ALL YOUR PRODUCT BENEFITS UNPACKED.

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Unlimit Your Life.

THE UNLIMITED

Insurance | Lifestyle | Rewards

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LIFE INSURANCE POLICY ("POLICY")
GENERAL TERMS & CONDITIONS FOR THE POLICY

IMPORTANT, PLEASE READ CAREFULLY

1. Your use of the insurance benefits is always subject to the terms and conditions of this policy, statutory notices, amendments, endorsements and addendums issued by us in terms of the policy; and must be read together with, and shall form a part of, this policy.
2. The policy is issued to you at your own request and without us providing you with any advice, we only provide factual information. Please read it carefully and ensure that it is appropriate to your needs. If not, please contact us. Also see **CANCELLATION OF YOUR INSURANCE BENEFITS** below.

WE WOULD LOVE TO HEAR FROM YOU

If you have any questions, or need assistance with your policy, you can get in touch with us in the following ways:


on our website www.theunlimited.co.za; or


call us on **0861 990 000**

ACCURACY OF INFORMATION

It is very important that you give The Unlimited and the Insurer honest and accurate information at all times. If you give The Unlimited and/or the Insurer false or incorrect information, your policy may be invalid or you may not be covered in full or in part. The Unlimited and the Insurer may rely on the accuracy and truthfulness of any information provided by you during any conversation and including in any proposal/application form or other information supplied by you or by The Unlimited on your behalf to the Insurer, including any relevant recorded phone calls made to or received by you.

If any claim or part thereof under this policy is in any way fraudulent, or if any fraudulent means or devices are used by you or anyone acting on your behalf, providing information regarding the claim for you, to obtain any insurance benefit under this policy (whether successfully, or not), or if any event is caused by or arises out of your intentional conduct, or any person acting on your behalf with your connivance; and/or any fraudulent information and/or documentation, whether created by you or any other party is provided by you or anyone acting on your behalf or with your connivance to us in substantiation or support of any claim under this policy and whether or not the claim itself is fraudulent; and/or if the quantum, in whole or part, of any claim is exaggerated by any degree whatsoever by you or anyone acting on your behalf or with your connivance, for any reason whatsoever and whether or not the claim itself is fraudulent; then any and all insurance benefits afforded in terms of this policy in respect of such claim will be forfeited and we will have no liability whatsoever to you in respect of such claim in its totality.

If the Insurer or The Unlimited fail to enforce any provision strictly or at all, this does not mean that we waive any of our rights thereto, nor does it mean that we may not enforce it thereafter.

GENERAL DEFINITIONS (what these words mean when used in this policy)

Subject to all the terms and conditions of the policy:

1. **accident** means an external, violent, unexpected and visible event, but which occurs at a time and place that can be identified. For example, a motor vehicle accident, an assault or burns.
2. **additional dependant** means any person, whose name and date of birth you have given to us and who are totally financially dependent on you. If you have chosen to cover an additional dependant, this means that from the date you add an additional dependant to this policy and throughout the lifetime of this policy, you (the policyholder) are totally responsible for the livelihood and support of your additional dependant and pay for their food, water, medicine, shelter and clothing. They must also be a member of your family through

blood or by a recognised legal relationship.
IMPORTANT: the number of additional dependants that you can add is stated in the **INSURANCE BENEFITS** section of this policy, at an additional cost to you, where applicable. Failure to provide The Unlimited with your additional dependant/s' details can result in the rejection of a claim, or the Insurer voiding the policy or parts thereof.

3. **child/ren** means your biological children, stepchildren, adopted children and children who are related to you by blood or a legally recognised relationship. The child/ren must be under the age of 21 and totally financially dependent on you. If you have chosen to cover your child/ren, this means that from the date you add a child to this policy and throughout the lifetime of this policy, you (the policyholder) are totally responsible for the livelihood of your child/ren and pay for their food, water, medicine, shelter and clothing.
IMPORTANT: You may add your child/ren to this policy from the day they are born alive (and up to the age of 21).
The number of children that you can add is stated in the **INSURANCE BENEFITS** section of this policy, at an additional cost to you, where applicable. You must provide The Unlimited with the name, surname and dates of birth of your child/ren and your child/ren must be on record to be covered under this policy. Failure to provide The Unlimited with your child/ren's details can result in the rejection of a claim, or the Insurer voiding the policy or parts thereof.
4. **due date** means the date of your premium deduction every month (your salary pay date).
5. **grace period** means the period of 15 (fifteen) days following a failed premium collection (calculated from the premium due date), within which you can make a payment to us. During the grace period, all insurance benefits will remain in force. In the event of a claim occurring during the grace period, if the claim is approved, you authorise us to deduct all outstanding premiums from the claim settlement amount.
6. **insured event** means a single accident which results in an insured person's admission/s to hospital because of an accidental injury or an insured person's death (accidental or natural), from any cause not excluded under this policy.
7. **insured person** means you, your spouse and/or any child or other additional dependant who is covered under this policy. They must be South African citizens or, if they aren't, they must have residential rights in South Africa.
8. **Insurer** means Centriq Life Insurance Company Limited (Reg. No. 1943/016409/06), a licensed life insurer and an authorised financial services provider (FSP Number 7370) (the Insurer), the company which provides you with your insurance benefits and which receives the premium every month.
9. **premium** means the amount payable to the Insurer every month for the insurance cover (the insurance benefits) under this policy. The premium is disclosed separately in the insurance benefits section of this policy.
10. **premium deduction** means the collection of your premium on the due date every month. The collection method will be via Persal (the National and Provincial Government's personnel salary system).
11. **spouse/partner** means a named person who you are married to by civil law, tribal custom or in terms of any religion, this includes your life partner. If you have chosen to cover your spouse, the details of your spouse must be on record, he/she must normally live with you in South Africa and you must be interdependent on each other. At the time of a claim, it is your responsibility to prove that you and your spouse are interdependent and that you normally live together.
When we use the word "partner", we refer to your spouse (as described above) or your life partner, whomever is named on your policy.
12. **start date** means the date of your first successful premium deduction and is the date on which all your insurance benefits are available (subject to waiting periods).
13. **waiting period** means the period specified in this policy/the **INSURANCE BENEFITS** section during which we need to successfully collect a specified minimum number of premiums from you before you are entitled to claim under this policy. Please note, the specified minimum number of premium deductions required to meet the waiting periods start from when a person is added to the policy and cover for the applicable insured person will also only begin once the Insurer has received the required minimum number of

premiums for that person.

14. **we/us/our** means The Unlimited Group (Pty) Limited, acting on our own behalf or on behalf of the Insurer. We provide the intermediary services and binder functions on behalf of the Insurer in respect of the insurance benefits you have chosen. The Unlimited Group (Pty) Limited is an authorised Financial Services Provider (FSP No. 21473).
15. **you/your** means the policyholder and includes additional lives insured/ dependants, where applicable.

HOW WILL WE COMMUNICATE WITH YOU?

