TERMS AND CONDITIONS

The Unlimited Medical Insurance

CONTENTS PAGE

KEY INFORMATION AND DISCLOSURE DOCUMENT ("KID DOCUMENT")

This document contains important information about the policy as required by Rule 11(5) of the Policyholder Protection Rules, please make sure that you read and understand it.

Please keep this document together with your policy wording and if you have any questions, please contact us.

Please note:

- This document serves as evidence of the fact that you have agreed to the cover provided in the policy.
- Although the policy is offered to you by **The Unlimited**, the insurer providing you with the policy benefits is **Bryte Insurance Company Limited (the "insurer")**, a licensed non-life insurer and an authorised financial services provider.
- The underwriting managing agent (the **"UMA"**) which determines the premium for the policy and manages the claims on behalf of the insurer is **Unity Health, a division of Ambledown Financial Services (Pty) Ltd** , an authorised Financial Services Provider.
- You can get in touch with us at any time by calling us on **0861 990 000**, or on our website www.theunlimited.co.za.
- You have been provided with your policy terms and conditions which explain how the policy works, as well as general and special limitations and exclusions, details of the insurer, the premiums payable, and other requirements and rules that form an integral part of the agreement between you and the insurer.
- **Please make sure that you read the full terms and conditions, and if you have any questions, please call us.**

Below is a summary of key information. For comprehensive information, always refer to your full policy terms and conditions:

a.	**The type of policy that you have**	• Your policy is a non-life insurance policy. • This is not a medical scheme and the cover is not the same as that of a medical scheme, nor is it a substitute for medical scheme membership.
b.	**When your policy benefits will be available**	On receipt of your first premium, The Unlimited will pay the insurer the first premium and your policy will start on the first day of the next calendar month (the "start date"). You are entitled to your policy cover from the start date and to claim benefits if an insured incident occurs, however, if there is a waiting period, you or any person insured, will not have cover until the waiting period has ended. Please note: the insurer reserves the right to pro-rate each insured person's policy benefits during their first calendar year of cover under the policy. This is a month-to-month policy. It will renew on the same terms each time The Unlimited successfully collects your premium from you.
c.	**Cancellation of your policy**	You may cancel your policy by contacting The Unlimited and giving us 31 (thirty-one) days' notice of your intention to cancel. The Unlimited will request cancellation of the policy with the insurer on your behalf. You can contact us on 0861 990 000, The insurer may also cancel your policy in writing: • immediately for fraudulent or dishonest actions, including non-disclosures • for non-payment of premiums (subject to the 15-days grace period) • for any other reason after 31 days' notice to you

d.	**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 policy benefit has yet been claimed or paid, you have the right to cancel the policy by giving us written or telephonic notice within 14 days of your terms and conditions being sent to you OR from a reasonable date on which it can be deemed that your terms and conditions were sent to you. The insurer will comply with your request for cancellation within 31 days of receiving your cancellation notice and will refund all premiums or monies paid by the premium-payer, minus any cost of any risk cover enjoyed.
e	**Premium payable**	Please refer to your benefit schedule for all premiums payable under your policy. Please remember that all child/ren that you choose to cover on your policy must be a member of your family through blood or by a recognised legal relationship and totally financially dependent on you. This means that from the date you add a child to this policy and throughout the lifetime of this policy, you (the main member) are totally responsible for the livelihood and support of the insured child and pay for their food, medicine, shelter, money, education and clothing. Premiums are reviewed every year in January (the start of each calendar year). Increases may be due to inflati von/market/claim experience. There may be a necessary interim increase during the calendar year hould changes in claims experience or utilisation require it, however, The Unlimited will always give you 31 days' notice of any increase to your premium.
f.	**How and when your premiums must be paid**	Your premium (which forms part of your payment to The Unlimited) is paid monthly in advance on the due date you agreed with The Unlimited (on your call log or application document). The premium will be paid by debit order using the bank account details you provided to The Unlimited. To ensure you are always covered under the policy and to avoid cancellation and unpaid debit order costs, please make sure you have sufficient funds in your account. IMPORTANT: The Unlimited may debit your premium on a different date from the day agreed if there is a better chance of collecting the premium and keeping you covered. You will find further details under the section "**PAYMENT AND NON-PAYMENT OF YOUR PREMIUM**" in your policy wording. REMEMBER: If the due date falls on a public holiday or a weekend, the premium will be collected on the first business day before or after the due date.
g.	**December collections of premiums**	In December, The Unlimited may collect your premium on an earlier date than your standard due date and they will give you 31 days' notice of their intention to do so. The earlier debit date usually falls during the first or second week of December, e.g. by the 7th of December.

h.	**What happens if you do not pay your premiums**	If you do not pay your premium as agreed, and subject to the grace period (see below), your policy will be suspended and you will not have access to your policy benefits until you have paid The Unlimited ALL missed premiums. Please contact The Unlimited on 0861 990 000 for assistance with manual payments. The grace period is 15 (fifteen) days and it is calculated from the payment collection (due) date. If you miss a payment, you will have a 15-day grace period within which to make a manual payment to The Unlimited. During the grace period, the policy benefits will remain in force and you will remain covered as long as you make a manual payment to The Unlimited. If The Unlimited does not receive payment within the 15-day grace period, your policy will be suspended and you will not have access to your policy benefits until you have paid The Unlimited ALL missed premiums. The grace period applies from the second month of cover.
i.	**Remuneration**	From the total premium you pay, the insurer pays: • Ambledown Financial Services (Pty) Ltd a monthly binder fee of 25% of the premium for services performed on behalf of the insurer. • The Unlimited a monthly commission not exceeding 20% of the premium for intermediary services performed on behalf of the insurer
j.	**Nature & extent of your policy benefits**	Subject to the terms and conditions in your policy wording and benefit schedule, which was sent to you when you took out this policy, your policy benefits are: **Primary Health Care And Wellness Policy** • Primary care benefits • Primary care optional benefit: GP pre-authorisation waiver (only if you have chosen to add this benefit to your policy) • Wellness programme benefits **Hospital Care Policy** • Hospital care benefits For details on the above benefits, benefit specific terms, conditions and overall benefit limitations, please see "**THE POLICY BENEFITS**" and "**TABLE OF POLICY BENEFITS**" in your policy wording.
k.	**Waiting periods**	A waiting period means the specified period following the start date of the policy during which no benefits are payable under the terms of the policy. The waiting periods apply to you and your dependants. An insured person will have the following waiting periods, starting from the start date applicable to that insured person, subject to all premiums being successfully received by the insurer: • a **2 (two) calendar month** waiting period applies to all policy benefits (unless otherwise stated in "**THE POLICY BENEFITS**" section of your policy wording); • if an insured incident occurs because of an emergency, you are covered for the hospital care benefits from the start date of the policy; • a **12 (twelve) calendar month** waiting period applies to the chronic benefit and the basic optometry benefit; • a **9 (nine) calendar month** waiting period applies to the pre-birth maternity benefit. • Underwriting periods from a previous policy will be carried over to the new policy if they are still active, provided there is no break in cover exceeding 90 days. If the break exceeds 90 days, full underwriting will apply to the new policy.

I.	**Exclusions on the policy**	The exclusions are specific items, losses or events that are not covered by this policy. Below is a list of the general exclusions on the policy. 1. Routine, follow-up, and administrative exclusions: • Routine physical examinations or diagnostic tests performed when there are no clinical symptoms or objective signs of a health problem. • Diagnostic procedures such as x-rays or laboratory tests, unless related to a medical condition or disability confirmed by a prior consultation with a practitioner. • Follow-up treatment for the same symptoms within three (3) days of the initial consultation. • Follow-up consultations with specialists. • More than three (3) consecutive consultations for the same diagnosis (ICD-10 code), unless there is documented clinical justification. • More than one consultation per day with a general practitioner, nurse, or virtual consultation for the same insured person. • Procedures performed by a practitioner that is not listed under the approved tariff code descriptions. • Telephonic consultations; • Costs that the UMA's clinical review team determines to be: o not medically necessary or appropriate for the insured person's condition; o inconsistent with accepted treatment type, frequency, or duration; • All clinical or medical reports required for claims that are under review; • Casualty follow-up consultations. • Any follow-up treatments required 3 (three) months from the date of discharge. • Procedures that are planned in advance and are not related to an insured incident. • Revision or corrective surgeries related to an earlier surgery that was covered by this policy. • Any medical transportation service for non-emergency purposes and any medical transportation not performed by ER24 without prior authorisation. • Any policy benefit requiring pre-authorisation where such pre-authorisation was not obtained before the procedure or treatment. 2. Exclusions based on medical conditions or treatments: • Investigations, treatments, or surgery for obesity or any medical condition directly or indirectly caused by or related to obesity. • Treatments for artificial insemination, infertility, or contraception. • Supply of medication that is not listed on the UMA's medicine formulary. • Cosmetic surgery or surgery directly or indirectly caused by, related to, or resulting from the insured incident. • Robotic surgery, specialised mechanical or computerised appliances or equipment, or any related service providers. • Any accident where the initial incident occurred before the insured person's commencement date on this policy. • Events not directly related to an accident or emergency as defined. • External prostheses or appliances such as artificial limbs.

