the section titled SEVERE ILLNESS BENEFIT are met.

The Policyholder will inform PPS Insurance in writing of a change in the life insured's occupation within 30 days from the date on which the life insured changed his occupation or no longer substantially practices the occupation reflected on the latest Policy Certificate issued by PPS Insurance. Please refer to the section titled CHANGE OF OCCUPATION.

If the life insured is disabled during the benefit term, PPS Insurance will pay the Sum Assured in respect of the OSRB DISABILITY COVER. The OSRB DISABILITY COVER will only be payable if:

- the life insured is in the opinion of PPS Insurance significantly unable to perform his own specifically nominated occupation as a result of a disease, injury or accident. The occupation nominated for this purpose is reflected in the latest Policy Certificate issued by PPS Insurance; and
- the disability is in the opinion of PPS Insurance permanent, significant and severe.

Sum Assured
The initial Sum Assured in respect of the OSRB DISABILITY COVER is reflected on the latest Policy Certificate issued by PPS Insurance.

Declared annual increases will increase the Sum Assured on the 1st of January each year at the discretion of PPS Insurance, without proof of insurability. Upon such an increase, the premium will increase accordingly.

The Policyholder is entitled to apply to PPS Insurance for the Sum Assured to be increased. The Sum Assured will be increased subject to the acceptance of the application to increase the Sum Assured by PPS Insurance and subject to the requirements and conditions imposed by PPS Insurance. An application to increase the Sum Assured must be made in writing in the manner prescribed by PPS Insurance.

Exclusions
Please refer to the section titled LOADINGS AND EXCLUSIONS.

Waiting Period
There is no waiting period in respect of the OSRB DISABILITY COVER.

Increase in premiums
The premium pattern is reflected on the latest Policy Certificate issued by PPS Insurance.

At the sole discretion of PPS Insurance, annual increases in benefits may be declared to reduce the eroding effects of inflation. Benefits will increase by the declared percentage for effective cover on the 1st of January each year. The premium for additional benefits will be based on the life insuredõs age next birthday at the time of the increase.

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.

46. SEVERE ILLNESS BENEFIT

The SEVERE ILLNESS BENEFIT will automatically commence (without any underwriting) on the first day after the day:

- on which DISABILITY COVER or OSRB DISABILITY COVER automatically ceased as a result of the life insured reaching the age of 66 years; or
- on which DISABILITY COVER or OSRB DISABILITY COVER automatically ceased as a result of the termination date for the cover as reflected in the latest Policy Certificate issued by PPS Insurance being reached **and** the life insured being at least 59 years old on the date on which DISABILITY COVER or OSRB DISABILITY COVER automatically ceased; or
- on which the DISABILITY COVER or OSRB DISABILITY COVER was cancelled by PPS Insurance upon receipt of notification by the policyholder in terms of the requirements set out in the section titled CHANGE OF OCCUPATION of the fact that the life insured is no longer employed **and** the life insured being at least 59 years old on the date on which DISABILITY COVER or OSRB DISABILITY COVER is cancelled.

The SEVERE ILLNESS BENEFIT will not commence if the DISABILITY COVER or OSRB DISABILITY COVER ceased or was cancelled for any reason other than the abovementioned reasons or if any premiums were outstanding with respect to the DISABILITY COVER or OSRB DISABILITY COVER.

If the life insured suffers any of the dread diseases, trauma or physical impairments listed in Appendix D, PPS Insurance will pay 100% of the Sum Assured in respect of the SEVERE ILLNESS BENEFIT.

If the life insured suffers a dread disease, trauma or physical impairment that is not listed in Appendix D, PPS Insurance will pay 100% of the Sum Assured in respect of the SEVERE ILLNESS BENEFIT if the life insured suffers a dread disease, trauma or physical impairment pursuant to the occurrence of a serious medical or physical condition that:

- Results in at least a class 4 rating in the American Medical Association ñGuidelines to the Evaluation of Permanent Impairmentò and results in a Whole Person Impairment (WPI) severity of at least 35%; and
- results in confinement to a bed or wheelchair, for lives assured older than 75; and
- is permanent and unlikely to change in spite of further medical or surgical treatment.

The SEVERE ILLNESS BENEFIT will end automatically on the first of the following events occurring:

- Death of the life insured; or
- Cancellation by the Policyholder; or
- Cancellation of the benefit by PPS Insurance; or
- Payment of the Sum Assured.

The section titled CHANGE OF OCCUPATION will not be applicable to the SEVERE ILLNESS BENEFIT.

The Sum Assured
The Sum Assured will be the lesser of:
- The Sum Assured of the relevant DISABILITY COVER or OSRB DISABILITY COVER from which the SEVERE ILLNESS BENEFIT was converted on the day it ceased; and
- The maximum Sum Assured with respect to the SEVERE ILLNESS BENEFIT as determined by PPS Insurance in its sole discretion from time to time.

The Sum Assured in respect of the SEVERE ILLNESS BENEFIT is reflected on the latest Policy Certificate issued by PPS Insurance.

Declared annual increases will increase the Sum Assured on the 1st of January each year at the discretion of PPS Insurance, without proof of insurability. Upon such an increase, the premium will increase accordingly. Please refer to the section titled PREMIUMS.

Exclusions
Please refer to the section titled LOADINGS AND EXCLUSIONS.

Please refer to any specific exclusions included in Appendix D.

Any specific underwriting loadings or exclusions applicable to the relevant DISABILITY COVER or OSRB DISABILITY COVER from which the SEVERE ILLNESS BENEFIT was converted will automatically apply to the SEVERE ILLNESS BENEFIT and will be reflected on the latest Policy Certificate issued by PPS Insurance.

Waiting period
There is no initial waiting period applicable to a claim for a SEVERE ILLNESS BENEFIT.

Survival Period
The SEVERE ILLNESS BENEFIT is paid subject to a general survival period of 14 days together with any further survival period reflected in Appendix D. The life insured must survive for a period of 14 days after the event occurs or the condition is diagnosed.

Increase in premiums
The premium pattern is reflected on the latest Policy Certificate issued by PPS Insurance.

At the sole discretion of PPS Insurance, annual increases in benefits may be declared to reduce the eroding effects of inflation. Benefits will increase by the declared percentage for effective cover on the 1st of January each year. The premium for additional benefits will be based on the life insuredõs age next birthday at the time of the increase.

THE SICKNESS AND PERMANENT INCAPACITY BENEFIT

47. SICKNESS AND PERMANENT INCAPACITY

The Sickness and Permanent Incapacity Benefit consists of the Sick Pay Benefit, including the Actual Business Expense Benefit, and the Permanent Incapacity Benefit. The benefits applicable to, or where appropriate the benefits selected by, each Policyholder or Student Policyholder will be reflected in the latest Policy Certificate issued by PPS Insurance.

If a Sickness and Permanent Incapacity Policyholder is unable to attend to his usual professional duties due to sickness or permanent incapacity as defined in the PPS ProviderÊ 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 ProviderÊ Policy.

If a PPS KickStart Policyholder is unable to attend to his usual professional duties due to sickness as defined in the PPS ProviderÊ Policy, PPS Insurance will pay a Sick Pay Benefit due in terms of the PPS KICKSTART SICKNESS BENEFIT, subject to the terms and conditions set out in the PPS ProviderÊ Policy.

The SICKNESS AND PERMANENT INCAPACITY BENEFIT and PPS KICKSTART SICKNESS 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 on the first of the following events occurring:

- death of the Policyholder;
- cancellation by the Policyholder;
- termination of the PPS ProviderÊ Policy or cancellation of the SICKNESS AND PERMANENT INCAPACITY BENEFIT by PPS Insurance as provided for in the 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;
- upon the Policyholder reaching the respective expiry ages for the Sick Pay Benefit and Permanent Incapacity Benefit as reflected in the latest Policy Certificate issued by PPS Insurance, provided that if the Policyholder is in receipt of a Permanent Incapacity Benefit in terms of his contract on the day that he reaches the expiry age for the Permanent Incapacity Benefit both his Sick Pay Benefit and Permanent Incapacity Benefit will end;
- where the Policyholder 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 PPS KICKSTART SICKNESS BENEFIT will end on the first of the following events occurring:

- death of the Policyholder;
- cancellation by the Policyholder;
- termination of the PPS ProviderÊ Policy or cancellation of the Sick Pay Benefit by PPS Insurance as provided for in the contract;
- on the day the Policyholder attains the age of 34 years

The PPS KICKSTART SICKNESS BENEFIT consists of the Sick Pay Benefit only, i.e. a Policyholder does not have the Permanent Incapacity Benefit. Student Policyholders who acquired the Student Sickness Benefit on or after 1 March 2015 (i.e. the benefit incepted on or after 1 March 2015) will have a Sick Pay Benefit only.

SICK PAY BENEFIT

The waiting period in respect of the Sick Pay Benefit will be reflected in the latest Policy Certificate issued by PPS Insurance and can be either a 7 day or a 30 day waiting period.

7 day waiting period: The Policyholder will qualify for a 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 a Total Sick Pay Benefit. If, however, after a period of qualifying for a Total Sick Pay Benefit as set out before 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 a Partial Sick Pay Benefit. If a subsequent claim for a Sick Pay Benefit is submitted to PPS Insurance following a previous successful claim for the same condition, the 7 day waiting period will be waived by PPS Insurance and the Policyholder will qualify for a Total or Partial Sick Pay Benefit, whichever is applicable, from the first day on which he is unable to carry out his professional duties due to sickness.

If a Policyholder to whom the 7 day waiting period applies is not totally unable to carry out his professional duties for at least seven consecutive days as described above, such Policyholder may still qualify for a Sick Pay Benefit under the 30 day waiting period as described hereunder.

30 day waiting period: The Policyholder will qualify for a Sick Pay Benefit provided that he is unable, either totally or partially, to carry out his professional duties for at least 30 consecutive days due to sickness. In such an event the Sick Pay Benefit will be paid on either a Total or a Partial basis, whichever is applicable, prospectively from the 31st day of consecutive sickness. If a subsequent claim for a Sick Pay Benefit is submitted to PPS Insurance within a period of three months of a previous successful claim for the same condition, the 30 day waiting period will be waived by PPS Insurance and the Policyholder will qualify for a Total or Partial Sick Pay Benefit, whichever is applicable, from the first day on which he is unable to carry out his professional duties due to sickness.

Student Policyholders: A Student Policyholder will qualify for a Total Sick Pay Benefit if he was totally unable to attend to his normal duties or activities 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 attend to his normal duties or activities due to sickness. A Student Policyholder will not qualify for any Partial Sick Pay Benefits. If a subsequent claim for a Total Sick Pay Benefit is submitted to PPS Insurance following a previous successful claim for the same condition, the 7 day waiting period will be waived by PPS Insurance and the Student Policyholder will qualify for a Total Sick Pay Benefit from the first day on which he is totally unable to attend to his normal duties or activities due to sickness.The quantum of any Sick Pay Benefit payable to a Student Policyholder will not be limited due to the fact that he is not earning any income from the practice of any profession.

In no instance will any Sick Pay Benefit be payable to any Policyholder for an amount in excess of the maximum cover amounts as determined by PPS Insurance from time to time.

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 under either the 7 day or 30 day waiting period pregnancy complication sickness benefit criteria (The waiting period applicable to each individual Policyholder is reflected in the latest Policy Certificate issued by PPS Insurance), 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 a policyholder to whom the 7 day waiting period applies (Refer to the latest Policy Certificate issued by PPS Insurance) 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. In such instance payment will be made retrospectively from the first day of hospitalisation up until the date on which the Policyholder is discharged or the date of delivery of the unborn child or on termination of the pregnancy, whichever occurs first.

Where a sickness is directly or indirectly attributable to pregnancy, confinement or miscarriage, but the specific sickness contracted by a policyholder to whom the 30 day waiting period applies (Refer to the latest Policy Certificate issued by PPS Insurance) 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 30 consecutive days. In such instance payment will be made prospectively from the thirty first day of hospitalisation up until the date on which the Policyholder is discharged or the date of delivery of the unborn child or on termination of the pregnancy, whichever occurs first.

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 ProviderÊ 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. PPS Insurance may however, in its sole and absolute discretion, extend the Sick Pay Benefit of any Policyholder for a further period not exceeding 180 days whereafter the Policyholder will then be assessed for the Permanent Incapacity Benefit in accordance with the Permanent Incapacity Assessment Process.

A Policyholder who is in receipt of Sick Pay Benefit, will continue to pay premiums during such period of sickness.

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 a 728 day Sick Pay Benefit period for any sickness as described above, 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. If the Policyholder is then awarded a Permanent Incapacity Benefit as described hereunder, such Permanent Incapacity Benefit shall be paid in substitution of any Sick Pay Benefit for the particular sickness.

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 Policyholderôs impairment will permanently affect his ability to perform his usual professional duties and any further improvement in his functional/vocational capacity is unlikely. Policyholders who first acquired the Sickness and Permanent Incapacity Benefit on or after 1 March 2015 (i.e. the benefit incepted on or after 1 March 2015) will only be assessed for the Permanent Incapacity Benefit after the full 728 days of Sickness Benefits for a particular sickness or accident have been exhausted;
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 Policyholderôs ability to apply his mental and decision making skills, required to perform his usual professional duties, as a primary consideration;
d) a Policyholderôs physical/cognitive/functional and vocational capacity vs. the physical/cognitive/ functional and vocational demands of his usual professional duties;
e) the Policyholderôs 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 Policyholderôs 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 first acquired the SICKNESS AND PERMANENT INCAPACITY BENEFIT prior to 1 March 2015 (i.e. the benefit incepted before 1 March 2015) and who has been awarded a Partial Permanent Incapacity award of 20% or 60%:

- and remains working within his profession, may elect whether or not to continue paying premiums. Where such a Policyholder elects to continue paying premiums he will still be allowed to file claims for any sickness unrelated to that for which he is receiving a permanent incapacity award. Such a policyholder will only be allowed to file claims for Total Sickness Benefits which, if successful, will be paid in substitution of the Partial Permanent Incapacity award for the relevant claim period;
- and ceases to work within his profession, will not 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 Policyholder who first acquired the SICKNESS AND PERMANENT INCAPACITY BENEFIT on or after 1 March 2015 (i.e. the benefits incepted on or after 1 March 2015) and who has been awarded a Partial Permanent Incapacity award of 20% or 60% will not continue to pay premiums and will not be allowed to file any further Sickness Benefit claims. Such a policyholder may however apply for a review of his Partial Permanent Incapacity award in accordance with the Permanent Incapacity Assessment Process.

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 the benefit, when he shall again become entitled to all the cover available in terms of such 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

The Permanent Incapacity Benefit will end upon the Policyholder reaching the expiry age for the Permanent Incapacity Benefit as reflected in the latest Policy Certificate issued by PPS Insurance.

Benefit Options

The Benefit options described under (a) to (e) hereunder only apply to Policyholders who first acquired the SICKNESS AND PERMANENT INCAPACITY BENEFIT prior to 1 March 2015, i.e. the benefit incepted before 1 March 2015.

The Policyholder may qualify for the following benefit options in the discretion of PPS Insurance:

(a) Ordinary Benefit Option: Units of Ordinary Benefit entitle the Policyholder to either Sick Pay Benefit or Permanent Incapacity Benefit. The payment rates in respect of Units of Ordinary Benefit are determined by PPS Insurance. The monthly benefit amounts that a Policyholder will be entitled to receive in respect of claims for the Total Sick Pay Benefit and the Partial Sick Pay Benefit and the Total Permanent Incapacity Benefit are reflected in the latest Policy Certificate issued by PPS Insurance. Where the Policyholder was not Sick or Permanently Incapacitated for an entire month he will be entitled to receive a pro-rata daily benefit for each day of Sickness or Incapacity. Where the Policyholder qualifies for a Partial Permanent Incapacity Benefit, he will be paid the amount reflected in the Policy Certificate 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: Units of A Supplementary Benefit entitle the Policyholder to Sick Pay Benefit. The payment rates in respect of Units of A Supplementary Benefit are determined by PPS Insurance. The monthly benefit amounts that a Policyholder will be entitled to receive in respect of claims for the Total Sick Pay Benefit and the Partial Sick Pay Benefit are reflected in the latest Policy Certificate issued by PPS Insurance. Where the Policyholder was not Sick for an entire month he will be entitled to receive a pro-rata daily benefit for each day of Sickness.