1. We will communicate with you via email, SMS or WhatsApp, using the cell phone number and/or email address you provided The Unlimited when you took out this policy. This will be the agreed method of giving you any notice required by the policy or by law.
2. **We will always communicate with you using your last known details (including the details of your dependants and beneficiary, where relevant)** to fulfil your policy cover and to process any claims you may have. If any of your contact details change, including your current contact number (cell phone), email address, physical and/or postal address, please call The Unlimited immediately on 0861 990 000.

FOR COMPLAINTS AND COMPLIANCE

1. It is important that you are happy with your policy. If you are unhappy for any reason, please call us on 0861 990 000 and give us a chance to see if we can set things right.
2. If you are still not happy, then refer to '**HOW TO SUBMIT A COMPLAINT**' in the **STATUTORY NOTICE OF DISCLOSURES AND OTHER LEGAL REQUIREMENTS** section below.

PAYMENT AND NON-PAYMENT OF PREMIUMS

It is your responsibility to pay your premium every month or you will not be covered.

1. Payment of premiums:
    - 1.1 **If you are a Government employee and have given us your Persal number:**
        - 1.1.1. you have authorised your employer to deduct the premium from your salary via Persal (National and Provincial Government's personnel salary system);
        - 1.1.2. you agree that, should any changes in terms of this policy resulting in either the cancellation of the policy or an increase in premium be required, such changes need to be communicated to Persal first and the change may only be effective up to 60 days later. This means that you may have another premium deduction before the change is effective. **For example:** if an instruction to cancel this policy is received by Persal on the 25th of June, the cancellation may only be effective up to 60 days later during the following month, or the month after in August (and the premium will still be deducted from your salary in July).
    - 1.2. The premium is due in advance and this policy will not be binding on us or the Insurer until your first successful premium deduction.
    - 1.3. This policy is month-to-month. It will renew on the same terms each time your premium deduction is successful.
2. Unpaid premiums:
    - 2.1. If the Insurer does not receive the premium by the due date every month, you will have NO cover. **The Insurer will not double deduct missed premiums the following month.**
    - 2.2. You have a grace period of 15 (fifteen) days, calculated from the due date within which to make a manual payment to us. During the grace period, all insurance benefits will remain in force. However, in the event of a valid claim occurring during this period, the outstanding premium can be deducted from the claim settlement amount. If we do not receive payment within the 15 days, you will not have cover.

Example: premium due date is the 1st of May. If you miss a premium deduction, you will only have until the 16th of May to make a manual payment to us. If you don't, you will not have cover.

3. Debit order collections of premiums:
   - 3.1. If the Government is unable to deduct the premium in favour of the Insurer from your salary via Persal, you have authorised us to deduct the premium from any of your bank accounts which you have given us. Your debit order will be presented to your bank on the same day as the due date unless you reject the request from your bank to authenticate your debit order mandate.
   - 3.2. In the event of your debit order being unsuccessful, we use a tracking system that allows us to process your debit on another date if need be, to improve the likelihood of a successful debit order collection. This allows you to keep your policy active, but it remains your obligation to see that all premiums are paid manually when any collection of premiums fail.
   - 3.3. If your premium is not received, you agree that we may, at our discretion, try and collect from your account a further 3 times. At each attempt the grace period of 15 (fifteen) days will apply.
     - 3.3.1. if we cannot collect the premium after 4 consecutive attempts, the policy will automatically end. This means that your policy will be cancelled. **PLEASE NOTE:** You and any person insured will not be entitled to any insurance benefits during any month where we do not successfully collect a premium from you.
   - 3.4. **IMPORTANT:** your premium may be collected on a different date from the due date because of a public holiday or weekend, without notifying you. Any bank charges incurred as a result will be for your own account.
   - 3.5. If you dispute your monthly debit order with the result that the debit order is reversed by your bank, and provided the debit order mandate is not cancelled, we may, subject to the terms of this policy, resubmit the debit order mandate for collection in the month following the dispute/s.

AMENDMENTS TO COVER OR PREMIUMS

1. **We reserve the right to amend, add or change the premium, insurance benefit waiting period or terms and conditions of this policy, including your cover, by giving 31 days' written notice to you of our intention to do so.**
2. Any variations and or changes, referred to above, including any premium rate adjustment will be binding on you and can be applied at any time to the existing terms and conditions after 31 days' notice of these changes have been sent to you, but please remember that it may still take up to 60 days from the date of communication to you to become effective.
3. If you choose to cancel your policy during the 31-day notice period of amendment to the policy, you will not be entitled to a refund of premiums already paid.

WHEN DOES YOUR COVER START AND WHEN DOES IT AUTOMATICALLY END?

1. On receipt of your first premium by the Insurer, your policy will start (the start date). The start date of your policy will be the date of your first successful premium deduction. **Please note:** the instruction for your first premium deduction will need to be communicated to Persal first and your start date may only be effective up to 45 days later. This means that you may only have your first premium deduction in the following month/s.
   For example: if an instruction for your first premium deduction is received by Persal on the 25th of June, your first premium deduction may only happen up to 45 days later during the following month, or the month after in August (and the start date of your policy will only happen on the date of that first premium deduction).
2. You are entitled to your insurance benefits from the start date, subject to any waiting period that may apply.
3. If you are unsure when your cover starts, please contact us to confirm the start date of your policy.
4. You must be under the age of 65 to be covered under this policy. The policy

will automatically end when you turn 70 or immediately on the death of the policyholder.

5. Any insurance benefits that apply to your dependants will also end should this policy end for any reason or when your dependants:
   5.1. In the case of children, turn 21; and
   5.2. In the case of adults, turn 70.

CANCELLATION OF YOUR POLICY

1. You can cancel your policy at any time. CALL US ON 0861 990 000 OR EMAIL US ON CUSTOMERCARE@THEUNLIMITED.CO.ZA. Please remember that your cancellation may take up to 60 days to take effect.
2. There is a cooling-off period of 31 days (calculated from when you received these terms and conditions OR from a reasonable date on which it can be deemed that you received them) within which you can cancel and receive a refund, **BUT ONLY IF YOU HAVE NOT USED** any of the insurance benefits. Cancellation of your policy will include cancellation of ALL your insurance benefits.
3. The Insurer can cancel or void the policy (or sections thereof) at any time if you do not fulfil your duties under this policy or if you misrepresent material facts, are dishonest or fraudulent in your actions, by the insurer notifying you immediately in writing of cancellation/voidance for fraudulent or dishonest actions or the non-payment of premiums.
4. The Insurer may cancel this policy in writing by giving you 31 days' notice (or such other period as may be mutually agreed and/or otherwise prescribed by this policy).
5. When this policy is cancelled (by you or by the Insurer) and no further premiums are received by you, all cover and benefits under it will end from the date it is cancelled.

TRANSFER OR CASH-IN

Your policy, or any rights in your policy, cannot be transferred to another person. You cannot take out a loan against your policy. Your policy is month-to-month and does not pay out any profits, nor can it be cashed-in for money.

REPLACEMENT INSURANCE

We do not provide financial advice to customers. If this policy, or any part of this policy is replacing an existing policy you have, make sure that you have carefully compared the insurance premiums, insurance benefits and terms and conditions.

CLAIMS PROCESS CONDITIONS

These are detailed claims conditions that must be in place or complied with by you so that you can enjoy the insurance benefits.