- Contact lenses.
- Optometry or dentistry benefits claimed in the final month of cover under the policy, regardless of the duration of the policy.

3. Conduct and lifestyle-related exclusions:
   - Suicide, attempted suicide, or self-inflicted injuries, unless sustained in an attempt to preserve another human life.
   - Failure to follow medical advice or adhere to prescribed treatment.
   - Use of any drug or narcotic unless prescribed and taken as directed by a practitioner, as well as drug addiction treatment and rehabilitation services.
   - Any illness or event caused by or related to the use or use of alcohol.
   - Reckless or negligent acts or omissions by the insured or anyone acting on their behalf, including failure to take reasonable precautions to prevent or minimise harm.
   - Participation in:
     - active military duty, police duty, or police reservist duty;
     - aviation activities other than as a passenger on a licensed commercial flight;
     - any race or speed contest or activity involving non-mechanically propelled vehicles; and/or
     - professional or hazardous sports or activities (any pursuit or activity where it is recognised that there is an increased risk of injury or a sport or activity where one receives monetary compensation).
4. Employment-related exclusions:
   - Injuries sustained on duty or injuries directly or indirectly related to the insured person's work activities, including accidents and repetitive strain injuries.
5. High-risk, political, or uninsurable incidents:
   - Any claims arising from:
     - nuclear weapons, nuclear material, ionising radiation, or radioactive contamination (including nuclear fuel combustion and fission);
     - war, hostilities, civil war, mutiny, or warlike actions, whether declared or not;
     - military uprisings, insurrections, rebellions, revolutions, martial law, or related enforcement;
     - participation in civil unrest, including but not limited to riots, strikes, lockouts, labour disturbances, or public disorder;
     - acts intended to overthrow or influence any government or authority by violence, terrorism, intimidation, or fear;
     - acts aimed at causing political, economic, or social change, or inspiring fear in the public;
     - illegal activities;
     - loss, damage, cost, liability, expense, or consequential loss of any kind, directly or indirectly caused by, resulting from, arising out of, or in connection with an interruption, failure, interference, or suspension of the electricity supply to the South African national electricity grid, regardless of the reason for the interruption, including but not limited to damage to infrastructure, the inability or failure (whether partial or total) of any utility provider to generate, transmit or distribute electricity, or any other cause
     - other causes or incidents that are not insured or are specifically excluded under this policy

m.	**How to claim**	All treatment for an insured incident MUST be provided by a network service provider ("SP"), unless otherwise stated under the "**TABLE OF POLICY BENEFITS**" section in your policy wording. Please call 0861 990 000 for a list of our network service providers. Unity Health (the "UMA") administers the claims on behalf of the insurer. They settle claims in two ways: • directly to the service provider; or • as a reimbursement to an approved claimant. Please check each policy benefit under the "**TABLE OF POLICY BENEFITS**" section in your policy wording to see if pre-authorisation is required before you receive any treatment. • If pre-authorisation is required, please call **0861 990 000** before receiving any treatment or advice from a network SP. • If pre-authorisation is not required, you may proceed with treatment from a network SP. Where a claim requires the UMA to reimburse you (or any other approved claimant), you agree to, call or WhatsApp us on **0861 990 000** to request a **reimbursement form. You must notify the UMA of your claim by sending them your completed reimbursement form within 120 (one hundred and twenty) days** from the date of the insured incident. All supporting claim documents will need to be sent back to the UMA, as reasonably required by the UMA, **within 12 (twelve) calendar months** from the date of the insured incident. Important, please ensure that all documents and information requested is comprehensive and complete so that the UMA can finalise your claim. **If you do not provide all the required information, the UMA will close the claim.** All costs incurred for claiming your policy benefits or submitting claim documentation are for your account. This includes clinical reports for claims that are under review.
n.	**The assessment of risk based on the information you provided to us**	The information you have provided us with is considered material to our assessment of the risk, so it must be accurately and properly disclosed. The accuracy and completeness of all answers, statements or other information provided by or on behalf of you is your responsibility.
o.	**Your obligation to keep the information you have with us updated**	It is important to keep all the information you have recorded with us (including the details of your spouse and children) updated. Please contact The Unlimited to update your details, to get further information about your cover and to check that your chosen dependants qualify for the cover under this policy. If you add people that do not qualify, it could lead to a claim being repudiated or cover voided.
p.	**How we will communicate with you**	Our main method of communication with you will be by SMS or WhatsApp to the cellphone number you have given to The Unlimited or by email to the email address you have provided. This is also the agreed method of giving you any notice required by this insurance policy or by law.

PRIMARY HEALTH CARE AND WELLNESS PROGRAMME POLICY WORDING

OPERATIVE CLAUSE

In consideration of, and conditional upon, the prior payment of the premium by the policyholder; and the acceptance thereof by or on behalf of Bryte Insurance Company Limited (the "insurer"), the insurer agrees to pay the **POLICY BENEFITS** for an insured person, for an insured incident occurring during the period of insurance, up to the limit of indemnity and policy benefits, as stated in the policy and your benefit schedule.

IMPORTANT, PLEASE READ CAREFULLY

1. Please note: this policy wording, together with any declaration you have made, and your benefit schedule (which was sent to you separately when you took out this policy), constitutes the agreement between you, the Underwriting Managing Agent ("UMA"), the insurer and The Unlimited (the "policy"). Your use of the policy benefits is always subject to the terms and conditions, as contained in this policy wording, any declaration you have made and your benefit schedule, as well as any statutory notices, amendments, endorsements and addendums issued by us in terms of your policy; and must be read together with, and shall form a part of, the policy.
2. This policy is issued to you at your own request and without The Unlimited providing you with any advice, they only provide factual information. Please read it carefully and ensure that it is appropriate for your needs. Please review your cover regularly to ensure that it remains accurate and appropriate. If not, please contact The Unlimited. Please see the "**CANCELLATION OF YOUR POLICY**" section below. If this policy, or any part of this policy, is replacing an existing policy or any part of an existing policy you have, make sure that you have carefully compared the insurance premiums, policy benefits and terms and conditions.
3. By agreeing to the cover under this policy, you and all insured persons indemnify and hold The Unlimited, Unity Health (the "UMA") and Bryte Insurance Company Limited (the "insurer") harmless from any liability, costs or expenses arising from the failure to provide services and/or the provision of defective services by any practitioner and/or SP (including emergency services as well as hospital providers).
4. This policy takes precedence over any conflicting information, whether found in any form of marketing collateral, promotional material, or verbal communication. In the event of discrepancies between this policy and any other sources of information, the terms and conditions outlined in this policy shall govern and override all other representations, unless explicitly stated otherwise in writing.
5. **This is not a medical scheme, and the cover is not the same as that of a medical scheme. This policy is not a substitute for medical scheme membership.**

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 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, the UMA and the insurer ("us") honest and accurate information at all times. If you give us false or incorrect information, your policy may be invalid or you may not be covered.

In the event of any fraud, misdescription, misrepresentation, exaggeration or non-disclosure of material facts, we reserve the right, at any time, to void your policy or parts thereof, cancel your policy or reject any benefit claim.

If the insurer, the UMA 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.

Please note: in the event that we are unable to successfully verify your identity, we will void your policy from the start date and there will be no agreement between you and us - this means that your policy never started. You will have no cover under the policy benefits.

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

Please note: where age is mentioned in this policy, it will be the age at last birthday; and when we refer to "you/your" in the policy wording, it includes any dependant (child and/or adult dependant, as defined) you have chosen to add to your policy (where relevant).

Subject to all the terms and conditions of this policy:

1. **accident** means a sudden external, violent, unexpected and visible event which occurs at a time and place that can be identified and results in an insured person suffering bodily injury (injury to the body caused by an accident, and excludes sickness or disease).
2. **adult dependant** means:

   2.1 **your spouse/partner.** Your **spouse/partner** means a person to whom you are married by civil law, tribal custom or in terms of any religion, including your life partner. Your spouse or life partner must normally live with you in South Africa and you must be interdependent on each other. When we use the word "partner", we refer to your spouse (as described above) or your life partner, whomever is named on your policy. Or;

   2.2 **your child/ren who have attained the age of 21** (twenty-one) ("**adult child**"), but who are still totally financially dependent on you. This means that from the date you add an adult child to this policy and throughout the lifetime of this policy, you (the policyholder) are totally responsible for the livelihood and support of your adult child/ren and pay for their food, water, medicine, shelter and clothing. Your **adult child/ren** means your biological children, stepchildren, adopted children or children who are related to you by blood or a legally recognised relationship, who are over the age of 21 (twenty-one) years. Or;

   2.3 **your parent/s. Parent/s** means your parent/s and/or your legally recognised parent/s-in-law.

   You must provide The Unlimited with the name, surname and dates of birth of all your adult dependants and they must all be on record to be covered under this policy. Failure to provide The Unlimited with your adult dependant/s' details can result in the rejection of a claim, or the insurer voiding the policy or parts thereof.

   PLEASE NOTE: any adult child above the age of 26 (twenty-six) may need to provide a medical report to establish dependency before any policy benefit claim for an adult child will be approved and paid.

3. **benefit schedule** means the separate document which is sent to you when you buy benefits from The Unlimited. Please refer to your benefit schedule for the details of your benefits, including the premiums payable to the insurer for your policy benefits.
4. **child/ren** means your biological children, stepchildren, adopted children and children who are related to you by blood or a legally recognised relationship. **Your child/ren must be under the age of 21** (twenty-one) and totally financially dependent on you. 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.

