glu

Life Insurance product guide.

Financial Togetherness™

Plan, Insure, Invest with us.

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About glu

1. Introduction

glu, a division of PPS Insurance Company Limited, aims to share Mutuality with more South Africans. glu does this through straightforward but meaningful benefits, and an innovative and easy to access digital platform for financial advisers and policyholders. The platform allows transparent and seamless access to glu's offerings and encourages interaction and engagement, while making the experience smooth and efficient for everyone involved – that's the glu way.

2. The glu philosophy

glu seamlessly combines cutting-edge technology with a personal human touch – something we like to call 'Digital with Heart'. Through user-friendly processes, innovative digital tools, seamless automation and genuinely meaningful benefits, glu removes the anxiety out of managing finances. We are serious about the precision and integrity of our financial solutions, yet playful in our engagement.

3. The glu target market

glu's benefits are available to all individuals over 18, but they are primarily tailored for a core member base aged 25 to 55.

This group generally includes individuals with degrees or diplomas, or those affiliated with PPS through family, employer or product. The primary target audience typically earns R30 000 or more per month.

4. Mutuality & glu

glu policyholders automatically become glu members. While they don't have voting rights, this elevates the principles of mutuality by ensuring that all the value we create is shared among our members.

This builds a strong sense of community and ensures that everyone's needs and interests are put first. It's a system that focuses on the collective well-being and success of our members.

5.

Profit-Share

Members under the age of 60, that join glu, are eligible for a Profit-Share policy, which will be automatically issued in time for the first profit-share participation. Policyholders with active benefits at the time of the annual Profit-Share declaration, will share in glu's profits. The notional Profit-Share declaration is calculated based on the proportion of premiums paid by the member in the previous financial year. This notional Profit-Share vests and becomes accessible at regular intervals throughout the policy's duration.

5.1

Allocations of Profit-Share

Around April each year, a notional Profit-Share bonus is declared into the policyholder's glu Profit-Share policy. This bonus is based on the members insurance premiums paid, and their accumulated Profit-Share balance. Members earn notional Profit-Share bonuses from all their glu policies and products in the PPS Group, in accordance with each of the products' rules. All the bonuses are allocated into a single glu Profit-Share policy. While the bonuses can be positive or negative (based on glu's financial performance and/or market returns), accumulated Profit-Share can never reflect as negative. Notional Profit-Share allocations and the inaccessible portion of Profit-Share is not guaranteed.

5.2

Accessing Profit-Share

Profit-Share becomes accessible to the member only once it vests. Profit-Share vests and becomes accessible in stages, with 20% of the Profit-Share policy value becoming accessible after the 10-year policy anniversary, and thereafter 20% of the policy value every five years. When the policy has been active for 25 years, or when the policyholder turns 65 (whichever happens first), remaining Profit-Share balances becomes accessible, and all subsequent profit-share bonuses for that policy are immediately accessible thereafter.

5.3

Death or terminal illness

Upon the death of the member, if not already withdrawn, the accessible portion of the Profit-Share will be paid to the beneficiaries nominated in the Profit-Share Policy. The inaccessible Profit-Share is also payable with a death or terminal illness claim. This is similar to the inaccessible Profit-Share balance at the start of the year, allowing for investment returns up to the claim payment date and any relevant costs. If the policy ends before the Profit-Share bonus declaration, due to a death, disability or critical illness claim, the member will receive their Profit-Share as an enhanced benefit with their claim.

5.4

Impact of claims

Although claims reduce the pool of profits available for allocation, they do not affect the Profit-Share balance of individual members. All valid claims are paid without reducing the member's accumulated Profit-Share balance directly. However, higher claims may impact the overall profitability of glu, potentially reducing Profit-Share bonuses.

5.5

Policy lapses

If a glu life insurance policy is cancelled or lapses before the full Profit-Share Policy becomes accessible, any rights to that policy's inaccessible Profit-Share will be forfeited. If the policy ends before the notional Profit-Share allocation date, it is excluded from the allocation process. glu doesn't do pro-rata profit assignments if a policy was cancelled or lapsed during the year. Forfeited Profit-Share is returned to glu to increase cover, provide value-adding services and enhance future Profit-Share allocations of remaining members.

Key features of the glu suite of benefits

The glu suite of benefits includes Life Cover, Disability Cover, Critical Illness Cover and Income Protection Cover.

1.

Cover

1.1

Minimum and maximum cover amounts

Each benefit comes with its own range of cover amounts. A member can have multiple policies, the total cover across all policies must not exceed the maximum limit for each benefit. Be aware that Automatic Cover Increases can push a member's cover above these limits.

glu's automated underwriting rules determine the maximum cover for each applicant, based on the income disclosed and maximum cover amounts applicable per benefit.

1.2

Qualifying entry ages

Each benefit has specific age restrictions that apply when adding new benefits or increasing existing ones after a policy starts. The age considered is the member's age at the time the quote is requested for the policy or benefit enhancement.

The initial premium rate is based on the member's age at the time when the quote is generated, and even if an applicant reaches the maximum entry age between the quote and start date, glu will still process the application.

Premium calculations at each policy anniversary will be based on the current age at that anniversary.

1.3

Policy term and expiry of benefits

The policy's duration depends on the longest in force standalone benefit. Each benefit follows its own terms and expiration rules. Adding or removing benefits can therefore change the policy duration.

Remember, the Profit-Share policy can't exist without any active life insurance benefits.

1.4

Parties to a policy

A policy covers the following roles and responsibilities:

Policy owner, member and life insured

The policy owner, member and the Life Insured must be the same individual. They must meet the specified criteria, including age limits, eligibility, underwriting requirements, legal obligations and residency in the Republic of South Africa.

Child

If a policy includes Critical Illness Cover, our automatic Child Critical Illness cover applies to biological, legally adopted or stepchildren. There are no underwriting requirements, but children must meet age limits, and pre-existing conditions are excluded. There is no limit to the number of children covered under this cover.
In the case of stepchildren, supporting documentation will be required.

Cessionary

A cessionary is a recognised registered credit provider to whom some or all rights to the policy are transferred through a cession. A cession is valid only once it is acknowledged by glu.

Beneficiary

A beneficiary is a person or legal entity that is designated to receive insurance benefits when they become payable. Up to six beneficiaries can be nominated per policy, and if no beneficiary is nominated, or if the beneficiary isn't alive when a life insured passes away, the benefit amount goes to the estate of the life insured.

Premium Payer

The premium payer is usually the member, but glu can make exceptions upon written request. The premium payer must have a South African bank account, and all payments will be made via debit order in ZAR.

2.

Non-disclosure, misrepresentation & fraud

glu can adjust or deny a claim if the disclosures about the life insured include inaccurate or incomplete information. If there's deliberate fraud or misrepresentation, the claim will be adjusted or denied, and the policy may be voided from inception.

2.1

Fraud prevention measures

glu may employ various measures to prevent and detect fraud. All actions taken will be in accordance with applicable laws and regulations.

glu reserves the right to request proof of lost income at any time.

3.

Exclusions

The underwriter might decline to offer a new application or changes to an existing policy on, standard terms and conditions.

Alternatively, they may propose different terms and conditions to the policy with loadings or exclusions that are specific to the Life Insured, for one or more covers.

Standard exclusions apply to all policies.

3.1

Standard exclusions

glu does not cover a claim event if the Life Insured experiences harm due to:

- gross negligence,
- deliberately place themselves in harm's way like actively taking part in riots, terrorism, civil commotion, uprising, or trying to overthrow the government,
- actively takes part in unlawful or criminal activities,
- taking part in regular high-risk activities that have not been disclosed to us,
- excessive alcohol consumption that impairs judgment or physical abilities or worsens existing physical or psychological conditions,
- excessive use, misuse of drugs, narcotics or similar substances not prescribed by a licensed medical practitioner or not used as prescribed, or poison that should be known to be harmful.

3.2

Specific exclusions

Based on the information in an application, quotation and medical details, the underwriters may identify specific exclusions for an applicant. These exclusions will be shared as an 'offer,' which must explicitly be accepted by the life insured.

3.3

Waiting periods

Claims can be submitted from the start date of the policy. However, certain claim events, such as critical illness or income protection, may require specific qualifying periods before a payout is made, such as a critical illness survival period or income protection waiting period.

3.4

Notifiable changes

The member must inform glu of the following changes:

- Change in occupation or duties within the current occupation
- Change in employment status
- Change in the amount of business travel required
- Change in smoker status
- Relocation outside of South Africa
- Start or stop regular high-risk activities

glu defines smoking as using any smoking device or system in the past 12 months, regardless of how often. This includes cigarettes, e-cigarettes (e.g. vapes), hookahs, cigars and hubbly-bubbly. If an applicant stopped smoking, they must have quit for at least 12 months to qualify for non-smoker status, and we may ask for a cotinine test.

When you notify glu of such an event, the underwriting practice at that time may lead to:

- The premiums and benefits remaining unchanged
- Adjusting the cover amount
- Adjusting the premiums
- Amending the cover's terms and conditions
- Cancelling the cover and offering an alternative that the member qualifies for

4.

Premiums

4.1 Premium calculations

The policy premium is the total of all premiums for each cover on the policy. Premiums are based on rating factors including the member's age, health, lifestyle, cover amount, cover type, income, level of education and occupation. Actuarial data is used to determine premiums and typically higher risks mean higher premiums.

4.2 Fees

No monthly policy or benefit fee is applied.

4.3 Premium frequency

Premiums must be paid monthly.

4.4 Commencement date, premiums and due date

Premiums are paid monthly by debit order in advance. If the chosen day is later than the number of days in a month, it will default to the last day of that month. If the debit order day falls on a non-business day, glu may move it to the previous or following business day.

The member can select a future start date for the policy, as long as the acceptance is done while the underwriting decision is still valid.

If the member selects an immediate start date for the policy, a pro-rata premium is due immediately. glu will initiate an ad-hoc debit to collect the premium on the same day or the next business day. Afterwards, premiums will follow a normal billing cycle. The policy anniversary will revert to the 1st day the month of commencement.

If the cut-off for the chosen debit order date has already passed for the billing cycle, glu will initiate an immediate ad-hoc debit to collect the premium.

4.5 Premium payment methods allowed

glu only accepts debit orders for regular monthly premium payments.

4.6 Minimum and maximum premiums

A minimum monthly premium of R200 applies to all new policies. If the quoted premium falls below this amount, the policy benefits must be adjusted or cover increased to meet this minimum requirement.

There is no maximum premium limit.

4.7 Premium on Pause

A member can apply to temporarily stop paying premiums on the entire policy or on specific cover types. This is called Premium on Pause. It offers flexibility when a member is experiencing temporary financial difficulties, while keeping the policy active. It is important to note that during this pause, claims are not covered.

The following terms and conditions apply:

- A member can temporarily stop paying premiums, for up to three calendar months.
- Premium on Pause is only available if the cover has been active for six months, and can only be implemented once in every five year cycle.
- All premiums must be up to date before a pause can start. glu has the discretion to backdate a pause under special circumstances.
- Premiums cannot be paused on any cover that is ceded.
- Cover can resume after the pause without new underwriting assessments, however at least one premium must be paid before making a claim. glu reserves the right to request a declaration of health before cover resumes or to shorten the pause period.
- Premium on Pause cannot be backdated to a period for which a premium was paid, and no premiums will be reimbursed to enable a backdated premium pause.
- Ad-hoc policy changes can be made during the pause, but they will take effect only after the premium pause ends.
- Regular policy processes, like premium and Automatic Cover Increases, continue during a pause.

4.8 Changes to the rating factors that affect the premium

Where a member advises us of a change in any of their rating factors that impacts their premium, it will normally be effective on the 1st of the following month. glu doesn't usually allow a change to be backdated unless there are special circumstances.

4.9 Premium guarantees

glu doesn't offer premium guarantees which means that material changes in the expected experience of the product may lead to a rate review. In the event that this happens, the member will be informed in writing.

5.

Premium and cover increases

5.1

Premium patterns

Level

Premiums remain unchanged **for the same level of cover,** regardless of the member's age. If an Automatic Cover Increase option was chosen, the cover and premium will increase accordingly.

Age-rated

Premiums automatically increase each year on the policy anniversary based on the member's age. These increases are separate from any Automatic Cover Increase selected, which increases both cover amount and its premium on the same policy anniversary date.