1. When can you claim?
   1.1. As soon as the Insurer has received your first premium (the start date), you are entitled to cover and to claim your insurance benefits if an insured event occurs; however, if there is a waiting period, you or any person insured, will not have cover until the waiting period has ended. You can further only claim for the insurance benefits covered if we successfully receive your premium every month; and if you comply with all the terms, conditions, limitations and exclusions contained in this policy.
   PLEASE NOTE: Where the insurance is varied or extended, the insurance provided by any additional benefit, special clause, variation and extension, schedule or addendum is subject to the terms, conditions, exclusions and limitations of this policy from the date of change.
   1.2. **The insured event must have happened in South Africa, it must be after the start date and an exclusion must not apply.**
2. Time period to submit a claim:
   2.1. Your claim form and supporting claim documents must be submitted to us by you or the nominated beneficiary or alternative claimant (where applicable) within 30 days of the insured event. If we do not receive the information we need, the Insurer will close your claim.
3. How to claim your insurance benefits:
   3.1. It's simple, CALL US on 0861 990 000 and we will guide you through the process.

3.2. **Your claim documents can be sent by any of the methods below to:**
THE UNLIMITED – CLAIMS DEPARTMENT

Postal address:	Private Bag X7028, Hillcrest, 3650
Physical Address:	No. 3 The Boulevard, Westway Office Park, Intersection of Spine Road and The Boulevard, Westville, KwaZulu-Natal, South Africa, 3610
Email address:	tuclaims@iua.co.za
Fax number:	086 206 4069

3.3. Please see **YOUR INSURANCE BENEFITS** section for a list of documents required to finalise your claim.
3.4. **All costs incurred from submitting a claim are for your account.**
3.5. On approval of a valid claim, the cash payout can be used for any purpose you see fit.

4. General requirements for any claim:
4.1. **We have the right to request additional supporting documents at any time** if we are unable to validate the claim with all the information requested in this policy and the claim forms.
4.2. **IMPORTANT:** Details of the additional information we may require will be provided with your claim form. If we request the additional information from you, it is because it is necessary for us to finalise the claim. We will require your co-operation in providing us with the additional information.
4.3. If you do not comply with our reasonable requests, do not co-operate in the investigation of claims or you do not give us specific claim documents/information, the Insurer may close or repudiate your claim.
4.4. **If we approve your claim, you (or any other approved claimant) will be required to provide us with a copy of the claimant's identity document and South African bank statement that clearly shows the name and address of the account holder, the account number, as well as the bank date stamp.**
4.5. Payment made to any approved claimant will discharge our and the Insurer's liability and obligations arising out of the event/s which led to the claim.
4.6. In the event that a benefit is paid as a result of any misrepresentation, non-disclosure, misdescription or fraudulent action, the beneficiary/claimant will be obliged to repay or return the benefit received under this policy and we will be entitled to take legal action to recover the benefit and/or any costs associated with such legal action.
4.7. **There are other important details which you will find in this document under the section STATUTORY NOTICE OF DISCLOSURES AND OTHER LEGAL REQUIREMENTS. Please make sure you read and understand it and if you have any questions, please call us on the number we have provided.**

5. Claim repudiations:
5.1. If the Insurer repudiates your claim, we will notify you of the repudiation. If you wish to challenge the repudiation, you will have 90 (ninety) days to make written representations to us or the Insurer (complaints@centriq.co.za). The insurer has 45 (forty-five) days from receipt of such written representation to notify you of their final decision.
5.2. If the Insurer's decision remains unchanged, you have 180 (one hundred and eighty) days from the expiry of the above 90 (ninety) day period to:
5.2.1. institute legal action (if you do not, you may no longer have any claim); and/or
5.2.2. lodge a complaint to the FAIS Ombud, to the National Financial Ombud Scheme or the Financial Sector Conduct Authority.
5.3. **There are more important details about this process in the STATUTORY NOTICE OF DISCLOSURES AND OTHER LEGAL REQUIREMENTS section below.**

GENERAL POLICY EXCLUSIONS (what you are not covered for)

General exclusions are specific items, losses or events that are not covered by this policy. **It is very important that you understand and take note of these.**

1. The Insurer will NOT cover any claim if you have:
   1.1. added additional dependants who are not related to you through blood or a legally recognised relationship and who are not totally financially dependent on you for their livelihood, support and payment of their food, water, medicine, shelter and clothing at the time of the incident that led to a claim under this policy;
   1.2. added children who are either over the age of 21 or not totally financially dependent on you for their livelihood, support and payment of their food, medicine, shelter, education, money and clothing at the time of the incident that led to a claim under this policy.
   PLEASE NOTE: at the time of a claim, you must also prove that each of your children and additional dependants are a member of your family through blood or by a recognised legal relationship and are totally financially dependent on you as described above.
2. The Insurer will NOT cover any claim where at the time of the incident that led to a claim under this policy:
   2.1. the insured event occurred before the start date of this policy or outside the borders of South Africa;
   2.2. you failed to pay any premium on or before the due date, subject to the provisions of this policy;
3. The Insurer will NOT cover any claim where at the time of the incident, or immediately before, you or any life insured:
   3.1. partook in any actions of war, invasion, act of foreign enemy, hostilities, civil war/unrest, rebellion, riot, revolution, terrorist attack;
   3.2. were exposed to nuclear reaction or radiation of any kind;
   3.3. attempted to commit or had wilful involvement in any unlawful/illegal act or wilful exposure to a needless peril or dangerous conduct (a conscious decision to expose yourself to a potential risk of injury or death that the reasonable person would choose to avoid);
   3.4. was driving or operating any motor vehicle, motorcycle or similar without a valid driver's licence and/or permit;
   3.5. attempted suicide or intentional self-harm/injury;
   3.6. committed suicide or any intentional self-harm that results in death, unless the waiting period is met;
   3.7. committed fraud or attempted fraud, or did not tell us the truth or did not give us all the correct details, including about your health (now or when you claim);
   3.8 partook in any of the below high-risk activities/occupations:
      3.8.1. any sport as a professional;
      3.8.2. parachuting, skydiving, hang gliding, wrestling, boxing or martial arts;
      3.8.3. racing, speed or endurance tests on or in power driven vehicles or crafts;
      3.8.4. flying other than as a passenger in a licensed passenger carrying aircraft piloted by a duly qualified person;
      3.8.5. mountaineering of any nature, wall/rock climbing and bouldering;
      3.8.6. bungee-jumping, scuba-diving, steeple-chasing, water-skiing, rugby, ice hockey, winter sports, polo;
      3.8.7. game hunting;
      3.8.8. quad biking;
      3.8.9. digging or sinking of mine pits or shafts, underground mining activities or the manufacture or use of explosives;
      3.8.10. consumed, used and/or abused any intoxicating substance (for example, however not limited to, medication, illegal narcotics/drugs as well as alcohol and/or alcohol poisoning); including driving under the influence of such intoxicating substances whether tested for substance use or not.