   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.
5. **dependant/s** means:

   5.1 your child/ren (as defined); and/or

   5.2 your adult dependant/s (as defined).
6. **chronic condition** means a health condition where an insured person, who is registered with the UMA for chronic benefits, requires ongoing medical attention and management over an extended period of time, as specified in this policy.
7. **chronic disease treatment plan** means allocated benefits for the treatment, the diagnosis, the medical management and the medication of a registered chronic condition.
8. **due date** means the date you have agreed with The Unlimited for the debit order collection of your premium every month.
9. **emergency** is an event of a sudden and, at the time, unexpected onset of a health condition that requires immediate treatment, where failure to provide treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ, body part or would place the insured person's life in jeopardy.

10. **family** means the policyholder and all dependants (as defined) on the policy, provided they are insured persons.
11. **hospital/medical facility** means any institution in the Republic of South Africa which, in the opinion of the insurer, meets each of the following criteria:
    11.1 has a diagnostic and therapeutic facility for surgical and medical diagnosis treatment and care of persons in need of medical attention by or under the supervision of medical practitioners;
    11.2 provides nursing services supervised by registered nurses or nurses with equivalent qualifications;
    11.3 is not, other than incidentally, either a mental institution or a convalescent home, lodging facility or ward, rehabilitation or step-down facility (unless otherwise pre-authorised by the UMA);
    11.4 is not a place of rest for the aged or a place for drug addicts or alcoholics or a health hydro or natural cure clinic or similar establishment; and
    11.5 is not an institution providing long-term care for the blind, deaf, uncommunicative or other handicapped persons.
12. **illness** means any disease or illness, that manifests itself during the period of insurance, regarded as a state of not being physically or mentally well due to a generally recognised set of symptoms and signs determined by medical practitioners. Some illnesses will need evidence of diagnosis through special investigation. There may be diseases or illnesses for which objective proof of diagnosis will be required. If such proof cannot be provided on request, this illness will not be covered.
13. **insured incident** means a single accident and/or emergency and/or illness that results in an insured person undergoing certain treatment or advice, from any cause not excluded under this policy.
14. **insured person** means you (as defined) or any of your dependants (as defined).
15. **insurer** means Bryte Insurance Company Limited Reg. No: 1965/006764/06, a licensed non-life insurer, an authorised financial services provider FSP (17703) and the underwriter of the policy.
16. **medical tariff** means the standard tariff as agreed to by the UMA and the SP for payment of medical services:
17. **medicine formulary** is a list of prescription medications, both generic and brand name, approved by the UMA.
18. **network** means a selected group of pre-approved service providers with which the UMA has contracted.
19. **practitioner** means a legally qualified healthcare professional registered with the relative governing authorities in South Africa (such as the Health Professions Council of South Africa, the South African Nursing Council, etc.)
20. **pre-authorisation** means the process of requesting and obtaining prior provisional approval from the UMA before an insured person can access a particular policy benefit.
21. **premium** means the monthly amount collected by The Unlimited and paid to the insurer for the policy cover (see THE POLICY BENEFITS). The premium is disclosed separately in your benefit schedule.
22. **service provider ("SP")** means a health care provider which has contracted with the UMA to be part of the network.
23. **start date** means the first day of the calendar month following the first successful collection of your premium by The Unlimited; and is the date on which all your policy benefits become available (subject to the waiting periods).
24. **treatment** means any form of medical investigation; examination by; consultation with; or a surgical procedure performed by a medical practitioner for the purpose of treating or monitoring an insured person's medical condition.
25. **The Unlimited** means The Unlimited Group (Pty) Limited, an authorised financial services provider, acting as an intermediary by providing certain services in respect of the policy underwritten by the insurer.
26. **UMA** means Unity Health (the underwriting managing agent), a division of Ambledown Financial Services (Pty) Ltd, an authorised financial services provider and the company that determines the premium for the policy, and manages the claims on behalf of the insurer.
27. **waiting period** means the period specified in this policy during which The Unlimited needs to successfully collect a specified number of premiums from you before you are entitled to claim under this policy. Remember, the minimum premiums start from when a person is added to the policy and cover for the applicable insured person will begin on the first day of the calendar month following the date the insurer has received the required minimum number of premiums.
28. **we/us/our** means the UMA (acting in their own capacity), the insurer (acting in their own capacity) and The Unlimited (acting in their own capacity). When we use the words "we", "our" or "us", the terms and conditions are relevant and binding between you and the UMA, the insurer and The Unlimited.
29. **you/your** means the policyholder and reference to "you" in the policy wording includes your dependants on this policy, where applicable.

HOW WE WILL 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. This is also how we will notify you of any premium increases, cover changes or other changes to your policy.
2. **We will always communicate with you using your last known details** 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 **0861 990 000** and give The Unlimited a chance to see if they can set things right. They will communicate with the insurer on your behalf.
2. If you are still not happy and would like to submit a formal complaint to the insurer, please refer to **HOW TO SUBMIT A COMPLAINT** in the **STATUTORY NOTICE OF DISCLOSURES AND OTHER LEGAL REQUIREMENTS** section below.

TRANSFERRING YOUR INTEREST IN THE POLICY OR CASH-IN

You cannot transfer your financial interest, or any rights, in this policy to anyone else. 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.

JURISDICTION AND CURRENCY

The policy is only valid within the territory of South Africa. All payments will be made in the currency of South Africa. Your policy will be governed by the laws of the Republic of South Africa, whose courts will have jurisdiction in any dispute arising under your policy.

PAYMENT AND NON-PAYMENT OF YOUR PREMIUM

1. It is your responsibility to pay your premium every month or you will not be covered.
2. The policy will be valid for 1 (one) calendar month and is automatically renewed on the same terms for a further calendar month every time your premium is received by the insurer.
3. **Please note:** additional premiums are payable for each insured person who is aged 56 (fifty-six) or older on the date they are added to this policy.
4. Payment of premiums:

    4.1 Please note: your total premium, stated in your benefit schedule, is collected by The Unlimited and paid to the insurer on your behalf, every month. Payment to The Unlimited is deemed to be payment to the insurer.

    4.2 The premium is due in advance and this policy will not be binding on the insurer until the first premium has been received.

    4.3 You must pay your premium by debit order. If you reject the request from your bank to authenticate your debit order mandate (DebiCheck), your policy will not start and there will be no agreement between you and us. This will also result in no cover of the policy benefits. The Unlimited will also not present the debit order for collection if you suspend your DebiCheck authentication before the start date of this policy. They will regard the suspension as your instruction to them not to start the agreement.

    4.4 Your debit order will be presented to your bank on the due date. Please contact The Unlimited if you want to change the collection (due) date you have agreed with them.

    4.5 If there is a better chance of collecting your premium and keeping your policy benefits active, The Unlimited may debit your premium on a different date from the date you give them.

    4.6 IMPORTANT: your premium may be collected on a different date due to a public holiday or weekend, without notifying you. Any bank charges incurred as a result will be for your own account.

5. Unpaid premiums:

    5.1 **If The Unlimited does not successfully collect the premium by the agreed due date every month, and subject to the grace period, your policy will be suspended and you will not have access to your policy benefits until you have paid The Unlimited ALL missed premiums.** The Unlimited will not attempt to collect arrear (missed) premiums. Please contact The Unlimited on 0861 990 000 for assistance with manual payments.

5.2 If you miss a premium, you have a grace period of 15 (fifteen) days, calculated from the premium collection (due) date within which to make a manual payment to The Unlimited. During the grace period, the policy cover will remain in force and you will remain covered as long as you make a manual payment to The Unlimited. If The Unlimited does not receive payment within the 15 (fifteen) days, you will have no cover for that month and your policy will be suspended. The grace period only applies from the second month of cover.

Example: your premium due date is the 1st of May. If you miss a premium, you will only have until the 16th of May to make a manual payment to The Unlimited. If you don't, you will not have cover for the month of May, and your benefits will be suspended.

5.3 In the event of your debit order being unsuccessful, The Unlimited uses a tracking system that allows them to process your debit on another date 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 during the grace period when any debit order is unsuccessful.

5.4 If your premium is not received, or if you suspend the DebiCheck authentication of your debit order mandate after the start date of this policy, this will not automatically result in the cancellation of your policy and The Unlimited will still be entitled to present the debit order for collection. You agree that they may, at their discretion, try and collect further monthly premiums from your account in accordance with the law, including rules prescribed by the Payments Association of South Africa. The grace period of 15 (fifteen) days will apply from the date of each missed premium.

5.5 If any further attempts to collect your premium fail we reserve the right to cancel your policy immediately. We will notify you when this happens. If we successfully debit your bank account again, the date of that collection will be the new due date.