5.2 Automatic Cover Increases

The member can choose the cover amount to remain the same, or include an Automatic Cover Increase (ACI) to boost their cover amount every year on their policy anniversary. This will also result in an increase of the premium, based on the additional cover amount and in the case of age-rated premium pattern, the member's age at the time of the increase. An ACI and related premium increase will be in addition to age-rated premium increases if the age rated premium pattern was selected.

An ACI of 3%, 5% or CPI (capped to 10%) can be chosen for each cover, however adding or increasing an ACI on existing cover may require a declaration of health and glu's approval. The ACI applies even if premiums are in arrears.

In the case of cover that allow multiple claims, escalation will apply to the remaining cover amount.

The member can pause the ACI for the following year, provided they let glu know at least one month before the policy anniversary. The cover and cover related premium increase will not be applied until the following policy anniversary.

glu reserves the right to request a declaration of health if ACI is selected on existing cover or if ACI is reinstated after prolonged discontinuation. In the case of benefits that allow multiple claims, escalation will apply to the remaining cover amount.

6.

Policy and cover ceasing

6.1 Policy lapses

The policy will be cancelled if its premium is not paid within two calendar months of its due date.

6.2 Policy and cover termination

Cover ends when:

- It reaches the end of its term.
- The cover or policy is cancelled or lapses.
- The benefit amount is paid in full, except for Critical Illness Cover, which reinstates for unrelated conditions.
- The member passes away.

The policy ends when all cover has terminated.

6.3 Reinstatement

A member may request to reinstate cancelled cover within 90 days after the cancellation date.

If a policy lapsed due to non payment, a member may request to reinstate within 30 days of the lapse date, provided that all premiums are paid in full. A medical assessment may be required to determine if any relevant information has changed since the original application. The outcome of the medical assessment could result in additional costs or exclusions.

Should any benefits be cancelled by glu, then these benefits cannot be reinstated.

After the expiry of the periods mentioned above, reinstatement isn't possible, and the member must apply for a new policy. This new policy will replace the old one.

6.4 Cooling off

A member may cancel their policy within 31 days from the policy start date if no claims have been made.

The 31 day cooling off period also applies to any policy changes, if no claims have been made. Any difference in premium will be refunded.

Policy changes include adding new benefits or changing benefit options, but doesn't apply to changes that are automatic, like Automatic Cover Increases.

6.5 Cancellation

A member can cancel their policy or any associated cover by giving at least one calendar month written notice to memberservices@glumutual.co.za. The cancellation takes effect on the last day of that notice month.

7.

Continuation of cover

In most cases, if one benefit on a policy has a claim, the other benefits can continue. Except:

- If the member passes away, all cover on the policy will end.
- If there's a successful claim on Accelerated Disability Cover, the associated Life Cover will decrease by the claimed amount, and the policy will continue with the reduced Life Cover amount (if any remains). If there's no Life Cover left, the Life Cover ends.

8.

Cessions

If a policy's rights for Life Cover, Critical Illness Cover or Disability Cover are ceded (fully or in part) to a registered credit provider as security or collateral, then while the rights are ceded, glu will pay the institution that holds the policy rights before paying the member, beneficiaries or estate. Cessions should be added at the policy level and not individual benefit level. If a ceded policy has an Income Protection benefit on it, no benefits will be payable to the cessionary in respect of any claims under the Income Protection benefit.

- Rights can be ceded to up to four different cessionaries at the same time, and glu will follow the terms of each registered cession. Each cession must be registered with glu.
- Each ceded amount must be larger than R250 000.
- Premiums must be up to date for a policy to be ceded.
- No changes that could harm the cession holder's interests can be made to ceded benefits, and only the cession holder can cancel a security cession.
- If Life Cover is fully ceded, the Immediate Needs Benefit for that Life Cover can't be claimed.
- A Premium on Pause isn't allowed on a cover with a cession.


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Systems and processes @ glu

1.

Processing of claims

1.1

Claim notification

It's important to let us know about a claim as soon as possible after the claim event. A claim notification and all the required documents can be submitted through the glu portal or **memberservices@glumutual.co.za** can provide assistance when required. A claim will be officially registered only upon glu receiving all of the necessary documents. Once the claim is submitted, our claims team will acknowledge receipt and provide guidance on the next steps. We strive to make the claim process as seamless as possible.

1.2

Late notification

Claims submitted more than twelve months after the claim event won't be paid, unless glu agrees that the delay was unavoidable based on the circumstances. In cases of late notification, please ensure that all relevant details and supporting documentation are provided to help us assess the circumstances surrounding the delay. Our team will review the claim based on the information provided and while we aim to be accommodating, late submission may impact the assessment and settlement processes.

1.3

Deduction of outstanding premiums

Any arrears premiums at the time of the claim being admitted will be deducted from the claim amount before it's paid to the cessionary, member, or beneficiary.

1.4

How to claim

You always hope you'll never need it, but that's exactly why you choose to protect yourself. When it's time to claim, we want to make sure everything goes as smoothly as possible. You can submit your claim on our website at **www.glumutual.co.za**, or email us at **claims@glumutual.co.za**.

2.

General

2.1

Quote validity

A quote is valid for thirty days from the date it's created. It needs to be accepted within this timeframe. If not, the quote expires and a new one will be required.

If an application needs manual underwriting, an additional thirty days from the referral date is provided to accept the terms offered. If it is not accepted within this timeframe, the quote will need to be regenerated, using the current age of the applicant.

2.2

Underwriting validity

glu's underwriting decision is valid for thirty days. Should the policy not start within this time, the decision will expire and the application process will need to be restarted.

Life Cover

SECTION D

1. Life Cover

1.1 Purpose of the cover

glu Life Cover pays out a lump sum to help take care of families and dependents in the unfortunate event that the Life Insured passes away. It helps in a few ways:

- By providing financial security for dependents.
- By covering debts and liabilities.
- By assisting with estate planning and inheritance.
- By helping with funeral and other end-of-life expenses.

1.2 Cover description

glu Life Cover includes an **Immediate Needs Benefit**. This pays an advance of R100 000 from the Life Cover amount to the Immediate Needs beneficiary within 48 hours of glu receiving the required documentation. It is designed to help your family with immediate costs such as funeral expenses. The balance of the Life Cover is paid to the nominated beneficiaries or to the estate.

If the policy is ceded, the **Immediate Needs Benefit** is not applicable, and ceded benefits are paid to the cessionary registered on the policy, before any payments are made to beneficiaries.

glu Life Cover also includes a **Terminal Illness Benefit** which pays the Life Cover as a lump sum if the member is diagnosed with a terminal illness and an assessment by the glu Chief Medical Officer confirms that they have less than 12 months to live.

No additional premium is charged for the Immediate Needs or Terminal Illness benefits.

More About:

Terminal Illness Benefit

Claims for terminal illness will only be accepted if:

- Life Cover is active when the claim is made.
- The Life Cover is not in a Premium on Pause status.
- The claim event or condition is not excluded by the policy, including pre- existing conditions.
- glu's Chief Medical Officer, supported by medical specialists and any requested evidence, determines that the member has less than 12 months to live.
- The Terminal Illness Benefit is claimed more than 12 months before turning 65, if the Life Cover term is to age 65.

The Terminal Illness benefit ends if:

- The member passes away.
- There's a lapse or cancellation of Life Cover.
- The cover term ends.
- Where the Life Cover term is to age 65, then it ends 12 months before the Life Cover end date.

Immediate Needs Benefit

- If a member has more than one policy with Life Cover, the R100 000 advance payment will be combined across all their policies.
- If different beneficiaries have been named for this cover on each policy, the R100 000 maximum will be split proportionally among them, based on the Life Cover Benefit amount on each policy.
- A member must choose who should receive this cover when they start the policy. This choice can be updated later. This person should be over the age of 18 to ensure a quick payout.
- Immediate Needs Benefit is not applicable if a policy is ceded.
- If the cover has been active for less than three months, a more detailed assessment will be performed which could result in the payout taking longer than 48 hours.

1.3

Cover limits and entry ages

Cover	Minimum initial cover amount	Maximum initial cover amount	Restrictions	
Life Cover	R100 000	R25 000 000	Subject to underwriting and reinsurance	
Role player	**Term**		**Entry age**	
			Min	**Max**
Life Insured	Whole of Life		18	64
Life Insured	Cover to age 65		18	59

1.4

Cover term

- The cover goes to age 65 or Whole of Life. Where age 65 is selected, the Terminal Illness Benefit will expire at age 64.

1.5

Exclusions

- The Standard Exclusions in section 3.1 also apply to the Life Cover, Immediate Needs Benefit and Terminal Illness Benefit.
- The two year suicide exclusion period applies only to any increased portion of Life Cover from the date of the increase. The original Life Cover amount remains subject to its initial suicide exclusion period.

1.6

Claims processing

- Please remember, if an Immediate Needs Benefit payment is made, it doesn't guarantee that the rest of the Life Cover will be paid out, as each claim is reviewed separately.

2.

Critical Illness Cover

2.1 Purpose of the cover

glu Critical Illness Cover pays out a lump sum for specific critical illnesses including diagnosed conditions, injuries, treatments or interventions. It helps with:

- Financial support for medical costs and unexpected expenses like rehabilitation.
- Supplementing lost income.
- Paying off debts.
- Supplementing health insurance.

2.2 Cover description

Two possible Benefit options are available:

Severity Based Critical Illness Cover

Severity Based

- Pays a lump sum as percentage of the cover amount if the member is diagnosed with any of the critical illnesses, conditions, treatments or interventions listed in the Annexure.
- The severity of the condition determines the percentage of the cover paid: 5%, 10%, 25%, 50%, 75% or 100%.
- Additional payments may be made if the condition worsens up to a maximum of 100% for related claims.
- The cover amount is only reduced by previous payouts if the claim is for a related condition. Even if a claim is paid in full (100%), the cover remains active and unchanged for unrelated future events.

Enhanced Payout Critical Illness Cover

Enhanced Payout

- Pays a lump sum if the member is diagnosed with any of the listed critical illness, conditions, treatments or interventions. 100% of the cover amount is paid for most listed conditions.
- For certain conditions, the payout may vary based on the severity and can be less than 100% of the cover amount.
- The cover amount is only reduced by previous payouts if the claim is for a related condition. Even if a claim is paid in full (100%), the cover remains active and unchanged for unrelated future events.

Child Critical Illness Benefit (an automatically included benefit)

- The cover amount is calculated as 10% of the parent's Critical Illness Cover amount, capped at a maximum of R250 000. The payment is determined in accordance with the parent's selection of the Severity Based or Enhanced Payout options.
- If a parent has multiple policies, the maximum R250 000 payout will be combined across all their policies.
- If more than one parent has Critical Illness Cover with glu, the maximum benefit amount increases to R500 000 per child. The benefit will be split proportionately based on the total cover amount across all relevant policies.

Example

Parent 1 Enhanced Payout Critical Illness Cover with us sum assured = R3 500 000
Parent 2 Severity Based Critical Illness Cover with us sum assured = R2 500 000

Child sum assured i.r.o. Parent 1 = min {10% X R3 500 000 or R250 000} = R250 000
Child sum assured i.r.o. Parent 2 = min {10% X R2 500 000 or R250 000} = R250 000

If the Child is diagnosed with stage 1 Hairy Cell Leukemia, the payments would be as follows:
Parent 1: 100% * R250 000 = R250 000
Parent 2: 25% * R250 000 = R62 500

- Each child can receive up to 100% of the Child Critical Illness Benefit amount for listed critical illnesses.
- If a child gets an unrelated critical illness, 100% of the Child Critical Illness benefit amount can be claimed again.
- There's no limit on how many children can be covered, but they must be biological, legally adopted or stepchildren.
- A Child Critical Illness claim won't affect the cover of the primary life insured.

2.3 Cover options

glu offers only Standalone Critical Illness Cover.

2.4 Cover limits and entry ages

Cover	Minimum initial cover amount	Maximum initial cover amount	Restrictions
Critical Illness cover	R100 000	R6 000 000	Subject to underwriting and reinsurance capacity
Child Critical Illness Benefit		Minimum of 10% of the parent's Critical Illness Cover, or R250 000 per parent	Benefit amount is limited to the parent's cover amount

Role player	Term	Entry age	
		Min	Max
Life Insured	Cover to age 65	18	59
Life Insured	Whole of Life	18	64

Note: Children are covered from birth, until they reach the age of 18. The maximum is increased to R500,000 if more than one parent has cover.