SANCTIONS

1. This policy excludes cover, and the Insurer is not liable to pay for any claim, nor provide any insurance benefit under this policy to the extent that the provision of such cover, payment of such claim or provision of such insurance

benefit would expose either us or the Insurer to any sanction, prohibition or restriction under United Nations resolutions or any trade, economic, personal or other sanctions, laws or regulations of the European Union, United Kingdom, United States of America and the Republic of South Africa or any other country or political or economic zone.

2. The Insurer has the right to cancel any insurance benefit/policy, section and/or item should we or the Insurer become aware that you, your dependents or beneficiaries are listed on one of the sanctions lists which we or the Insurer are required to screen against.

THE INSURANCE BENEFITS

A. ACCIDENTAL INJURY CASH BENEFIT (ACCIDENT CASH BENEFIT)

1. Specific additional definitions for your accidental injury cash benefit
   - 1.1. **accidental injury** means an injury sustained because of an accident which causes you or any other insured person to be admitted to a hospital by a doctor for a period of 24 hours in a row or more, and which injury could not have been attended to as an out/day patient or at home.
   - 1.2. **additional treatment** means any treatment you or another insured person receives for conditions other than the treatment received or required to be received directly related to the insured event for which you or any other insured person are covered.

2. Important information about your accidental injury cash benefit
   - 2.1. This is not a hospital plan. **THERE IS NO COVER FOR ILLNESS CLAIMS OR HOSPITALISATION FOR ILLNESS.**
   - 2.2. This is **not a medical scheme**. The cover is not the same as a medical scheme and is not a substitute for medical scheme membership.

3. Benefit: accidental injury cash benefit
   We will pay an insured person the daily amount stated in the benefit limits table below, following their admission to hospital for a full day (that is 24 hours in a row), because of an injury caused by an accident (accidental injury).

Benefit limits	Premiums payable to the Insurer
Your maximum benefit limit is **R200,000.00 (two hundred thousand Rand) per insured event**, per insured person. An insured person will be covered for **R2,000.00 (two thousand Rand) per day, for up to 100 days**, for each full day spent in hospital because of an accidental injury. **Who is covered?** 1. **You**, the main member, and **your spouse,** provided that we have your and your spouse's name and date of birth on record. 2. **Children (up to a maximum of 5) and additional dependants (up to a maximum of 3).** If you choose to cover children and/or additional dependants, we require that: • we have their names and dates of birth on record. • children must be under the age of 21 years. All children and additional dependants must be related to you through blood or a legally recognised relationship and they must be totally financially dependent on you i.e. you are responsible for their livelihood.	The premium for you and your spouse is R77.01 per month. The following additional premium/s will be payable for including your: • Children (up to a maximum of 5) - additional R10.22 per month. • Additional dependants (up to a maximum of 3) - additional R25.47 per month for each additional dependant.

• we have received the additional premium/s for all additional lives insured, where applicable. • **Maximum payout (accidental injury cash benefit only).** If you have any other health insurance policies, the maximum daily limit per insured person for hospitalisation for an accidental injury cannot exceed R4,200.00 from all policies combined. We are not liable to pay or contribute more than our pro rata portion of the maximum payable daily limit, subject to the maximum limit provided by this policy, whichever is the lesser.	

4. Waiting periods specific to your accidental injury cash benefit
There is no waiting period for your accidental injury cash benefit.

5. Who will we pay?
We will pay you, by payment into your South African bank account.

6. Compulsory documents/information required for accidental injury cash benefit claims:
PLEASE NOTE: The medical information, in the form of hospital admission forms/hospital records detailing treatment that you need to provide us with, must be obtained by you from the clinic/hospital or the doctor/nurse that treated the insured patient.
   6.1. Completed claim form.
   6.2. Please provide copies of the specific medical information we require to process your claim, as follows:
      6.2.1. The date and time of the insured person's admission into and discharge from the hospital/clinic;
      6.2.2. Contact details of the hospital;
      6.2.3. The final diagnosis of the accidental injury/injuries and the reason for the time spent in hospital;
      6.2.4. All medication and treatment administered to the insured person;
      6.2.5. The details of any procedures the insured person underwent; and
      6.2.6. The long-term prognosis for the insured person's injuries.
   6.3. Where an incident was, or should be, reported to the SAPS, you may have to provide us with a copy of the police or accident report.

7. Specific additional exclusions for your accidental injury cash benefit
   7.1. Please refer to the GENERAL POLICY EXCLUSIONS which will be applicable to this insurance benefit.
   7.2. We will also **NOT** pay any ACCIDENTAL INJURY CASH BENEFIT claim:
      7.2.1. if any injuries are treated in a casualty unit or if injuries are, or should be, treated as an outpatient or a day case at a hospital;
      7.2.2. if additional treatment is required and/or where the treatment of another or underlying medical condition/ complication and/or illness prolongs the stay in hospital e.g. underlying condition of diabetes prolongs an accidental injury admission;
      7.2.3. if the treatment received was only for pain relief, physiotherapy and/or traction, soft tissue injuries including all admissions for the treatment of sprain and

strain injuries;

7.2.4. for any elective or planned medical procedures whatsoever; and

7.2.5. for treatment of mental or psychological conditions; any pregnancy-related treatment or operations.

B. EMERGENCY MEDICAL SERVICES ("EMS")

1. Who provides the emergency medical services ("EMS") benefit?
CIMS SA (Pty) Ltd is the service provider which will provide the EMS benefit.

2. Benefit coverage:

Benefit coverage	Premiums payable to the Insurer
Who is covered? 1. **You**, the main member, and **your spouse,** provided that we have your and your spouse's name and date of birth on record. 2. **Children (up to a maximum of 5) and additional dependants (up to a maximum of 3).** If you choose to cover children and/or additional dependants, we require that: • we have their names and dates of birth on record. • children must be under the age of 21 years. All children and additional dependants must be related to you through blood or a legally recognised relationship and they must be totally financially dependent on you i.e. you are responsible for their livelihood. • we have received the additional premium/s for all additional lives insured, where applicable.	The premium for you and your spouse is R69.46 per month. The following additional premium/s will be payable for including your: • Children (up to a maximum of 5) - additional R6 per month. • Additional dependants (up to a maximum of 3) - additional R6.36 per month for each additional dependant.

3. Benefit: emergency medical services

3.1. **24-hour medical advice and information hotline – telephonic**
Qualified nursing staff are available 24 hours a day to provide general medical information and advice via telephone.

3.2. **24-hour emergency medical advice and assistance hotline - telephonic.**
When you call the telephonic emergency medical advice and assistance hotline, whereby operators will:

3.2.1. guide you through a medical crisis situation;

3.2.2. provide emergency medical advice; and

3.2.3. arrange the support you require via the medical emergency alarm centre.

3.3. **Emergency medical response to the scene of a medical emergency (primary response)**
In the instance of a medical emergency, taking logistical constraints into account (e.g. availability of suitable landing sites and prevailing weather conditions), an appropriate road and/or air response will be undertaken utilising an ambulance, a rapid response vehicle or a helicopter whichever is the most medically appropriate - all of which

are manned by appropriately qualified and experienced emergency care practitioners, paramedics or doctors. Such transport will be despatched to the scene of a medical emergency where appropriate lifesaving support will be provided. If necessary, you will be stabilised before emergency medical transportation is provided.