5.6 Any bank charges incurred because of failed collections will be for your own account.

5.7 If you dispute your monthly debit order payment with the result that the payment is reversed by your bank, and provided the debit order mandate is not cancelled, The Unlimited 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. The insurer may change the premium, waiting period or terms and conditions of this policy, including your cover, by giving 31 (thirty-one) days' written notice to you of its intention to do so.
2. Premiums are reviewed every year in January (the start of each calendar year). Increases may be applied due to inflation/market/claim experience. There may be a necessary interim increase during the year, however, The Unlimited will always give you 31 days' notice of any increase to your premium.
3. 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 (thirty-one) days' notice of these changes have been sent to you.
4. If you choose to cancel your policy during the 31 (thirty one) day notice period, you will not be entitled to a refund of premiums already paid.

WHEN DOES YOUR COVER START?

1. On receipt of your first premium, The Unlimited will pay the insurer the first premium and your policy will start on the first day of the next calendar month (the start date). For example, if The Unlimited successfully collects your first premium on the 20th June, the start date of your policy will be 1st July.
2. The insurer reserves the right to pro-rate policy benefits for each insured person joining during the calendar year.
3. You are entitled to your policy cover from the start date, subject to any waiting period.
4. **Waiting periods:** each insured person will have the following waiting periods applied to their policy benefits, starting from the start date applicable to that insured person, subject to all premiums being successfully received by the insurer.

   4.1 a 2 (two) calendar month waiting period applies to all policy benefits (unless otherwise stated);

   4.2 a 12 (twelve) calendar month waiting period applies to the chronic benefit and the basic optometry benefit (if you are covered under the optometry benefit);

   4.3 a 9 (nine) calendar month waiting period applies to the pre-birth maternity benefit.
5. If you are unsure when your cover starts, please contact The Unlimited to confirm the start date of your policy.
6. The minimum entry age for cover under this policy for you, the policyholder, is 18 (eighteen) years old.

CANCELLATION OF YOUR POLICY

1. You may cancel your policy by contacting The Unlimited and giving us 31 (thirty-one) days' notice of your cancellation. The Unlimited will request cancellation of the policy with the insurer on your behalf. **Call 0861 990 000 or email customercare@theunlimited.co.za.**
2. There is a cooling-off period of 14 (fourteen) 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) in which you can cancel and receive a refund on any premiums paid, **BUT ONLY IF YOU HAVE NOT SUBMITTED OR BEEN PAID OUT FOR A CLAIM** under this policy.
3. The insurer can terminate 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, and/or are dishonest or fraudulent in your actions. The insurer will notify you immediately in writing of the termination/voidance for fraudulent or dishonest actions or the non-payment of premiums. All policy benefits will be cancelled from the date of termination and you will not be entitled to any refund of premiums.
4. The insurer may cancel this policy in writing by giving you 31 (thirty one) 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 from you, your policy will be cancelled on our system immediately and all cover and benefits will end at midnight on the last day of the calendar month for which your last premium was received.
6. Should this policy end for any reason, any policy benefits that apply to your dependants will also end. However, in the event of your death, your spouse may elect to continue the cover under this policy as the policyholder by notifying us within 60 (sixty) days of your death.
7. **Please note:** if you have not yet submitted a claim for an insured incident that happened before the date of cancellation of this policy, you will have a maximum of 3 (three) months after the date of cancellation to submit your claim, including ALL required supporting documents, to the UMA.

CLAIMS PROCESS AND CONDITIONS

These are detailed claims conditions that must be in place or complied with by you so that you can make use of the policy benefits.

Please call The Unlimited on **0861 990 000** if you need help with your claim. Alternatively, you can check The Unlimited App for a list of network service providers and other claims information and processes; access to your virtual membership card; your plan details; policy benefit limits and access to online GP consultations.

1. When can you claim?

   1.1 You are entitled to cover from the start date and to claim benefits if an insured incident 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 policy benefits covered if we successfully receive your premiums every month; and if you comply with all the terms, conditions, limitations and exclusions contained in this policy.

   1.2 **The insured incident must have happened within the borders of South Africa, it must be after the start date and an exclusion must not apply.**

2. Specific conditions for all claims:

   2.1 All treatment for an insured incident MUST be provided by a network SP. Please call **0861 990 000** or refer to The Unlimited App for a list of our network service providers.

   2.2 Unity Health (the "UMA") administers the claims on behalf of the insurer. They settle claims in two ways:

      2.2.1 directly to the SP; or

      2.2.2 as a reimbursement to an approved claimant, up to the benefit limit.

3. How do you claim your policy benefits?

   3.1 Please check each policy benefit under the **TABLE OF POLICY BENEFITS** section below to see if pre-authorisation is required **before** you receive any treatment.

      3.1.1 If pre-authorisation is required, please call **0861 990 000** before receiving any treatment or advice from a network SP.

      3.1.2 If pre-authorisation is not required, you may proceed with treatment from a network SP.

      3.1.3 **Please note:** to ensure optimal patient management and care, the UMA may require pre-authorisation to access policy benefits in respect of any service provider at any time for a particular insured person.

3.2 Where a claim requires the UMA to reimburse you (or any other approved claimant), you agree to:

3.2.1 call or WhatsApp us on **0861 990 000** to request a **reimbursement form. You must notify the UMA of your claim by sending them your completed reimbursement form within 120 (one hundred and twenty) days** from the date of the insured incident. All supporting claim documents will need to be sent back to the UMA, as reasonably required by the UMA, **within 12 (twelve) calendar months** from the date of the insured incident.

3.2.2 provide the UMA with a certified copy of the claimant's identity document and proof of the South African bank account, which clearly shows the name and address of the account holder, the account number, as well as the bank date stamp. These documents should not be older than 3 months.

3.3 All costs incurred for claiming your policy benefits or submitting claim documentation are for your account. This includes clinical reports for claims that are under review.

3.4 **Please note:** for all claims under this policy, if you do not comply with the UMA's reasonable requests, do not cooperate in the investigation of claims or you do not give the UMA specific claim documents/information within 12 (twelve) calendar months from the date of the insured incident, the insurer will reject the claim and the claim will prescribe. This means that we will have no further liability, nor obligation to the claim. If the claim is subject to an awaiting court action between you and the insurer, the claim will still be valid.

3.5 Payment made to any approved claimant will discharge liability and obligations arising out of the event/s which led to the claim.

4. General conditions for any claim:

4.1 **The UMA has the right to request additional supporting documents at any time** if they are unable to validate a claim. If the UMA requests additional information from you, it is because it is necessary for them to finalise the claim. They will require your co-operation in providing them with the additional information.

4.2 **The insurer may also require the UMA to inspect all current and/or past medical records, including the results of blood tests, and request that an insured person undergoes a medical examination for your account.** In the event that another opinion proposes a different treatment or medicine, the UMA may, at its discretion, require that the alternative treatment plan or medicine be followed for claims to be payable. Where the insured person is not you (the policyholder), you or a legal guardian will be required to obtain the necessary permission or consent for the insured person to undergo a medical examination, failing which, the claim may be cancelled.

4.3 In the event that a policy benefit is paid as a result of any misrepresentation, non-disclosure, misdescription or fraudulent action, the nominated 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.

4.4 **There are other important details which you will find in the STATUTORY NOTICE OF DISCLOSURES AND OTHER LEGAL REQUIREMENTS section below. Please make sure you read and understand it and if you have any questions, please call The Unlimited on the number provided.**

5. Claim repudiations:

5.1 If the insurer rejects your claim, the UMA will notify you of the rejection. If you wish to challenge the rejection, you will have 90 (ninety) days to make written representations to the insurer (claims.complaints@brytesa.com). The insurer has 45 (forty-five) days from receipt of such written representation to notify you of its 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.**

THE POLICY BENEFITS (a summary of what you are covered for)

In the event of an insured person suffering an insured incident, treatment (as defined) will be provided by a network SP, limited to the following:

A. Primary healthcare benefits:

1. Medical consultations with a network general practitioner ("GP"), network nurse or approved specialist (Premium Medical Insurance cover only);

2. Medication that forms part of the formulary, as prescribed or dispensed by a network GP, network nurse, specialist or dental practitioner;
3. Diagnostic pathology based on the approved list of tests, provided such pathology was specifically requested by a network GP;
4. Basic diagnostic radiology based on the approved list of x-rays, provided such radiology was specifically requested by a network GP or dental practitioner;
5. **Premium Medical Insurance cover only:** basic dental treatment provided by a dental practitioner or dental therapist;
6. **Premium Medical Insurance cover only:** optometric wellness examination and/or the provision of eyeglasses prescribed by a network optometrist.

B. Wellness programme benefits:

1. Wellness assessments, health screenings and telephonic advice.

IMPORTANT: please refer to the **TABLE OF POLICY BENEFITS** below for the policy benefit specific conditions and policy benefit specific limitations. Please refer to the **POLICY EXCLUSIONS** section in this document for a list of policy benefit exclusions (when we will NOT pay your claim).

TABLE OF POLICY BENEFITS

Please check beneath the name of each policy benefit in this section to determine if a claim requires you to follow the pre-authorisation process prior to an insured person receiving any treatment or advice. If pre-authorisation is required, simply call **0861 990 000** and follow the prompts through the pre-authorisation process.

PLEASE NOTE: should any treatment cost exceed the agreed tariff between the UMA and the SP, you will be liable to pay the balance of the cost directly to the SP for the treatment received.

PLEASE NOTE: some of the benefits below are only applicable to our Premium Medical Insurance policyholders. If you have bought the Essential Medical Insurance benefits from us, please check below each benefit as some of the benefits do not apply to your chosen cover. Please also refer to your benefit schedule for the details of your chosen cover.