2.5 Cover term

The cover goes to age 65 or Whole of Life, and from birth to age 18 for a Child (subject to a maximum of the main benefit term).

2.6 Exclusions

In addition to the Standard Exclusions in the policy, glu won't pay claims for events, disabilities or illnesses resulting from:

- Chronic fatigue
- Fibromyalgia
- Chronic pain

To qualify for a claim payment, the member must follow the best treatment available for their condition, as per internationally accepted guidelines for the condition. glu will consider the affordability and accessibility of the treatment for the member.

2.7 Survival period

The member or child must survive for at least 14 days after meeting the claim requirements before a claim can be processed. If the member or child happens to pass away within this period, no claim will be paid.

2.8 Waiting period

There's no waiting period for this cover, however it might take time to determine the severity of the condition. glu will process the claim as quickly as possible.

2.9 Reinstatement of cover

Since a member can claim multiple times under this cover, either for the same or different conditions, premiums will continue to be paid even after a claim is made.

2.10 Related conditions

A related claim is a condition or illness that is directly or indirectly related to a previous claim, where in glu's opinion, the subsequent condition is a progression, complication, outcome or treatment for the original claim. It includes an event that shares a common cause or effect with any previous illness or condition. Certain medical conditions or categories are always deemed to be related- for instance the cardiovascular, or cancer categories (except if a new cancer is completely unrelated to the previous one).

If less than 100% of the cover amount has been paid out, a claim can be made for a related condition if it's more severe than the previous one. Up to 100% of the cover can be received for these related conditions. Once 100% is paid, no further claims in this category will be accepted.

If a single event results in multiple illnesses, conditions, treatments or interventions (simultaneous claims), the condition with the highest severity will be compensated. The maximum cover for simultaneous claims from the same event or cause is 100%.

2.11 Unrelated conditions

Unrelated events will be paid up to 100% of the cover amount, regardless of previous payments from the benefit category. The cover amount will not be reduced by previous payouts if the claim is for an unrelated condition.

2.12 Claims processing and benefit categories

A claim will be paid if the criteria are met, and the benefit is still active.

Critical Illness and trauma related injuries are divided into different categories. Each category lists conditions for claim events and the percentage of the cover amount that can be claimed, subject to any limits and conditions. There is a payout limit of 100% of the cover amount per category.

If a previously claimed illness gets worse (a progressive claim), an additional payment may be made according to the benefit category. This extra payment will be the current cover amount minus any previous payments, and may not exceed 100% of the cover amount.

3.

Disability Cover

3.1 Purpose of the cover

glu Disability Cover pays out a lump sum if a member becomes permanently disabled or impaired.
It provides for:

- Financial support during disability.
- Supplementing lost income.
- Unforeseen expenses.
- Paying off debts.
- Maintaining and enhancing quality of life.

3.2 Cover description

Two possible cover options are available:

Functional Disability Cover

Functional

Functional Disability cover pays a lump sum if the member becomes functionally impaired, and unable to perform daily activities due to illness or injury. The cover pays out a percentage of the cover amount as a lump sum depending on meeting the requirements listed in the Functional Disability claim definitions in the Annexure. The percentage is calculated using the defined criteria for Functional Disability and considers the severity of the disability or impairment.

If 25%, 50% or 75% of the cover amount is paid, the remaining cover amount is reduced by the payout amount, and premiums will be reduced accordingly. Claims for new conditions will be based on the remaining cover amount. This remaining cover amount will continue to increase with ACI that apply to the Functional Disability Cover. If 100% of the cover amount is paid, the cover ends, and no further premiums or claims apply.

Example

With R1m Disability Cover, a previous 25% claim leaves R750 000.
An unrelated 50% claim, which is R375 000 will be paid, leaving R375 000 in cover. Premiums are reduced accordingly.

Comprehensive Disability Cover

Comprehensive

This benefit combines both **occupational** and **functional** definitions for assessing disability claims. Claims are first evaluated based on occupational disability, and if they don't qualify, they are then assessed under functional disability.

For the occupational definition, a lump sum equal to 100% of the cover amount is paid if:

- The member becomes disabled to the extent that they are unable to work in their own occupation, due to injury, illness or accident.
- An assessment by glu deems the disability to be permanent, significant and severe.
- The medical condition or impairment has stabilized to the extent that further improvement is unlikely, with or without further treatment.

If a partial claim of 25%, 50% or 75% is paid under the functional disability definition, the remaining cover amount and premium is adjusted accordingly. Once the full lump sum is paid, the cover ends, and no further premiums or claims apply.

3.3 Cover options

Accelerated Functional / Comprehensive

glu offers Functional or Comprehensive Disability Cover as Accelerated or Standalone options. Under the Accelerated option when a valid claim is paid:

- The Life Cover will be reduced by the amount paid through the Accelerated Disability Benefit, and the premiums for Life Cover will decrease accordingly.
- The reduced Life Cover amount will still grow with any chosen Automatic Cover Increases (ACI).
- If an ACI happens between the claim event date and the claim payment date, the increase will be adjusted based on the reduced Life Cover amount after the disability claim.
- If the Accelerated Disability Cover paid out is the full value of the Life Cover, both covers will end.

3.4 Cover limits and entry ages

Cover	Minimum initial cover amount	Maximum initial cover amount	Restrictions
Standalone Disability Cover	R100 000	R20 000 000	Subject to underwriting and reinsurance capacity
Accelerated Disability Cover	R100 000	R20 000 000	Cover amount must be <= Life Cover benefit amount. Subject to underwriting and reinsurance capacity

Role player	Benefits	Entry age	
		Min	Max
Life Insured	Standalone Disability	18	59
Life Insured	Accelerated Disability	18	59

3.5 Cover term

The cover offered is to age 65.

3.6 Exclusions

Besides glu's standard exclusions, a claim will not be paid if the member doesn't follow the best treatment or rehabilitation available, according to internationally accepted guidelines for the condition. glu will consider the affordability and accessibility of the treatment for the member.

3.7 Claims processing and benefit categories

The Functional Disability Cover is divided into different categories. Each category has its own criteria for claim events and the percentage of the cover amount payable. glu may request additional evidence to assess whether the claim fits into any of the categories and if the condition is permanent.

Multiple categories

If a single claim falls under multiple categories with the same claim percentage, glu will choose one category for the payment.

Multiple claims

If multiple claims from the same event or related conditions are made across different categories, glu will pay based on the category with the highest claim percentage. If the member passes away before the disability is confirmed as permanent, no claim will be paid.

4. Income Protection Cover

4.1 Purpose of the cover

The Income Protection Cover provides cover on the temporary or permanent disability of the Life Insured. The cover can be used to provide for:

- Replacement of lost income
- Financial security during recovery

4.2 Cover description

Income Protection provides a monthly income if a member can no longer work in their own occupation, due to temporary or permanent illness, impairment or disability. It is offered up to the age of 65 with a minimum term of five years.

The cover requires a recipient of the cover to undergo regular assessments to see if they are still unable to do their job, either fully or partially. Proof of lost income will be required after 12 months of claim payments.

4.3 Income Protection waiting period

The Income Protection waiting period is the time from when incapacity begins (the date of the claim event) until claim payments start. A waiting period of 1, 3 or 6 months can be chosen.

If a new claim is related to a previous one, and occurs within 3 months after the last payment, the waiting period for the new claim is waived, and it will be considered a continuation of the original claim. Claims unrelated to previous payments or occurring more than 3 months later will have a new waiting period. There is no limit to the amount of unrelated claims a member can submit.

4.4 Instant Claims

The Instant Claims list includes guaranteed claim conditions and are payable immediately without the need to prove lost income.

Terms and conditions:

- Only applicable to the one-month waiting period.
- Payment periods begin after completing the one-month waiting period.
- Benefits paid upon receipt of proof that event matches defined claim conditions.
- If the disability continues beyond the guaranteed period, the assessment reverts to a standard occupational disability process.

Instant Claims List	
Fracture of ankle	1 month
Fracture of calcaneus	1 month
Fracture of lower leg (tibia or fibula)	1 month
Fracture of kneecap	1 month
Fracture of scapula	1 month
Fracture of upper arm (humerus)	1 month
Fracture of hand requiring ORIF or Injury to hand requiring tendon repair	1 month
Having undergone a spinal fusion	1 month
Having undergone a CABG	1 month
Coma for >96 hours (not medically induced)	1 month
Having undergone a major joint replacement (shoulder, hip, knee or ankle)	1 month
Fracture of femur	2 months
Fracture of pelvis	2 months
Fracture of spine (cervical, thoracic or lumbar)	2 months
Fracture of facial bones Le Fort III	2 months
Confirmed paraplegia or quadriplegia	2 months
Having undergone a major organ transplant (includes bone marrow/ stem cell transplant)	2 months
Terminal illness as per the required definition	2 months
Third degree burns >20% body surface area	2 months
Amputation of a hand, arm, foot or leg (above or below knee)	2 months

4.5 Definition of income

- **Salaried employees: monthly salary less taxes and excluding discretionary bonuses.**
- **Business owners: member's share of fees and profits from services or sales, less business expenses and taxes.**
- **Where income fluctuates, glu applies the average of the preceding three years.**
- **Income does not include passive earning like rent or dividends from investments.**

4.6 Cover limits and entry ages

Cover	Minimum initial cover amount	Maximum initial cover amount	Restrictions	
Income Protection cover	R2 000 pm	R150 000 pm	A maximum of 100% net of tax income	
Role player	**Term**		**Entry age**	
			Min	**Max**
Life Insured	Income Protection Cover to age 65		18	59

4.7 Cover term

After the Income Protection waiting period, the claim will be assessed. Upon approval, the benefit will be paid until the earlier of:

- The member passing away
- The end of the month the member turns 65
- The member is no longer considered disabled or can work in their own occupation

Payments for the first and last month of a claim will be proportional based on the number of days entitled in those months.

4.8 Automatic cover increases

A claim in payment will increase at the in-claim escalation rate until the termination of the claim. While a member is receiving benefits from a claim, ACI are applied annually on the benefit anniversary on the cover amount, and continue even if the member is receiving benefits from a claim, to be applied to any future claims.

4.9 Claims payout

glu allows a maximum cover amount of 100% after-tax income for our Income Protection Cover. If the member becomes disabled or incapacitated, glu will cover the lost income up to the cover amount listed in the policy snapshot, up to a maximum of 100% of the after-tax income earned before becoming disabled or incapacitated. Income Protection payments are made monthly, if the selected waiting period is met, as long as the cover is active at the end of the waiting period.

If, after being considered disabled, the member is deemed capable of working in their own occupation, the claim payment may be reduced accordingly. glu will assess what they could earn considering the level of incapacity.

At claim stage, glu reserves the right to adjust claim payments based on any ongoing income earned. The reduction in benefit amount will be done after 12 months of benefit payments.

4.10 Claims processing

glu will only approve a claim once we receive proof that the member has been continuously unable to work, either fully or partially, for the entire waiting period, and all policy requirements are fulfilled.

Once a claim is approved, it will undergo regular reviews to assess the member's eligibility for ongoing payments. This includes attending required appointments and submitting updated reports on time. If a case manager is assigned, the member must participate in the case management program.

glu can be requested to convert the monthly income payout into a lump sum payment. If, in glu's opinion, the member is permanently impaired, the monthly claim amount may be commuted into a lump sum benefit. The decision and the lump sum amount will be determined solely by glu.

If the policy or cover is cancelled before the waiting period ends, Income Protection payments will not start.

In-claim escalations

When starting the policy, in-claim escalations of 0%, 5% or CPI (up to a maximum of 10% per year) can be chosen. On the anniversary of the claim payment start date, the claim amount will increase by this in-claim escalation percentage.

Related claims

In glu's opinion, a related claim is a condition or illness that is directly or indirectly related to a past claim or claim event and where the subsequent condition is a complication of, outcome of, or treatment for a previous illness or condition for which payment was received under this policy.

Multiple claims

If there is more than one claim, glu will assess them together and consider the overall loss of income, keeping in mind the maximum benefit limits. An additional claim can be made at any time, but the deferred waiting period requirements still apply.