3.4. **Emergency medical transportation – pre-hospital**
In the event of your involvement in a medical emergency, we will arrange and pay for emergency medical transportation where required. For the avoidance of doubt:

3.4.1. You will be transported to a government hospital (and not a private hospital) in the event that you do not have sufficient and current medical aid cover, or in the event that the emergency medical personnel are unable to establish whether you are a paid-up member of a medical aid, e.g. due to the fact that you are unconscious;

3.4.2. The decision as to whether your circumstances constitute a medical emergency for which emergency medical transportation will be provided shall be in the sole and absolute discretion of the medical personnel in the alarm centre;

3.4.3. The choice of which medical facility you are transported to shall be in sole and absolute discretion of the attending emergency paramedic services. You waive any and all claims against us should you suffer any loss and or damages as a direct or indirect result of the choice of medical facility.

3.4.4. Medical considerations including the degree of urgency, your state and fitness to travel and other relevant considerations including, but not limited to, airport availability, weather conditions and distance to be covered as assessed by the emergency medical alarm centre doctor and support staff will determine whether emergency medical transportation will be provided by medically equipped fixed wing air ambulance, helicopter, scheduled commercial flight or road ambulance.

3.5. **In the case whereby the initial emergency medical transportation was provided by the 24-hour call centre, the following additional benefits are available to the member where applicable and medically justifiable:**

3.5.1. **Inter-hospital transfer:**
After the initial emergency medical transportation, an inter-hospital or inter-facility transfer comprises the one-way transportation by road or air ambulance, whichever is most medically appropriate in the opinion of the emergency medical alarm centre doctor, to a more suitable or appropriate medical facility for managing your condition.

3.5.1.1 **Upgrade transfer:**
If the emergency medical alarm centre doctor, in consultation with your attending doctor, determines that you should be transferred and admitted (one way transfer) to an alternate medical facility (because the necessary treatment cannot be continued at the present facility), the emergency medical alarm centre will arrange and pay for your transportation to another medical facility which is willing to accept you and where treatment can be provided (after you have been stabilised), subject to the limits specified in the benefit table. This service does not include diagnostic transfers for medical procedures or investigations.

3.5.1.2. **Downgrade transfer:**
Transfer to a step-down medical facility will only be approved on a medically justified basis as authorised by the emergency medical alarm centre doctor. This transfer will be to the most appropriate and closest

facility to the medical facility where you are being treated as an inpatient, and is limited to a single transfer per hospitalisation event.

3.5.1.3. **Medical repatriation:**
In the event that you are hospitalised outside your home town, (being a distance greater than 100 km from your ordinary place of residence), the emergency medical alarm centre will arrange and pay, up to the limits specified in the benefit table, for your repatriation to a medical facility in or near your home town provided the provision of such service is, in the sole opinion of the emergency medical alarm centre doctor, regarded as being medically justified (long-term inpatient treatment is required) and that medical supervision is required for such transfer. The means of transportation and timing of the repatriation will be determined at their sole discretion.

3.5.2. **Escorted return of minors:**
In the event of your minor children being stranded as a result of your hospitalisation whereby the emergency medical transportation was provided through the programme, we will arrange and pay for the transportation of the minor children, under supervision where necessary, into the care of a person nominated by you, within South Africa.

3.5.3. **Compassionate visits:**
Should you be hospitalised, whereby the emergency medical transportation was provided through the programme, further than 100kms outside of your ordinary place of residence for a period exceeding five (5) consecutive days, we will arrange and pay up to R2 000 (including VAT) for the economy class transportation of a close relative to visit you.

4. How to access the EMS benefit?

4.1. You must contact the 24-hour call centre dedicated number and provide your membership number, personal particulars, the place and telephone number where you or your representative can be reached and a brief description of the emergency and the nature of the assistance required

4.2. Where you need a medical transfer or relocation you or your representative must inform the 24-hour call centre of the names, addresses and telephone numbers of the treating hospital, the attending doctor and, if available, your family doctor.

4.3. IMPORTANT: If an emergency requires that you are taken directly to a medical facility without first contacting the dedicated 24-hour call centre, you must notify the dedicated 24-hour call centre within 72 (seventy two) hours of the medical emergency having occurred.

4.3.1. If you have a medical aid, the invoice for ambulance transportation will be submitted to your medical aid for payment.

4.3.2. If you do not have a medical aid and you incorrectly receive an invoice from the ambulance service provider despite having contacted the 24-hour call centre, you may submit the invoice to Cims South Africa for reimbursement within 2 (two) months of the date of the medical emergency, together with supporting documentation to: Cims South Africa, PO Box 1468, Sunninghill, 2157.

5. IMPORTANT: when we will not provide you with the EMS benefit

We are under no obligation to provide any services to you in circumstances resulting, directly or indirectly from:

5.1. Services being rendered without the dedicated 24-hour call centre's authorisation or intervention.

5.2. Minor (i.e. non-life threatening) illness or injury which, in the sole opinion of the emergency medical alarm centre personnel, can be

adequately treated locally, by your family general practitioner for example, and which do not require emergency medical transportation.

5.3. Wilful and self-inflicted injury or self-induced illness, as well as insanity, alcoholism, drug or substance abuse or self-exposure to needless peril (except in an attempt to save human life).

5.4. Professional sport or sport undertaken on a national or provincial competitive basis.

5.5. Your commission of, or your attempt to commit, an unlawful act.

5.6. Your active participation in war (whether declared or not), invasion, act of foreign enemy, hostilities, civil war, rebellion, riot, revolution or insurrection nor for any consequence or loss which is a direct result of nuclear reaction or radiation.

5.7. Any events which occurred prior to the receipt by The Unlimited of your first fee payable in terms of this membership agreement.

5.8. Your failure to pay any fee on or before the due date for payment.

6. Specific terms and conditions for your EMS benefit

6.1. If you are transported to a medical facility by another service provider, we will only reimburse you to the limit of the tariffs which we have negotiated with our service providers. You will be liable for any shortfall.

6.2. We may at any time, and at our own cost, institute proceedings in your name to obtain compensation or secure an indemnity from any third party in respect of any loss or injury giving rise to the provision of services by our service providers.

6.3. Neither our service providers, nor their agents and/or employees are liable or responsible for the negligence, whether gross negligence or otherwise, wrongful acts and/or omissions of any person or persons or legal entity which provide direct or indirect services to you in terms of this policy agreement.

C. LIFE COVER: DEATH CASH BENEFIT AND EXTENDED DEATH CASH BENEFIT (PAYMENTS BACK BENEFIT)

1. Specific additional definitions for your death cash benefit and extended death cash benefit (payments back benefit)

1.1. **accidental death** means your death because of an accident. In cases of accidental death, a post-mortem and an inquest are held.

1.2. **acquired immune deficiency syndrome/AIDS** has the meaning given to it by the World Health Organisation and includes, without limitation, Opportunistic Infection, Malignant Neoplasm, Human Immune Deficiency Virus (HIV), Encephalopathy (dementia), HIV Wasting Syndrome or any disease or illness in the presence of a seropositive test for HIV or confirmation of treatment – and regardless whether the illness caused further problems such as tuberculosis, gastroenteritis, multiple organ failure, hepatitis, stroke, immunocompromised system or pneumonia.