A. PRIMARY HEALTHCARE BENEFITS

1. UNLIMITED CONSULTATIONS AT A NETWORK GENERAL PRACTITIONER ("GP")

Pre-authorisation is required for this benefit, unless you have opted to add the GP pre-authorisation waiver benefit to your policy (see below), in which case an insured person will not be required to get pre-authorisation prior to each network GP visit.

Please note: all GP consultations are subject to the UMA's patient and risk management protocols. This means that for the benefit of all patients, claims are monitored for deliberate overuse of this benefit.

1.1 An insured person has access to unlimited consultations at a network GP, including specified procedures which can be performed in the consulting rooms, provided that:

1.1.1 the consultation is at the consulting rooms of the GP during the normal consulting hours of the network GP; and

1.1.2 pre-authorisation has been obtained for each GP consultation.

1.2 Cervical smears are included the GP consultation fees (including all materials used during the procedure).

1.3 Procedures performed in GP rooms are limited to the following approved procedures:

Tariff Code	Description
0206	Intravenous treatment/infusion: chargeable once per 24 hours
0244	Repair of the nail bed
0255	Drainage of subcutaneous abscess onychia paronychia pulp space or avulsion of nail
0259	Removal of foreign body superficial to the deep fascia (except hands)
0300	Stitching of soft-tissue injuries: Stitching of wound: including normal aftercare

0301	Stitching of soft tissue injuries: Additional wounds stitched at the same session
0307	Excision and repair by direct suture; excision of nail fold or other minor procedures
0308	Each additional small procedure done at the same time
0316	Fine needle aspiration for soft tissue (all areas)
0317	Aspiration of cyst or tumour
0887	Limb cast (excluding after-care) (modifier 0005 not applicable)
1136	Nebulisation (in rooms)
1192	Peak expiratory flow only
4188	Urine dipstick, per stick (irrespective of the number of tests on a stick)
2133	Circumcision: Clamp procedure
2139	Circumcision: Dorsal slit of the prepuce (independent procedure)
2137	Circumcision: Surgical excision other than by clamp or dorsal slit, any age

1.4 **Optional GP pre-authorisation waiver:**

1.4.1 You may add the GP pre-authorisation waiver benefit to your policy to access your GP consultations benefit without first obtaining pre-authorisation to do so.

1.4.2 If you have chosen to take this benefit, the benefit comes at an additional cost to you, per policy, per month. Please call us on 0861 990 000 for assistance with adding this benefit to your policy.

2. OUT-OF-NETWORK GP CONSULTATIONS

No pre-authorisation is required for this benefit.

An insured person has access to consultations at an out-of-network GP, subject to:

2.1 a maximum of 2 (two) visits per insured person, per calendar year, which is refundable up to a limit of R345 (three hundred and forty-five Rand) per consultation;

2.2 only the consultation at the out-of-network GP being covered. Medication or referrals for pathology and radiology will not be covered.

2.3 the insured person paying upfront for the consultation and claiming for reimbursement from the UMA. Please note that any reimbursement is paid back to the policyholder.

3. NURSE CONSULTATIONS

No pre-authorisation is required for this benefit.

3.1 An insured person has access to unlimited consultations for minor ailments via a network of nurse practitioners, during the normal consulting hours at network pharmacy clinics (Alpha Pharm, Clicks, Dischem or The Local Choice).

3.2 Use your membership card, found in The Unlimited App, at a network pharmacy at any time during operating hours to make use of this benefit.

3.3 Nurse practitioners can provide medication for minor ailments up to schedule 2 (two). Medication is subject to the approved medicine formulary.

4. TELEMEDICINE CONSULTATIONS

No pre-authorisation is required for this benefit.

4.1 An insured person has access to unlimited virtual GP consultations. Virtual consultations are available through network pharmacies that have a nurse clinic partnered with Healthforceor AlphaDoc (Alpha Pharm, Dischem, Clicks or The Local Choice).

4.2 If, during a nurse consultation at a network pharmacy, the nurse assesses that you need a virtual GP consultation, the nurse will arranged it for you.

5. SPECIALIST CONSULTATIONS (for Premium Medical Insurance policyholders only)

If you have bought the Premium Medical Insurance cover from us, the additional terms, conditions, limitations and exclusions in this section will also apply to you and all dependants (where applicable).

Please refer to your benefit schedule for the details of your cover.

Pre-authorisation is required for this benefit.

5.1 An insured person has access to specialist consultations, subject to:

5.1.1 a limit of R1 675 (one thousand, six hundred and seventy-five Rand) per visit, with an overall limit of R3 500 (three thousand, five hundred Rand) per family, per calendar year;

5.1.2 a referral by a network GP with proof of failed treatment;

5.1.3 pre-authorisation being obtained for each specialist consultation; and

5.1.4 the insured person paying upfront for the consultation and claiming for a reimbursement from the UMA if the specialist has not submitted the account directly to the UMA for payment.

5.2 This benefit will be pro-rated should you take out this policy during a calendar year.

PLEASE NOTE: this benefit covers your consultation and any costs for non-formulary medication and tests not on the approved list (such as blood tests and x-rays) prescribed by the specialist. All these costs will be paid from the same benefit limit. Claims are processed on a "first-come, first-served" cost basis, which means that once the total benefit limit has been reached, you will be responsible for any further costs. If the specialist prescribes acute medication according to the medicine formulary, this will be paid from the acute medication benefit.

6. ACUTE MEDICATION

No pre-authorisation is required for this benefit.

An insured person has access to unlimited acute medication as dispensed or prescribed by a network GP at one or more of the consultations referred to in the above benefits, subject to:

6.1 the medicine being dispensed or prescribed for acute illnesses only; and

6.2 all prescribed medicine being limited to the medicine formulary approved by the UMA for acute illnesses and Formulary Reference Pricing (FRP), as amended from time to time and available through:

6.2.1 network pharmacies (show your membership card once you get to the pharmacy); or

6.2.2 dispensing network GPs.

7. CHRONIC BENEFIT

Pre-registration of the insured person's chronic condition is required for this benefit.

7.1 An insured person has access to the chronic benefit, subject to:

7.1.1 registration of the chronic condition through the UMA prior to claiming this benefit;

7.1.2 the 12 (twelve) calendar month waiting period being met; and

7.1.3 all prescribed medicine being limited to the medicine formulary approved by the UMA for chronic conditions and Formulary Reference Pricing (FRP), as amended from time to time and available through network pharmacies.

7.2 Medicines are limited to the following chronic conditions:

Chronic condition	Description
Asthma	A chronic inflammatory disease of the airways, characterised by recurring symptoms of reversible airflow obstruction and bronchospasm.
Chronic Obstructive Pulmonary Disorder	A type of obstructive lung disease characterised by chronically poor airflow that typically worsens over time.
Diabetes Type 1/insulin-dependent Diabetes Mellitus	A metabolic disease in which a person has high blood sugar resulting from the body's failure to produce insulin.
Diabetes Type 2/non-insulin-dependent Diabetes Mellitus	A metabolic disease in which a person has high blood sugar resulting from insulin resistance, a condition in which cells fail to use insulin properly, sometimes also with an absolute insulin deficiency.
Epilepsy	Along-term neurological disorder characterised by epileptic seizures. These seizures are episodes that can vary from brief and nearly undetectable to long periods of vigorous shaking and tend to recur with no immediate underlying cause.

HIV/AIDS/human immunodeficiency virus infection/acquired immunodeficiency syndrome	A disease of the human immune system caused by infection with the human immunodeficiency virus.
Hyperlipidaemia	Abnormally elevated levels of any or all lipids and/or lipoproteins in the blood.
Hypertension	A chronic condition in which the blood pressure in the arteries is highly elevated.
Tuberculosis	A highly contagious disease caused by a bacteria known as Mycobacterium tuberculosis. TB generally affects the lungs, but it also can invade other organs of the body, like the brain, kidneys, and lymphatic system.

8.3 How to register a chronic condition and claim the chronic benefit?

8.3.1 If, during a consultation at a network GP, the network GP diagnoses a chronic condition, the GP will need to provide a medical report to start the process of registration of the insured person's chronic condition. Once the application process is successfully complete, the UMA will approve the chronic disease treatment plan.

8.3.2 Once the insured person's chronic disease treatment plan has been confirmed, all prescribed chronic medicine will be available monthly at a network pharmacy or via delivery to the insured person's home address by Medipost.

8.3.3 Prescriptions can be emailed to mrx2@medipost.co.za for deliveries. Medipost pharmacy will contact you to get the delivery details.

8. BASIC DENTISTRY (for Premium Medical Insurance policyholders only)

If you have bought the Premium Medical Insurance cover from us, the additional terms, conditions, limitations and exclusions in this section will also apply to you and all dependants (where applicable).

Please refer to your benefit schedule for the details of your cover.

No pre-authorisation is required for basic dentistry, however, please check that the dental practitioner charges the UMA rates before your visit.

8.1 An insured person has access to a dental practitioner, or dental therapist, for basic dental treatment for pain and sepsis, including extractions, subject to:

8.1.1 a limit of R1 550 (one thousand, five hundred and fifty Rand) per insured person, per calendar year; and

8.1.2 an overall annual limit of R4 650 (four thousand, six hundred and fifty Rand) per family with 2 (two) or more dependants covered under the policy.