Premium during claim payment

Once a claim is approved, premiums won't need to be paid for the Income Protection Cover while the claim is being paid out. Normal policy processing, including policy anniversaries, continues as usual. If the policy has an age-rated premium pattern, any increases due to age will still apply annually to the premium amount. However, because the benefit is temporarily not requiring premiums during the claim period, no premiums will need to be paid during this time.

If a member returns to work and their cover resumes, Income Protection premiums will start again. Any changes in premiums will take effect from the next billing date to avoid pro-rate premiums that are due or payable.

4.11 Exclusions

Some occupations do not qualify for Income Protection, which is why it is important to notify glu of any occupation changes. Apart from glu's standard exclusions, cosmetic surgery, and any specifically excluded medical conditions, glu won't cover any claim if it arises from an event, disability or illness that happened because the member didn't follow the best available treatment or rehabilitation, as recommended by internationally accepted guidelines for the condition at the time. glu considers if the treatment is reasonably accessible and affordable.

Why you should become a glu Financial Adviser.

1.

Helping you grow your client base

In the past, some of your clients might have felt left out due to the exclusive nature of PPS offerings. With glu you now have a unique opportunity to expand your client base. By offering the distinctive feature of mutuality through Profit-Sharing, you can attract and serve a broader range of clients than ever before. It's an opportunity to create meaningful connections and build long-term success together.

2.

The glu digital channel

2.1

The benefits of seamless processing

Efficiency is key in your role as a Financial Adviser. With glu's digital channel and its seamless straight-through processing, you can focus on providing personalised advice and building strong relationships with your clients. glu's advanced systems and processes enhance the client experience by speeding up response times and ensuring smoother interactions – resulting in higher client satisfaction and loyalty.

2.2

Leads generation and marketing

Imagine having access to viable leads directly through glu's lead generation process. You'll effortlessly tap into potential clients within the identified target market. glu competitively stands out with strategies like networking, content marketing, social media engagement and partnerships. These tactics generate awareness and interest among your ideal clients, making it easier for you to connect, nurture and convert prospects into loyal clients.

3.

How you will be compensated

3.1

Commission

You have the power to choose how you earn with three flexible commission structures:

- 100% Upfront Commission
- 100% As-and-When Commission
- or a tailored blend that totals 100%

Upfront Commission: First, the primary commission payment, and after 12 months, receive the secondary commission payment equal to one-third of the primary payment. As-and-When Commission: Earn a fixed percentage with each premium payment. Subject to the terms and conditions set out under the gMF structure.

3.2

Commission clawback

glu ensures fairness. Full statutory clawback applies to Upfront Commission. As-and-When Commission, paid on premiums that are later unpaid or reversed, will also be clawed back.

3.3

Commission sacrifices

You can sacrifice up to 100% of your commission. Any commission sacrifice made will result in a discount to your client's premium.

Annexure
Functional Disability Claim Definitions

CARDIOVASCULAR	
Definition	The diagnosis of a heart disease resulting in the permanently impaired functioning of the Life Assured's heart, as defined and measured by the following functional impairment criteria at least 6 months after the diagnosis is confirmed and treatment instituted. The worst score from Category A measurements will be added to the worst score from Category B measurements to arrive at a total impairment score. The total impairment score will be used to adjudicate the payment of the lump sum impairment benefit. Claimants will be required to be under the care of a specialist cardiologist, be on optimal treatment and have attained maximal medical improvement. The six-minute walk distance must be performed with heart rate monitoring, with an appropriate peak heart rate response of > 100bpm attained for the test.
Layman's description	This benefit pays for heart disease that causes permanent damage and/or reduced functioning of the heart. The patient must be treated by a heart specialist. Such damage or poor heart function must be measured using different blood tests, some values obtained from a sonar of the heart, and a walking test that measures exercise ability (which can be affected by a cardiac condition). These tests can only be done at least six months after the diagnosis has been confirmed and completely and fully treated, as one must allow time for recovery on treatment. The test results are used in a scoring model, and the total score determines the percentage of the sum assured to be paid. The more severe the permanent damage and impaired function, the higher the percentage pay-out.

	Age < 50		Age >50	
Category A	**NT ProBNP**	**Score**	**NT ProBNP**	**Score**
	<100 pg/ml	+0	<100 pg/ml	+0
	100-300 pg/ml	+1	100-450 pg/ml	+1
	301-450 pg/ml	+2	451-900 pg/ml	+2
	451-1000 pg/ml	+3	901-1800 pg/ml	+3
	>1000 pg/ml	+4	>1800 pg/ml	+4

Or

All ages	
LVEF	**Score**
>50%	+0
<50%	+1
<45%	+2
<40%	+3
<35%	+4

	All ages	
Category B	**New York Heart Association Classification**	**Score**
	1	+0
	2	+0
	3	+1
	4	+2

Or

All ages	
6-Minute Walk Test	**Score**
> 300m	+0
<300m	+1
<200m	+2

Payment Tiers	
Lump Sum	
Payment Percentage	**Score**
25%	3
50%	4
75%	5
100%	6

CANCER	
Definition	The diagnosis of cancer, resulting in the functional impairment of the Life Assured, as defined and measured by the following functional impairment criteria. The impairment definition will be used to adjudicate the payment of the lump sum impairment benefit. Claimants will be required to be under the care of the appropriate specialist and be on optimal treatment.
Layman's description	This benefit pays when cancer is the cause of loss of function. The patient must be under the care of an appropriate specialist. Benefits are paid according to staging and/or impact of the Cancer on the ability of the person to do normal Activities of Daily Living (ADLs).

Payment Tiers	
Cancer is defined as 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. It must be confirmed by a histology report from an accredited pathology laboratory.	
Qualification Criteria	**Payment Percentage**
Stage II, III, or IV Cancer undergoing immunotherapy, chemotherapy, or radiation therapy with an Eastern Cooperative Oncology Group (ECOG) status of 2 or more, more than 6 months since diagnosis.	50%
Haematological malignancy, stage III or higher on an internationally recognised, appropriate staging system e.g. Ann-Arbor, undergoing immunotherapy, chemotherapy, or radiation therapy with an Eastern Cooperative Oncology Group (ECOG) status of 2 or more, more than 6 months since diagnosis.	50%
WHO Grade II, III, or IV brain tumour undergoing immunotherapy, chemotherapy, or radiation therapy with an Eastern Cooperative Oncology Group (ECOG) status of 2 or more, more than 6 months since diagnosis.	50%
Any Cancer resulting in a permanent Eastern Cooperative Oncology Group (ECOG) status of 3 or more.	100%

GASTROINTESTINAL TRACT	
Definition	The diagnosis of a gastrointestinal disease or disorder, resulting in the permanent functional impairment of the Life Assured, as defined and measured by the following functional impairment criteria. The single worst score will determine the impairment score. The impairment score will be used to adjudicate the payment of the lump sum impairment benefit. Claimants will be required to be under the care of a specialist gastroenterologist, 6 months after diagnosis and must be on optimal medical and/or surgical management and have attained maximal medical improvement.
Layman's description	This benefit pays for established disease of the gastrointestinal system, resulting in permanent dysfunction. The condition must be severe enough to cause unintentional weight loss, resulting in being considered underweight in relation to one's height for a period of at least 6 months. It is also payable if a person has no anal control and has permanent faecal incontinence.

All ages	
Definition	**Score**
Body Mass Index < 16 kg/m2 for a period of more than 6 months.	1
Body Mass Index < 15 kg/m2 for a period of more than 6 months.	2
Permanent, uncontrolled faecal incontinence, not amenable to medical or surgical therapy, present for a period of more than 6 months.	2

Payment Tiers	
Lump Sum	
Payment Percentage	**Score**
50%	1
100%	2

HEARING DISORDERS

Definition	The diagnosis of permanent hearing loss, resulting in the permanent functional impairment of the Life Assured, as defined and measured by the following functional impairment criteria. The single worst score will determine the impairment score. The impairment score will be used to adjudicate the payment of the lump sum impairment benefit. Claimants will be required to be under the care of an ear, nose and throat specialist and be on optimal treatment. All hearing measurements must be performed with the use of appropriate hearing aids. At least two hearing measurements must be performed 6 months apart.
Layman's description	This benefit pays for specified levels of permanent hearing loss. The patient must be under the care of an ear, nose and throat specialist. Such permanent hearing loss will be measured using at least two hearing tests with hearing aids (an audiogram) done six months apart. Benefits are paid according to the severity of hearing loss. The more severe the permanent damage, the higher the percentage pay-out.

All ages		
Tier	**Definition**	**Score**
50%	Average hearing loss of >79dB in both ears over the frequencies 500, 1000, 2000, 3000 Hz.	2
100%	Average hearing loss of >90dB in both ears over the frequencies 500, 1000, 2000, 3000 Hz.	3

Payment Tiers	
Lump Sum	
Payment Percentage	**Score**
50%	2
100%	3

LIVER DISEASE

Definition	The diagnosis of chronic liver disease resulting in the permanent functional impairment of the Life Assured, as defined and measured by the following functional impairment criteria. The single worst score will determine the impairment score. The impairment score will be used to adjudicate the payment of the lump sum impairment benefit. Claimants will be required to be under the care of a specialist physician or gastroenterologist and be on optimal treatment. At least two Child-Pugh assessments more than 6 months apart must be performed in order to assess chronic liver disease.
Layman's description	This benefit pays for chronic liver disease that causes reduced functioning and/or permanent damage of the liver. Such damage or poor liver function will be measured using a scoring system used by doctors. This involves assessing the degree of liver damage with blood tests, accumulation of fluid in the abdomen, and the effect on brain function. There is a six-month waiting period from the time of diagnosis. The percentages of the sum assured paid, increase with worsening liver disease. A 100% will be paid for patients awaiting liver transplant. This will require confirmation by the treating specialist and evidence that the patient's name is on an official South African transplant list.
Exclusion	Liver disease attributed to the use of alcohol.

All ages	
Definition	**Score**
Chronic Liver disease classified as Child-Pugh Class A	1
Chronic Liver disease classified as Child-Pugh Class B	2
Chronic Liver disease classified as Child-Pugh Class C	3
Awaiting liver transplant on a recognised South African or international transplant list	3

Payment Tiers	
Lump Sum	
Payment Percentage	**Score**
25%	1
50%	2
100%	3

RENAL AND UROGENITAL	
Definition	The diagnosis of chronic progressive renal disease or urological disease resulting in the permanently impaired functioning of the Life Assured, as defined and measured by the following functional impairment criteria. The single worst score from category A or B will determine the impairment score. The impairment score will be used to adjudicate the payment of the lump sum impairment benefit. Claimants will be required to be under the care of a specialist physician or nephrologist and be on optimal treatment. At least two eGFR (Glomerular Filtration Rate) measurements more than 6 months apart must be performed to assess chronic progressive renal disease.
Layman's description	This benefit pays for kidney disease that causes permanent damage and/or reduced functioning of the kidneys or urinary system. Such damage or poor kidney function will be measured using kidney function tests, six months apart. Whether dialysis is required permanently, must be confirmed by the treating doctor. These tests can only be done once it is evident that the kidney disease is irreversible. Various levels of reduction in kidney function are paid out based on varying percentages of the sum assured, incrementally increasing from moderate to worst impairment. A benefit for loss of control of the bladder requiring the use of a permanent catheter has also been included.

Category A	All ages	
	eGFR	Score
	≥50 mL/min/1.73 m2	0
	<50 mL/min/1.73 m2	2
	<40 mL/min/1.73 m2	3
	<15 mL/min/1.73 m2	4

Or

Category B	All ages	
		Score
	Undergoing haemodialysis	4
	Undergoing peritoneal dialysis	4
	Having Undergone a Renal Transplant	4
	Permanent and total urinary incontinence with ongoing use of an indwelling catheter	2

Payment Tiers	
Lump Sum	
Payment Percentage	Score
25%	2
50%	3
100%	4

MENTAL HEALTH	
Definition	The diagnosis of a mental health disorder, resulting in the permanent functional impairment of the Life Assured, as defined and measured by the following functional impairment criteria. The impairment score will be used to adjudicate the payment of the lump sum impairment benefit. Claimants will be required to be under the care of appropriate healthcare professionals as specified below. Any claims with co-existing substance or alcohol abuse will be deferred until 1 year after successful rehabilitation, without relapse, at a PPS recognised facility is complete.
Layman's description	This benefit pays for specified, permanent, irreversible mental illness, diagnosed in accordance with the latest international guidelines. The patient must be under the care of a psychiatrist, and on all treatment options, as well as adherence to treatment plans must have been followed by the patient. In all cases, confirmation of impairment will be required by a second, independent psychiatrist.