A Policyholderôs Units of A Supplementary Benefit will be cancelled on the day that he attains the expiry age for the Sickness Benefit as reflected in the latest Policy Certificate issued by PPS Insurance. No further premiums or benefits will thereafter be payable in respect of such cancelled units.

(c) B Supplementary Benefit Option: Units of B Supplementary Benefit entitle the Policyholder 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 Benefits declared by PPS Insurance.

The payment rates in respect of Units of B Supplementary Benefit are determined by PPS Insurance. The monthly benefit amounts that a Policyholder will be entitled to receive in respect of claims for the Total Sick Pay Benefit and the Partial Sick Pay Benefit are reflected in the latest Policy Certificate issued by PPS Insurance. Where the Policyholder was not Sick for an entire month he will be entitled to receive a pro-rata daily benefit 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: Units of Deferred Benefit entitle the Policyholder to Permanent Incapacity Benefit.

The payment rates in respect of Units of Deferred Benefit are determined by PPS Insurance. The monthly benefit amounts that a Policyholder will be entitled to receive in respect of claims for the Total Permanent Incapacity Benefit are reflected in the latest Policy Certificate issued by PPS Insurance. Where the Policyholder was not Permanently Incapacitated for an entire month he will be entitled to receive a pro-rata daily benefit for each day of Incapacity. Where the Policyholder qualifies for a Partial Permanent Incapacity Benefit, he will be paid the amount reflected in the Policy Certificate 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 expiry age for the Permanent Incapacity Benefit as reflected in the latest Policy Certificate issued by PPS Insurance. No further premiums or benefits will thereafter be payable in respect of such cancelled units.

(e) Accident Benefit Option: Units of Accident Benefit entitle the Policyholder 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.

The payment rates in respect of Units of Accident Benefit are determined by PPS Insurance. The monthly benefit amounts that a Policyholder will be entitled to receive in respect of claims for the Total Sick Pay Benefit, the Partial Sick Pay Benefit and the Total Permanent Incapacity Benefit are reflected in the latest Policy Certificate issued by PPS Insurance. Where the Policyholder was not Sick or Permanently Incapacitated for an entire month he will be entitled to receive a pro-rata daily benefit for each day of Sickness or Incapacity. Where the Policyholder qualifies for a Partial Permanent Incapacity Benefit, he will be paid the amount reflected in the Policy Certificate 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. Provided that he complies with the requirements of his contract for Hospital Rider Benefit, it entitles him to a Hospital Benefit that shall be equal to the monthly Hospital Benefit amount displayed in the Policy Certificate, paid pro-rata for the days on which the Policyholder was hospitalised and unable to work.

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 expiry age for the Sickness Benefit as reflected in the latest Policy Certificate issued by PPS Insurance. In the event that the Sickness Benefit does not have an expiry age (i.e. the Policyholder enjoys whole of life Sickness Benefit Cover) the Hospital Rider Benefit will be cancelled at the end of the month during which the Policyholder attains the age of 65 years.

(b) Family Hospital Benefit: The Family Hospital Benefit is available as a rider benefit in respect of the Sick Pay Benefit.

Provided that he complies with the requirements of his contract for the Family Hospital Benefit, the Policyholder will be entitled to a Family Hospital Benefit that shall be equal to the monthly Family Hospital

Benefit amount displayed in the Policy Certificate, paid pro-rata for the days on which the Policyholder's Spouse or Child was hospitalised.

The Policyholder will be entitled to receive a daily benefit for each day that the Policyholder's Spouse or any Child of the Policyholder is hospitalised, provided that the hospitalisation lasts for at least 4 consecutive days (3 consecutive nights). The benefit will then be paid retrospectively from the 1st day of hospitalisation. The Family Hospital Benefit will pay for a maximum of 182 days in a calendar year if the Spouse or Child is a member or dependent on the Profmed Medical Scheme and 91 days in a calendar year in all other circumstances. If multiple family members are hospitalised at the same time, the Family Hospital Benefit pays only a single benefit for the family member hospitalised the longest up to the maximum days described.

> **Child Terminal Illness Benefit**: The Policyholder will be entitled to receive a lump sum payment of an amount equal to 12 months' Sick Pay Benefits, subject to a maximum payment limit of R 600 000, if a Child of the Policyholder is diagnosed with a terminal illness and is given less than 12 months to live. A survival period of 14 days applies, i.e. the Child has to survive for at least 14 days following the diagnosis of the Terminal Illness before the Child Terminal Illness benefit will be paid. The Policyholder will not be entitled to claim Hospital Benefits for the child during this 12 month period.
>
> **Child Death Benefit**: If a Child of the Policyholder dies **and** no benefit was payable to the Policyholder in respect of that Child under the Child Terminal Illness Benefit, the Policyholder will nevertheless be entitled to receive a lump sum payment of an amount equal to 1 months' Sick Pay Benefits, subject to a maximum payment limit of a) R10 000 if the Child is under the age of 6 years; or b) R30 000 if the Child is under the age of 14 years; or c) R50 000 if the Child is over the age of 14 years.

For the purpose of the Family Hospital Benefit a "Child" shall mean a person who is either a biological Child, a legally adopted Child, or a step Child of the Policyholder and who is the biological or legally adopted child of the spouse of the Policyholder, at the date of diagnosis of the sickness which gave rise to the claim under the Family Hospital Benefit, and who is between the ages of 4 months and 21 years old. The Policyholder's cover will therefore commence on the later date of the date when the Child attains the age of 4 months or on the commencement date of the Policy and cover will cease on the Child's 21st birthday.

For the purpose of the Family Hospital Benefit a "Spouse" shall mean a person to whom the Policyholder is married at the date of the diagnosis of the sickness which gave rise to the claim under the Family Hospital Benefit and who is under the age of 70 years. A "Marriage" for the purpose of the Family Hospital Benefit shall be restricted to the following relationships:

- a Civil Marriage concluded and duly registered in terms of the Marriage Act of 1961; or
- a Customary Marriage concluded and duly registered in terms of the Customary Marriages Act of 1998; or
- A Civil Union, in the form of either a marriage or civil partnership, concluded and duly registered in terms of the Civil Union Act of 2006; and

for which a valid marriage certificate can be produced.

A Policyholder's cover will therefore commence on the later date of the date on which the person became the Spouse of the Policyholder or on the commencement date of the Policy and cover will cease on the Spouse's 70th birthday.

Upon receipt of any claim under the Family Hospital Benefit PPS Insurance may request the Policyholder to submit such proof as PPS Insurance may, in its sole discretion, require in order to satisfy itself that the requirements for a valid claim under the Family Hospital Benefit have been complied with. This may include, but will not necessarily be limited to, proof of hospitalisation, a medical report from the Child's or

Spouse's treating doctor, a copy of the unabridged birth certificate of the Child, a copy of the official adoption court order and/or official proof of the registration of the adoption with the Registrar of Adoptions, a copy of the marriage certificate pertaining to the Spouse etc. Where PPS Insurance, in its sole discretion, deems it necessary it may also request the Policyholder to submit medical records pertaining to the Policyholder's Spouse or Child and any failure by the Policyholder to submit such records, or to procure the necessary consent from his/her Spouse or Child for the release of such records, may lead to the rejection by PPS of the Policyholder's claim under the Family Hospital Benefit.

Exclusions:

- No claim will be paid under the Family Hospital Benefit (including the Child Terminal Illness Benefit and the Child Death Benefit) for any condition that existed in the Child or Spouse prior to the date on which the Policyholder became eligible for the Family Hospital Benefit. The exclusion also applies to conditions that directly or indirectly caused or aggravated the claim event. Lastly the exclusion also applies to all symptoms experienced by the Child or Spouse that could have revealed the illness or condition before the Policyholder became eligible for the Family Hospital Benefit in respect of such Child or Spouse.
- No claim will be paid under the Family Hospital Benefit (including the Child Terminal Illness Benefit and the Child Death Benefit) if the condition which the Child or Spouse suffers from is a result of a willful or negligent act committed by the Policyholder or the Policyholder's Spouse.
- No claim will be paid for routine pregnancy or childbirth. Hospitalisation for pregnancy complications prior to delivery will be considered.
- No claim will be paid under the Family Hospital Benefit (including the Child Terminal Illness Benefit and the Child Death Benefit) for the first 182 days after the effective date of issue of the Family Hospital Benefit.

The Family Hospital Benefit will cease on the day that the Policyholder attains the expiry age reflected in the latest Policy Certificate issued by PPS Insurance.

(c) Permanent Incapacity Booster: In order to acquire this Rider Benefit, the Policyholder has to apply for the Permanent Incapacity Booster. It is available as a rider benefit in respect of the Permanent Incapacity 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 a Permanent Incapacity Booster 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.No further benefits in terms of Sick Pay Benefit and/or Permanent Incapacity Benefit are available once the Permanent Incapacity Booster award has been made and all premiums for these benefits will cease accordingly.

Requirements for acquiring the Permanent Incapacity Booster Benefit: The Policyholder will only qualify for this rider benefit if he, at the time of applying for this rider benefit:

(i) holds Permanent Incapacity cover;
(ii) has not yet attained the age of 62 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 Permanent Incapacity Booster Benefit will only be issued by PPS Insurance as a rider benefit in respect of a Policyholder's Permanent Incapacity cover (excluding any Units of Accident Benefit). Should the Policyholder's Permanent Incapacity cover be increased or reduced in terms of this contract, the Permanent Incapacity Booster 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 Permanent Incapacity Booster Benefit in respect of:

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

The exclusions listed in (i) to (iii) above apply only to the Permanent Incapacity Booster 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 Policyholderôs functioning and ability to practice his nominated specific occupation, his benefits in terms of the Permanent Incapacity Booster Benefit, once awarded by PPS Insurance, will not be reviewed. The Permanent Incapacity Booster Benefit will expire on the same day that the Policyholderôs Permanent Incapacity cover expires as indicated in the latest Policy Certificate issued by PPS Insurance

Restrictions on the amount of cover held by the Policyholder

PPS Insurance will determine the minimum and maximum amount of cover that a Policyholder may hold. Subject to such minimums and maximums, a Policyholder may hold any amount of cover provided that his cover will at no stage exceed the following limits:

- Cover under the Sick Pay Benefit will be limited to the greater of either a) 2/3^{rds} of the Policyholderôs Gross Personal Income (the Policyholderôs Gross Professional Income before taxes and other deductions minus his actual business expenses, as determined by PPS) and 100% of the Policyholderôs actual business expenses (expenses paid to 3rd parties in the normal operation of the Policyholderôs business, as determined by PPS) prior to any claim or b) the Policyholderôs Net of Tax Personal Income (the Policyholderôs Gross Professional Income after taxes and other deductions minus his actual business expenses, as determined by PPS) plus 100% of the Policyholderôs actual business expenses prior to any claim
- Cover under the Permanent Incapacity Benefit will be limited to the Policyholderôs Net of Tax personal income, as determined by PPS, prior to any claim.

A Student Policyholder and a PPS KickStart Policyholder may hold such amounts of cover 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.

Annual increase of Benefits declared by PPS Insurance

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

The following conditions will apply to such an issue of benefits:

1. Each year PPS Insurance will consider the economic factors and indicators which it believes relevant or applicable to Policyholdersôbenefits 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 being eroded or diminished, then PPS Insurance may in its entire discretion, decide upon percentages by which the benefits of all Policyholders will be increased on 1 January of the following year.
2. The percentage increase so determined will be calculated on each Policyholderôs existing benefits as at 31 December of the immediately preceding year.
3. The Policyholder will pay a premium for the additional benefits so issued to him at the applicable rate for his age at the date of issue.
4. The benefits so issued will be subject to the premium loadings and/or exclusions that applied to the immediately preceding issue of benefits to the Policyholder..
5. Subject to the rights of Policyholders who are in receipt of Partial Permanent Incapacity Benefits that remain working and elect to still pay premiums, Policyholders who have been declared permanently incapacitated will not be issued with these additional benefits.
6. Policyholders who are in receipt of Sick Pay Benefit or Partial Permanent Incapacity Benefit that remain working and still pay premiums, shall be issued with these additional benefits and subject to payment of the premiums in respect thereof shall be entitled to the benefits from the date on which they are issued.

Bonus benefits for permanently incapacitated Policyholders

PPS Insurance may annually issue bonus benefits in respect of those benefits held by the Policyholder that provide for Permanent Incapacity cover, to those Policyholderôs who have been declared permanently incapacitated (excluding Policyholders who have been declared partially permanently incapacitated that remain working and elect to still pay premiums) subject to the following conditions:

1. The value of the bonus benefits 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 benefits shall then be issued from a date to be determined by PPS Insurance.
2. The permanently incapacitated Policyholder will not be required to pay any premiums in respect of such bonus benefits. The bonus benefits will qualify for bonus allocations in respect of the Policyholderôs apportionment account as described hereafter.
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 benefits issued to him in the past. He will pay a premium for the retained bonus benefits 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 benefits will be deemed to be benefits for all purposes under his contract.

Applying for Additional Benefits

A Policyholder may apply for additional benefits provided that the amount of cover held by him after issue of such additional benefits will not exceed the maximums as determined by PPS Insurance from time to time or as determined by reference to his income derived from the practice of his profession.

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

Policyholders who are in receipt of Permanent Incapacity Benefits in terms of this contract or PPS KickStart Policyholders will not be entitled to apply for additional benefits.

Guaranteed right to additional Units of Benefit

Notwithstanding the other provisions of this contract, 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 Benefits

A Policyholder may, subject to the approval of PPS Insurance, reduce the benefits held by him at any time provided that the amount of cover held by him after such reduction will not be less than the minimums prescribed by PPS Insurance from time to time. 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 benefits.

The benefits to be cancelled will be the benefits last issued to him. The reduction of premiums will be the cost of the specific benefits so cancelled.

If a Policyholderôs income derived from the practice of his profession is reduced at any stage, he is obliged to request PPS Insurance to reduce the benefits held by him in order to ensure that at no stage the benefits held by him will cause his cover to exceed the maximum limits as determined by PPS Insurance.

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 from age 66 onwards

In addition to the rules and requirements in respect of the Sick Pay Benefit as described elsewhere in this contract, and with the only exception being Policyholders whoôs Permanent Incapacity Benefits expire at the age of 70 years (refer to the latest Policy Certificate issued by PPS Insurance), the following additional restriction will apply to a Policyholderôs Sick Pay Benefit from the date on which he attains the age of 66 years. From the age of 66 years the Policyholder will only be entitled to claim the Sick Pay

Benefit, on either a Total or a Partial basis, for a maximum aggregate period of 182 days in any 365 day cycle.

Any Policyholder who has attained the age of 71 years will be allowed to retain his Sick Pay Benefit held in terms of his contract, without additional medical examination, subject to the conditions that:

1. he will not be entitled to claim any Partial Sick Pay Benefits;
2. a Policyholder to whom the 7 day waiting period applies (refer to the latest Policy Certificate issued by PPS Insurance) will only qualify for Total Sick Pay Benefits if he was totally unable to carry out his professional duties for at least 14 consecutive days due to sickness. The benefit will then pay retrospectively from the 1st day on which the Policyholder was totally unable to carry out his professional duties due to sickness;
3. a Policyholder to whom the 30 day waiting period applies (refer to the latest Policy Certificate issued by PPS Insurance) will only qualify for Total Sick Pay Benefits if he was totally unable to carry out his professional duties for at least 30 consecutive days due to sickness. The benefit will then pay prospectively form the 31st day on which the Policyholder was totally unable to carry out his professional duties due to sickness;
4. he will only be entitled to claim total Sick Pay Benefits for a maximum aggregate period of 90 days in any 365 day cycle;
5. 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 or elsewhere in this contract, 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 ProviderÊ 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.

The PPS KICKSTART SICKNESS BENEFIT excludes any medical conditions affecting the life insured which were diagnosed before or after policy inception and where symptoms started or any treatment was required (including over the counter medication, prescribed medication or counseling) prior to commencement of cover. It also includes any condition that required time off studies or work.

Benefit limitations applicable to the Sickness and Permanent Incapacity Benefit

Should a claim be awarded under the Sickness and Permanent Incapacity Benefit, the Total Sickness Benefit will be limited to R1.2 million per year (R100 000 per month), the Partial Sickness Benefit will be limited to R600 000 per year (R50 000 per month) and the Permanent Incapacity Benefit will be limited to R1.2 million per year (R100 000 per month) multiplied by the Permanent Incapacity award of 20%, 60% or 100%. The limitation will apply to:

- any psychiatric, psychological or emotional disorder or associated symptoms, including side effects or complications of treatment. This limitation applies to any stress related conditions, consequences of any alcohol or drug use, or psychiatric, psychological or emotional disorders associated with a physical, functional or non-organic condition; and
- will also apply to any form of chronic fatigue syndrome from any cause, myalgic encephalitis, yuppie flu, (including any related or similar disorders as they may become known), or fibromyalgia, or any impairment caused by chronic pain disorders.