1.3. **natural death** means the death of an insured person because of a natural cause such as a medical condition/illness (e.g. cancer, stroke or heart attack).

2. Important information about your death cash benefit and extended death cash benefit (payments back benefit)

2.1. This is **NOT A FUNERAL POLICY**

2.2. **Waiting periods apply**

2.3. You are only covered for death which occurred within of the borders of South Africa.

3. Benefit: death cash benefit

We will pay a lump sum amount on the death of an insured person

from any cause not excluded under the policy, up to the benefit limit as stated in the benefit limits table below.

<table>
<tr><th>Benefit limits</th><th>Premiums payable to the Insurer</th></tr>
<tr><td>
R20 000.00 (twenty thousand Rand) for natural death.

Important: If you choose to cover your children, the benefit limits for children are set to the following sliding scales:
<table>
<tr><th>Age of child/ren</th><th>Benefit limits for natural death</th></tr>
<tr><td>From the day your child is born alive, up to 11 months old</td><td>R2 000.00</td></tr>
<tr><td>Child 1 – 5 years</td><td>R4 000.00</td></tr>
<tr><td>Child 6 – 13 years</td><td>R6 000.00</td></tr>
<tr><td>Child 14 – 21 years</td><td>R8 000.00</td></tr>
</table>
Who is covered?

1. You, the main member, and your spouse, provided that we have your and your spouse's name and date of birth on record

2. Children (up to a maximum of 5) and additional dependants (up to a maximum of 3)

If you choose to cover children and/or additional dependants, we require that:
• we have their names and dates of birth on record.
• children must be under the age of 21 years. All children and additional. dependants must be related to you through blood or a legally recognised relationship and they must be totally financially dependent on you i.e. you are responsible for their livelihood.
• we have received the additional premium/s for all additional lives insured, where applicable.
</td><td>
The premium for you and your spouse is R45.74 per month.

The following additional premium/s will be payable for including your:
• Children (up to a max of 5) – additional R28.79 per month.
• Additional dependants (up to a maximum of 3) – additional R12.72 per month for each additional dependant.
</td></tr>
</table>

4. Benefit: extended death cash benefit (payments back benefit)
We will pay on the death of the main member (you) from any cause not excluded under the policy, up to the benefit limit as stated in the benefit limits table below.

Benefit limits	Premium payable to the Insurer
This amount will be calculated from your first successful premium deduction, up to the last premium successfully received by the Insurer before your death. To be clear, this benefit can only be claimed if you (the policyholder) pass away and not if the policy is terminated for any other reason. Interest is not applicable and will not be paid. **Who is covered?** **You**, the policyholder only. This insurance benefit cannot be claimed if another insured person passes away. Remember, this benefit is only available when the policyholder dies.	The premium is R6.79 per month.

5. Waiting periods specific to your death cash benefit and extended death cash benefit (payments back benefit)
   - 5.1. Claims for your natural death (including natural death resulting from venereal disease, AIDS, or HIV or AIDS-related complications) have the following waiting periods for the event giving rise to the claim:
     - 5.1.1. the waiting period starts from the date we successfully receive your first payment (including the premium) and ends after a minimum of 12 (twelve) payments (including the premium) have been received.
     - 5.1.2. Claims for suicide or any self-inflicted death: the waiting period will start from the date we successfully receive your first payment (including the premium) and ends after a minimum of 24 (twenty-four) payments (including the premium) have been received.
     - 5.1.3. There is no waiting period if your death is caused by an accident (accidental death).

6. Nominated beneficiaries

You must nominate a beneficiary when you take out the policy. A nominated beneficiary is any one person who we will pay in the event of your (the main member's) death. Your nominated beneficiary does not need to be someone who is insured under this policy, it is the person you choose to receive the benefit payout in the event of your death. It is your responsibility as the main member to advise us of your nominated beneficiary, including his/her identity number, contact details and date of birth, and any changes you make in this regard. You may change your beneficiary any time prior to a death claim for you, the main member, by notice in writing or by contacting us telephonically. This is the only way to nominate or change a beneficiary after you have taken out this policy. No testamentary instrument (e.g. a Will) will change the beneficiary you have nominated. If no beneficiary has been nominated or none is alive when you die, the insurance benefit will be paid as set out in this insurance benefits section. Only one beneficiary can be nominated at any one time.

IMPORTANT: please ensure that your nominated beneficiary, your spouse and your family members are aware of the insurance benefits and how they can claim in the event of your death.

IMPORTANT: **it is only in the event of the main member's death (your death) that the nominated beneficiary will be paid. In all other claims you, the main member, will be the claimant and the beneficiary.**

7. Who will we pay?
   7.1. We will pay you, by payment into your South African bank account, from which we have collected the payment (including the premium).
   7.2. If you, the main member, have died and there is a claim approved for your death, we will pay the proceeds of a valid claim to:
      7.2.1. The nominated beneficiary, if you have nominated such beneficiary. You must provide us with the details of your nominated beneficiary prior to your death. At time of claiming we will require proof of their identity (Certified copy of ID) and proof of their South African bank account which also reflects their residential address and including other information that we may require to ensure that the correct person is paid and that they do not appear on a sanctions list; or
      7.2.2. the claimant, where you have not nominated a beneficiary, or failed to provide us with all the information of a beneficiary. The claimant is:
         7.2.2.1. your recognised spouse. We will require proof of their identity, residential address, proof of their South African bank account and status (for example: ID book, proof of marriage, proof of cohabitation or interdependency); or
         7.2.2.2. The executor of your estate (letters of executorship will be required); or any claimant that has a Letter of Authority to claim, provided they can verify their identity (for example, ID book and letters of executorship/authority). We will also require proof of the late estate South African bank account details, into which the claim will be paid.
         Please note: We will need to conduct screening on beneficiaries and claimants in compliance with money laundering legislation prior to making claim payments.

8. Compulsory documents/information required for your death cash benefit and extended death cash benefit (payments back benefit)
   8.1. Completed claim form
   8.2. Copies of:
      8.2.1. Deceased's ID (Certified copy).
      8.2.2. Death certificate (Certified copy).
      8.2.3. Notification of death form, completed by a doctor (otherwise called a DHA-1663/DHA-1680 form).
      8.2.4. Police report (for accidental death claims only).
      8.2.5. Motor vehicle accident report, (motor accident death claims only).