All Ages	
Schizophrenia and other Psychotic Disorders	
The diagnosis of schizophrenia or another psychotic disorder according to the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria.	
Payment Percentage	The permanent inability to function independently in society confirmed by the following criteria:
100%	1. Confirmation of the diagnosis by at least two psychiatrists, one of whom is not involved with treatment of the client*. The independent psychiatrist must confirm the impairment in function by means of an assessment. Permanent impairment of function means permanent dependence on a full-time caregiver for daily needs. **AND** 2. Documented compliance to the prescribed treatment including but not limited to drug levels of medications. **AND** 3. A Global Assessment of Functioning Scale score of 40% or less.

All Ages	
Mood and Anxiety Disorders	
Payment Percentage	Diagnosis of a mood or anxiety disorder, according to the latest DSM criteria, confirmed by at least two psychiatrists, one of whom is not involved with treatment* of the client, with failure of treatment defined as:
50% of sum insured up to a maximum of R1 000 000, payable once during the lifetime of the policy.	1. Failure of pharmaceutical treatment as defined by the South African Society of Psychiatrists (SASOP). **AND** 2. Documented failure of therapeutic psychological sessions confirmed by the treating clinical psychologist (non-compliance does not qualify as failure). **AND** 3. Documented hospital admission by a psychiatrist for psychiatric treatment within the last 2 years. **AND** 4. A Global Assessment of Functioning Scale score of 40% or less or a Personal Health Questionnaire-9 (PHQ-9) score of 20 or more.

*glu will be responsible for the selection and remuneration of the independent psychiatrist.

Payment Percentage	Diagnosis of a psychiatric condition according to the latest DSM criteria resulting in permanent institutionalisation in a recognised psychiatric facility or being placed under permanent curatorship by the Master of the High Court in South Africa.
100%	

MUSCULOSKELETAL	
Definition	The diagnosis of a musculoskeletal disorder, resulting in the permanent functional impairment of the Life Assured, as defined and measured by the following functional impairment criteria. The worst score from Category A measurements will be added to the worst score from Category B measurements to arrive at an impairment score OR a single score from Category C will determine the impairment score. The impairment score will be used to adjudicate the payment of the lump sum impairment benefit. Claimants will be required to be under the care of an appropriate specialist, be on optimal treatment and have attained maximal medical improvement.
Layman's description	This benefit category pays when certain defined injuries or diseases affect the functioning of the limbs, spine, muscles and joints. It includes benefits for spinal surgery, joint replacements, certain amputations and burns. There is a six-month waiting period before a benefit can be assessed. The use of assistive devices to walk is also taken into account.
Exclusion	Rhizotomy.

Category A	**Spine**	
	Spinal Stenosis not amenable to surgical intervention.	+1
	Surgery and implantation of prosthesis/ses into the vertebra at 1 level.	+1
	Surgery and implantation of prosthesis/ses into the vertebra at 2 levels.	+2
	Surgery and implantation of prosthesis/ses into the vertebra at 3 or more levels.	+3
	Limbs	
	Having Undergone a Total Arthroplasty to any of the shoulder, elbow, hip or knee joints.	+1
	Having Undergone an Arthrodesis to any of the shoulder, elbow, hip or knee joints.	+2

Category B	Presence of Radiculopathy - Single Level.	+1
	Presence of Radiculopathy at >1 Level or bilateral.	+2
	Presence of Myelopathy.	+2
	Use of Assistive Device - Single limb prosthesis.	+1
	Use of Assistive Device - Wheelchair** or Two Limb prostheses.	+2
	Use of Biologic Therapy for Autoimmune arthritis.	+1
	Unsuccessful Total Arthroplasty is defined as the inability to do 3 or more basic Activities of Daily Living (ADLs) as a result of the condition. The impairment must be unlikely to improve with surgical or medical treatment.	+2

**Permanent use of wheelchair

Category C	**Loss of or Loss of use of Hands and/or Feet**	
	Amputation of, or total and permanent loss of function of non-dominant hand below the wrist.	3
	Amputation of, or total and permanent loss of function of the dominant hand below the wrist.	4
	Amputation of, or total and permanent loss of function of the non-dominant upper limb above the wrist.	4
	Amputation of, or total and permanent loss of function of the dominant upper limb above the wrist.	5
	Amputation of, or total and permanent loss of use of the lower limb at or below the level of the ankle.	3
	Amputation of, or total and permanent loss of function of the lower limb at or above the level of the knee.	4
	Amputation of, or total and permanent loss of function of both lower limbs.	5
	Burns	
	Partial Thickness burns to ≥30% of the body surface area.	3
	Full Thickness burns to ≥10% of the body surface area.	4
	Full Thickness burns to ≥20% of the body surface area.	5
	Full Thickness burns to ≥30% of the face.	4
	Full Thickness burns to ≥50% of the face.	5

Payment Tiers	
Lump Sum	
Payment Percentage	**Score**
25%	3
50%	4
100%	5

RESPIRATORY	
Definition	The diagnosis of a chronic respiratory disease resulting in the permanent functional impairment of the Life Assured, as defined and measured by the following functional impairment criteria. The worst score from Category A measurements will be added to the worst score from Category B measurements to arrive at an impairment score. The impairment score will be used to adjudicate the payment of the lump sum impairment benefit. Claimants will be required to be under the care of a specialist pulmonologist, be on optimal treatment and have attained maximal medical improvement. • At least two lung function tests, 6 months apart, must be performed by a specialist pulmonologist, must meet American Thoracic Society (ATS) criteria, and must include pre and post bronchodilator measurements. • The six-minute walk distance must be performed with heart rate monitoring, with an appropriate peak heart rate response of > 100bpm attained for the test. • The six-minute walk distance will not be required in claimants using domiciliary oxygen.
Layman's description	This benefit pays for chronic lung disease that causes permanent damage and/or reduced functioning of the lungs. The patient must be treated by a lung specialist. Such damage or poor lung function will be measured using lung function tests and a walking test that measures exercise ability (which can be affected by a respiratory condition). Lung function tests can only be done by a registered pulmonologist (lung specialist) and must meet internationally accepted quality criteria to ensure optimal patient effort and coordination. Two sets of lung function tests must be done at least six months apart to prove that the disease is irreversible. The test results are used in a scoring model, and the total score determines the percentage of the sum assured to be paid. The more severe the permanent damage, the higher the percentage pay-out.

Category A	All ages	
	FEV1	Score
	<54% of predicted	+2
	<45% of predicted	+3
	<40% of predicted	+4

Or

All ages	
FVC	Score
<60% of predicted	+2
<50% of predicted	+3
<45% of predicted	+4

Or

All ages	
DLco	Score
< 54% predicted for age	+2
< 45% predicted for age	+3
< 40% predicted for age	+4

Category B	All ages	
	6-Minute Walking Distance (6MWD)	Score
	>300m	-1
	<300m	+0
	<200m	+1
	The use of domiciliary oxygen for at least 8 hours in a 24-hour period	+1

Payment Tiers	
Lump Sum	
Payment Percentage	Score
25%	2
50%	3
100%	≥4

NEUROLOGICAL

Definition	The diagnosis of a neurological disease or disorder, resulting in the permanent functional impairment of the Life Assured, as defined and measured by the following functional impairment criteria. The single worst score will determine the impairment score. The impairment score will be used to adjudicate the payment of the lump sum impairment benefit. Claimants will be required to be under the care of a specialist neurologist and/or neurosurgeon (where applicable), must be on optimal medical and/or surgical management, and have attained maximal medical improvement.
Layman's description	This benefit pays for permanent loss of function due to injury or disease affecting the brain, or spinal cord. The patient must be under the care of a neurologist or neurosurgeon. It must be evident that the loss of function is permanent, even after optimal treatment.
Exclusion	Dementia attributable to alcohol or drug use. Psychiatric causes of dementia as well as pre-clinical dementia identified by biomarkers in the absence of any cognitive or behavioural symptoms. Psychiatric causes of loss of speech.

All ages	
Definition	Score
Total and permanent loss of speech.	2
Permanent Hemiplegia, Quadriplegia or Paraplegia.	2
Head injury with 30 days continuous admission to a hospital or recognised rehabilitation centre and resulting in a permanent MMSE*** score of ≤ 21 confirmed with two MMSE scores at least 6 months apart.	2
Diagnosis of Parkinson's, Alzheimer's, or other forms of dementia with a permanent MMSE*** score of ≤ 21 confirmed with two MMSE scores at least 6 months apart.	2

Payment Tiers	
Lump Sum	
Payment Percentage	Score
100%	2

***Mini Mental State Examination – a tool used by healthcare professionals to assess cognitive impairment.

VISUAL SYSTEM	
Definition	The diagnosis of a disease or disorder of the visual system, resulting in the permanent functional impairment of the Life Assured, as defined and measured by the following functional impairment criteria. The single worst score will determine the impairment score. The impairment score will be used to adjudicate the payment of the lump sum impairment benefit. Claimants will be required to be under the care of a specialist ophthalmologist, be on optimal treatment and have attained maximal medical improvement. All visual assessments must be performed with the use of appropriate visual aids. At least two visual assessments must be performed 6 months apart.
Layman's description	This benefit pays for specified levels of permanent visual loss. The patient must be under the care of an ophthalmologist (eye specialist). Vision loss will be measured using at least two vision tests performed with the use of appropriate visual aids at least six months apart. Benefits are paid according to severity of visual loss. The more severe the permanent damage, the higher the percentage pay-out.

All ages	
Definition	**Score**
Total loss of vision in one eye defined as best corrected Snellen score of <6/60.	1
Visual loss defined as best corrected binocular vision Snellen score of < 6/30.	2
Homonymous Hemianopia.	2
Visual field defect resulting in <70 degrees temporal field in each eye.	2
Visual field defect resulting in <10 degrees in each eye.	3
Complete Blindness defined as best corrected binocular vision Snellen score of < 6/120.	3

Payment Tiers	
Lump Sum	
Payment Percentage	**Score**
25%	1
50%	2
100%	3

CATCH ALL	
Definition	The diagnosis of a disease or disorder, resulting in the functional impairment of the Life Assured, as defined and measured by the following functional impairment criteria. Claimants will be required to be under the care of an appropriate specialist, must be on optimal medical and/or surgical management and must have attained maximal medical improvement.
Layman's description	The intention of this benefit is to pay for severe conditions, or a combination of conditions, not listed elsewhere, that render the person permanently confined to a bed. The person must be under treatment of an appropriate specialist and warrant 24-hour nursing care at home or in a nursing facility.

All ages	
Definition	**Score**
Permanently bedridden and receiving permanent 24-hour nursing care at home or a nursing facility.	1

Payment Tiers	
Lump Sum	
Payment Percentage	**Score**
100%	1

Activities of Daily Living (ADLs)

Basic Activities of Daily Living

• Bathing – the ability to wash/bathe oneself independently.
• Transferring – the ability to move oneself from a bed to a chair or from a bed to a toilet independently
• Dressing – the ability to take off and put on one's clothes independently.
• Eating - the ability to feed oneself independently. This does not include the making of food.
• Toileting – the ability to use a toilet and cleanse oneself thereafter, independently.
• Locomotion on a level surface – the ability to walk on a flat surface, independently.
• Locomotion on an incline – the ability to walk up a gentle slope, or a flight of steps independently.

Advanced Activities of Daily Living

• Driving a car – the ability to open a car door, change gears or use a steering wheel.
• Medical care – the ability to prepare and take the correct medication.
• Money management – the ability to do one's own banking and to make rational financial decisions.
• Communicative activities – the ability to communicate either verbally or written.
• Shopping – the ability to choose and lift groceries from shelves as well as carry them in bags.
• Food preparation – the ability to prepare food for cooking as well as using kitchen utensils.
• Housework – the ability to clean a house or iron clothing.
• Community ambulation with or without assistive device, but not requiring a mobility device – the ability to walk around in public places using only a walking stick if necessary.
• Moderate activities – activities like moving a table, pushing a vacuum cleaner, bowling, golf, etc.
• Vigorous activities – able to partake in running, heavy lifting, sports, etc.

Note: All Activities of Daily Living (ADLs) will be assessed with the use of assistive devices where appropriate.