48. PPS PROFIT-SHARE ACCOUNT™

When the PPS ProviderÊ Policy is issued to a Policyholder for the first time, PPS Insurance shall create a PPS Profit-Share Account™ for such Policyholder.

1. The PPS Profit-Share Account™ is a non-vesting account divided into two parts ï the ñApportionment Accountò and the ñSpecial Benefit Accountò.

2. PPS Insurance shall create Investment Reserves which shall be credited or debited, as the case may be:

   (1) at the end of each financial year or more frequently if thought fit with:
   (a) profits or losses realised on the sale of investments net of any tax; and
   (b) amounts by which PPS Insurance has decided to write up or down the value of some or all of the investments;
   (2) at the end of each financial year or more frequently if thought fit with:
   (a) such amounts derived from the ordinary revenue of PPS Insurance as PPS Insurance may determine; and
   (b) bonus allocations as set out hereafter.

3. (1) For the purpose of establishing Apportionment Accounts:

   (a) "Revenue" shall mean:
   (i) premiums and interest on arrear premiums;
   (ii) investment income;
   (iii) amounts forfeited by Policyholders where all their products or benefits are cancelled before having attained the age of 60 years;
   (iv) unclaimed moneys reverting to PPS Insurance;
   (v) such other moneys as PPS Insurance shall from time to time determine to be revenue of PPS Insurance.

   (b) "Expenditure" shall mean:
   (i) moneys spent in providing any benefits under the PPS ProviderÊ Policy;
   (ii) part refunds of premiums in terms of paragraph 6.6 hereafter;
   (iii) expenses of administration;
   (iv) any tax, *impost* or levy; and
   (v) such other amounts as PPS Insurance shall from time to time determine to be expenditure.

   (c) "Benefit Option" shall mean any of the following:
   1. The Sickness and Permanent Incapacity Benefit Option Comprising of the following:
   1.1. Ordinary Benefit Option;
   1.2. A Supplementary Benefit Option with Hospital benefit;
   1.3. B Supplementary Benefit Option with Hospital benefit;
   1.4. Accident Benefit Option with Hospital benefit;
   1.5. Ordinary Benefit Option with Hospital benefit;
   1.6. A Supplementary Benefit Option;
   1.7. B Supplementary Benefit Option;
   1.8. Accident Benefit Option; and
   1.9. Deferred Benefit Option.

   2. The Professional Life Provider Benefit Option, provided that the premiums

payable by the Policyholder in respect of this Benefit Option are calculated by taking into account the policyholderôs gender and smoking status.
3. The Professional Health Provider Benefit Option.
4. The Professional Disability Provider Benefit Option, provided that the premiums payable by the Policyholder in respect of this Benefit Option are calculated by taking into account the policyholderôs gender and smoking status.
5. The Accidental Death Benefit Option.
6. Any other product or benefit option as determined by PPS Insurance from time to time.

(d) "Income" shall mean:
item (i) and (v) of the definition of revenue in paragraph (a) that for each of Benefit Options 2, 3, 4, 5 and 6 is in respect of that Benefit Option.

(e) "Outgo" shall mean:
1) Items (i) to (v) of the definition of expenditure in paragraph (b) that for each of Benefit Options 2, 3, 4, 5 and 6 is in respect of that Benefit Option; and
2) ñOutgoòwill include any amounts required to be transferred to or released from Policyholder reserves; or any other adjustments made by PPS Insurance to ensure the equitable treatment of policyholders. Such transfers and adjustments will be determined annually by the statutory actuary to PPS Insurance.

(2) The Apportionment Account created for each Policyholder under this contract shall be credited or debited (as the case may be) each year with interest allocations and profit or loss allocations as described hereafter.

(3) At the end of each financial year:

(a) Interest shall be credited to each Policyholder's Apportionment Account which interest shall be calculated at a rate to be determined by PPS Insurance in consultation with the statutory actuary on the amount, if any, standing to the credit of such Apportionment Account at the end of the immediately preceding financial year. Such interest credits shall be termed "interest allocations".

(b) For each of the Benefit Options in 2 to 6 there shall be calculated for each Policyholder in that Benefit Option his aggregate premium, being the total premium (Excluding optional rider benefits and premium loadings applied) in such Benefit Option held by him at the end of each month of such year for which premiums were paid.

(c) PPS Insurance shall determine the income and outgo for such financial year in respect of Benefit Options 2 to 6. The income less outgo shall, if positive (being a surplus) be credited or if negative (being a deficiency) be debited to each Policyholderôs Apportionment Account. The surplus or deficiency will be in the proportion that the Policyholderôs aggregate premium paid (excluding optional rider benefits and any premium loadings applied) for each Benefit Option bears to the total of the aggregate premiums paid (excluding optional rider benefits and any premium loadings applied) of all Policyholders holding sums assured in each Benefit Option. Such surplus or deficiency shall be termed ñbonus allocationò

(d) For Benefit Options 1.1 to 1.9 there shall be calculated for each Policyholder holding Units of Benefit in that Benefit Option his aggregate unit holding, being the sum of the number of units in such Benefit Option held by him at the end of each month of such year for which premiums were paid, or are not payable for a Policyholder who is Permanently Incapacitated (Refer to Section 47 which deals with Permanent Incapacity). For options 1.1 and 1.5 the aggregate unit holding

shall be calculated separately for Full Premium Policyholders and for Reduced Premium Policyholders.

(e) PPS Insurance shall determine the revenue and expenditure of PPS Insurance.

(f) The sum of:
(i) the revenue; and
(ii) the sum of all deficiencies in benefit options 2 to 6; less the sum of:

(iii) the expenditure; and
(iv) the interest allocations; and
(v) the sum of all surpluses in benefit options 2 to 6; and
(vi) any amounts required to be transferred to or released from Policyholder reserves which are required in terms of the Long Term Insurance Act 1998 or any other adjustments made by PPS Insurance to ensure the equitable treatment of policyholders (Such transfers and adjustments will be determined annually by the statutory actuary to PPS Insurance);

shall, if positive, be hereinafter referred to as the Sickness and Permanent Incapacity Benefit surplus, or, if negative, be hereinafter referred to as the Sickness and Permanent Incapacity Benefit deficiency, and shall be dealt with respectively as set out hereafter. The Sickness and Permanent Incapacity Benefit surplus or deficiency shall be allocated to each Policyholder's Apportionment Account with reference to his aggregate unit holding in each Sickness and Permanent Incapacity Benefit Option. Such surplus or deficiency shall be termed ñSickness and Permanent Incapacity bonus allocationò

(g) If the ñSickness and Permanent Incapacity bonus allocationòfor Benefit Option 1.1 exceeds 13 cents, a Full Premium Policyholder shall have allocated to his Apportionment Account an amount of 13 cents, multiplied by his aggregate unit holding in option 1.1. The balance of the òSickness and Permanent Incapacity bonus allocationòfor Benefit Option 1.1 over the amount so allocated shall be credited to the Apportionment Account of each Full Premium Policyholder and Reduced Premium Policyholder in the proportion that his aggregate unit holding in Benefit Option 1.1 bears to the total of the aggregate unit holdings of all such Policyholders in Benefit Option 1.1.

(h) If the òSickness and Permanent Incapacity bonus allocationòfor Benefit Option 1.1 is less than 13 cents, the Sickness and Permanent Incapacity Benefit surplus shall be credited to each Full Premium Policyholder's Apportionment Account in the proportion that his aggregate unit holding in Benefit Option 1.1 bears to the total of the aggregate unit holdings of all such Policyholders in Benefit Option 1.1 and no part of the òSickness and Permanent Incapacity bonus allocationòfor Benefit Option 1.1 shall be allocated to the Apportionment Accounts of Reduced Premium Policyholders.

(4) Any residual surplus or shortfall not allocated to policyholders or reserves in terms of clause 3 above will be allocated to reserves or policyholders in a manner deemed equitable by PPS Insurance in conjunction with the statutory actuary.

4. In addition to interest and bonus allocations to Policyholders' Apportionment Accounts as set out above, PPS Insurance may annually credit the following special bonus allocations to the Apportionment Accounts of the following Policyholders:

(1) PPS Insurance may annually credit a special bonus allocation to the Apportionment Accounts of those Policyholders (the Retirement Annuity Fund

holding Policyholders) who have taken retirement annuity policies with the Professional Provident Society Retirement Annuity Fund (the RA Fund). In determining this special bonus, PPS Insurance shall at the end of each financial year determine the revenue received by PPS Insurance in the administration of this Fund.

If this revenue exceeds expenditure, the excess or such portion thereof as PPS Insurance in its sole discretion may determine (the RA Fund excess), shall annually be credited as a special bonus allocation to the apportionment accounts of the RA Fund holding Policyholders.

The special bonus allocation credited to each RA Fund holding Policyholder in respect of a financial year shall be equal to his aggregate premium paid to the RA Fund during such financial year divided by the aggregate RA premiums paid by all RA Fund holding Policyholders multiplied by the RA Fund excess.

(2) PPS Insurance may annually credit a special bonus allocation to the Apportionment Accounts of those Policyholders (the PPS Investments holding Policyholders) who hold products of Professional Provident Society Investments (PPS Investments). In determining this special bonus, PPS Insurance shall at the end of each financial year determine the profits received by it from PPS Investments. PPS Insurance shall thereafter, in its sole discretion, determine the portion of such operating profits to be credited as special bonus allocations to the Apportionment Accounts of such PPS Investments holding Policyholders. The special bonus allocation credited to each PPS Investments holding Policyholder shall be in the proportion that his average fund value over the course of the financial year bears to the overall fund value of PPS Investments over the course of the financial year. For the purpose of this special bonus allocation a PPS Investments holding Policyholderõs average fund value shall include all ñqualifying assetsòas determined and defined by PPS Investments from time to time.

(3) PPS Insurance may annually credit a special bonus allocation (the Medical Aid Products Bonus Allocation) to the Apportionment Accounts of those Policyholders who are also members of the Profmed Medical Scheme (Profmed holding Policyholders). In determining this special bonus, PPS Insurance shall at the end of each financial year determine the revenue received by Professional Medical Scheme Administrators (Pty) Ltd, a wholly owned subsidiary company of PPS Insurance, in the administration of the Profmed Medical Scheme.

If this revenue exceeds expenditure, the excess or such portion thereof as PPS Insurance in its sole discretion may determine shall annually be credited as a special bonus allocation to the Apportionment Accounts of the Profmed holding Policyholders.

The special bonus allocation credited to each Profmed holding Policyholder in respect of a financial year shall be in proportion that the Policyholderõs aggregate premium paid to the Profmed Medical Scheme bears to the total of the aggregate premiums paid by all Profmed holding Policyholders to the Profmed Medical Scheme.

5. In addition to any other interest and bonus allocations, PPS Insurance shall annually, or more frequently as it may in its sole discretion decide, allocate a special Black Economic Empowerment (BEE) bonus as follows:

5.1 For the initial period commencing 31 December 2006 the entire special BEE bonus will be applied to the recoupment of the initial funding arrangements that were put in place to facilitate the BEE restructuring;

5.2 Once the initial funding arrangements (including all interest and all other costs of such funding) have been recouped, the special BEE bonus will be allocated to the Apportionment Account of each Qualifying Black Policyholder in the proportion that his holding of Qualifying Units of Benefit bears to the aggregate of all Qualifying Units of Benefit held by all Qualifying Black Policyholders. The initial funding arrangements will be deemed to be recouped when the accumulated value of the entire special BEE bonus allocation equates to the initial funding amount plus interest and other costs at the net rate of investment return earned on PPS Insurance Policyholder funds.

5.3 For the purposes of this paragraph 5, Qualifying Black Policyholders shall be all existing Black Policyholders who hold Units of Ordinary Benefit or who only hold Units of Accident Benefit at 31 December 2008 and:

(1) a Black Policyholder shall be a Black person for the purposes of the Broad Based Black Economic Empowerment Act, 2003;

(2) only the Units of Ordinary Benefit held by Ordinary Policyholders and Units of Accident Benefit held by Accident Policyholders, who are Black Policyholders at 31 December 2008, shall be classified as Qualifying Units of Benefit (QUB). Any additional Units of Benefit purchased after 31 December 2008, including those purchased as a result of declared annual increases, shall not be classified as QUB. Once a QUB has been cancelled or terminated in any way it shall not be reinstated;

(3) the special BEE bonus per QUB shall be calculated as a % of the Operating Profit plus a % of the Investment Profit earned each year, Divided by the number of QUB at 31 December 2008; where the % of the Operating Profit and Investment Profit are set so that the aggregate Special BEE bonus (if calculated at 31 December 2006 on a prospective basis) would result in at least 25% of the Economic Interest being distributed to Black Policyholders;

(4) the Economic Interest is 10% of the Profit; and

(5) the Profit is the operating profit plus the investment profit of the business as a whole determined by PPS Insurance.

6. Benefits payable to the Policyholder

Benefits will become due and payable to the Policyholder in the following circumstances:

6.1 Where all the products and benefits held by him in terms of the PPS ProviderÊ Policy are cancelled prior to him having attained the age of 60 years, the amount payable to him will be an amount equal to the full amount standing to his credit in his Apportionment Account less such amount in interest allocations to his Apportionment Account as PPS Insurance in its full and absolute discretion may decide, which amount shall be forfeited to PPS Insurance. This amount, however, will not exceed the amount of interest allocations credited to him during the last two financial years of him being a policyholder in terms of the PPS ProviderÊ Policy. In addition to this, PPS Insurance in its sole discretion may pay to or in respect of such Policyholder a special benefit derived from the investment reserves of PPS Insurance. Such special benefit shall constitute the Special Benefit Account. In determining such benefit, PPS Insurance shall have regard to his Apportionment Account balance and the duration of him being a Policyholder in terms of the PPS ProviderÊ Policy. The special benefit will, however, not be paid where cover is terminated by PPS Insurance in terms of the provisions of this contract or where, for a reason other than death, cover ceases within three years of his becoming a Policyholder.

6.2 Where all the products and benefits (Excluding the PPS Profit-Share Account™ Benefit) held by him in terms of the PPS ProviderÊ Policy are cancelled on or after the day on which he attained the age of 60 years but before he attains the age of 66 years, the full amount standing to his credit in his PPS Profit-Share Account™ will be payable to him and all allocations to his PPS Profit-Share Account™ as described above will cease. If he exercises the Vested PPS Profit-Share Account option as set out hereafter, the full amount standing to his credit in his PPS Profit-Share Account™ will be transferred in accordance with the terms and conditions of such option.

6.3 Where the Sickness and Permanent Incapacity benefit is cancelled on or after the day on which he attained the age of 60 years but before he attains the age of 66 years the full amount standing to his credit in his PPS Profit-Share Account™ will become due to him. In such an event the Policyholder may exercise the following options:

a) Provided that at least one of the other PPS Provider Policy Benefits (Excluding the PPS Profit-Share Account™ Benefit) remains in force the Policyholder may select to keep his PPS Profit-Share Account™ benefit in force as a notional benefit until he reaches the age of 66. PPS shall continue to credit or debit such a Policyholder's notional PPS Profit-Share Account™ with interest and profit or loss allocations as described above; or
b) The Policyholder may select to exercise the Vested PPS Profit-Share Account option as set out hereafter in which case the full amount standing to his credit in his PPS Profit-Share Account™ will be transferred in accordance with the terms and conditions of such option; or
c) The Policyholder may select to receive the full amount standing to his credit in his PPS Profit-Share Account™ in one lumpsum payment whereafter all allocations to his PPS Profit-Share Account™ as described above will cease and his PPS Profit-Share Account™ will automatically terminate.

The Policyholder shall inform PPS Insurance of his selection in writing at its Head Office in the manner prescribed by PPS Insurance from time to time. In the event that the Policyholder fails to exercise an option at the time of the cancellation of his Sickness and Permanent Incapacity benefit in accordance with this paragraph 6.3, the option described in paragraph a) above shall automatically apply if at least one of the other PPS Provider Policy Benefits (Excluding the PPS Profit-Share Account™ Benefit) remains in force and the option described in paragraph b) above shall automatically apply in all other instances. In the event that the Policyholder fails to exercise an option as aforesaid and the option described in paragraph b) is automatically applied, PPS Insurance shall select an Investment Portfolio in respect of the investment of such a Policyholder's Vested PPS Profit-Share Account Benefit at its (PPS') own discretion.