IMPORTANT: STATUTORY NOTICE OF DISCLOSURES AND OTHER LEGAL REQUIREMENTS (IN TERMS OF THE FINANCIAL ADVISORY AND INTERMEDIARY SERVICES ACT "FAIS")

As an insurance policyholder, you have the right to the following information:

DETAILS OF THE INTERMEDIARY

(the binder holder)

Company Name:	The Unlimited Group (Pty) Ltd (The Unlimited)
Physical Address:	No. 3 The Boulevard, Westway Office Park, Intersection of Spine Road and The Boulevard, Westville, KwaZulu-Natal, South Africa, 3610
Postal Address:	Private Bag X7028, Hillcrest, 3650
Telephone Number:	0861 990 000
Fax Number:	0865 009 307
Email Address:	info@theunlimited.co.za
Website:	www.theunlimited.co.za
Company Registration Number:	2002/002773/07
FSP License Number:	21473
VAT Number:	4360161139
Details of FAIS Compliance:	Moonstone Compliance
Compliance Officer:	Ms CL Payne
Postal Address:	25 Quantum Street, Technopark, Stellenbosch, 7600
Telephone Number:	021 883 8000
Fax Number:	021 883 8005
Email Address:	cpayne@moonstonecompliance.co.za

a.	**Conflict of interest**	In accordance with our conflict management policy, we place a high priority on our customers' interests. We will try to identify, manage and as far as reasonably possible avoid any such instances. Our "Conflict of Interest" policy is available on our website at www.theunlimited.co.za.
b.	**Cooling-off rights**	As this is a month-to-month policy (duration of less than 31 days), a cooling-off period in terms of the Policyholder Protection Rules is not required. We do, however, offer the following cooling-off rights: If there has been no insured event and no benefit has yet been claimed or paid, you have the right to cancel the policy by giving us written or telephonic notice within 31 days of you receiving this Statutory Notice of Disclosures OR from a reasonable date on which it can be deemed that you received this Statutory Notice of Disclosures. The Insurer will comply with your request for cancellation within 31 days of receiving your cancellation notice and will refund all premiums or moneys paid by the premium-payer provided there has been no claim.
c.	**Insurance cover**	The Unlimited holds professional indemnity and fidelity insurance.
d.	**Intermediary services**	The Unlimited does not provide advice as defined in the FAIS Act, we only provide factual information. To ensure that you make a financial commitment to a product that is appropriate to your needs, as determined by you, you must request all the necessary documentation and information you feel necessary for you to make an informed choice before you make a final decision.

e.	**Written mandate to act on behalf of the insurer**	Yes, The Unlimited acts as a non-mandated intermediary in terms of a Binder Agreement with the Insurer. The Unlimited earns binder fees in respect of the binder functions and incidental activities undertaken on behalf of the Insurer.
f.	**Whether more than 10% of the insurer's shares are held or whether more than 30% of total remuneration was received from the Insurer**	The Unlimited does not hold more than 10% of the Insurer's shares and has not received more than 30% of the total remuneration from one insurer in the preceding calendar year. The Unlimited is not an associate company of the Insurer.
g.	**Waiver of rights**	The law does not allow a financial services provider to request or induce in any manner a customer to waive any right or benefit conferred on them in terms of legislation, nor allow a financial services provider to act on any such waiver. Any such waiver is null and void.
h.	**Financial Intelligence Centre Act (FICA)**	Please note that in terms of the Financial Intelligence Centre Act, the Insurer as well as The Unlimited, are obliged to report suspicious and unusual transactions that may facilitate money laundering to the authorities. We also conduct sanctions screening to ensure that we are not conducting business with individuals who appear on sanctions lists. If you are a Domestic Prominent Influential Person or a Foreign Prominent Influential Person in terms of the FICA Act please let us know by calling our call centre.
i.	**Legal status**	The Unlimited is an authorised financial services provider (FSP21473). License limitations: • We must inform the Registrar of any business information change within 15 days. • We must maintain a list of all our Key Individuals and Representatives, and we must provide a copy of the register to the Registrar. • We accept responsibility for services provided by our representatives, whilst acting in the scope of their employment/contracts and confirm that some services are rendered under supervision – please refer to the FSCA's webpage to view a full list of our representatives. Steps to follow: 1. Go to www.fsca.co.za 2. Click on "Regulated Entities" 3. Under the heading "Regulated Entities and Persons" click on "FAIS" 4. Click on "Financial Service Providers" 5. Insert our FSP Number 21473 in the field "Search for FSP No" 6. Click on "Details" and select the information that you wish to view. • We may not provide business under a license that has not been changed in accordance with the provisions of the FAIS Act. • Our insurance products must qualify as financial products, as contemplated by the FAIS Act. We are licensed to provide intermediary services in respect of Category 1, Long-Term Insurance Sub-categories A, B1, B2, B1-A, B2-A and Short-Term Insurance Personal Lines (A1), Short-Term Personal Lines A1 and Short-Term Insurance Commercial Lines.

DETAILS OF THE INSURER

(that underwrites the insurance benefits, and which is a licensed life insurer and an authorised financial services provider)

Company Name:	Centriq Life Insurance Company Limited
Physical Address:	The Oval, Second Floor, West Wing, Wanderers Office Park, 52 Corlett Drive, Illovo, 2196
Postal Address:	PO Box 55674, Northlands, 2116
Telephone Number:	011 268 6490
Fax Number:	011 268 6495
Website:	www.centriq.co.za
Company Registration Number:	1943/016409/06
FSP License Number:	7370
VAT Number:	4310210481
Details of internal Compliance Department:	
Telephone Number:	011 268 6490
Email Address:	compliance@centriq.co.za

HOW TO SUBMIT A COMPLAINT

Step 1: Initial Complaints Process

If you have a complaint about this policy or our service in general, you can write to us at info@theunlimited.co.za or call our Customer Care line on 0861 990 000/ 031 716 9600 or fax us on 0865 009 307. Please view our full Complaint Process on www.theunlimited.co.za

Step 2: Dispute Resolution Process

Should the outcome of your complaint not be in your favour, then you have the right to request The Unlimited to have the matter reviewed.
We will notify you of the name and contact details of The Unlimited representative that will be tasked to facilitate the dispute resolution process; and
When a decision has been reached you will be provided with the outcome of such decision together with reasons.

Step 3: Representation to the Insurer

Should you not be satisfied with the outcome of your dispute resolution by The Unlimited, and feedback is provided that is not in your favour, you may make representation to Centriq Life Insurance Company Limited by addressing your concerns to:

The Complaints Specialist:	
Telephone:	011 268 6490
Email Address:	complaints@centriq.co.za

Step 4: External Dispute Resolution

We encourage clients to endeavour to resolve a complaint with us and/or the Insurer first, before submitting a complaint to the relevant Ombudsman. However, you may use any of the channels provided as you see appropriate.
If you remain unsatisfied or if our feedback provided to you is not in your favour, then you have the right to have the decision/process reviewed by an authorised external party being:

National Financial Ombud Scheme

Cape Town physical address:	Claremont Central Building, 6th Floor, 6 Vineyard Road, Claremont, 7700
Johannesburg physical address:	110 Oxford Road, Houghton Estate, Illovo, Johannesburg, 2198
Share call number:	0860 800 900
Email Address:	info@nfosa.co.za
Website:	www.nfosa.co.za

The Financial Advisory and Intermediary Services (FAIS) Ombudsman
If you are not satisfied with the way the product was sold to you or the disclosures that were made to you, you may submit your complaint in writing to the FAIS Ombud at:

Postal Address:	PO Box 41, Menlyn Park, 0063
Physical Address:	Menlyn Central Office Building, 125 Dallas Avenue, Waterkloof Glen, Pretoria, 0010
Telephone Number:	012 762 5000
Sharecall:	086 066 3274
Email Address:	info@faisombud.co.za
Website:	www.faisombud.co.za