Annexure
Critical Illness conditions

The definitions below apply to Policyholders who purchase the **CRITICAL ILLNESS COVER.**

Cardiovascular

Heart Attack of specified severity:

A Heart Attack or Acute Myocardial Infarction (MI) is defined as acute myocardial injury confirmed by a certified physician as having occurred as a direct consequence of acute myocardial ischemia resulting from inadequate blood supply to the heart.

The diagnosis must be confirmed by a physician or cardiologist. The evidence must show a definite acute myocardial infarction due to obstructive coronary heart disease. Other acute coronary syndromes, including but not limited to angina, are not covered by this definition.

1.

This is defined as the death of heart muscle, due to inadequate blood supply, as evidenced by all three of the following criteria:

i. Compatible clinical symptoms **AND**
ii. Characteristic ECG changes indicative of myocardial ischaemia or myocardial infarction as per Annexure A (a) **AND**
iii. Raised cardiac biomarkers defined as any one of the following Troponin or Non-Troponin Markers as below.

Cardiac Biomarkers				Severity Based	Enhanced Payout
Troponin Marker		**Value**			
Assay (test)	**Troponin Type**	**Unit: ng/L**	**Unit: ng/ml**		
Roche hsTnT	Tnt	>500	>0,5		
Abbott ARCHITECT	TnI	>1500	>1,5		
Beckman AccuTnI	TnI	>2500	>2,5		
Siemens Centaur Ultra	TnI	>3000	>3,0		
Siemens Dimension RxL	TnI	>3000	>3,0		
Siemens Stratus CS	TnI	>3000	>3,0		
Conventional TnT	TnT	>500	>0,5		
Conventional AccuTnI	TnI	>250	>0,25		

Non-Troponin Markers	Value		
Raised CK-MB mass	Raised above the upper limit of normal laboratory reference range but not meeting the severity C definition (i.e. below 2 times the upper limit of normal laboratory reference range) in acute presentation phase.	25%	100%
Total CPK elevation	Raised above the upper limit of normal laboratory reference range but not meeting the severity C definition (i.e. below 2 times the upper limit of normal laboratory reference range) in acute presentation phase, with at least 6% being CK-MB.		

2.

This is defined as the death of heart muscle, due to inadequate blood supply, as evidenced by any of the following combinations of criteria:

Compatible clinical symptoms **AND** raised cardiac biomarkers as below
OR
Compatible clinical symptoms **AND** new pathological Q-waves on ECG as defined in Annexure A (b) of SCIDEP1
OR
New pathological Q-waves on ECG as defined in Annexure A (b) of SCIDEP1 **AND** raised cardiac biomarkers as below
OR
ST-segment and T-wave changes on ECG indicative of myocardial injury as defined in Annexure A (a) of SCIDEP1
AND raised cardiac biomarkers as per SCIDEP1 Level C

Severity Based	Enhanced Payout
50%	100%

Cardiac Biomarkers			
Troponin Marker		**Value**	
Assay (test)	**Troponin Type**	**Unit: ng/L**	**Unit: ng/ml**
Roche hsTnT	TnT	>1000	>1,0
Abbott ARCHITECT	TnI	>3000	>3,0
Beckman AccuTnI	TnI	>5000	>5,0
Siemens Centaur Ultra	TnI	>6000	>6,0
Siemens Dimension RxL	TnI	>6000	>6,0
Siemens Stratus CS	TnI	>6000	>6,0
Conventional TnT	TnT	>1000	>1,0
Conventional AccuTnI	TnI	>500	>0,5

Non-Troponin Markers	Value
Raised CK-MB mass	Raised 2 times or more the upper limit of normal laboratory reference range in acute presentation phase.
Total CPK elevation	Raised 2 times or more the upper limit of normal laboratory reference range in acute presentation phase, with at least 6% being CK-MB.

3.

A heart attack that meets the criteria as defined under Level 2, with permanent impairment in one or more of the following functional criteria, as measured 6 weeks post-infarction: Criterion Value:

1. METS 2-7
2. Left Ventricular Ejection Fraction (LVEF) 30%-50%
3. Left ventricular end-diastolic diameter (LVEDD) 59mm-72mm
4. Ultrasound Fractional Shortening 16%-25%

Severity Based	Enhanced Payout
75%	100%

4.

A heart attack that meets the criteria as defined under Level 2, with permanent impairment in one or more of the following functional criteria, as measured 6 weeks post-infarction.

Criterion Value:

1. New York Heart Association (NYHA) Functional Class 4
2. METS 1 or less
3. Left Ventricular Ejection Fraction (LVEF) <30%
4. Left Ventricular End-Diastolic Diameter (LVEDD) >72mm
5. Ultrasound Fractional Shortening <16%

Severity Based	Enhanced Payout
100%	100%

Post coronary artery intervention Myocardial Infarction (MI)

1) REQUIRES ALL OF THE FOLLOWING:
   a) Percutaneous Coronary Intervention (PCI)
   b) Confirmed acute Myocardial Infarction occurring within 24 hours post PCI
   c) Raised Cardiac Markers post intervention as below:

i) Cardiac Troponin Assay

Cardiac Biomarkers			
Troponin Marker		**Value**	
Assay (test)	**Troponin Type**	**Unit: ng/L**	**Unit: ng/ml**
Roche hsTnT	Tnt	>500	>0,5
Abbott ARCHITECT	TnI	>1500	>1,5
Beckman AccuTnI	TnI	>2500	>2,5
Siemens Centaur Ultra	TnI	>3000	>3,0
Siemens Dimension RxL	TnI	>3000	>3,0
Siemens Stratus CS	TnI	>3000	>3,0
Conventional TnT	TnT	>500	>0,5
Conventional AccuTnI	TnI	>250	>0,25

OR

ii) Raised CK-MB mass reference range post intervention raised above the upper limit of normal laboratory reference range but below 4 times the upper limit of normal laboratory.

Severity Based	Enhanced Payout
25%	100%

2) REQUIRES ALL OF THE FOLLOWING:

a) Coronary Artery By-Pass Graft (CABG)
b) Confirmed acute MI, occurring within 24 hours post CABG
c) Raised Cardiac Markers post intervention as below:

i) Cardiac Troponin Assay

Severity Based	Enhanced Payout
50%	100%

Cardiac Biomarkers			
Troponin Marker		**Value**	
Assay (test)	**Troponin Type**	**Unit: ng/L**	**Unit: ng/ml**
Roche hsTnT	Tnt	>1000	>1,0
Abbott ARCHITECT	TnI	>3000	>3,0
Beckman AccuTnI	TnI	>5000	>5,0
Siemens Centaur Ultra	TnI	>6000	>6,0
Siemens Dimension RxL	TnI	>6000	>6,0
Siemens Stratus CS	TnI	>6000	>6,0
Conventional TnT	TnT	>1000	>1,0
Conventional AccuTnI	TnI	>500	>0,5

OR
ii) Raised CK-MB mass raised 4 times or more the upper limit of normal laboratory reference range post intervention.

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1 SCIDEP (Standardised Critical Illness Definitions Project) – ASISA (Association for Savings and Investment South Africa)

Cardiac Surgery and/or procedures specified below:	Severity Based	Enhanced Payout
The performing of cardiac surgery by a cardio-thoracic surgeon or cardiologist. Submissions of reports from the cardio-thoracic surgeon or cardiologist will be required.		
Coronary artery disease necessitating a PTCA and/or stenting to at least 1 vessel. Endovascular repair of an Atrial Septal Defect or Ventricular Septal Defect. Cardiac Arrhythmia having undergone pathway ablation or a pacemaker insertion.	25%	25%
Pericardiectomy. Any heart valve repair or valvotomy procedure. Surgical repair of an atrial myxoma. Open repair of an Atrial Septal Defect or Ventricular Septal Defect. Arrhythmia having undergone a defibrillator insertion.	50%	50%
Coronary Artery Bypass Grafting (CABG) of any 1 vessel.	50%	100%
Coronary Artery Bypass Grafting (CABG) of 2 vessels.	75%	100%
Heart valve replacement of one or more heart valves. Surgical repair of a left ventricular aneurysm. Coronary Artery Bypass Grafting (CABG) of 3 or more vessels.	100%	100%

Cardiomyopathy and Heart Failure as specified below:	Severity Based	Enhanced Payout
Cardiomyopathy or chronic congestive heart failure receiving optimal treatment for at least 6 months. Thereafter, the cardiac impairment must be confirmed on echocardiogram with an Ejection Fraction <40% based on 2 readings at least 3 months apart, or NT-ProBNP > 450pg/mL ages younger than 75 years, or, NT-ProBNP more than 900 pg/mL ages 75 and older. The ejection fraction and NT-ProBNP measurements must be done while on optimal treatment.	75%	75%
Cardiomyopathy or chronic congestive heart failure receiving optimal treatment for at least 6 months. Thereafter, the cardiac impairment must be confirmed on echocardiogram with an Ejection fraction of<30% based on 2 readings at least 3 months apart, or NT-ProBNP > 900pg/mL ages younger than 75 years, or, NT-ProBNP more than 1800 pg/mL ages 75 and older. The ejection fraction and NT-ProBNP measurements must be done while on optimal treatment.	100%	100%

Aortic and Peripheral Artery Surgery as specified below:	Severity Based	Enhanced Payout
Carotid artery disease having undergone stenting or angioplasty.	25%	25%
Undergoing of surgery to repair or correct an aneurysm, obstruction, or a coarctation of the following arteries: brachiocephalic, femoral, iliac, renal, splenic, subclavian and superior mesenteric. Carotid artery disease having undergone unilateral endarterectomy or bypass graft.	50%	50%
Undergoing of surgery 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. Peripheral arterial disease resulting in an ABI <0.7 and persistent claudication, ulceration or gangrene. Carotid artery disease having undergone bilateral endarterectomy or bypass graft.	100%	100%

Cancer

Benefit Description

Cancer refers to a malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukaemia, lymphoma, multiple myeloma and sarcoma. The stages for solid cancers are correlated to the general classification used by the American Joint Committee on Cancer (AJCC). For haematological cancers, the relevant international staging system must be used. For brain tumours, the WHO classification of tumours of the central nervous system must be used.

The following conditions are excluded from this definition:

• Tumours which are histologically described as benign, pre-malignant or low malignant potential. Any tumour classified as carcinoma in-situ (Tis) or (Ta) by the latest edition of the AJCC Cancer Staging Manual.
• All cancers only identified from tumour cells, pieces of DNA, or any other biomarkers, any of which may be present in the blood, saliva, urine, or other bodily fluids, including, but not limited to, tests known as "liquid biopsies".
• All myelodysplastic syndromes and myeloproliferative neoplasms including but not limited to, essential thrombocythemia, primary myelofibrosis, polycythemia vera.
• Primary cutaneous lymphoma and dermatofibrosarcoma which are confined to the skin and which have not spread to the lymph nodes or distant sites.

Cancer of specified severity:	Severity Based	Enhanced Payout
Prostate Cancer Stage 1 except T2N0M0 Gleason <6.	5%	5%
Stage 1 Squamous or Basal Cell Skin Carcinoma having undergone skin graft or skin flap (only a single claim is payable).	10%	10%
Chronic Lymphocytic Leukaemia (Stage 0 Rai, Binet A, Low Risk CLL-IPI). Stage 1 Lymphoma (Ann Arbor classification). Hairy Cell Leukaemia. Medically necessary Prophylactic bilateral total mastectomy (not for cosmetic purposes) as confirmed by genetic testing. Bilateral or unilateral mastectomy for ductal carcinoma in-situ. WHO Grade I Brain Tumour. Prostate Cancer Stage 2 or T2N0M0 Gleason <6. Stage 1 Melanoma. Any other stage 1 Cancer not defined above, excluding any other form of skin cancer.	25%	100%
Chronic Lymphocytic Leukaemia (Stage I or II Rai, Binet B, Intermediate risk requiring treatment CLL-IPI). Stage 2 Lymphoma (Ann Arbor Classification). Chronic Myeloid Leukaemia (not requiring bone marrow transplantation). Multiple Myeloma Stage 1 – 2 (Durie-Salmon Scale). WHO Grade 2 Brain Tumour. Prostate Cancer Stage 3 except T4N0M0 any Gleason. Any other stage 2 Cancer not defined above.	50%	100%
Chronic Lymphocytic Leukaemia (Stage III or IV Rai, Binet C, High risk or Very high Risk CLL-IPI). Stage 3 or 4 Lymphoma (Ann Arbor classification system). Acute Myeloid Leukaemia. Acute Lymphocytic Leukaemia. Chronic Myeloid Leukaemia (having undergone bone marrow transplantation). Multiple Myeloma Stage 3 (Durie-Salmon Scale). WHO Grade 3 or 4 Brain Tumour. Prostate Cancer Stage 4 or T4N0M0 any Gleason. Any other stage 3 or 4 Cancer not defined above.	100%	100%

Neurological

Stroke of specified severity:

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull, resulting in neurological deficit, confirmed by neuro-imaging investigation and appropriate clinical findings by a specialist neurologist. Symptoms and signs as well as imaging must confirm a new stroke.