6.4 When a Policyholder attains the age of 66 years the full amount standing to his credit in his PPS Profit-Share Account™ will become due to him notwithstanding the fact that any of the PPS Provider Policy Benefits still remain in force. In such an event the following shall apply:

a) Provided that the Sickness and Permanent Incapacity benefit remains in force the Policyholder may select to keep his PPS Profit-Share Account™ benefit in force as a notional benefit. PPS shall continue to credit or debit such a Policyholder's notional PPS Profit-Share Account™ with interest and profit or loss allocations as described above; or
b) The Policyholder may select to exercise the Vested PPS Profit-Share Account option as set out hereafter in which case the full amount standing to his credit in his PPS Profit-Share Account™ will be transferred in accordance with the terms and conditions of such option; or
c) In the event that the Policyholder does not have a Sickness and Permanent Incapacity benefit in force PPS Insurance shall implement the Vested PPS Profit-Share Account option as described hereafter.

The Policyholder shall inform PPS Insurance of his selection in writing at its Head Office in the manner prescribed by PPS Insurance from time to time. In the event that the Policyholder fails to exercise an option at the time of his 66th birthday the option described in paragraph a) above shall automatically apply as long as there is an in-force Sickness and Permanent Incapacity benefit. If there is no in-force Sickness and Permanent Incapacity benefit then the option described in paragraph c) above shall automatically apply. In the event that the Policyholder fails to exercise an option as aforesaid and the option described in paragraph c) is automatically applied, PPS Insurance shall select an Investment Portfolio in respect of the investment of such a Policyholder's Vested PPS Profit-Share Account Benefit at its (PPS') own discretion.

6.5 Where the PPS Provider's Policy is terminated due to his death, the full amount standing to his credit in his PPS Profit-Share Account™ will be paid to the person or persons nominated by him as beneficiaries to the contract, or to his deceased estate where he was predeceased by all the nominated beneficiaries or where he failed to nominate any beneficiaries. If payment is made after the end of the third calendar month following receipt by PPS Insurance of sufficient information to enable PPS to make a decision as to the payment of the death benefits, interest will be paid at a rate to be determined by PPS Insurance in respect of the period from the end of such third calendar month to date of payment.

6.6 In addition to the payments referred to in this paragraph 6, there shall be paid to or in respect of a Policyholder who ceases to be a Policyholder other than at the end of a financial year and whose Apportionment Account, therefore, receives no profit or loss allocation as set out above in respect of such year, a part refund of the premiums due and paid or payable by the Policyholder whilst he was a Policyholder during such year. Such refund shall be one-twelfth of the profit or loss allocation per Unit of Benefit or per aggregate premium paid (excluding optional rider benefits and any premium loadings applied), whichever is applicable, of the Benefit Option held, declared in respect of the preceding financial year, for each month from 1 January of such year to the date on which his participation terminates, less a discount of 10 per cent. If, at the time of termination of cover, no profit or loss allocation had been declared yet in respect of such preceding financial year, the profit and loss allocation declared most recently will, for the purposes of this section, be deemed to have also been declared in respect of such preceding financial year. Such refund shall not in any event exceed 50 per cent of the premiums paid or payable by the Policyholder during such year. The refund shall not be payable where this contract is terminated by PPS Insurance or where for a reason other than death, benefits cease within six months of his becoming a Policyholder.

6.7 No benefit will be payable where the Policyholder's policy is cancelled, for a reason other than his death, within six months of the policy having been issued to him.

7. The Vested PPS Profit-Share Account Option:

Provided that he has attained the age of 60 years, the Policyholder may exercise the Vested PPS Profit-Share Account option in the following circumstances:

(1) where all the products and benefits held by him in terms of the PPS Provider's Policy (Excluding the PPS Profit-Share Account™ Benefit) are cancelled in accordance with the provisions of paragraph 6.2 above; or

(2) Where the Sickness and Permanent Incapacity benefit is cancelled in accordance with the provisions of paragraph 6.3 above; or

(3) Where a Policyholder attains the age of 66 years in accordance with the provisions of paragraph 6.4 above.

Where the Vested PPS Profit-Share Account option is exercised by the Policyholder or implemented by PPS Insurance as set out above, the funds available in his PPS Profit-Share Account™ on the date of exercising or implementation of such option, will become available to

him to be transferred to an investment portfolio chosen by the Policyholder from a list of portfolios made available by PPS Insurance for such purpose from time to time.

From the day on which the Vested PPS Profit-Share Account option was exercised or implemented as set out above, the Apportionment Account will not exist as a separate entity under the Vested PPS Profit-Share Account any longer. All special bonus allocations from such Policyholderôs PPS Retirement Annuity Fund and PPS Investments products, if applicable, will thereafter be credited directly to his Vested PPS Profit-Share Account. All allocations to his PPS Profit-Share Account™ as described above in respect of the PPS Provider products will cease.

The Policyholder, who holds a Vested PPS Profit-Share Account, may from time to time withdraw funds from such account.

The Policyholderôs Vested PPS Profit-Share Account will not be cancelled merely because all funds have been withdrawn from such fund.

The Vested PPS Profit-Share Account option may not be exercised by the Policyholder where his PPS ProviderÊ Policy is cancelled due to the following reasons:

(a) non-disclosure by the Policyholder of, or misrepresentation by the Policyholder in respect of, information material to the assessment of the risk insured against by PPS Insurance;
(b) a false claim for benefits submitted by the Policyholder knowing such claim to be false;
(c) a claim submitted by the Policyholder where he knows and conceals the fact that the materialisation of the insured event is attributable to excessive indulgence in liquor or drugs, immorality or disorderly conduct, or where the sickness is intentionally self-inflicted or self-induced; or
(d) improper, unworthy or disgraceful conduct by the Policyholder which will materially at the time of issue or at the time of any variation affect the risk under this contract.

Appendix A
These definitions are applicable from 1 September 2009

CARDIOVASCULAR

a. HEART ATTACK

Definition:
Means the death of a portion of the heart muscle arising from inadequate blood supply to the relevant area. The diagnosis shall be supported and the severity level confirmed if the following criteria are present and confirmed by a cardiologist at least 30 days after the event.

- Clinical features including typical chest pain;
- Confirmatory new electrocardiogram changes (ECG) changes;
- Diagnostic elevation of specific cardiac markers, such as CK-MB or troponin.

Exclusions:

- Acute coronary syndrome without infarction; stable or unstable angina.
- Payment of this benefit category excludes Cardiomyopathy benefits and vice versa.

Severity Levels:
Four out of the seven criteria to apply under the applicable level.

Severity A – 100%

1. Persisting pathological cardiovascular symptoms such as chest pain, dyspnoea (Grade III ï IV NYHA), ankle swelling.
2. Resting ECG: Persistent Q-waves
3. Stress ECG: ST segment changes > 2 mm in any stage of exercise or exercise terminated due to cardiac symptoms (chest pain, dizziness)
4. 30 Day post infarction ejection fraction less than 40% and echocardiographic evidence of myocardial damage, e.g. akinesis or dyskinesis
5. Angiography (if performed): Three or more coronary vessels significantly diseased*
6. Ongoing appropriate medication to control cardiac symptoms, e.g. ACE inhibitors; Betablockers; Angiotensin II Receptor Blockers; plus Prophylactic medication
7. Persisting arrhythmias (atrial fibrillation or supraventricular tachycardia)

Severity B – 75%

1. Occasional cardiac symptoms on exertion (Grade II NYHA)
2. Resting ECG: Persistent Q-waves
3. Stress ECG: Significant ST segment changes of 1 ï 2 mm or cardiac symptoms occurring during exercise (chest pain, dizziness, dyspnoea)
4. 30 Day post infarction ejection fraction 40 - 49% and echo evidence of myocardial damage, e.g. akinesis or dyskinesis
5. Angiography (if performed): Three vessels significantly diseased*
6. Any cardiac medication to control cardiac symptoms in addition to prophylactic medication as in Severity D
7. Persisting arrhythmias (atrial fibrillation or supraventricular tachycardia)

Severity C – 50%

1. Substantial recovery, with minimal cardiac symptoms (Grade I NYHA)
2. Resting ECG: Persistent Q-waves
3. Stress ECG: significant ST changes of 1 - 2 mm but no cardiovascular symptoms (chest pain, dizziness)
4. 30 Day post infarction ejection fraction Ó50% and echocardiographic evidence of myocardial damage, e.g. akinesis or dyskinesis
5. Angiography (if performed): at least two vessels significantly diseased*
6. No additional cardiac medication other than prophylactic medication as in Severity D
7. No persisting arrhythmias

Severity D – 25%

1. Full recovery, no further symptoms
2. Resting ECG within normal limits (i.e. no Q-wave visible)
3. Stress ECG: no significant ST segment changes, no chest pain or dizziness
4. 30 Day post infarction ejection fraction Ó50% with no Cardiac enlargement on X-ray, or echo evidence of myocardial damage, e.g. akinesis or dyskinesis
5. Angiography (if performed): At least one vessel involved*
6. Prophylactic medication only, e.g. aspirin, statins; Betablockers
7. No persisting arrhythmias

* Main vessels only e.g. Circumflex, Right Coronary Artery, Left Anterior Descending

b. CARDIAC SURGERY AND PROCEDURES

Definition:
The completion of cardiac surgery by a cardio-thoracic surgeon. Submissions from the hospital and reports from the cardio-thoracic surgeon or cardiologist will be required.

Severity A – 100%

- Heart valve replacement of one or more heart valves by means of open heart surgery (thoracotomy)
- Coronary artery bypass grafting (CABG) of 3 or more main vessels*

Severity C – 50%

- Coronary artery bypass grafting (CABG) of 1 or 2 main vessels*
- Pericardiectomy or any heart valve repair procedure by sternotomy

Severity D – 25%

- Coronary artery disease involving 2 or more vessels necessitating a PTCA and/or stenting to each vessel
- Coronary artery disease requiring a second PTCA with more than 1 stent, more than 6 months after the initial procedure.
- Percutaneous valvotomy

* Main vessels only e.g Circumflex, Right Coronary Artery, Left Anterior Descending

CARDIOMYOPATHY

Definition:
Severity A – 100%
Cardiomyopathy confirmed on echocardiogram and resulting in permanent and irreversible physical impairments to the degree of at least Class IV of the New York Heart Association Classification of Cardiac Impairment with METS < 3 or EF ≤ 20% based on an average of 2 readings 3 months apart.

Severity B – 75%
Cardiomyopathy confirmed on echocardiogram and resulting in permanent and irreversible physical impairments to the degree of at least Class III of the New York Heart Association Classification of Cardiac Impairment with METS < 5 or EF ≤ 30% based on an average of 2 readings 3 months apart.

c. AORTIC SURGERY

Severity C – 50%
Undergoing of surgery via a thoracotomy or laparotomy to repair or correct an aortic aneurysm, an obstruction of the aorta or a coarctation of the aorta. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches.

Exclusions:
Surgery performed using endarterial techniques only are specifically excluded.

BLOOD

1. APLASTIC ANAEMIA

Severity A – 100%
Irreversible bone marrow failure resulting in anaemia, neutropenia and thrombocytopenia. The diagnosis must be based on a bone marrow biopsy.
Two out of the following three values must be present:

1. Absolute neutrophil count of 500 per cubic millimetre or less;
2. Absolute reticulocyte count of 20,000 per cubic millimetre or less; and
3. Platelet count of 20,000 per cubic millimetre or less.

NEUROLOGICAL

2. STROKE

Definition:
Any cerebrovascular incident or stroke producing neurological sequelae lasting more than **24 hours** and including infarction of brain tissue, haemorrhage and embolisation from an extracranial source. Evidence of permanent neurological damage must be confirmed by a neurologist approved by PPS Insurance **3 months** after the event. Signs appropriate to the brain area affected must be present.

Exclusions:
Transient ischaemic attacks (TIAs), cerebral symptoms due to migraine, cerebral injury resulting from trauma or hypoxia and vascular disease affecting the eye or optic nerve as well as ischaemic disorders of the vestibular system are excluded.

Severity Levels:
Using the Whole Person Impairment rating from the American Medical Association Guide to the Evaluation of Permanent Impairment. This takes into account all parts of the body that may be affected.

Severity A – 100%
Whole Person Impairment of 30% or above
Severity B – 75%
Whole Person Impairment of between 20% - 29%
Severity C – 50%
Whole Person Impairment of between 11% - 19%
Severity D – 25%
Whole Person Impairment of 10% or less

3. MULTIPLE SCLEROSIS

Definition:
Means the life insured has Multiple Sclerosis confirmed by CT or MRI scan, where the condition is characterised by the demyelination in the brain and spinal cord. There must be more than one clearly distinct episode of well-defined neurological deficit causing persisting neurological deficit, which remains permanent. A consultant neurologist approved by PPS Insurance must confirm the diagnosis.

Exclusions:
A single episode of Multiple Sclerosis from which remission occurred.

Severity Levels:
Using the Whole Person Impairment rating from the American Medical Association Guide to the Evaluation of Permanent Impairment. This takes into account all parts of the body that may be affected.

Severity A – 100%
Whole Person Impairment of 30% or above
Severity B – 75%
Whole Person Impairment of between 20% - 29%
Severity C – 50%
Whole Person Impairment of between 15% - 19%
Severity D – 25%
Whole Person Impairment of between 10% - 14%

4. MUSCULAR DYSTROPHY

Definition:
Unequivocal diagnosis of Muscular Dystrophy by a consultant neurologist as approved by PPS Insurance.

Severity Levels:
Using the Whole Person Impairment rating from the American Medical Association Guide to the Evaluation of Permanent Impairment. This takes into account all parts of the body that may be affected.

Severity A – 100%
Whole Person Impairment of 30% or above
Severity B – 75%

Whole Person Impairment of between 20% - 29%
Severity C – 50%
Whole Person Impairment of between 15% - 19%
Severity D – 25%
Whole Person Impairment of between 10% - 14%

5. MOTOR NEURON DISEASE

Definition:
Unequivocal diagnosis of Motor Neuron Disease (Amyotrophic lateral sclerosis) by a consultant neurologist as approved by PPS Insurance.

Exclusions:
Nervous lesions of inflammatory or toxic origin.

Severity Levels:
Using the Whole Person Impairment rating from the American Medical Association Guide to the Evaluation of Permanent Impairment. This takes into account all parts of the body that may be affected.

Severity A – 100%
Whole Person Impairment of 30% or above
Severity B – 75%
Whole Person Impairment of between 20% - 29%
Severity C – 50%
Whole Person Impairment of between 15% - 19%
Severity D – 25%
Whole Person Impairment of between 10% - 14%

6. PARKINSON'S DISEASE

Definition:
Means the life insured has Parkinson's Disease where the condition cannot be significantly controlled with treatment and results in signs of progressive incapacity.

Exclusions:
Parkinsonism resulting from the side effects of medication; alcohol, drug-induced or toxic causes of Parkinson's disease.

Severity Levels:
Severity A – 100%
Whole Person Impairment of 25% or above.
Severity D – 25%
On confirmation of the diagnosis by an appropriate specialist approved by PPS Insurance.

7. DEMENTIA OR ALZHEIMER'S DISEASE

Definition:
Whilst practicing as a professional, means the life insured has Alzheimer's Disease or other Dementia. The diagnosis must confirm permanent irreversible failure of brain function and result in significant cognitive impairment for which no other recognisable cause can be identified. Significant cognitive impairment means a deterioration or loss of intellectual capacity. An appropriate specialist approved by PPS Insurance must confirm the diagnosis.

In retirement, means the life insured has Alzheimerôs Disease or other Dementia. The diagnosis must confirm permanent irreversible failure of brain function and result in significant cognitive impairment needing constant supervision for which no other recognisable cause can be identified. An appropriate specialist approved by PPS Insurance must confirm the diagnosis.

Exclusions:
Alcohol or drug related dementia.
Severity A – 100%
Significant cognitive impairment with loss of intellectual capacity.