The Financial Sector Conduct Authority (FSCA)

Postal Address:	PO Box 35655, Menlo Park, 0102
Physical Address:	Riverwalk Office Park, Block B, 41 Matroosberg Road (Corner of Garsfontein and Matroosberg Roads), Ashlea Gardens, Extension 6, Menlo Park, Pretoria, 0081
Telephone Number:	012 428 8000 or 0800 203 722
Website:	www.fsca.co.za

OTHER IMPORTANT MATTERS

- You must be informed of any material changes to the information in this notice. If the information was given orally, it must be confirmed in writing within 31 days.
- If any complaint to The Unlimited or the Insurer is not resolved to your satisfaction, you may submit the complaint to the National Financial Ombud Scheme or the FAIS Ombud.
- If your premium is paid by means of debit order, it may only be in favour of one legal entity or person and may not be transferred without your approval.
- Unless you commit fraud, the Insurer must give you at least 31 days' notice in writing of its intention to cancel cover.
- The Insurer must give reasons for rejection of your claim.
- The Insurer may not cancel your insurance merely by informing The Unlimited. There is an obligation to make sure that the notice has been sent to you.
- You are entitled to a copy of the policy documents and copy of the voice log of the sale free of charge.
- Polygraphs or similar tests are not obligatory, and claims may not be rejected solely based on a failure of such test.
- Should you have any complaints about the availability or adequacy of the information we have given you, please let us know on 0861 990 000.
- Your policy documents contain the name, class and type of policy, special terms and conditions, exclusions, waiting periods, as well as details of procedures to follow in the event of a claim. Should anything not be clear, please contact The Unlimited on the numbers provided above.

WARNING

- Do not sign any blank or partially completed application forms.
- Complete all forms in ink.
- Keep all documents you receive.
- Make a note of what was said to you.
- Don't be pressurised to buy the product.
- Incorrect or non-disclosure by you of material facts may have a negative impact on the assessment of a claim under your policy.

TREATING THE CUSTOMER FAIRLY (TCF)

We are committed to ensuring that all our customers are treated fairly and that every member of our team understands what TCF means to our business. Being a brand-led business means that we put the customer at the centre of everything we do. The systems and processes we have put in place ensure that all of our customers are treated fairly at every interaction.

We only partner with and select suppliers of benefits and services that are able to demonstrate their respect in treating customers fairly and they uphold the

TCF principles for all interactions of the customer relationship for which they are responsible. It is important that they are in alignment and agree to our TCF objectives in every interaction that they may have with our customers.

HOW WE USE YOUR PERSONAL INFORMATION

Please read this section carefully as it contains important information about the personal details that you have given to us. Please make sure that you provide this section of the Statutory Notice of Disclosures to any other party related to this insurance as it contains information about the protection of your, as well as their personal information. Information about the parties to this policy (agreement) or persons whose interests are protected by this agreement may be processed for the various legal reasons outlined below.

This section of the Statutory Notice of Disclosures is intended to summarise key privacy disclosures. We handle the personal information you provide to us in accordance with this section, read with the Privacy Policy available at: www.theunlimited.co.za

The policyholder ("**you**") hereby warrants and understands that we, including our authorised agents, partners and service provider/contractors may:

1. Collect information:
   - 1.1. from you directly; from your use of our products and services; from your engagements and interactions with us; from public sources, shared databases and from third parties.
   - 1.2. That you provide to us and store it in a shared database, verify it against legally recognised sources and use it, for example, for any decision concerning the continuance of your agreement/policy or the meeting of any claim you submit. Such information may be given to any insurer or its agent and authorised agents, partners and service provider/contractors.
   - 1.3. including (amongst others), information about your criminal or credit history, insurance history, marital status, national origin, age, sex, sex life, language, birth, education, financial history, identifying number, email address, physical address, telephone number, online identifiers, social media profile, health, disability, pregnancy, biometric information (like fingerprints, your signature or voice), race or ethnic origin, trade union membership, political persuasion, financial history, criminal history and your name.
   - 1.4. that you warrant you are authorised to provide to us in respect of personal information of third parties. In doing so you indemnify us, including our authorised agents, partners and service provider/ contractors, against any and all losses by or claims made against them and us as a result of you not having the required authorisation.

2. Process your information for the following reasons (amongst others):
   - 2.1. to enable us to underwrite policies and assess risks fairly, for the performance of your insurance agreement and the enforcement of our contractual rights and obligations:

     Note: Any personal information provided to us, including sensitive health information and that of minor children, will be collected and used to allow us to fulfil our obligations to you in terms of this agreement and to assess risks fairly. In addition, the Personal Information may be shared internally with our departments (who need this information) or externally with third parties to comply with insurance obligations or legal requirements or in the exercise of our rights. Please contact us should you have any objections.

   - 2.2. to comply with legislative, regulatory, risk and compliance requirements, codes of conduct and industry agreements or to fulfil reporting requirements and information requests.
   - 2.3. to process payment instruments and payment instructions (like a debit order).

2.4. to do affordability assessments, credit assessments and credit scoring.
2.5. to manage and maintain your agreement/policy or relationship with us.
2.6. to disclose and obtain information about you from credit bureaus regarding your credit history.
2.7. to enable you to participate in the debt review process under the National Credit Act 34 of 2005.
2.8. for security, identity verification and to check the accuracy of your information.
2.9. where required, we may transfer your personal information outside of South Africa in compliance with the law.
2.10. for customer satisfaction surveys, promotional and other competitions.
2.11. using automated means (without human intervention in the decision-making process) to make decisions about you or your application for any product or service. You may query the decision made about you.
2.12. to conduct market and behavioural research, including scoring and analysis to determine if you qualify for products and services; and to market to you or provide you with products, goods and services. If you purchase products or services from us, we can market other similar products and services to you even after this agreement ends and share market innovations with you.
2.13. Payment of the premium also entitles you to be notified of further product offerings as well as preferential pricing if you buy additional benefits from us.

3. Share your information with the below persons (amongst others) who are bound to keep it secure and confidential:

▪ Attorneys, tracing agents, & debt collectors when enforcing agreements	▪ Debt counsellors & payment distribution agents during any debt review process
▪ Payment processing service providers, merchants, banks to process payment instructions	▪ Insurers and other financial institutions when providing insurance or assurance
▪ Our partners, service providers, agents, sub-contractors to offer and provide products and services to you	▪ Regulatory authorities, ombudsman, governments, local and international tax authorities & credit bureaus when we must share it with them

4. The Unlimited automatically updates and keeps your information accurate
We may submit your information to, and receive information about you from, credit institutions (such as credit bureaus) to update, process and monitor your information to guide us in making decisions about product development and suitability of offerings, affordability, market conduct and activities related to our business. We may also do this to ensure the quality and accuracy of your identity and contact information to ensure we can make positive contact with you; and your status as a home loan holder, vehicle owner or credit card holder to offer suitable goods and services to you that are affordable and that you may be interested in.

5. Your rights:
You have data protection rights which are described in detail on www.theunlimited.co.za. To request access to your information, contact us at the contact details provided above