8.1.3 a defined list of dental procedures approved by the UMA.

8.2 This benefit will be pro-rated should you take out this policy during a calendar year.

8.3 The defined list of dental procedures approved by the UMA includes:

8.3.1 **Basic dentistry - list of dental procedures:**

Tariff Code	Description	Benefit limit
8101	Full mouth examination, charting and treatment planning	Maximum 1 (one) per Annum
8104	Specific consultation	Maximum 1 (one) per visit
8107	X-Rays	Maximum of 2 (two) per visit
8109	Gloves and masks	Maximum 2 (two) per visit
8110	Sterile tray	Maximum 1 (one) per visit
8112	X-Rays	Maximum of 2 (two) per visit
8131	Non-specified emergency treatment	Maximum 1 (one) per visit
8132	Pulpectomy (Pulp Removal)	Maximum 2 (two) per visit
8145	Local anaesthetic	Maximum 1 (one) per visit
8159	Scaling and polishing	Once per calendar year

8162	Fluoride treatment (policyholder and adult dependants only)	Once per calendar year
8201	Extraction	Max 1 per quadrant the second and additional extractions must be claimed under code 8202
8202	Extraction	Maximum 1 (one) per visit
8731	Incision and drainage of abscess – intraoral – pyogenic	Maximum 1 (one) per visit
9011	Incision and drainage of abscess – intraoral – pyogenic	Maximum 1 (one) per visit
9013	Incision and drainage of abscess – intraoral – pyogenic	Maximum 1 (one) per visit

9.3.2 **Restoration – List of dental procedures:**

Tariff Code	Description	Benefit limit
8341	Amalgam	1 (one) surface
8342	Amalgam	2 (two) surfaces
8343	Amalgam	3 (three) surfaces
8344	Amalgam	4 (four) or more surfaces
8351	Resin	1 (one) surface
8352	Resin	2 (two) surfaces
8353	Resin	3 (three) surfaces
8354	Resin	4 (four) or more surfaces
8367	Resin	1 (one) surface, posterior
8368	Resin	2 (two) surfaces, posterior
8369	Resin	3 (three) surfaces, posterior
8370	Resin	4 (four) or more surfaces, posterior

9. BASIC OPTOMETRY (for Premium Medical Insurance policyholders only)

If you have bought the Premium Medical Insurance cover from us, the additional terms, conditions, limitations and exclusions in this section will also apply to you and all additional lives insured/dependants (where applicable).

Please refer to your benefit schedule for the details of your cover.

No pre-authorisation is required for this benefit, however, please call us on 0861 990 000 if you do not live near a Spec-Savers or Execuspecs optometrist.

9.1 An insured person has access to a network optometrist for an optometric wellness examination, and when required, a basic pair of frames and clear plastic single vision or bifocal lenses (approved by the UMA), every 24 (twenty-four) months, subject to:

9.1.1 qualifying norms, including an unaided visual acuity of worse than 6/9 on the Snellen Scale (an eye chart used to measure and determine visual acuity) for distance vision and near vision; a refraction requirement exceeding 0,5 (zero point five) dioptre sphere and /or 0,5 (zero point five) dioptre cylinder on distance vision and 1,25 (one point two five) dioptre sphere on near vision; and for the granting of bifocals, compliance with both the distance vision and near vision qualifying norms and age more than forty (40) years;

9.1.2 terms and conditions agreed by the UMA with the network optometrist.

9.1.3 examinations conducted by network optometrists only, including and limited to Spec-Savers and Execuspecs optometrists.

9.2 An insured person is covered for one standard frame, up to the value of R599 (five hundred and ninety-nine Rand), and 1 (one) pair of clear standard spectacle lenses every 24 (twenty-four) calendar months.

10. BASIC RADIOLOGY

Pre-authorisation is only required for this benefit if x-rays are requested by a specialist, requested during a casualty visit or in hospital following an accident. Please call us on **0861 990 000** for the **prescribed radiology request form** which will need to be completed before receiving any treatment.

No pre-authorisation is required if the requested x-rays are part of the defined list of x-rays below.

10.1 An insured person has access to black and white diagnostic x-rays, subject to:

10.1.1 a referral given by a network GP at 1 (one) or more of the consultations referred to above;

10.1.2 a defined list of x-ray procedures approved by the UMA;

10.1.3 all x-rays done by a radiologist identified by the UMA.

10.2 The defined list of x-rays approved by the UMA includes:

Tariff Code	Description	Tariff Code	Description
30110	Chest, two views, anteroposterior (AP) and lateral	72120	Left knee including patella
64100	Left forearm	72125	Right knee including patella
64105	Right forearm	72140	Left patella
65130	Left wrist	72145	Right patella
65135	Right wrist	71100	Left femur
65100	Left hand	71105	Right femur
65105	Right hand	73100	Left lower leg
65120	Finger	73105	Right lower leg
65140	Left scaphoid	74100	Left ankle
65145	Right scaphoid	74105	Right ankle
62100	Left humerus	74120	Left foot
62105	Right humerus	74125	Right foot
63100	Left elbow	74130	Left calcaneus
63105	Right elbow	74135	Right calcaneus
72100	Left knee, one or two views	74145	Toe
72105	Right knee, one or two views		

11. BASIC PATHOLOGY

Please call us on **0861 990 000** for the **prescribed pathology request form** which will need to be completed before receiving any treatment.

Pre-authorisation is only required for this benefit if blood tests are requested by a specialist; requested during a casualty visit or in hospital following an accident.

No pre-authorisation is required if the requested blood tests are part of the defined list of pathology tests below.

11.1 An insured person has access to diagnostic pathology tests, subject to:

11.1.1 a referral given by a network GP at 1 (one) or more of the consultations referred to above;

11.1.2 a defined list of basic pathology tests approved by the UMA;

11.1.3 all pathology done by a pathologist identified by the UMA (Ampath, Lancet and Pathcare).

11.2 The defined list of pathology tests approved by the UMA includes:

Tariff Code	Description and benefit limit (where relevant)	Tariff Code	Description and benefit limit (where relevant)
3742	Erythrocyte sedimentation rate	4032	Creatinine
3755	Full blood count (including Items 3739, 3762, 3783, 3785, 3791)	4049	Glucose tolerance STD 2hrs 75

3762	Haemoglobin estimation	4052	Glucose tolerance test (3 specimens)
3785	Leucocyte total count	4053	Oral glucose tolerance test (OGTT)
3797	Platelet count	4057	Glucose quantitative (blood)
3816	T and B-cells EAC markers (limited to 1 marker only for CD4/8 counts) **Limited to 1 per insured person per calendar year.**	4064	Glycated haemoglobin Chromatography/HBA1C **Limited to 2 per insured person per calendar year**
3865	Parasites in blood smear	4113	Potassium
3883	Concentration techniques for parasites	4114	Sodium
3885	Direct prep. AFB (TB micro)	4130	Aspartate aminotransferase (AST)
3916	Mycobacterial culture	4131	Alanine aminotransferase (ALT)
3947	C-Reactive protein	4139	Adenosine deaminase, (ADA) CSF/ fluid/serum
3948	IgG specific antibody titer ELISA/ EMT per Ag	4147	Triglyceride **Limited to 1 per insured person per calendar year**
4001	Alkaline phosphate	4151	Urea
4009	Bilirubin total	4171	Urea and Electrolytes
4025	Cholesterol, HDL/LDL, triglycerides **Limited to 1 per insured person per calendar year**	4188	Urine Dipstick, per stick (irrespective of number of tests on stick)
4026	LDL cholesterol (chemical determination) **Limited to 1 per insured person per calendar year**	4352	Occult blood monoclonal antibodies
4027	Cholesterol total **Limited to 1 per insured person per calendar year**	4559	Liquid based cytology
4028	Lipogram – HDL cholesterol **Limited to 1 per insured person, per calendar year**	4566	Vaginal or cervical smears **Limited to 1 per insured person, per every 3 calendar years after the age of 21.**

12. COVID-19 SCREENING

Pre-authorisation is required for this benefit.

12.1 An insured person is covered for COVID-19 screening, subject to:

12.1.1 a referral given by a network GP;

12.1.2 the test result being positive. If your test result is negative, you will have to pay for the test; and

12.1.3 a limit of 1 (one) positive test per insured person, per calendar year.

12.2 The defined list of COVID-19 screening tests approved by the UMA includes:

Tariff Code	Description
3974	Polymerase chain reaction (PCR)
CO19	PCR SARS-COV-2

3979	SARS-COV-2-PCR
4434	Bacteriological DNA identification (PCR)

13. PRE-BIRTH MATERNITY BENEFIT

Pre-authorisation is required for this benefit.

An insured person has access to a gynaecologist, subject to:

13.1 a limit of 3 (three) visits and 3 (three) x 2D ultrasound scans, per insured person, per calendar year;

13.2 an overall annual limit of R4 175 (four thousand, one hundred and seventy-five Rand) per family, per calendar year; and

13.3 the insured person paying upfront for the visit and/or ultrasound scan and claiming a reimbursement from the UMA.

B. WELLNESS PROGRAMME

No pre-authorisation is required for the benefits under the wellness programme (unless otherwise stated), as described below.