8. BENIGN BRAIN TUMOUR

Severity A – 100%
Means a life-threatening, non-malignant tumour in the brain, giving rise to characteristic symptoms of increased intracranial pressure such as papilloedema, mental symptoms, seizures and sensory impairment. The tumour must result in neurological deficit causing at least 25% Whole Person Impairment that is permanent. The presence of the underlying tumour must be confirmed by imaging studies such as CT Scan or MRI. Cysts, granulomas, cholesteatomas, haematomas, malformations in or of the arteries or veins of the brain or spine are excluded.

TRANSPLANTS

9. MAJOR ORGAN TRANSPLANT

Severity A – 100%
On completion of one or more transplants of the heart, lung, liver, kidney, small bowel or bone marrow as a recipient.

Exclusions:
Excluding the transplantation of the Islets of Langerhans only; stem cells; transplant of all other organs, parts of organs or tissue is excluded.

CANCER

10. CANCER

Definition:
Means the presence of one or more malignant tumours characterised by uncontrolled growth and spread of malignant cells and the invasion or destruction of normal tissue. Must be confirmed by a histology report from an accredited pathology laboratory.

Exclusions:
- Tumours showing the malignant changes of Carcinoma-in-situ (including cervical dysplasia CIN-1, CIN-2 and CIN-3) or which are histologically described as premalignant are excluded.
- All skin cancers localised or infiltrating including, but not limited to, the following are excluded:
  - Hyperkeratosis
  - basal cell carcinoma
  - squamous cell carcinoma
  - melanomas of less than 1.0mm (Breslow method) depth.
- Non-life threatening prostatic cancers which are histologically described as TNM classification T1a and T1b (but not T1c) or of another equivalent or lesser qualification, papillary micro-carcinoma of the thyroid or bladder.

Severity A – 100%
Cancer, Stage IV, showing lymphatic or blood spread to distant lymph nodes or distant metastases; Chronic Lymphocytic Leukaemia (CLL) - Stage 3 and 4; Stage 4 Lymphomas, Acute Myeloid Leukaemia (AML) - any Stage; Chronic Myeloid Leukaemia (requiring bone marrow transplant); Acute Lymphocytic Leukaemia - any Stage; Multiple Myeloma Stage 3.

Severity B – 75%
Cancer, Stage III, within organ of origin with spread to regional lymph nodes; Stage 3 Lymphomas.

Severity C – 50%
Cancer, Stage II, within organ of origin with contiguous spread to adjacent organs but no lymph node involvement; CLL - Stage 2; Stage 2 Lymphomas; Chronic Myeloid Leukaemia (not requiring bone marrow transplantation); Multiple Myeloma Stage 1 and 2.

Severity D – 25%
- Cancer, Stage I, confined to the primary organ; CLL - Stage 0-1; Stage 1 Lymphomas; Hairy cell leukaemia
- Prophylactic bilateral total mastectomy not for cosmetic purposes

MUSCULOSKELETAL

11. PARALYSIS (Quadriplegia/Paraplegia)

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.

Exclusions:
Partial or temporary paralysis.

12. LOSS OF USE OF LIMBS (only 1 benefit should be paid in this instance)

Definition:
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,

Limb	Maximum benefit for condition*	Severity level
One hand ï dominant	770 855	C
One hand ï non-dominant	770 855	D
Both hands	1 541 706	B
One arm	1 156 280	B
Both arms	GPI Sum Assured	A
One foot	462 512	D
Both feet	1 541 706	C
One leg	1 541 706	C
Both legs	GPI Sum Assured	A
One arm and one leg	GPI Sum Assured	A

*PPS Insurance may increase the maximum benefits annually at its sole discretion.

13. AMPUTATION

Definition:

ñThumbò requires loss of the whole thumb from the metocarpo-phalangeal joint.
ñFingerò requires loss of the whole finger from the metocarpo-phalangeal joint.

Amputation of:	Maximum benefit for condition*	Severity level
Amputation of the:		
Thumb	154 171	D
3 fingers and thumb	385 426	C
4 fingers and thumb	616 682	C
Four toes and big toe	154 171	D
1 or more fingers	123 336	D

*PPS Insurance may increase the maximum benefits annually at its sole discretion.

TRAUMA

14. COMA

Severity A – 100%
Failure of cerebral function characterised by total unresponsiveness to all external stimuli, persisting continuously with the use of a life support system for a period of at least **96 hours**.

Exclusions:
Coma resulting directly from alcohol or drug abuse is excluded.

15. GUNSHOT WOUNDS

Severity A – 100%
Penetrating gunshot wound to the head, neck, chest, abdomen or pelvic area requiring surgical intervention by means of a craniotomy, thoracotomy or laparotomy.

Exclusions:
Superficial gunshot wounds, gunshot wounds to the legs (including hips), gunshot wounds to the arms (including shoulders).

16. 3RD DEGREE BURNS

Severity A – 100%
Tissue injury caused by thermal, electrical or chemical agents causing third degree or full thickness burns to at least 20% of the body surface area as measured by the Rule of Nines or the Lund or Browder Body Surface Chart.

17. ACCIDENTAL HIV INFECTION

Severity A – 100%
Infection by any Human Immunodeficiency Virus or being diagnosed as having Acquired Immune Deficiency Syndrome if the infection can be proved to the satisfaction of PPS Insurance as being due to:

- The result of an accident during the course of carrying out normal occupational duties as a medical or dental practitioner registered with the Health Professions Council of South Africa (HPCSA).
- The transfusion of infected blood or blood products from a transfusion service recognised by PPS Insurance in the Republic of South Africa. The institution that provided the blood must admit liability.
- Indecent assault. The offense must have resulted in the opening of a criminal case by the police.

In the case of accidental HIV infection while carrying out normal occupational duties or as the result of indecent assault, any incident giving rise to a potential claim must be:

- Reported to PPS Insurance within **10 days** of the incident and
- Be supported by a negative HIV antibody test, taken within **3 days** of the incident.
- Prophylactic treatment must be taken for a full period of 28 consecutive days to the satisfaction of PPS Insurance.

Exclusions:
Infection in any other manner, including infection as a result of sexual activity or intravenous drug use.
This benefit will not apply in the case that an internationally recognised medical cure is found for AIDS.

18. RECONSTRUCTIVE SURGERY OF FACIAL DISFIGUREMENT DUE TO INJURY, ACCIDENT OR ASSAULT

Definition:
The undergoing of the following reconstructive surgical procedures (single or multiple) for extensive and significant repair to facial bone and/or skin injuries, due to injury, accident or assault, which renders the applicant permanently facially disfigured. The surgery must, in the opinion of PPS Insurance, be deemed necessary. The face is defined as the front portion of the head ï the eyes, nose, mouth, forehead, cheeks, and chin but excluding the ears. All corrective procedures should have been completed and the Reconstructive Surgeon in charge must indicate that no further surgery or procedures will provide any future enhancements/improvements to the injury.

Exclusion:
Cosmetic procedures or cosmetic surgery for any other reason than restoration or reconstruction as described in the definition.

Severity Levels:
Severity A – 100% (maximum benefit for this condition is R770 855. PPS Insurance may increase the maximum benefits annually at its sole discretion)
Disfigurement involving the entire area between the hairline and lower jaw on both sides of the face.

Severity B – 75% (maximum benefit for this condition is R501 055. PPS Insurance may increase the maximum benefits annually at its sole discretion)
Disfigurement involving the entire area between the hairline and lower jaw on one side of the face or alternately, 50% of the facial area.

Severity C – 50% (maximum benefit for this condition is R385 426. PPS Insurance may increase the maximum benefits annually at its sole discretion)
Disfigurement involving any quadrant of the face, or 25% of the area of the face as defined above.

Severity D – 25% (maximum benefit for this condition is R192 714. PPS Insurance may increase the maximum benefits annually at its sole discretion)
Significant disfigurement, as determined by PPS Insurance, of any one of the following:

- Nose
- Cheek bone
- Lips

KIDNEY AND UROLOGICAL

19. KIDNEY FAILURE

Severity A – 100%
Chronic irreversible kidney failure requiring continuous regular dialysis.

Exclusion:
Acute kidney failure requiring short-term dialysis.

CONNECTIVE TISSUE

20. RHEUMATOID ARTHRITIS

Severity A – 100%
Widespread chronic progressive joint destruction with significant deformity affecting at least three major joint groups (e.g. feet, hands, hips, knees, wrists).
In addition to this, four of six criteria are required:

- Morning stiffness
- Soft tissue swelling in 3 joint groups
- Symmetrical swelling in joints
- Presence of rheumatoid nodules
- Elevated rheumatoid factor
- Appropriate radiographic changes

21. SYSTEMIC LUPUS ERYTHEMATOSUS WITH NEPHRITIS

Severity A – 100%
Systematic lupus erythematosus will be restricted to those forms of systematic lupus erythematosus, which involve the kidneys (Type III to Type V Lupus nephritis, established by renal biopsy, and in accordance with the WHO classification). Other forms, discoid lupus and those forms with haematological and joint involvement will be specifically excluded. The final diagnosis is to be supported by a certified doctor specialising in Rheumatology and Immunology as approved by PPS Insurance.

Exclusions:
Discoid lupus and those forms with haematological and joint involvement will be specifically excluded.

22. SCLERODERMA

Severity A – 100%
A multisystem disorder of unknown cause characterised by fibrosis of the skin, blood vessels and visceral organs including the gastrointestinal tract, lungs, heart and kidneys.

Diagnosis must be supported by biopsy and the disorder should have affected one of the following; pulmonary, cardiac, gastro ï intestinal, renal systems. Cutaneous scleroderma and sclerodactyly are specifically excluded.

RESPIRATORY

23. RESPIRATORY FAILURE

Severity A – 100%
End stage lung disease. Both of the following must be fulfilled:
- Proof of necessary and permanent oxygen therapy for at least 8hrs/day and
- FEV1 test results of less than 1 litre

24. LOBECTOMY

Severity C – 50%
Removal of one complete lung
Severity D– 25%
Removal of a lobe of a lung not for donor purposes

GASTROINTESTINAL

25. ULCERATIVE COLITIS

Severity A – 100%
For the purposes of this policy, Ulcerative Colitis shall mean acute Fulminant Ulcerative Colitis with life threatening electrolyte disturbances usually associated with intestinal distention and a risk of intestinal rupture. It must involve the entire colon with severe bloody diarrhoea and systemic signs and symptoms and for which the treatment is total colectomy and/or ileostomy. Diagnosis must be based on histopathological features. Surgery in the form of colectomy and/or ileostomy should form part of the treatment.

26. CROHN'S DISEASE

Severity A – 100%
Crohnς disease is a chronic granulomatous inflammatory disease. The disease must require surgical intervention after one of the following:
- fistula formation, or
- intestinal obstruction, or
- intestinal perforation

of 2 or more sites.
The characteristic post-surgical histopathological features must confirm diagnosis.

27. LIVER FAILURE

Severity A – 100%
Liver Failure means end stage liver failure with permanent jaundice, ascites or encephalopathy

28. CHRONIC PANCREATITIS

Severity A – 100%
Pancreas transplant including partial transplant of the pancreas.

Severity C – 50%

A chronic inflammation of the pancreas, characterised by fibrosis and resulting in chronic pain, diabetes mellitus or persistent gastro ï intestinal tract disturbances. Diagnosis based on presentation of the following triad of findings: Pancreatic Calcification; Steatorrhea and established Diabetes mellitus or alternatively < 10% exocrine function remaining.

EAR NOSE AND THROAT

29. LOSS OF HEARING

Severity B – 75%
Means irrecoverable Loss of Hearing in both ears, with an auditory threshold of more than 90 decibels, as a result of sickness or injury. No benefits will be payable if in general specialist opinion a hearing aid, device, or implant could result in the partial or total restoration of hearing.

30. LOSS OF SPEECH

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.

VISUAL

31. LOSS OF SIGHT

Definition:
Total irreversible loss of sight as confirmed by an ophthalmologist as a result of injury or disease with a best corrected visual acuity of 6/120 or less.

Exclusion:
Temporary visual impairment that can be corrected by medical or surgical treatment, implants or appliances.

Condition	Maximum benefit for condition*	Severity Level
One eye	308 342	C
Both eyes	GPI Sum Assured	A

*****PPS Insurance may increase the maximum benefits annually at its sole discretion.

Appendix B

1. **CARDIOVASCULAR**

a. HEART ATTACK

Definition:
Means the death of a portion of the heart muscle arising from inadequate blood supply to the relevant area. The diagnosis shall be supported and the severity level confirmed if the following criteria are present and confirmed by a cardiologist at least 30 days after the event.
- Clinical features including typical chest pain;
- Diagnostic elevation of specific cardiac markers, such as CK-MB or troponin.

Exclusions:
- Acute coronary syndrome without infarction; stable or unstable angina.
- Payment of this benefit category excludes Cardiomyopathy benefits and vice versa.

Condition:
At least four out of the seven criteria to apply.

CORE 100%
- Full recovery, no further symptoms
- Resting ECG within normal limits (i.e. no Q-wave visible)
- Stress ECG: no significant ST segment changes, no chest pain or dizziness
- 30 Day post infarction ejection fraction Ó 50% with no Cardiac enlargement on X-ray, or echo evidence of myocardial damage, e.g. akinesis or dyskinesis
- Angiography (if performed): At least one vessel involved*
- Prophylactic medication only, e.g. aspirin, statins; Betablockers
- No persisting arrhythmias

* Main vessels, e.g. Circumflex, Right Coronary Artery, Left Anterior Descending

b. CARDIAC SURGERY AND PROCEDURES

Definition:
The completion of cardiac surgery by a cardio-thoracic surgeon. Submissions from the hospital and reports from the cardio-thoracic surgeon or cardiologist will be required.

CORE 100%
- Heart valve replacement of one or more heart valves by means of open heart surgery (thoracotomy)
- Coronary artery bypass grafting (CABG) of 1 or more main vessels*
- Pericardiectomy or any heart valve repair procedure by sternotomy

* Main vessels, e.g. Circumflex, Right Coronary Artery, Left Anterior Descending

Severity D – 25%
- Coronary artery disease involving 2 or more vessels necessitating a PTCA and/or stenting to each vessel
- Coronary artery disease requiring a second PTCA with more than 1 stent, more than 6 months after the initial procedure.
- Percutaneous valvotomy

c. CARDIOMYOPATHY

Definition:
Severity A – 100%
Cardiomyopathy confirmed on echocardiogram and resulting in permanent and irreversible physical impairments to the degree of at least Class IV of the New York Heart Association Classification of Cardiac Impairment with METS < 3 or EF ≤ 20% based on an average of 2 readings 3 months apart.

Severity B – 75%
Cardiomyopathy confirmed on echocardiogram and resulting in permanent and irreversible physical impairments to the degree of at least Class III of the New York Heart Association Classification of Cardiac Impairment with METS < 5 or EF ≤ 30% based on an average of 2 readings 3 months apart.

d. AORTIC SURGERY

Severity C – 50%
Undergoing of surgery via a thoracotomy or laparotomy to repair or correct an aortic aneurysm, an obstruction of the aorta or a coarctation of the aorta. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches.

Exclusions:
Surgery performed using endarterial techniques only are specifically excluded.

BLOOD

2. **APLASTIC ANAEMIA**

Severity A – 100%
Irreversible bone marrow failure resulting in anaemia, neutropenia and thrombocytopenia. The diagnosis must be based on a bone marrow biopsy.
Two out of the following three values must be present:
- Absolute neutrophil count of 500 per cubic millimetre or less;
- Absolute reticulocyte count of 20,000 per cubic millimetre or less; and
- Platelet count of 20,000 per cubic millimetre or less.

NEUROLOGICAL

3. **STROKE**

Definition:
Any cerebrovascular incident or stroke producing neurological sequelae lasting more than **24 hours** and including infarction of brain tissue, haemorrhage and embolisation from an extracranial source. Evidence of permanent and significant neurological damage must be confirmed by a neurologist approved by PPS Insurance **3 months** after the event. Signs appropriate to the brain area affected must be present.

Exclusions:
Transient ischaemic attacks (TIAs), cerebral symptoms due to migraine, cerebral injury resulting from trauma or hypoxia and vascular disease affecting the eye or optic nerve as well as ischaemic disorders of the vestibular system are excluded.

CORE 100%
Using the Whole Person Impairment rating from the American Medical Association Guide to the Evaluation of Permanent Impairment. This takes into account all parts of the body that may be affected.

Any score on the Whole Person Impairment.