The following conditions are excluded from this definition:

• Transient ischaemic attack; this is defined as a transient episode of neurologic dysfunction (irrespective of duration) caused by focal brain, spinal cord, or retinal ischemia, without acute infarction (on neuroimaging investigations).
• Vascular disease affecting the eye or optic nerve.
• Migraine and vestibular disorders.
• Traumatic injury to brain tissue or blood vessels.

Severity levels will be assessed by a full neurological examination by a specialist neurologist any time after three months.

	Severity Based	Enhanced Payout
Almost full recovery, with minor residual symptoms or signs, as measured by a permanent objective neurological deficit that is evident on physical examination that has persisted for a continuous period of at least three months after the onset of the stroke.	25%	100%
Can function independently, but has impairment as measured by the inability to do 3 or more advanced Activities of Daily Living (ADLs).	50%	100%
Cannot function independently, as measured by the inability to do 6 or more advanced Activities of Daily Living (ADLs).	75%	100%
Needs constant assistance, as measured by the inability to do 3 or more basic Activities of Daily Living (ADLs).	100%	100%

Multiple Sclerosis of specified severity:

Diagnosis of Multiple Sclerosis is characterised by the demyelination of myelinated axons in the brain or spinal cord. The diagnosis must be confirmed with clinical evidence, and any relevant special investigations including MRI. There must have been more than one clearly distinct episode of well-defined neurological deficit at least 6 months apart. A physician or neurologist must confirm the diagnosis. Exclusion: A single episode of Multiple Sclerosis from which remission occurred.

	Severity Based	Enhanced Payout
On diagnosis of Multiple Sclerosis and meeting above criteria.	50%	100%
On diagnosis of Multiple Sclerosis and causing permanent impairment (measured at least 3 months after diagnosis) resulting in the inability to function independently, as measured by the inability to do 6 or more advanced Activities of Daily Living (ADLs).	75%	100%
On diagnosis of Multiple Sclerosis and causing permanent impairment (measured at least 3 months after diagnosis), that results in the need for constant assistance, as measured by the inability to do 3 or more basic Activities of Daily Living (ADLs).	100%	100%

Muscular Dystrophy of specified severity:

Unequivocal diagnosis of Muscular Dystrophy by a neurologist as approved by PPS Insurance.

	Severity Based	Enhanced Payout
On diagnosis of Muscular Dystrophy.	50%	100%
On diagnosis of Muscular Dystrophy and causing permanent impairment (measured at least 3 months after diagnosis) resulting in the inability to function independently, as measured by the inability to do 6 or more advanced Activities of Daily Living (ADLs).	75%	100%
On diagnosis of Muscular Dystrophy and causing permanent impairment (measured at least 3 months after diagnosis), that results in the need for constant assistance, as measured by the inability to do 3 or more basic Activities of Daily Living (ADLs).	100%	100%

Motor Neuron Disease of specified severity:	Severity Based	Enhanced Payout
Unequivocal diagnosis of Motor Neuron Disease (Amyotrophic lateral sclerosis) by a neurologist. Exclusions: Nervous lesions of inflammatory or toxic origin.		
On diagnosis of Motor Neuron Disease.	100%	100%

Parkinson's Disease of specified severity:	Severity Based	Enhanced Payout
Unequivocal diagnosis of Parkinson's disease by a neurologist. Exclusions: Parkinsonism resulting from the side effects of medication, alcohol, drug-induced or toxic causes of Parkinson's disease.		
On diagnosis of Parkinson's Disease.	25%	100%
Causing permanent impairment (measured at least 3 months after diagnosis) resulting in the ability to function independently, but has impairment as measured by the inability to do 3 or more advanced Activities of Daily Living (ADLs).	50%	100%
Causing permanent impairment (measured at least 3 months after diagnosis) resulting in the inability to function independently, as measured by the inability to do 6 or more advanced Activities of Daily Living (ADLs).	75%	100%
Causing permanent impairment (measured at least 3 months after diagnosis), that results in the need for constant assistance, as measured by the inability to do 3 or more basic Activities of Daily Living (ADLs).	100%	100%

Dementia or Alzheimer's Disease of specified severity:	Severity Based	Enhanced Payout
The diagnosis of Alzheimer's Disease or another Dementia must be confirmed by the treating physician, psychiatrist or neurologist. With the claimant working: 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. With the claimant not working: The diagnosis must confirm permanent irreversible failure of brain function and result in significant cognitive impairment*, needing constant supervision by a full-time registered caregiver or frail care facility, for which no other recognisable cause can be identified. *Significant cognitive impairment is defined by the MMSE scores described below. Exclusions: 1. Alcohol or drug-related dementia. 2. Psychiatric causes of dementia are excluded. 3. Pre-clinical dementia identified by biomarkers in the absence of any cognitive or behavioural symptoms.		
Resulting in 2 MMSE scores ≤ 21, at least 6 months apart, and confirmed by an independent neuropsychiatrist.	50%	100%
Resulting in 2 MMSE scores ≤ 18, at least 6 months apart, and confirmed by an independent neuropsychiatrist.	100%	100%

Paralysis specified below:	Severity Based	Enhanced Payout
Permanent quadriplegia, paraplegia, hemiplegia, diplegia or confirmed Cauda Equina syndrome as a result of injury to or disease of the spinal cord or brain. Exclusion: Paralysis due to psychological disorders.	100%	100%

Myasthenia Gravis of specified severity:	Severity Based	Enhanced Payout
The unequivocal diagnosis of Myasthenia Gravis which must be confirmed by a physician or neurologist.		
On diagnosis of Myasthenia Gravis.	25%	100%
Causing permanent impairment (measured at least 3 months after diagnosis) resulting in the ability to function independently, but has impairment as measured by the inability to do 3 or more advanced Activities of Daily Living (ADL).	50%	100%
Causing permanent impairment (measured at least 3 months after diagnosis) resulting in the inability to function independently, as measured by the inability to do 6 or more advanced Activities of Daily Living (ADLs).	75%	100%
Causing permanent impairment (measured at least 3 months after diagnosis), that results in the need for constant assistance, as measured by the inability to do 3 or more basic Activities of Daily Living (ADLs).	100%	100%

Guillain-Barré Syndrome of specified severity:	Severity Based	Enhanced Payout
The unequivocal diagnosis of Guillain-Barré Syndrome which must be confirmed by a physician or neurologist.		
On diagnosis of Guillain-Barré Syndrome with admission to an Intensive Care Unit (ICU).	25%	25%
On diagnosis of Guillain-Barré Syndrome with full-time care required for basic Activities of Daily Living (ADLs) related to upper and lower limb impairment e.g. washing and bathing, mobilising, toileting and dressing which cannot be performed without assistance, for at least 2 consecutive months.	50%	100%
On diagnosis of Guillain-Barré Syndrome causing permanent paralysis of one or more limbs, OR causing the Life Insured to be permanently wheelchair-bound due to lower limb paralysis.	100%	100%

Intracranial or Spinal Cord lesion requiring surgery specified below:	Severity Based	Enhanced Payout
The diagnosis of an intracranial lesion, spinal cord lesion, or injury giving rise to neurological symptoms must be confirmed by the appropriate treating specialist with appropriate imaging. For the purposes of this definition, the spinal cord is considered to end at the Conus Medullaris and does not include the Filum Terminale, or the group of nerves known as the Cauda Equina. Exclusion: 1. Surgery to the spinal column and skull.		
Having undergone intracranial surgery, cranial reconstruction or surgery to the spinal cord. This excludes burr hole surgery.	25%	25%
Deemed inoperable, or post-surgery, and causing permanent impairment (measured at least 3 months after diagnosis) resulting in the ability to function independently, but has impairment as measured by the inability to do 3 or more advanced Activities of Daily Living (ADLs).	50%	100%
Deemed inoperable, or post-surgery, and causing permanent impairment (measured at least 3 months after diagnosis) resulting in the inability to function independently, as measured by the inability to do 6 or more advanced Activities of Daily Living (ADLs).	75%	100%
Deemed inoperable, or post-surgery, and causing permanent impairment (measured at least 3 months after diagnosis), that results in the need for constant assistance, as measured by the inability to do 3 or more basic Activities of Daily Living (ADLs).	100%	100%

Transplants

Organ Transplants specified below:	Severity Based	Enhanced Payout
On a recognised South African waiting list for, or on completion of a transplant of the heart, lung, liver, kidney, pancreas, small bowel or bone marrow, as a recipient. If on a waiting list, the treating specialist must confirm so in writing. Exclusions: 1. Pancreatic islet cell transplants. 2. Transplantation of any other organ or tissue.	100%	100%

Musculoskeletal

Loss of or Loss of use of Hands, Feet and/or Limbs:	Severity Based	Enhanced Payout
Amputation of or total and permanent loss of function of non-dominant hand below the wrist.	25%	100%
Amputation of, or total and permanent loss of function of the dominant hand below the wrist.	50%	100%
Amputation of, or total and permanent loss of function of the non-dominant upper limb above the wrist.	50%	100%
Amputation of, or total and permanent loss of function of the dominant upper limb above the wrist.	100%	100%
Amputation of, or total and permanent loss of use of the lower limb at or below the level of the ankle.	25%	100%
Amputation of, or total and permanent loss of function of the lower limb at or above the level of the knee.	50%	100%
Amputation of, or total and permanent loss of function of both lower limbs at the level of the ankle joint or higher.	100%	100%
Amputation of, or total and permanent loss of function of both upper limbs at the level or the wrists of higher.	100%	100%

Kidney and Urological

Chronic Progressive Renal Failure specified below:	Severity Based	Enhanced Payout
The diagnosis of chronic progressive renal failure where the life insured is under the care of a nephrologist and on optimal treatment. At least two eGFR measurements more than 6 months apart must be performed in order to assess chronic progressive renal failure. Exclusion: Reversible acute kidney failure.		
On diagnosis of chronic progressive renal failure, with a permanent eGFR < 50ml/min.	25%	25%
On diagnosis of chronic progressive renal failure, with a permanent eGFR < 40ml/min.	50%	100%
On diagnosis of chronic progressive renal failure, with a permanent eGFR < 15ml/min, or undergoing peritoneal dialysis or haemodialysis.	100%	100%

Acute Renal Failure specified below:	Severity Based	Enhanced Payout
On diagnosis of acute renal failure, having undergone 5 treatments of haemodialysis.	25%	25%

Total Nephrectomy specified below:	Severity Based	Enhanced Payout
Having undergone a total nephrectomy, not for donor purposes.	25%	25%

Orchidectomy specified below:	Severity Based	Enhanced Payout
Having undergone a bilateral orchidectomy. (Gender reassignment is specifically excluded).	25%	25%

Cystectomy specified below:	Severity Based	Enhanced Payout
Having undergone a partial cystectomy of at least 50% of the bladder.	25%	50%
Having undergone a total cystectomy.	100%	100%

Endocrine

Endocrine Disease specified below:	Severity Based	Enhanced Payout
On diagnosis of any of the following endocrine diseases, confirmed by a specialist endocrinologist, and supported by appropriate investigations: Thyroid storm Diabetes insipidus Acute adrenal crisis (excluding adrenal fatigue) Addison's disease Simmond's disease Conn's syndrome Cushing's syndrome Glycogen storage disease	10%	10%