Please call us on **0861 990 000** or refer to The Unlimited App for a list of network pharmacies/GPs, then show your membership card at the pharmacy/GP and have the screening/vaccine (as listed below in this section).

An insured person has access to the following wellness programme benefits:

1. HEALTH SCREENINGS AT NETWORK PHARMACIES

1.1 limited to one screening per insured person, per calendar year; and

1.2 limited to blood pressure, cholesterol, glucose levels, body mass index (BMI), waist circumference, HIV and pre and post-test counselling.

2. PAP SMEARS AT NETWORK PHARMACIES AND NETWORK GPS

2.1 limited to 1 (one) pap smear every 3 (three) calendar years, after the age of 21 (twenty-one).

2.2 Your GP may or may not offer pap smears as part of the consultation fee.

3. PROSTATE-SPECIFIC ANTIGEN (PSA) SCREENING AT NETWORK PHARMACIES

3.1 limited to 1 (one) PSA screening every 2 (two) calendar years, after the age of 50 (fifty).

3.2 PSA screenings are subject to availability.

3.3 PSA screenings done at a laboratory will not be covered.

4. VACCINATION PROGRAMME

4.1 Pre-authorisation is required for Pneumococcal vaccines.

4.2 Vaccines are subject to availability.

4.3 The following vaccinations are available from network pharmacies:

Vaccine	Benefit limit
Influenza	This benefit is available annually and only payable if administered by no later than 31 May in each calendar year.
Tetanus	This benefit is available once every 10 (ten) calendar years.
Hepatitis A & B	This benefit is available once per insured person during their lifetime.
Pneumococcal	This benefit is available once every 5 (five) calendar years for an insured person aged 60 (sixty) or older and for an insured person with severely compromised immune systems. Pre-authorisation is required.

5. TELEPHONIC ASSISTANCE PROGRAMME

5.1 The service is available 24/7 over the phone and the benefit is unlimited.

5.2 Telephonic and virtual counselling services are provided by registered counsellors who follow specific procedures and clinical protocols.

5.3 Counselling for critical incidence/trauma counselling, HIV, legal advice and financial advice is included.

5.4 Face-to-face counselling can be arranged for the insured person's own account.

POLICY EXCLUSIONS (what you are not covered for)

The following general exclusions apply to your policy. It is very important that you understand and take note of these.

1. Routine, follow-up, and administrative exclusions:
   - 1.1 Routine physical examinations or diagnostic tests performed when there are no clinical symptoms or objective signs of a health problem.
   - 1.2 Diagnostic procedures such as x-rays or laboratory tests, unless related to a medical condition or disability confirmed by a prior consultation with a practitioner.
   - 1.3 Follow-up treatment for the same symptoms within three (3) days of the initial consultation.
   - 1.4 Follow-up consultations with specialists.
   - 1.5 More than three (3) consecutive consultations for the same diagnosis (ICD-10 code), unless there is documented clinical justification.
   - 1.6 More than one consultation per day with a general practitioner, nurse, or virtual consultation for the same insured person.
   - 1.7 Procedures performed by a practitioner that is not listed under the approved tariff code descriptions.
   - 1.8 Telephonic consultations;
   - 1.9 Costs that the UMA's clinical review team determines to be:
     - 1.9.1 not medically necessary or appropriate for the insured person's condition;
     - 1.9.2 inconsistent with accepted treatment type, frequency, or duration;
   - 1.10 All clinical or medical reports required for claims that are under review;
   - 1.11 Any policy benefit requiring pre-authorisation where such pre-authorisation was not obtained before the procedure or treatment.
2. Exclusions based on medical conditions or treatments:
   - 2.1 Investigations, treatments, or surgery for obesity or any medical condition directly or indirectly caused by or related to obesity.
   - 2.2 Treatments for artificial insemination, infertility, or contraception.
   - 2.3 Supply of medication that is not listed on the UMA's medicine formulary.
   - 2.4 External prostheses or appliances such as artificial limbs.
   - 2.5 Contact lenses.
   - 2.6 Optometry or dentistry benefits claimed in the final month of cover under the policy, regardless of the duration of the policy.
3. Conduct and lifestyle-related exclusions:
   - 3.1 Suicide, attempted suicide, or self-inflicted injuries, unless sustained in an attempt to preserve another human life.
   - 3.2 Failure to follow medical advice or adhere to prescribed treatment.
   - 3.3 Use of any drug or narcotic unless prescribed and taken as directed by a practitioner, as well as drug addiction treatment and rehabilitation services.
   - 3.4 Any illness or event caused by or related to the use or use of alcohol.
   - 3.5 Reckless or negligent acts or omissions by the insured or anyone acting on their behalf, including failure to take reasonable precautions to prevent or minimise harm.
   - 3.6 Participation in:
     - 3.6.1 active military duty, police duty, or police reservist duty;
     - 3.6.2 aviation activities other than as a passenger on a licensed commercial flight;
     - 3.6.3 any race or speed contest or activity involving non-mechanically propelled vehicles; and/or
     - 3.6.4 professional or hazardous sports or activities (any pursuit or activity where it is recognised that there is an increased risk of injury or a sport or activity where one receives monetary compensation).

4. Employment-related exclusions:

   4.1 Injuries sustained on duty or injuries directly or indirectly related to the insured person's work activities, including accidents and repetitive strain injuries.

5. High-risk, political, or uninsurable incidents:

   5.1 Any claims arising from:

   5.1.1 nuclear weapons, nuclear material, ionising radiation, or radioactive contamination (including nuclear fuel combustion and fission);

   5.1.2 war, hostilities, civil war, mutiny, or warlike actions, whether declared or not;

   5.1.3 military uprisings, insurrections, rebellions, revolutions, martial law, or related enforcement;

   5.1.4 participation in civil unrest, including but not limited to riots, strikes, lockouts, labour disturbances, or public disorder;

   5.1.5 acts intended to overthrow or influence any government or authority by violence, terrorism, intimidation, or fear;

   5.1.6 acts aimed at causing political, economic, or social change, or inspiring fear in the public;

   5.1.7 illegal activities;

   5.1.8 loss, damage, cost, liability, expense, or consequential loss of any kind, directly or indirectly caused by, resulting from, arising out of, or in connection with an interruption, failure, interference, or suspension of the electricity supply to the South African national electricity grid, regardless of the reason for the interruption, including but not limited to damage to infrastructure, the inability or failure (whether partial or total) of any utility provider to generate, transmit or distribute electricity, or any other cause;

   5.1.9 other causes or incidents that are not insured or are specifically excluded under this policy.

6. Fraud-related exclusions: if any claim under this policy is:

   6.1 in any respect fraudulent (either wholly or in part); or

   6.2 if any fraudulent means or devices are used by the insured or any third party acting on the insured's behalf or with the knowledge or consent of the insured to obtain (or in an attempt to obtain) any benefit under this policy.

SANCTIONS

Notwithstanding any other terms under this insurance contract, no insurer shall be deemed to provide coverage or will make any payments or provide any service or benefit to any insured or other party to the extent that such cover, payment, service, benefit and/or any business or activity of the insured would violate any applicable trade or economic sanctions law or regulation.

FRAUD

In the implementation of this policy, the insured person undertakes to observe good faith and warrant that he/she shall neither do anything nor refrain from doing anything which might prejudice or detract from the rights, assets or interests of the Insurer, the Intermediary or the Underwriting Manager. This will include any incidents of fraud that the insured person is responsible for through any act or omission during the existence of this policy.

1. If any claim under this policy is:

   1.1. in any respect fraudulent (either wholly or in part); or

   1.2. if any fraudulent means or devices are used by the insured or any third party acting on the insured's behalf or with the knowledge or consent of the insured to obtain (or in an attempt to obtain) any benefit under this policy; or

   1.3. if any accident, loss, destruction, damage or liability be occasioned by the wilful act (or omission) or with the knowledge, consent or connivance of the insured, regardless of whether or not the claim in itself is fraudulent:

   1.3.1. all benefits under this policy will be forfeited in their entirety, and the Insurer will be entitled to recover any amounts already paid to the insured pursuant to the claim; and

   1.3.2. The Insurer will be entitled to cancel the policy with retrospective effect as at the date of the occurrence giving rise to the claim or the reported occurrence date, whichever occurred first (termination date); and

   1.3.3. in the event that the Insurer terminates the policy, the Insurer will be entitled to recover any amounts already paid to the insured from the termination date, irrespective of whether such payments were made pursuant to valid claims; and

   1.3.4. the insured will not be entitled to any refund of the premium in any circumstance.

2. For the purposes of this policy, fraud includes, but is not limited to, the insured person or anyone acting on the insured person's behalf:

   2.1. makes a false and dishonest, or exaggerated claim under this policy; or

   2.2. uses fraudulent means or devices, including the submission of false or forged documents in support of a claim, whether or not the claim is itself genuine; or

   2.3. submits a claim under this policy for loss or damage that was intentionally caused by the insured person or such person acting on the insured person's behalf; or

   2.4. suppresses, or deliberately withholds information, which would enable the Underwriting Manager or Insurer to refuse to pay a claim under this policy.