4. **MULTIPLE SCLEROSIS**

Definition:
Means the life insured has Multiple Sclerosis confirmed by CT or MRI scan, where the condition is characterised by the demyelination in the brain and spinal cord. There must be more than one clearly distinct episode of well-defined neurological deficit causing persisting neurological deficit, which remains permanent. A consultant neurologist approved by PPS Insurance must confirm the diagnosis.

Exclusions:
A single episode of Multiple Sclerosis from which remission occurred.

Severity Levels:
Using the Whole Person Impairment rating from the American Medical Association Guide to the Evaluation of Permanent Impairment. This takes into account all parts of the body that may be affected.

Severity A – 100%
Whole Person Impairment of 30% or above
Severity B – 75%
Whole Person Impairment of between 20% - 29%
Severity C – 50%
Whole Person Impairment of between 15% - 19%
Severity D – 25%
Whole Person Impairment of between 10% - 14%

5. **MUSCULAR DYSTROPHY**

Definition:
Unequivocal diagnosis of Muscular Dystrophy by a consultant neurologist as approved by PPS Insurance.

Severity Levels:
Using the Whole Person Impairment rating from the American Medical Association Guide to the Evaluation of Permanent Impairment. This takes into account all parts of the body that may be affected.

Severity A – 100%
Whole Person Impairment of 30% or above
Severity B – 75%
Whole Person Impairment of between 20% - 29%
Severity C – 50%
Whole Person Impairment of between 15% - 19%
Severity D – 25%
Whole Person Impairment of between 10% - 14%

6. **MOTOR NEURON DISEASE**

Definition:
Unequivocal diagnosis of Motor Neuron Disease (Amyotrophic lateral sclerosis) by a consultant neurologist as approved by PPS Insurance.

Exclusions:
Nervous lesions of inflammatory or toxic origin.

Severity Levels:
Using the Whole Person Impairment rating from the American Medical Association Guide to the Evaluation of Permanent Impairment. This takes into account all parts of the body that may be affected.

Severity A – 100%
Whole Person Impairment of 30% or above
Severity B – 75%
Whole Person Impairment of between 20% - 29%
Severity C – 50%
Whole Person Impairment of between 15% - 19%
Severity D – 25%
Whole Person Impairment of between 10% - 14%

7. **PARKINSON'S DISEASE**

Definition:
Means the life insured has Parkinson's Disease where the condition cannot be significantly controlled with treatment and results in signs of progressive incapacity.

Exclusions:
Parkinsonism resulting from the side effects of medication; alcohol, drug-induced or toxic causes of Parkinson's disease.

Severity Levels:
Severity A – 100%
Whole Person Impairment of 25% or above.
Severity D – 25%
On confirmation of the diagnosis by an appropriate specialist approved by PPS Insurance.

8. **DEMENTIA OR ALZHEIMER'S DISEASE**

Definition:
Whilst practicing as a professional, means the life insured has Alzheimer's Disease or other Dementia. The diagnosis must confirm permanent irreversible failure of brain function and result in significant cognitive impairment for which no other recognisable cause can be identified. Significant cognitive impairment means a deterioration or loss of intellectual capacity. An appropriate specialist approved by PPS Insurance must confirm the diagnosis.
In retirement, means the life insured has Alzheimer's Disease or other Dementia. The diagnosis must confirm permanent irreversible failure of brain function and result in significant cognitive impairment needing constant supervision for which no other recognisable cause can be identified. An appropriate specialist approved by PPS Insurance must confirm the diagnosis.

Exclusions:
Alcohol or drug related dementia.

Severity A – 100%
Significant cognitive impairment with loss of intellectual capacity.

9. **BENIGN BRAIN TUMOUR**

Severity A – 100%
Means a life-threatening, non-malignant tumour in the brain, giving rise to characteristic symptoms of increased intracranial pressure such as papilloedema, mental symptoms, seizures and sensory impairment. The tumour must result in neurological deficit causing at least 25% Whole Person Impairment that is permanent. The presence of the underlying tumour must be confirmed by imaging studies such as CT Scan or MRI. Cysts, granulomas, cholesteatomas, haematomas, malformations in or of the arteries or veins of the brain or spine are excluded.

TRANSPLANTS

10. **MAJOR ORGAN TRANSPLANT**

Severity A – 100%
On completion of one or more transplants of the heart, lung, liver, kidney, small bowel or bone marrow as a recipient.

Exclusions:
Excluding the transplantation of the Islets of Langerhans only; stem cells; transplant of all other organs, parts of organs or tissue is excluded.

CANCER

11. **CANCER**

Definition:
Means the presence of one or more malignant tumours characterised by uncontrolled growth and spread of malignant cells and the invasion or destruction of normal tissue. Must be confirmed by a histology report from an accredited pathology laboratory.

Exclusions:
- Tumours showing the malignant changes of Carcinoma-in-situ (including cervical dysplasia CIN-1, CIN-2 and CIN-3) or which are histologically described as premalignant are excluded.
- All skin cancers localised or infiltrating including, but not limited to, the following are excluded:
  - Hyperkeratosis
  - basal cell carcinoma
  - squamous cell carcinoma
  - melanomas of less than 1.0mm (Breslow method) depth.
- Non-life threatening prostatic cancers which are histologically described as TNM classification T1a and T1b (but not T1c) or of another equivalent or lesser qualification, papillary micro-carcinoma of the thyroid or bladder

CORE 100%
- Cancer, Stage I, confined to the primary organ to stage IV showing lymphatic or blood spread to distant lymph nodes or distant metastases; Chronic Lymphocytic Leukaemia (CLL) Stage 0 to 4; Stage 1 to 4 Lymphomas; Hairy cell leukaemia
- Acute Myeloid Leukaemia (AML)
- Chronic Myeloid Leukaemia (with or without bone marrow transplantation)
- Acute Lymphocytic Leukaemia (ALL)

- Multiple Myeloma stage 1 to 3

Severity D – 25%
- Prophylactic bilateral total mastectomy not for cosmetic purposes

MUSCULOSKELETAL

12. **PARALYSIS (Quadriplegia/Paraplegia)**

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.

Exclusions:
Partial or temporary paralysis.

13. **LOSS OF USE OF LIMBS** (only 1 benefit should be paid in this instance)

Definition:
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.

Limb	Maximum benefit for condition*	Severity level
One hand ï dominant	770 855	C
One hand ï non-dominant	770 855	D
Both hands	1 541 706	B
One arm	1 156 280	B
Both arms	GPI Sum Assured	A
One foot	462 512	D
Both feet	1 541 706	C
One leg	1 541 706	C
Both legs	GPI Sum Assured	A
One arm and one leg	GPI Sum Assured	A

*PPS Insurance may increase the maximum benefits annually at its sole discretion.

14. **AMPUTATION**

Definition:

ñThumbòrequires loss of the whole thumb from the metocarpo-phalangeal joint.
ñFingeròrequires loss of the whole finger from the metocarpo-phalangeal joint.

Amputation of:	Maximum benefit for condition*	Severity level
Amputation of the:		
Thumb	154 171	D
3 fingers and thumb	385 426	C
4 fingers and thumb	616 682	C
Four toes and big toe	154 171	D

1 or more fingers	123 336	D

*PPS Insurance may increase the maximum benefits annually at its sole discretion.

TRAUMA

15. **COMA**

Severity A – 100%
Failure of cerebral function characterised by total unresponsiveness to all external stimuli, persisting continuously with the use of a life support system for a period of at least **96 hours**.

Exclusions:
Coma resulting directly from alcohol or drug abuse is excluded.

16. **GUNSHOT WOUNDS**

Severity A – 100%
Penetrating gunshot wound to the head, neck, chest, abdomen or pelvic area requiring surgical intervention by means of a craniotomy, thoracotomy or laparotomy.

Exclusions:
Superficial gunshot wounds, gunshot wounds to the legs (including hips), gunshot wounds to the arms (including shoulders).

17. **3RD DEGREE BURNS**

Severity A – 100%
Tissue injury caused by thermal, electrical or chemical agents causing third degree or full thickness burns to at least 20% of the body surface area as measured by the Rule of Nines or the Lund or Browder Body Surface Chart.

18. **ACCIDENTAL HIV INFECTION**

Severity A – 100%
Infection by any Human Immunodeficiency Virus or being diagnosed as having Acquired Immune Deficiency Syndrome if the infection can be proved to the satisfaction of PPS Insurance as being due to:

- The result of an accident during the course of carrying out normal occupational duties as a medical or dental practitioner registered with the Health Professions Council of South Africa (HPCSA).
- The transfusion of infected blood or blood products from a transfusion service recognised by PPS Insurance in the Republic of South Africa. The institution that provided the blood must admit liability.
- Indecent assault. The offense must have resulted in the opening of a criminal case by the police.

In the case of accidental HIV infection while carrying out normal occupational duties or as the result of indecent assault, any incident giving rise to a potential claim must be:

- Reported to PPS Insurance within **10 days** of the incident and
- Be supported by a negative HIV antibody test, taken within **3 days** of the incident.
- Prophylactic treatment must be taken for a full period of 28 consecutive days to the satisfaction of PPS Insurance.

Exclusions:
Infection in any other manner, including infection as a result of sexual activity or intravenous drug use.
This benefit will not apply in the case that an internationally recognised medical cure is found for AIDS.

19. RECONSTRUCTIVE SURGERY OF FACIAL DISFIGUREMENT DUE TO INJURY, ACCIDENT OR ASSAULT

Definition:
The undergoing of the following reconstructive surgical procedures (single or multiple) for extensive and significant repair to facial bone and/or skin injuries, due to injury, accident or assault, which renders the applicant permanently facially disfigured. The surgery must, in the opinion of PPS Insurance, be deemed necessary. The face is defined as the front portion of the head ï the eyes, nose, mouth, forehead, cheeks, and chin but excluding the ears. All corrective procedures should have been completed and the Reconstructive Surgeon in charge must indicate that no further surgery or procedures will provide any future enhancements/improvements to the injury.

Exclusion:
Cosmetic procedures or cosmetic surgery for any other reason than restoration or reconstruction as described in the definition.

Severity Levels:
Severity A – 100% (maximum benefit for this condition is R770 855. PPS Insurance may increase the maximum benefits annually at its sole discretion)
Disfigurement involving the entire area between the hairline and lower jaw on both sides of the face.

Severity B – 75% (maximum benefit for this condition is R501 055. PPS Insurance may increase the maximum benefits annually at its sole discretion)
Disfigurement involving the entire area between the hairline and lower jaw on one side of the face or alternately, 50% of the facial area.

Severity C – 50% (maximum benefit for this condition is R385 426. PPS Insurance may increase the maximum benefits annually at its sole discretion)
Disfigurement involving any quadrant of the face, or 25% of the area of the face as defined above.

Severity D – 25% (maximum benefit for this condition is R192 714. PPS Insurance may increase the maximum benefits annually at its sole discretion)
Significant disfigurement, as determined by PPS Insurance, of any one of the following:

- Nose
- Cheek bone
- Lips

KIDNEY AND UROLOGICAL

20. KIDNEY FAILURE

Severity A – 100%
Chronic irreversible kidney failure requiring continuous regular dialysis.

Exclusion:
Acute kidney failure requiring short-term dialysis.

CONNECTIVE TISSUE

21. RHEUMATOID ARTHRITIS

Severity A – 100%
Widespread chronic progressive joint destruction with significant deformity affecting at least three major joint groups (e.g. feet, hands, hips, knees, wrists).
In addition to this, four of six criteria are required:

- Morning stiffness
- Soft tissue swelling in 3 joint groups
- Symmetrical swelling in joints
- Presence of rheumatoid nodules
- Elevated rheumatoid factor
- Appropriate radiographic changes

22. SYSTEMIC LUPUS ERYTHEMATOSUS WITH NEPHRITIS

Severity A – 100%
Systematic lupus erythematosus will be restricted to those forms of systematic lupus erythematosus, which involve the kidneys (Type III to Type V Lupus nephritis, established by renal biopsy, and in accordance with the WHO classification). Other forms, discoid lupus and those forms with haematological and joint involvement will be specifically excluded. The final diagnosis is to be supported by a certified doctor specialising in Rheumatology and Immunology as approved by PPS Insurance.

Exclusions:
Discoid lupus and those forms with haematological and joint involvement will be specifically excluded.

23. SCLERODERMA

Severity A – 100%
A multisystem disorder of unknown cause characterised by fibrosis of the skin, blood vessels and visceral organs including the gastrointestinal tract, lungs, heart and kidneys.
Diagnosis must be supported by biopsy and the disorder should have affected one of the following; pulmonary, cardiac, gastro ï intestinal, renal systems. Cutaneous scleroderma and sclerodactyly are specifically excluded.

RESPIRATORY

24. RESPIRATORY FAILURE

Severity A – 100%
End stage lung disease. Both of the following must be fulfilled:

- Proof of necessary and permanent oxygen therapy for at least 8hrs/day and
- FEV1 test results of less than 1 litre

25. LOBECTOMY

Severity C – 50%
Removal of one complete lung
Severity D– 25%

Removal of a lobe of a lung not for donor purposes

GASTROINTESTINAL

26. ULCERATIVE COLITIS

Severity A – 100%

For the purposes of this policy, Ulcerative Colitis shall mean acute Fulminant Ulcerative Colitis with life threatening electrolyte disturbances usually associated with intestinal distention and a risk of intestinal rupture. It must involve the entire colon with severe bloody diarrhoea and systemic signs and symptoms and for which the treatment is total colectomy and/or ileostomy. Diagnosis must be based on histopathological features. Surgery in the form of colectomy and/or ileostomy should form part of the treatment.

27. CROHN'S DISEASE

Severity A – 100%

Crohn's disease is a chronic granulomatous inflammatory disease. The disease must require surgical intervention after one of the following:

- fistula formation, or
- intestinal obstruction, or
- intestinal perforation

of 2 or more sites.

The characteristic post-surgical histopathological features must confirm diagnosis.

28. **LIVER FAILURE**

Severity A – 100%

Liver Failure means end stage liver failure with permanent jaundice, ascites or encephalopathy

29. **CHRONIC PANCREATITIS**

Severity A – 100%

Pancreas transplant including partial transplant of the pancreas.

Severity C – 50%

A chronic inflammation of the pancreas, characterised by fibrosis and resulting in chronic pain, diabetes mellitus or persistent gastro ï intestinal tract disturbances. Diagnosis based on presentation of the following triad of findings: Pancreatic Calcification; Steatorrhea and established Diabetes mellitus or alternatively < 10% exocrine function remaining.

EAR NOSE AND THROAT

30. LOSS OF HEARING

Severity B – 75%

Means irrecoverable Loss of Hearing in both ears, with an auditory threshold of more than 90 decibels, as a result of sickness or injury. No benefits will be payable if in general specialist opinion a hearing aid, device, or implant could result in the partial or total restoration of hearing.

31. LOSS OF SPEECH

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.

VISUAL

32. LOSS OF SIGHT

Definition:
Total irreversible loss of sight as confirmed by an ophthalmologist as a result of injury or disease with a best corrected visual acuity of 6/120 or less.

Exclusion:
Temporary visual impairment that can be corrected by medical or surgical treatment, implants or appliances.

Condition	Maximum benefit for condition*	Severity Level
One eye	308 342	C
Both eyes	GPI Sum Assured	A

*****PPS Insurance may increase the maximum benefits annually at its sole discretion.

Appendix C

1. ABORTION DUE TO AMNIOCENTESIS

Severity D – 25% (maximum benefit for this condition is R 30,835. PPS Insurance may increase the maximum benefits annually at its sole discretion)
Miscarriage directly or indirectly caused by amniocentesis within 7 days of amniocentesis

2. ABRUPTIO PLACENTAE

Severity C– 50%
Total or partial premature detachment of the placenta from the uterus during pregnancy.

Condition:
- Must require hospitalisation and a blood transfusion and/or
- Have disseminated intravascular coagulation (generation of blood clots in the circulating blood).

3. AMNIOTIC FLUID EMBOLISM

Severity A– 100%
Diagnosis of an amniotic fluid embolism requiring emergency treatment and intensive care admission.

4. ECTOPIC PREGNANCY

Severity D – 25%
Development of a fertilised ovum outside of the uterus. The ectopic pregnancy must have been terminated by laparotomy or laparoscopic surgery.

5. HYDATIDIFORM MOLE

Severity D – 25%
A growth of cysts forming in the uterus when the membrane surrounding the embryo degenerates. Confirmatory histological evidence will be required.