Connective Tissue

Connective Tissue Disease (CTD) and Autoimmune Diseases specified below:	Severity Based	Enhanced Payout
On confirmed diagnosis of Rheumatoid Arthritis, Systemic Lupus Erythematosus, Progressive Systemic Sclerosis, Sarcoidosis, Polyarteritis Nodosa, Giant Cell Arteritis, Wegener's Granulomatosis, Dermatomyositis, or Polymyositis. The diagnosis must be confirmed by a rheumatologist, according to specific criteria defined by the American College of Rheumatology. The life insured must be on medical therapy including DMARDS or Biological Medications. For CTD or Autoimmune Disorders with major organ involvement, the severity of involvement will be assessed under the relevant system which will be capped at a 100% payout. Should multiple organs be involved, the organ with the most severe impairment will qualify for the highest payout.		
On diagnosis of one of the above listed CTD or Autoimmune diseases and meeting the criteria above.	25%	25%
On diagnosis of one of the above listed CTD or Autoimmune diseases and having undergone major joint replacement or arthrodesis of any of the following musculoskeletal structures: shoulder, elbow, wrist, hip, knee or ankle or fusion of the spine at 2 or more vertebral levels.	50%	100%

Respiratory

Obstructive or Restrictive Lung Disease specified below:	Severity Based	Enhanced Payout
Obstructive or restrictive lung disease means the Life Insured must have been diagnosed by a pulmonologist and there must be permanent and irreversible changes to the functioning of the lung, assessed with the appropriate special tests, performed at least twice, and 6 months apart. For lung function tests, American Thoracic Society criteria for adequate testing must have been met. Claimants must be on optimal medical treatment at the time of the first test.		
On diagnosis of chronic obstructive or restrictive lung disease with a permanent FEV1, FVC, or DLCO of less than 50% of predicted.	50%	100%
On diagnosis of chronic obstructive or restrictive lung disease with a permanent FEV1, FVC, or DLCO of less than 40% of predicted.	100%	100%

Pulmonary Embolism specified below:	Severity Based	Enhanced Payout
Pulmonary embolism must have been diagnosed by a physician, with appropriate imaging.		
On diagnosis of pulmonary embolism.	25%	25%
Pulmonary embolism having undergone surgical intervention.	50%	100%

Pulmonary Hypertension specified below:	Severity Based	Enhanced Payout
Pulmonary hypertension must have been diagnosed by a pulmonologist or cardiologist, with appropriate testing.		
On haemodynamic diagnosis of irreversible pulmonary hypertension with mean pulmonary artery pressure >40mmHg OR; With compatible symptoms, the clinical diagnosis of pulmonary hypertension, with peak tricuspid regurgitation > 3,4 m.s-1 OR; With compatible symptoms, the clinical diagnosis of pulmonary hypertension, with peak tricuspid regurgitation between 2,9 m.s-1 and 3,4 m.s-1, and supporting echocardiographic signs from at least two of the following categories in keeping with internationally accepted clinical guidelines: a. ventricles b. pulmonary artery c. inferior vena cava and right atrium In all instances, the Life Insured must have been on optimal medical treatment for at least 6 months at the time of the assessment.	100%	100%

Bronchopleural Fistula specified below:	Severity Based	Enhanced Payout
On diagnosis of a bronchopleural fistula by a pulmonologist, with appropriate investigations.	25%	25%

Respiratory surgery specified below:	Severity Based	Enhanced Payout
On removal of a lobe of a lung, not for donor purposes.	25%	50%
On removal of more than one complete lobe, or removal of an entire lung, not for donor purposes.	75%	100%

Gastrointestinal

Inflammatory Bowel Disease specified below:	Severity Based	Enhanced Payout
A definite diagnosis of Ulcerative Colitis or Crohn's Disease by a gastroenterologist, with supporting clinical and histopathological features. A maximum of 100% of the sum assured is payable for this benefit, irrespective of any reinstatements.		
On diagnosis of Ulcerative Colitis or Crohn's Disease.	25%	50%
Despite optimal treatment, including disease modifying drugs and diet restriction, the complications of the disease have resulted in more than one surgical intervention other than for diagnostic purposes (the removal of benign polyps will be considered a diagnostic procedure). Having undergone hemicolectomy.	50%	100%
Resulting in any one of the following: Total colectomy; Permanent ileostomy; Permanent colostomy.	100%	100%

Bowel surgery specified below:	Severity Based	Enhanced Payout
Having undergone a hemicolectomy.	50%	100%
Having undergone a total colectomy. Having undergone a permanent colostomy. Having undergone a permanent ileostomy.	100%	100%

Liver Disease specified below:	Severity Based	Enhanced Payout
Exclusions: Any liver disease attributed to the use of alcohol.		
Chronic liver disease as diagnosed by a hepatologist Classified as Child-Pugh class A. Having undergone a partial hepatectomy due to illness or injury (this excludes a liver biopsy).	25%	50%
Chronic liver disease as diagnosed by a hepatologist Classified as Child-Pugh class B.	50%	100%
Chronic liver disease as diagnosed by a hepatologist Classified as Child-Pugh class C. On diagnosis of primary sclerosing cholangitis or biliary cirrhosis. On diagnosis of fulminant hepatic failure.	100%	100%

Pancreatic Disease specified below:	Severity Based	Enhanced Payout
Exclusions: Any pancreatic disease attributed to the use of alcohol.		
Partial pancreatectomy due to illness or injury.	25%	50%
Chronic pancreatitis, diagnosed by the appropriate specialist resulting in Diabetes Mellitus, requiring the permanent use of insulin. Chronic pancreatitis is defined as a continuing inflammatory disease of the pancreas characterised by irreversible morphologic changes and appropriate changes in pancreatic enzyme levels.	50%	100%
Complete pancreatectomy due to illness or injury.	100%	100%

Haematological

Aplastic Anaemia specified below:	Severity Based	Enhanced Payout
On diagnosis of aplastic anaemia by a specialist physician. The diagnosis must be based on a bone marrow biopsy.	100%	100%

Sensory

Loss of Hearing specified below:	Severity Based	Enhanced Payout
Having undergone a cochlear implant.	25%	25%
Permanent Hearing loss between 70-89 decibels (in both ears) at frequencies of 500, 1000, 2000, and 3000 Hz despite use of a hearing aid and not correctable by surgical procedures. The diagnosis must be confirmed by an otolaryngologist specialist and audiologist.	50%	100%
Permanent Hearing loss of more than 90 decibels (in both ears) at frequencies of 500, 1000, 2000, and 3000 Hz despite use of a hearing aid and not correctable by surgical procedures. The diagnosis must be confirmed by an otolaryngologist and audiologist.	100%	100%

Loss of Vision specified below:	Severity Based	Enhanced Payout
Irreversible loss of sight in one eye, as confirmed by an ophthalmologist, with a best corrected visual acuity of 6/120 or less in the affected eye. The visual loss is not correctable by aides or surgical procedures.	25%	25%
Irreversible loss of sight in both eyes, as confirmed by an ophthalmologist, with a best corrected visual acuity of 6/30 or less. The visual loss is not correctable by aides or surgical procedures.	50%	100%
Irreversible Hemianopia in both eyes, confirmed by an ophthalmologist. The visual loss is not correctable by aides or surgical procedures.	50%	100%
Irreversible loss of sight in both eyes, as confirmed by an ophthalmologist, with a best corrected visual acuity of 6/120 or less. The visual loss is not correctable by aides or surgical procedures.	100%	100%

Loss of Communication specified below:	Severity Based	Enhanced Payout
Total and permanent loss of the ability to produce intelligible speech as a result of irreversible damage to the larynx or its nerve supply from the speech centres of the brain. Medical evidence must be supplied to confirm laryngeal dysfunction and that the loss of speech has lasted for a continuous period of at least 12 months. Exclusion: All psychiatric causes of loss of speech.	100%	100%

Trauma

Traumatic Injury causing permanent impairment specified below:	Severity Based	Enhanced Payout
Significant and traumatic injury caused directly by unforeseen, external or violent means and is independent from any other cause. The condition, treatments and complications must be confirmed by a registered medical specialist within 12 months of the event.		
Admitted to hospital or a recognised rehabilitation centre for a continuous period of more than 30 days as a result of the injuries suffered.	25%	100%
Causing permanent impairment (measured at least 3 months after diagnosis) resulting in the ability to function independently, but has impairment as measured by the inability to do 3 or more advanced Activities of Daily Living (ADLs).	50%	100%
Causing permanent impairment (measured at least 3 months after diagnosis) resulting in the inability to function independently, as measured by the inability to do 6 or more advanced Activities of Daily Living (ADLs).	75%	100%
Causing permanent impairment (measured at least 3 months after diagnosis), that results in the need for constant assistance, as measured by the inability to do 3 or more basic Activities of Daily Living (ADLs).	100%	100%

Acquired Immune Deficiency Syndrome (AIDS) specified below:	Severity Based	Enhanced Payout
On diagnosis of AIDS meeting the following requirements: 1) Positive HIV blood test AND; 2) CD4 cell count of less than 200 after being compliant on anti-retroviral treatment for a minimum of 6 months OR a new diagnosis of any WHO AIDS defining illness after being on anti-retroviral treatment for a minimum of 6 months.	100%	100%

Accidental Contraction of Human Immunodeficiency Virus (HIV) specified below:	Severity Based	Enhanced Payout
Accidental HIV infection as a result of one of the following incidents: Accidental needle-stick injury whilst performing occupational duties as a health professional (recognised by the HPCSA) - Assisting at a road traffic accident - Receiving HIV infected blood from a transfusion - Receiving an organ transplant where the organ was previously infected with HIV - The victim of a violent crime or assault (including rape) which results in the opening of a criminal case by the police. In all cases, an HIV ELISA test, done at a SANAS accredited lab, must be done within 72 hours after the event leading to HIV exposure to confirm prior HIV negative status. A full course of post exposure prophylaxis must have been taken by the client for at least 28 consecutive days after the incident or event.	100%	100%

Penetrating gunshot wound/s specified below:	Severity Based	Enhanced Payout
Penetrating gunshot wound to the head, neck, chest, abdomen or pelvic area requiring surgical intervention by means of a craniotomy, exploration of the neck, thoracotomy or laparotomy.	100%	100%

Facial injury specified below:	Severity Based	Enhanced Payout
Diagnosis of Le Fort II or Le Fort III facial injuries.	25%	25%

Burns specified below:	Severity Based	Enhanced Payout
Tissue injury caused by thermal, electrical or chemical agents causing burns, as measured by the Lund or Browder Body Surface Chart.		
Partial thickness burns to ≥30% of the body surface area.	25%	100%
Full thickness burns to ≥10% of the body surface area.	50%	100%
Full thickness burns to ≥30% of the face.	50%	100%
Full thickness burns to ≥20% of the body surface area.	100%	100%
Full thickness burns to ≥50% of the face.	100%	100%

ICU

Intensive Care Unit (ICU) admission specified below:	Severity Based	Enhanced Payout
The benefit will pay 100% of the sum assured if the Life Insured is admitted to ICU with mechanical ventilation for at least 96 consecutive hours due to disease or trauma.	100%	100%
The benefit will pay 100% of the sum assured if the Life Insured is admitted to ICU for at least 10 consecutive days due to disease or trauma.	100%	100%

Activities of Daily Living (ADLs)

Basic Activities of Daily Living

- Bathing – the ability to wash/bathe oneself independently.
- Transferring – the ability to move oneself from a bed to a chair or from a bed to a toilet independently
- Dressing – the ability to take off and put on one's clothes independently.
- Eating - the ability to feed oneself independently. This does not include the making of food.
- Toileting – the ability to use a toilet and cleanse oneself thereafter, independently.
- Locomotion on a level surface – the ability to walk on a flat surface, independently.
- Locomotion on an incline – the ability to walk up a gentle slope, or a flight of steps independently.

Advanced Activities of Daily Living

- Driving a car – the ability to open a car door, change gears or use a steering wheel.
- Medical care – the ability to prepare and take the correct medication.
- Money management – the ability to do one's own banking and to make rational financial decisions.
- Communicative activities – the ability to communicate either verbally or written.
- Shopping – the ability to choose and lift groceries from shelves as well as carry them in bags.
- Food preparation – the ability to prepare food for cooking as well as using kitchen utensils.
- Housework – the ability to clean a house or iron clothing.
- Community ambulation with or without assistive device, but not requiring a mobility device – the ability to walk around in public places using only a walking stick if necessary.
- Moderate activities – activities like moving a table, pushing a vacuum cleaner, bowling, golf, etc.
- Vigorous activities – able to partake in running, heavy lifting, sports, etc.

Note: All Activities of Daily Living (ADLs) will be assessed with the use of assistive devices where appropriate.

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