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

As an insurance policyholder, or prospective policyholder, you have the right to the following information in respect of your non-life insurance product:

Details of the intermediary (The company that offered you the product)

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
Email Address:	customercare@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. The insurer does offer the following cooling-off rights: If there has been no insured incident and no benefit has yet been claimed or paid, you have the right to cancel the policy by giving the insurer written or telephonic notice within 14 (fourteen) days of you receiving this policy wording OR from a reasonable date on which it can be deemed that you received this policy wording. The insurer will comply with your request for cancellation within 31 (thirty-one) days of receiving your cancellation notice and will refund all premiums or moneys paid.

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 an intermediary in terms of an Intermediary Agreement with the insurer and earns a monthly commission not exceeding 20% of the premium. for services performed 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 Life 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.	**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 Subcategories A, B1, B2, B1-A, B2-A and Short-Term Insurance Personal Lines A1, Short-Term Personal Lines and Short-Term Insurance Commercial Lines.

Details of the insurer

(The company that underwrites the policy, a licensed non-life insurer and an authorised financial services provider)

Company Name:	**Bryte Insurance Company Limited (the "insurer")**
Physical Address:	**Rosebank Towers, Fifth Floor, 15 Biermann Avenue, Rosebank, 2196**
Postal Address:	**Rosebank Towers, Fifth Floor, 15 Biermann Avenue, Rosebank, 2196**
Telephone Number:	**011 088 7000**
Email address:	**nonclaimscomplaints@brytesa.com**
Website:	**www.brytesa.com**
Company Registration Number:	**1965/006764/06**
FSP License Number:	**I070/17703**
VAT Number:	**4530103581**

Details of internal compliance department:	
Telephone number:	**011 088 7000**
Email address:	**compliance@brytesa.com**

Professional Indemnity and/or Fidelity Cover:

Bryte Insurance Company Limited has Professional Indemnity Cover and a Fidelity Guarantee Cover in place.

Conflict of interest: Bryte Insurance Company Limited has a conflict-of-interest management policy in place and is available to clients on the website.

Details of FAIS compliance:	**Moonstone Compliance**
Telephone Number:	**021 883 8000**
Email:	**support@moonstonecompliance.co.za**

Details of the underwriting manager (The company that determines the premium for the policy, and manages the claims on behalf of the insurer)

Company Name:	**Unity Health, a division of Ambledown Financial Services (Proprietary) Limited (the "UMA")**
Physical Address:	**Ambledown House, Eton Office Park East, c/o Sloane and Harrison Streets**
Postal Address:	**PO Box 1862, Cramerview, 2060**
Telephone Number:	**0861 366 006**
Email address:	**info@unityhealth.co.za**
Website:	**www.unityhealth.co.za**
Company Registration Number:	**2004/006271/07**
FSP License Number:	**10287**
VAT Number:	**4340215856**

Details of internal compliance department:	
Telephone number:	**0861 262 533**
Email address:	**compliance@unityhealth.co.za**

Details of FAIS compliance:	**Moonstone Compliance**
Telephone Number:	**021 883 8000**
Email:	**support@moonstonecompliance.co.za**

Unity Health, a division of Ambledown Financial Services (Pty) Ltd, is an authorised financial services provider and licensed to render intermediary services relating to Short-Term Insurance Category 1 in respect of Short-Term Insurance Personal Lines and Short-Term Insurance Commercial Lines.

Unity Health, a division of Ambledown Financial Services (Pty) Ltd, has Professional Indemnity Insurance and Fidelity Guarantee Cover. Ambledown does not hold any shares in the insurer and more than 30% income was earned from the insurer in the last calendar year.

Conflict of interest: Ambledown Financial Services (Pty) Ltd has a conflict-of-interest management policy in place and is available to clients on the website.

Unity Health, a division of Ambledown Financial Services (Pty) Ltd, has a UMA agreement with the insurer and earns a monthly binder fee of 25% of the premium for services performed on behalf of the insurer.

How to submit a complaint

Step 1: initial complaints process

- If you have a complaint about how this policy was offered to you, please call The Unlimited on 0861 990 000/ 031 716 9600 or email. Please view The Unlimited's full Complaints Process on www.theunlimited.co.za.
- If you have a complaint about your claim, please contact Ambledown Financial Services (Pty) Ltd on 0861 262 533 or complaints@unityhealth.co.za.
- If you have a complaint about the service received, please contact Bryte Insurance Company Limited on 011 088 7000 or claims.complaints@brytesa.com.

Bryte Insurance Company Limited has a Complaints Procedure and a Complaints Resolution Policy available on request.

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 or the insurer to review the matter. We will notify you of the name and contact details of the person tasked to facilitate the dispute resolution process, and when a decision has been reached, you will be provided with the outcome of such a decision, together with reasons.

Step 3: Representation to the insurer

Should you remain dissatisfied with the outcome of your dispute you may make additional representation to Bryte Insurance Company Limited, by addressing your concerns to:

Bryte Insurance Company Limited Internal Resolutions:

Telephone:	**011 088 7000**
Email:	**complaints@brytesa.com**

Step 4: External Dispute Resolution

We encourage clients to endeavour to resolve a complaint with The Unlimited first, before submitting a complaint to the Ombudsman. However, you may utilise 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, Johannesburg, Gauteng, 2198**
Share call number:	**0860 800 900**
Email:	**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:	**P. O. 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:	**info@faisombud.co.za**
Website:	**www.faisombud.co.za**

The Financial Sector Conduct Authority (FSCA)

Postal Address:	**P.O. 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:	**012 428 8000 or 0800 20 37 22**
Website:	**www.fsca.co.za**

Particulars of the Information Regulator (for personal information breaches)

Telephone:	**010 023 5200**
Email address:	**POPIAComplaints@inforegulator.org.za**
Physical address:	**Woodmead North Office Park, Building A, 54 Maxwell Drive, Woodmead, Johannesburg, 2191**
Postal address:	**P.O. Box 31533, Braamfontein, 2017**

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 (thirty-one) 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 (thirty-one) days' notice in writing of its intention to cancel cover.

- The insurer must give reasons for the rejection of your claim.
- The insurer may not cancel your policy cover 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 a 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 a test.
- Should you have any complaints about the availability or adequacy of the information we have given you, please let The Unlimited 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.
- All material facts must be accurately and properly disclosed, and the accuracy and completeness of all answers, statements or other information provided by or on behalf of you are your responsibility.

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

We are bound by the terms and provisions of the Protection of Personal Information Act 4 of 2013 ("POPI Act"), as well as Section 51 of the Electronic Communications and Transactions Act, 2002 ("ECT Act") regarding the processing of your personal information. We may use any necessary legal means to check and validate the information you provide to us.

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

1. **You hereby warrant and agree that we, including our authorised agents, partners and service provider/contractors may:**

   1.1 collect information:

   (a) 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.

   (b) 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 authorised agents, partners and service provider/contractors.

(c) 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.

(d) 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.

1.2 process your information for the following reasons (amongst others):

(a) to underwrite policies, assess risks fairly, perform under your insurance agreement including the assessment of claims and enforce our contractual rights and obligations.

> **PLEASE NOTE:** This includes the collection and use of personal information provided to us, such as sensitive health information, including that of minor children, as permitted under section 32(1) of the POPI Act. In addition, such information may be shared internally with our departments (who need this information) and 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.

(b) where relevant, to instruct the insurer, the UMA, and any appointed medical provider/service provider (including emergency or hospital providers, and medical professionals or staff engaged by an insured person, the insurer or UMA), to ensure that an insured person receives appropriate and necessary medical services. This includes sharing necessary personal and health information about you and your dependants where required to support risk assessment, claims processing, performance of your insurance agreement or to enforce contractual rights.

(c) to comply with legislative, regulatory, risk and compliance requirements, codes of conduct and industry agreements or to fulfil reporting requirements and information requests.

(d) to submit payment instructions (like a debit order) to and receive payment performance feedback from our appointed sponsor bank(s) for the purposes of facilitating and managing your payment obligations under this agreement. This includes sharing your name, identification number, and bank account details with such bank(s) to enable payment collection and receiving data from them such as payment success or failure, reasons for failed payments and debit order mandate status (e.g. whether the mandate has been authenticated).

(e) to do affordability assessments, credit assessments and credit scoring including requesting and using limited credit information, such as income payment timing and payment behaviour, from credit bureaus or authorised third parties. By accepting our terms, you provide the necessary consent as required under the National Credit Act, 2005.

(f) to manage and maintain your agreement/policy or relationship with us.

(g) to disclose and obtain information about you from credit bureaus regarding your credit history.

(h) to enable you to participate in the debt review process under the National Credit Act 34 of 2005.

(i) for security, identity verification and to check the accuracy of your information.

(j) where required, we may transfer your personal information outside of South Africa in compliance with the law.

(k) for customer satisfaction surveys, promotional and other competitions.

(l) 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.

(m) 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.

(n) 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.

1.3 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 and 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.
▪ Medical professionals, healthcare institutions or facilities involved in providing necessary medical services to you or your dependants under the insurance agreement.	

2. **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 a credit bureau and our sponsor bank) 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 to determine 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.

3. **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.

   We may contact you to offer you our similar products and services, using the contact details you have provided. You may opt out of receiving such marketing communications at any time by emailing dataprivacy@theunlimited.co.za or calling **0861 990 000**.