6. HYPEREMESIS GRAVIDARUM

Severity D – 25% (maximum benefit for this condition is R 15,417. PPS Insurance may increase the maximum benefits annually at its sole discretion)
Hyperemesis gravidarum is a severe and intractable form of nausea and vomiting in pregnancy. It may result in weight loss; nutritional deficiencies; and abnormalities in fluids, electrolyte levels, and acid-base balance. For the purposes of this policy treatment must require a minimum hospital admission for 4 (four) days.

7. PLACENTA PRAEVIA

Severity D – 25% (maximum benefit for this condition is R 15,417. PPS Insurance may increase the maximum benefits annually at its sole discretion)

The condition in which the placenta is implanted in the lower segment of the uterus, extending to the margin of the internal os of the cervix or partially or completely obstructing the os, and requiring Caesarean section for this condition.

8. PULMONARY EMBOLISM

Severity B – 75%
Life threatening obstruction of the pulmonary artery or one of its main branches by an embolus (thrombus, air or fat embolism, foreign body). For this benefit, a claim is considered only during pregnancy or 2 weeks post partum.

9. SEVERE PRE-ECLAMPSIA AND ECLAMPSIA

Definition:
The diagnosis of severe pre-eclampsia or eclampsia by a gynaecologist or physician.

Severity B – 75%
Eclampsia. Convulsions, seizures or a coma occurring during or immediately after pregnancy as a complication of pre-eclampsia.

Severity D – 25%
Severe Pre-eclampsia characterised by: Blood pressure of 150/110mmHg, marked oedema, albuminuria > or =3+, visual disturbances or abdominal pain.

10. SHEEHAN'S SYNDROME

Severity level A – 100%
Hypopituitarism postpartum as a result of pituitary necrosis; caused by ischaemia resulting from a hypotensive episode during delivery. Diagnosis must be confirmed by a neurologist.

11. UTERINE RUPTURE

Severity C – 50%
Uterine rupture is the full thickness tear of the uterus into the abdominal cavity during labour.

Appendix D

CARDIOVASCULAR

d. HEART ATTACK

Definition:
Means the death of a portion of the heart muscle arising from inadequate blood supply to the relevant area. The diagnosis shall be supported and the severity level confirmed if the following criteria are present and confirmed by a cardiologist at least 30 days after the event.

- Clinical features including typical chest pain;
- Confirmatory new electrocardiogram changes (ECG) changes;
- Diagnostic elevation of specific cardiac markers, such as CK-MB or troponin.

Exclusions:

- Acute coronary syndrome without infarction; stable or unstable angina.
- Payment of this benefit category excludes Cardiomyopathy benefits and vice versa.

Severity A – 100%
Four out of the seven criteria to apply:

8. Occasional cardiac symptoms on exertion (Grade II NYHA)
9. Resting ECG: Persistent Q-waves remain over time
10. Stress ECG: Significant ST segment changes of 1 ï 2 mm or cardiac symptoms occurring during exercise (chest pain, dizziness, dyspnoea)
11. 30 Day post infarction ejection fraction less than 49% and echocardiographic evidence of myocardial damage, e.g. akinesis or dyskinesis
12. Angiography (if performed): Three vessels* significantly diseased
13. Ongoing appropriate medication to control cardiac symptoms e.g. ACE inhibitors, Betablockers, Angiotensin II Receptor Blockers plus prophylactic medication
14. Persisting arrhythmias atrial fibrillation or supraventricular tachycardia
15.

* Main vessels, e.g. Circumflex, Right Coronary Artery, Left Anterior Descending

e. CARDIAC SURGERY AND PROCEDURES

Definition:
The completion of cardiac surgery by a cardio-thoracic surgeon. Submissions from the hospital and reports from the cardio-thoracic surgeon or cardiologist will be required.

Severity A – 100%

- Heart valve replacement of one or more heart valves by means of open heart surgery (thoracotomy)
- Coronary artery bypass grafting (CABG) of 3 or more main vessels*

* Main vessels only e.g Circumflex, Right Coronary Artery, Left Anterior Descending

f. CARDIOMYOPATHY

Definition:
Severity A – 100%
Cardiomyopathy confirmed on echocardiogram and resulting in permanent and irreversible physical impairments to the degree of at least Class III of the New York Heart Association

Classification of Cardiac Impairment with METS < 5 or EF ≤ 30% based on an average of 2 readings 3 months apart.

BLOOD

1. APLASTIC ANAEMIA

Severity A – 100%
Irreversible bone marrow failure resulting in anaemia, neutropenia and thrombocytopenia. The diagnosis must be based on a bone marrow biopsy.
Two out of the following three values must be present:

4. Absolute neutrophil count of 500 per cubic millimetre or less;
5. Absolute reticulocyte count of 20,000 per cubic millimetre or less; and
6. Platelet count of 20,000 per cubic millimetre or less.

NEUROLOGICAL

2. STROKE

Definition:
Any cerebrovascular incident or stroke producing neurological sequelae lasting more than **24 hours** and including infarction of brain tissue, haemorrhage and embolisation from an extracranial source. Evidence of permanent and significant neurological damage must be confirmed by a neurologist approved by PPS Insurance **3 months** after the event. Signs appropriate to the brain area affected must be present.

Exclusions:
Transient ischaemic attacks (TIAs), cerebral symptoms due to migraine, cerebral injury resulting from trauma or hypoxia and vascular disease affecting the eye or optic nerve as well as ischaemic disorders of the vestibular system are excluded.

Severity Levels:
Using the Whole Person Impairment rating from the American Medical Association Guide to the Evaluation of Permanent Impairment. This takes into account all parts of the body that may be affected.

Severity A – 100%
Whole Person Impairment of 20% or above

3. MULTIPLE SCLEROSIS

Definition:
Means the life insured has Multiple Sclerosis confirmed by CT or MRI scan, where the condition is characterised by the demyelination in the brain and spinal cord. There must be more than one clearly distinct episode of well-defined neurological deficit causing persisting neurological deficit, which remains permanent. A consultant neurologist approved by PPS Insurance must confirm the diagnosis.

Exclusions:
A single episode of Multiple Sclerosis from which remission occurred.

Severity Levels:

Using the Whole Person Impairment rating from the American Medical Association Guide to the Evaluation of Permanent Impairment. This takes into account all parts of the body that may be affected.

Severity A – 100%
Whole Person Impairment of 20% or above

4. MUSCULAR DYSTROPHY

Definition:
Unequivocal diagnosis of Muscular Dystrophy by a consultant neurologist as approved by PPS Insurance.

Severity Levels:
Using the Whole Person Impairment rating from the American Medical Association Guide to the Evaluation of Permanent Impairment. This takes into account all parts of the body that may be affected.

Severity A – 100%
Whole Person Impairment of 20% or above

5. MOTOR NEURON DISEASE

Definition:
Unequivocal diagnosis of Motor Neuron Disease (Amyotrophic lateral sclerosis) by a consultant neurologist as approved by PPS Insurance.

Exclusions:
Nervous lesions of inflammatory or toxic origin.

Severity Levels:
Using the Whole Person Impairment rating from the American Medical Association Guide to the Evaluation of Permanent Impairment. This takes into account all parts of the body that may be affected.

Severity A – 100%
Whole Person Impairment of 20% or above

6. PARKINSON'S DISEASE

Definition:
Means the life insured has Parkinsonõs Disease where the condition cannot be significantly controlled with treatment and results in signs of progressive incapacity.

Exclusions:
Parkinsonism resulting from the side effects of medication; alcohol, drug-induced or toxic causes of Parkinsonõs disease.

Severity Levels:
Severity A – 100%
Whole Person Impairment of 25% or above.

7. DEMENTIA OR ALZHEIMER'S DISEASE

Definition:
Whilst practicing as a professional, means the life insured has Alzheimerõs Disease or other Dementia. The diagnosis must confirm permanent irreversible failure of brain function and result in significant cognitive impairment for which no other recognisable cause can be identified. Significant cognitive impairment means a deterioration or loss of intellectual capacity. An appropriate specialist approved by PPS Insurance must confirm the diagnosis.
In retirement, means the life insured has Alzheimerõs Disease or other Dementia. The diagnosis must confirm permanent irreversible failure of brain function and result in significant cognitive impairment needing constant supervision for which no other recognisable cause can be identified. An appropriate specialist approved by PPS Insurance must confirm the diagnosis.

Exclusions:
Alcohol or drug related dementia.
Severity A – 100%
Significant cognitive impairment with loss of intellectual capacity.

8. BENIGN BRAIN TUMOUR

Severity A – 100%
Means a life-threatening, non-malignant tumour in the brain, giving rise to characteristic symptoms of increased intracranial pressure such as papilloedema, mental symptoms, seizures and sensory impairment. The tumour must result in neurological deficit causing at least 25% Whole Person Impairment that is permanent. The presence of the underlying tumour must be confirmed by imaging studies such as CT Scan or MRI. Cysts, granulomas, cholesteatomas, haematomas, malformations in or of the arteries or veins of the brain or spine are excluded.

TRANSPLANTS

9. MAJOR ORGAN TRANSPLANT

Severity A – 100%
On completion of one or more transplants of the heart, lung, liver, kidney, small bowel or bone marrow as a recipient.

Exclusions:
Excluding the transplantation of the Islets of Langerhans only; stem cells; transplant of all other organs, parts of organs or tissue is excluded.

CANCER

10. CANCER

Definition:
Means the presence of one or more malignant tumours characterised by uncontrolled growth and spread of malignant cells and the invasion or destruction of normal tissue. Must be confirmed by a histology report from an accredited pathology laboratory.

Exclusions:
- Tumours showing the malignant changes of Carcinoma-in-situ (including cervical dysplasia CIN-1, CIN-2 and CIN-3) or which are histologically described as premalignant are excluded.
- All skin cancers localised or infiltrating including, but not limited to, the following are excluded:

- Hyperkeratosis
- basal cell carcinoma
- squamous cell carcinoma
- melanomas of less than 1.0mm (Breslow method) depth.

· Non-life threatening prostatic cancers which are histologically described as TNM classification T1a and T1b (but not T1c) or of another equivalent or lesser qualification, papillary micro-carcinoma of the thyroid or bladder

Severity A – 100%

- Cancer, Stage IV, showing lymphatic or blood spread to distant lymph nodes or distant metastases, or
- Cancer, Stage III, within organ of origin with spread to regional lymph nodes
- Chronic Lymphocytic Leukaemia (CLL) Stage 3 or 4
- Stage 3 or 4 Lymphomas
- Acute Myeloid Leukaemia (AML) any stage
- Chronic Myeloid Leukaemia (requiring bone marrow transplant);
- Acute Lymphocytic Leukaemia any stage
- Multiple Myeloma Stage 3
-

MUSCULOSKELETAL

11. PARALYSIS (Quadriplegia/Paraplegia)

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.

Exclusions:
Partial or temporary paralysis.

12. LOSS OF USE OF LIMBS (only 1 benefit should be paid in this instance)

Definition:
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.

Limb	Severity level
Both hands	A
One arm	A
Both arms	A
Both legs	A

TRAUMA

13. COMA

Severity A – 100%
Failure of cerebral function characterised by total unresponsiveness to all external stimuli, persisting continuously with the use of a life support system for a period of at least **96 hours**.

Exclusions:
Coma resulting directly from alcohol or drug abuse is excluded.

14. GUNSHOT WOUNDS

Severity A – 100%
Penetrating gunshot wound to the head, neck, chest, abdomen or pelvic area requiring surgical intervention by means of a craniotomy, thoracotomy or laparotomy.

Exclusions:
Superficial gunshot wounds, gunshot wounds to the legs (including hips), gunshot wounds to the arms (including shoulders).

15. 3RD DEGREE BURNS

Severity A – 100%
Tissue injury caused by thermal, electrical or chemical agents causing third degree or full thickness burns to at least 20% of the body surface area as measured by the Rule of Nines or the Lund or Browder Body Surface Chart.

16. ACCIDENTAL HIV INFECTION

Severity A – 100%
Infection by any Human Immunodeficiency Virus or being diagnosed as having Acquired Immune Deficiency Syndrome if the infection can be proved to the satisfaction of PPS Insurance as being due to:

- The result of an accident during the course of carrying out normal occupational duties as a medical or dental practitioner registered with the Health Professions Council of South Africa (HPCSA).
- The transfusion of infected blood or blood products from a transfusion service recognised by PPS Insurance in the Republic of South Africa. The institution that provided the blood must admit liability.
- Indecent assualt. The offense must have resulted in the opening of a criminal case by the police.

In the case of accidental HIV infection while carrying out normal occupational duties or as the result of indecent assault, any incident giving rise to a potential claim must be:

- Reported to PPS Insurance within **10 days** of the incident and
- Be supported by a negative HIV antibody test, taken within **3 days** of the incident.
- Prophylactic treatment must be taken for a full period of 28 consecutive days to the satisfaction of PPS Insurance.

Exclusions:
Infection in any other manner, including infection as a result of sexual activity or intravenous drug use.
This benefit will not apply in the case that an internationally recognised medical cure is found for AIDS.

KIDNEY AND UROLOGICAL

17. KIDNEY FAILURE

Severity A – 100%
Chronic irreversible kidney failure requiring continuous regular dialysis.

Exclusion:
Acute kidney failure requiring short-term dialysis.

CONNECTIVE TISSUE

18. RHEUMATOID ARTHRITIS

Severity A – 100%
Widespread chronic progressive joint destruction with significant deformity affecting at least three major joint groups (e.g. feet, hands, hips, knees, wrists).
In addition to this, four of six criteria are required:

- Morning stiffness
- Soft tissue swelling in 3 joint groups
- Symmetrical swelling in joints
- Presence of rheumatoid nodules
- Elevated rheumatoid factor
- Appropriate radiographic changes

19. SYSTEMIC LUPUS ERYTHEMATOSUS WITH NEPHRITIS

Severity A – 100%
Systematic lupus erythematosus will be restricted to those forms of systematic lupus erythematosus, which involve the kidneys (Type III to Type V Lupus nephritis, established by renal biopsy, and in accordance with the WHO classification). Other forms, discoid lupus and those forms with haematological and joint involvement will be specifically excluded. The final diagnosis is to be supported by a certified doctor specialising in Rheumatology and Immunology as approved by PPS Insurance.

Exclusions:
Discoid lupus and those forms with haematological and joint involvement will be specifically excluded.

20. SCLERODERMA

Severity A – 100%
A multisystem disorder of unknown cause characterised by fibrosis of the skin, blood vessels and visceral organs including the gastrointestinal tract, lungs, heart and kidneys.
Diagnosis must be supported by biopsy and the disorder should have affected one of the following; pulmonary, cardiac, gastro ï intestinal, renal systems. Cutaneous scleroderma and sclerodactyly are specifically excluded.

RESPIRATORY

21. RESPIRATORY FAILURE

Severity A – 100%
End stage lung disease. Both of the following must be fulfilled:

· Proof of necessary and permanent oxygen therapy for at least 8hrs/day and
· FEV1 test results of less than 1 litre

GASTROINTESTINAL

22. ULCERATIVE COLITIS

Severity A – 100%
For the purposes of this policy, Ulcerative Colitis shall mean acute Fulminant Ulcerative Colitis with life threatening electrolyte disturbances usually associated with intestinal distention and a risk of intestinal rupture. It must involve the entire colon with severe bloody diarrhoea and systemic signs and symptoms and for which the treatment is total colectomy and/or ileostomy. Diagnosis must be based on histopathological features. Surgery in the form of colectomy and/or ileostomy should form part of the treatment.

23. CROHN'S DISEASE

Severity A – 100%
Crohnõs disease is a chronic granulomatous inflammatory disease. The disease must require surgical intervention after one of the following:

- fistula formation, or
- intestinal obstruction, or
- intestinal perforation

of 2 or more sites.
The characteristic post-surgical histopathological features must confirm diagnosis.

24. LIVER FAILURE

Severity A – 100%
Liver Failure means end stage liver failure with permanent jaundice, ascites or encephalopathy

25. CHRONIC PANCREATITIS

Severity A – 100%
Pancreas transplant including partial transplant of the pancreas.

EAR NOSE AND THROAT

26. LOSS OF HEARING

Severity A – 100%
Means irrecoverable Loss of Hearing in both ears, with an auditory threshold of more than 90 decibels, as a result of sickness or injury. No benefits will be payable if in general specialist opinion a hearing aid, device, or implant could result in the partial or total restoration of hearing.

27. LOSS OF SPEECH

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.

VISUAL

28. LOSS OF SIGHT

Severity A – 100%
Total irreversible loss of sight in both eyes as confirmed by an ophthalmologist as a result of injury or disease with a best corrected visual acuity of 6/120 or less.

Exclusion:
Temporary visual impairment that can be corrected, by medical or surgical treatment, implants or appliances.

APPENDIX E

*** NOTE:** All Sick Pay Benefits paid in terms of Appendix E will cease automatically on the day of delivery of the unborn infant or on termination of the pregnancy, unless expressly stated otherwise.
*** NOTE:** Only Total Sick Pay claims will be considered for the pregnancy related conditions listed in Appendix E. Partial Sick Pay claims will not be considered.

7 Day waiting period pregnancy complication sickness benefit criteria

NOTE: Claims will only be paid after the 7 day waiting period if the policyholder has been totally booked-off from work for the full 7 day period by the treating obstetrician / gynecologist. In such instance payment will be made retrospectively from the first day on which the policyholder was totally booked-off from work subject to the Maximum Payment Periods listed in the final column of the appendix.

Condition	Minimum Claim Criteria	Benefit Requirements	Maximum Payment Periods*
Ectopic Pregnancy	A pregnancy developing outside the normal lining of the uterus.	• Proof of admission to hospital; and • A report from the policyholdersô treating obstetrician; and • A claim form (Declaration by Doctor Form) completed by the policyholdersô treating obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder.	• For a Laparoscopic procedure: 10 days, which shall include any period of hospitalisation; • 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.
Severe Abruptio Placenta	• Placenta separates from the uterus wall; and • Ultrasound evidence of significant retroplacental blood clot; and • Evidence of maternal complications related to blood loss as evidenced by low haematocrit, or hypovolaemic shock, or acute renal failure.	• Proof of admission to hospital; and • A report from the policyholdersô treating obstetrician; and • A claim form (Declaration by Doctor Form) completed by the policyholdersô treating obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder.	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.
Major Placenta Praevia	• The placenta totally covers the internal cervical os; and • Evidence of active bleeding which results in the policyholder requiring total bed rest.	• Proof of admission to hospital; and • A report from the policyholdersô treating obstetrician; and • A claim form (Declaration by	• 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

Condition	Minimum Claim Criteria	Benefit Requirements	Maximum Payment Periods*
		Doctor Form) completed by the policyholdersô treating obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder.	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 policyholdersô treating obstetrician; and • A claim form (Declaration by Doctor Form) completed by the policyholdersô 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. In addition to the above at least 3 of the following requirements must be met, as confirmed by the policyholdersô treating obstetrician: • Weight loss; and/or • Dehydration indicated by blood tests; and/or • Hyponatraemia; and/or • Hypokalaemia; and/or • Hypochloraemic Acidosis; and/or • Abnormalities in liver function indicated by liver function tests; and/or • Ketonuria; and/or • Haemoconcentration indicated by full blood count.	• Proof of admission to hospital; and • A report from the policyholdersô treating obstetrician, inclusive of copies of tests conducted which confirm the diagnosis; and • A claim form (Declaration by Doctor Form) completed by the policyholdersô treating obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder.	A total of 7 days per pregnancy, which shall include any period of hospitalisation.
Primary Post Partum Haemorrhage	• Blood loss >500 ml at vaginal delivery or >1 litre at caesarean section within 24	• Proof of admission to hospital; and	• If no hysterectomy is required: period of hospitalisation plus 7 days, unless the policyholder

Condition	Minimum Claim Criteria	Benefit Requirements	Maximum Payment Periods*
	hours after delivery; or • Bleeding associated with hypotension and tachycardia, or • Drop in haematocrit of 10 or more %; or • Bleeding requiring blood transfusion.	• A report from the policyholdersô treating obstetrician including copies of all relevant blood tests; and • A claim form (Declaration by Doctor Form) completed by the policyholdersô treating obstetrician; and • A claim form (Declaration by Member Form) completed by 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. • 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.
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; and/or • proteinuria >300mg/day; and/or • Impaired liver function with AST >40IU/l; and/or • Impaired renal function with plasma creatinine >100 micromol/l; and/or • Neurological problems including hyperreflexia (with clonus or severe headaches); and/or • Haematological disorders, thrombocytopaenia, and/or haemolysis.	• Proof of admission to hospital; and • A report from the policyholdersô treating obstetrician including copies of all relevant blood tests; and • A claim form (Declaration by Doctor Form) completed by the policyholdersô treating obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder.	• 14 days in total, which shall include any period of hospitalization, 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 policyholdersô treating obstetriciansô motivational report and Declaration by Doctor form, and must include blood pressure readings and biochemical test results confirming the continued health impairment 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 confirming the continued health impairment 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,	• Proof of admission to	Duration of the pregnancy plus 14 days post-delivery, unless the

Condition	Minimum Claim Criteria	Benefit Requirements	Maximum Payment Periods*
	occurring with pregnancy and having no other cause.	hospital; and • A report from the policyholdersô treating obstetrician; and • A claim form (Declaration by Doctor Form) completed by the policyholdersô treating obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder.	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.
Hydatidiform Mole	Benign form of gestational trophoblastic disease.	• Proof of admission to hospital; and • A report from the policyholdersô treating obstetrician; and • A claim form (Declaration by Doctor Form) completed by the policyholdersô 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.
Premature Rupture of Membranes	Membranes rupture before 37 weeks of pregnancy in the absence of uterine contractions.	• Proof of admission to hospital; and • A report from the policyholdersô treating obstetrician; and • A claim form (Declaration by Doctor Form) completed by the policyholdersô 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.
Premature Labour	Labour which begins prior to 37 weeks pregnancy or foetal mass estimated at <2500g. The benefit will only pay for true contractions of preterm	• Proof of admission to hospital; and • A report from the policyholdersô treating obstetrician; including copies	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

Condition	Minimum Claim Criteria	Benefit Requirements	Maximum Payment Periods*
	labour diagnosed by contractions which are regular, painful, progressively increase in duration and frequency, and cause effacement and dilatation of the cervix. Braxton Hicks contractions are specifically excluded.	of medical reports and tocograms indicating how diagnosis was made; and • A claim form (Declaration by Doctor Form) completed by the policyholdersô treating obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder.	payment will be made for the period for which the policyholder was booked-off from work.
High Risk Pregnancy	The following underlying maternal pathological conditions where the condition is aggravated by pregnancy and affects maternal health: - Cardiac disorders: valvular heart disease, cardiomyopathy, ischaemic disease, pericardial disease, heart failure; - Blood disorders: sickle cell disease; -Endocrine disorders: uncontrolled diabetes mellitus/ thyroid crisis; - Multiple pregnancy; - Chronic kidney disease; - Systemic lupus erythematosus; - Primary pulmonary hypertension; - Eisenmengers syndrome; - Current cancer chemotherapy or radiation therapy .	• Proof of admission to hospital; and • A report from the policyholdersô treating obstetrician; and • A claim form (Declaration by Doctor Form) completed by the policyholdersô treating obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder.	• For the duration of hospitalization, 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 policyholdersô treating obstetriciansô motivational report inclusive of copies of test results 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 extraction or evacuation of uterus.	• Proof of admission to hospital; and • A report from the policyholdersô treating obstetrician; and • A claim form (Declaration by Doctor Form) completed by the policyholdersô treating obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder.	• 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 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

Condition	Minimum Claim Criteria	Benefit Requirements	Maximum Payment Periods*
			payment will be made for the period for which the policyholder was booked-off from work.
Miscarriage: incomplete/inevitable/complete/ abortion due to amniocentesis.	Terminated pregnancy before the foetus is viable or up until 28 weeks pregnancy.	• Proof of admission to hospital; and • A report from the policyholdersô treating obstetrician; and • A claim form (Declaration by Doctor Form) completed by the policyholdersô treating obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder.	7 days, which shall include any period of hospitalisation.
Amniotic Fluid Embolism	Amniotic fluid in the general circulation.	• Proof of admission to hospital; and • A report from the policyholdersô treating obstetrician; and • A claim form (Declaration by Doctor Form) completed by the policyholdersô treating obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder.	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.
Sheehanôs Syndrome	Pituitary necrosis causing hypopituitarism.	• Proof of admission to hospital; and • A report from the policyholdersô treating obstetrician and copies of all clinical tests confirming the diagnosis; and • A claim form (Declaration by Doctor Form) completed by the policyholdersô treating obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder.	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.
Deep Vein Thrombosis or Pulmonary Embolism	Blood clot obstruction of a vein or pulmonary artery.	• Proof of admission to hospital; and	Duration of hospitalisation plus 7 days.

Condition	Minimum Claim Criteria	Benefit Requirements	Maximum Payment Periods*
		• Treatment with heparin; and • A report from the policyholdersô treating obstetrician including copies of all tests confirming the diagnosis; and • A claim form (Declaration by Doctor Form) completed by the policyholdersô treating obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder.	

30 Day waiting period pregnancy complication sickness benefit criteria.

NOTE: Claims will only be paid after the 30 day waiting period if the policyholder has been totally booked-off from work for the full 30 day period by the treating obstetrician / gynecologist. In such instance payment will be made prospectively from the thirty first day on which the policyholder was totally booked-off from work subject to the Maximum Payment Periods listed in the final column of the appendix.

Condition	Minimum Claim Criteria	Benefit Requirements	Maximum Payment Periods*
Ectopic Pregnancy	A pregnancy developing outside the normal lining of the uterus.	• Proof of admission to hospital; and • A report from the policyholdersô treating obstetrician; and • A claim form (Declaration by Doctor Form) completed by the policyholdersô treating obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder.	For a Laparotomy: a maximum of 12 days unless the policyholder was booked-off post laparotomy 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 Abruptio Placenta	• Placenta separates from the uterus wall; and • Ultrasound evidence of significant retroplacental blood clot; and • Evidence of maternal complications related to blood loss as evidenced by	• Proof of admission to hospital; and • A report from the policyholdersô treating obstetrician; and • A claim form (Declaration by Doctor Form) completed by the policyholdersô treating	The maximum payment period is to the date of delivery unless the policyholder is 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.

Condition	Minimum Claim Criteria	Benefit Requirements	Maximum Payment Periods*
	low haematocrit, or hypovolaemic shock, or acute renal failure.	obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder.	
Major Placenta Praevia	• The placenta totally covers the internal cervical os; and • Evidence of active bleeding which results in the policyholder requiring total bed rest.	• Proof of admission to hospital; and • A report from the policyholdersô treating obstetrician; and • A claim form (Declaration by Doctor Form) completed by the policyholdersô treating obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder.	• This benefit will only pay during the third trimester of the pregnancy; and • The maximum payment period is to the date of delivery unless the policyholder is 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 policyholdersô treating obstetrician; and • A claim form (Declaration by Doctor Form) completed by the policyholdersô treating obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder.	For a hysterectomy: a maximum of 12 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.
Primary Post Partum Haemorhage	• Blood loss >500 ml at vaginal delivery or >1 litre at caesarean section within 24 hours of delivery; or • Bleeding associated with hypotension and tachycardia, or • Drop in haematocrit of 10 or more %; or • Bleeding requiring blood transfusion.	• Proof of admission to hospital; and • A report from the policyholdersô treating obstetrician, including copies of all relevant blood tests; and • A claim form (Declaration by Doctor Form) completed by the policyholdersô treating obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder.	If a hysterectomy is required: a maximum of 12 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.
Pre-eclampsia	Newly diagnosed hypertension on two occasions measured at least	• Proof of admission to hospital; and	• A maximum of 14 days for the initial/first claim period, unless the policyholder was booked-

Condition	Minimum Claim Criteria	Benefit Requirements	Maximum Payment Periods*
	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; and/or • proteinuria >300mg/day; and/or • Impaired liver function with AST >40IU/l; and/or • Impaired renal function with plasma creatinine >100 micromol/l; and/or • Neurological problems including hyperreflexia (with clonus or severe headaches); and/or • Haematological disorders, thrombocytopaenia, and/or haemolysis.	• A report from the policyholdersô treating obstetrician including copies of all relevant blood tests; and • A claim form (Declaration by Doctor Form) completed by the policyholdersô treating obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder.	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 policyholdersô treating obstetriciansô motivational report and Declaration by Doctor form, and must include blood pressure readings and biochemical test results for the total further period claimed. Claims will be assessed on receipt of two- weekly declaration by doctor forms including aforementioned medical information confirming the continued health impairment for the duration of the claim period. The benefit will pay only if total bed rest is required as indicated by the obstetrician.
<u>Eclampsia</u>	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 policyholdersô treating obstetrician; and • A claim form (Declaration by Doctor Form) completed by the policyholdersô treating obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder.	• The maximum payment period is to the date of delivery 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. • Claims will be assessed on receipt of two- weekly motivational reports by the policyholdersô treating obstetrician and Declaration by Doctor form, and must include blood pressure readings and biochemical test results confirming the continued health impairment for the total further period claimed. The benefit will pay only if total bed rest is required as indicated by the obstetrician.

Condition	Minimum Claim Criteria	Benefit Requirements	Maximum Payment Periods*
Hydatidiform Mole	Benign form of gestational trophoblastic disease.	• Proof of admission to hospital; and • A report from the policyholdersô treating obstetrician; and • A claim form (Declaration by Doctor Form) completed by the policyholdersô treating obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder.	For treatment by hysterectomy: a maximum of 12 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.
Premature Rupture of Membranes	Membranes rupture before 37 weeks of pregnancy in the absence of uterine contractions.	• Proof of admission to hospital; and • A report from the policyholdersô treating obstetrician; and • A claim form (Declaration by Doctor Form) completed by the policyholdersô treating obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder.	• The maximum payment period is to the date of delivery unless the policyholder is 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. • Claims will be assessed on receipt of two- weekly motivational reports by the policyholdersô treating obstetrician and Declaration by Doctor form, for the total further period claimed. The benefit will pay only if total bed rest is required as indicated by the obstetrician.
Premature Labour	Labour which begins prior to 37 weeks pregnancy or foetal mass estimated at <2500g. The benefit will only pay for true contractions of preterm labour diagnosed by contractions which are regular, painful, progressively increase in duration and frequency, and cause effacement and dilatation of the cervix. Braxton Hicks contractions are specifically excluded.	• Proof of admission to hospital; and • A report from the policyholdersô treating obstetrician; including copies of medical reports and tocograms indicating how diagnosis was made; and • A claim form (Declaration by Doctor Form) completed by the policyholdersô treating obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder.	The maximum payment period is to the date of delivery unless the policyholder is 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. The benefit will pay only if total bed rest is required as indicated by the obstetrician.
High Risk Pregnancy	The following underlying maternal pathological conditions where the condition	• Proof of admission to hospital; and	• A maximum of 7 days unless the policyholder was booked-off from work for a shorter

Condition	Minimum Claim Criteria	Benefit Requirements	Maximum Payment Periods*
	is aggravated by pregnancy and affects maternal health: - Cardiac disorders: valvular heart disease, cardiomyopathy, ischaemic disease, pericardial disease, heart failure; - Blood disorders: sickle cell disease; -Endocrine disorders: uncontrolled diabetes mellitus/ thyroid crisis; - Multiple pregnancy; - Chronic kidney disease; - Systemic lupus erythematosus; - Chronic lung disorders: primary pulmonary hypertension; pulmonary fibrosis, bronchiectasis; - Eisenmengers syndrome; - Current cancer chemotherapy or radiation therapy.	• A report from the policyholdersô treating obstetrician clearly indicating effect on ability to continue working in occupation; and • A claim form (Declaration by Doctor Form) completed by the policyholdersô treating obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder.	period in which event payment will be made until the end of the period for which the policyholder was booked-off from work, for the initial/first claim period. • Any further claims after the initial/first claim period will be assessed on receipt of the policyholdersô treating obstetriciansô 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 hysterectomy	• Proof of admission to hospital; and • A report from the policyholdersô treating obstetrician; and • A claim form (Declaration by Doctor Form) completed by the policyholdersô treating obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder.	For treatment by hysterectomy only a maximum of 12 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.
Amniotic Fluid Embolism	Amniotic fluid in the general circulation.	• Proof of admission to hospital; and • A report from the policyholdersô treating obstetrician; and • A claim form (Declaration by Doctor Form) completed by the policyholdersô treating obstetrician; and • A claim form (Declaration by Member Form) completed by the policyholder.	The 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.


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