YOUR

MEDIGUARD

POLICY DOCUMENT

DUEPOINT

Introduction

The basis of the MediGuard Plan will be the Policy Application form which has been signed or agreed by you electronically, the Policyholder, and accepted by us, Constantia Life and Health Assurance Limited.

Subject to the Definitions, Defined Events, General Exceptions, General Conditions, Table of Benefits, Limitations and any Endorsements to the policy, the Company agrees to pay the benefits as stated in this policy for the Insured Person(s) for an Insured Incident occurring during the period of insurance up to the limit stated in this policy.

This policy wording, as amended from time to time, various administrative forms, application forms, policy schedules and certificates, declarations, authorisations and agreements pertaining to this policy supplied by Constantia Life and Health Assurance Limited, shall form the basis of this assurance contract.

In the event of any conflict between the provisions of this policy wording and that of any other documents as mentioned above, the provisions of this policy wording shall prevail.

Reward yourself first.

MediGuard Plan Terms and Conditions

Definitions

1. **"Company"** means Constantia Life and Health Assurance Company Limited (CLAH), Reg. No.: 1952/001635/06 and FSP No. 49986
2. **"Underwriting Manager"** means Unity Health, a division of Ambledown Financial Services (Pty) Ltd, Reg. No. 2004/006271/07, and FSP No. 10287.
3. **"Principal Insured Person"** means:
    a. The person who completed the application form and who's name appears in the plan schedule and who has been accepted by the Underwriting Manager on behalf of the Company as eligible for participation in the insurance provided by this policy; or
    b. The eldest person who has not attained the age of twenty-one (21) for who an application form has been completed and who has been accepted by the Underwriting Manager on behalf of the Company as eligible for participation in the insurance provided by this policy.
4. **"Adult Dependant"** means:
    a. The spouse of the Principal Insured Person who is not already insured under this policy or any other policy issued by the Company providing similar cover and where the spouse shall include a party to any union recognised by South African Law; or
    b. A child who has attained the age of twenty-one (21) and who is the natural/biological child, stepchild or legally adopted child placed under the foster care of the Principal Insured Person, who is not already insured under this policy or any other insurance issued by the Company providing similar cover, and who is financially dependent on the Principal Insured Person.
    c. And who's names appear in the Plan Schedule.
5. **"Eligible Child"** means:
    a. A child who has not attained the age of twenty-one (21) and who is the natural/biological child, stepchild or legally adopted child placed under the foster care of the Principal Insured Person, who is not already insured under this policy or any other insurance issued by the Company providing similar cover; or
    b. A child who has not attained the age of twenty-one (21) and who has at least one parent in common with the Principal Insured Person defined under 3 b) and who is not already insured under this policy or any other insurance issued by the Company providing similar cover.
    c. A child will no longer be a child when they reach the age of twenty-one (21) years or get married before the age of 21 (twenty-one) years, unless they are still full-time students, then they no longer qualify for benefits when they turn twenty-six (26).
    d. And who's name appears in the Plan Schedule.

    There will be no age restriction for children who are either mentally or physically incapacitated, always provided that the children are wholly dependent on the Principal Insured Person for support and maintenance.
6. **"Insured Person"** means:
    a. A Principal Insured Person, an Adult Dependant or an Eligible Child of a Principal Insured Person;
    b. Such other person as the Company may from time to time deem eligible.
    c. And who's name appears on the Plan Schedule.
7. **"Family"** means the Principal Insured Person and their Adult and Eligible Child dependants, provided they are Insured Persons.

8. **"Hospital"** means any institution in the territory of RSA which in the opinion of the Company meets each of the following criteria:
    a. 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;
    b. Provides nursing services supervised by registered nurses or nurses with equivalent qualifications;
    c. Is not, other than incidentally, either a mental institution or a convalescent home providing long term care;
    d. Is not a place of rest for the aged or a health hydro or natural cure clinic or similar establishment; and
    e. Is not an institution providing long-term care for the blind, deaf, dumb or other handicapped persons.
9. **"Accident"** means bodily injury caused by violent, external, physical and fortuitous means.
10. **"Illness"** means any somatic disease or illness, which 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.
11. **"Emergency"** is an event of a sudden and, at the time, unexpected onset of a health condition that requires immediate medical treatment, where failure to provide medical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the Insured Person's life in jeopardy.
12. **"Insured Incident"** means any one Accident and/or Emergency and/or Illness that necessitates an Insured Person to undergo certain Medical Treatment or advice.
13. **"Intermediary"** means the advisor, broker or consultant appointed by the Principal Insured Person to arrange terms of insurance and assist with queries pursuant to this policy, accredited in terms of FAIS, the Underwriting Manager and the Company.
14. **"Medical 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.).
15. **"Network"** means a selected group of service providers with which the Underwriting Manager has contracted with.
16. **"Medical Tariff"** means the standard tariff as agreed to by the Underwriting Manager and the Network Service Provider for payment of medical services.
17. **"Medical Treatment"** means any form of 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.
18. **"Schedule"** means the schedule attached to and forming part of this policy.
19. **"Territory"** means the Republic of South Africa.
20. **"Asthma"** means chronic inflammatory disease of the airways characterised by recurring symptoms of reversible airflow obstruction and bronchospasm.
21. **"Chronic Obstructive Pulmonary Disorder"** means a type of obstructive lung disease characterised by chronically poor airflow that typically worsens over time.
22. **"Diabetes Type 1"** or **"Insulin-dependent Diabetes Mellitus"** means metabolic diseases in which a person has high blood sugar resulting from the body's failure to produce insulin.

23. **"Diabetes Type 2" or "Non-insulin-dependent Diabetes Mellitus"** means metabolic diseases 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.
24. **"Epilepsy"** means long-term neurological disorders 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.
25. **"HIV / AIDS"** or "human immunodeficiency virus infection / acquired immunodeficiency syndrome" means a disease of the human immune system caused by infection with the human immunodeficiency virus.
26. **"Hyperlipidaemia"** means abnormally elevated levels of any or all lipids and/or lipoproteins in the blood.
27. **"Hypertension"** means a chronic medical condition in which the blood pressure in the arteries is highly elevated.
28. **"Tuberculosis (TB)"** means 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.
29. **"Snellen Scale"** means an eye chart used by eye care professionals and optometrists to measure and determine visual acuity.
30. **"Service Provider"** means a provider of health care appointed/approved by the Underwriting Manager.
31. **"Competitive Sport or Activity"** means a sporting activity involving an official or practice, event, race or contest.
32. **"Professional Sport or Activity"** means a sport activity where one receives a monetary compensation.
33. **"Road Accident Fund"** means the state insurer established by statute in the Republic of South Africa.
34. **"Pre-authorisation"** means the process of requesting and obtaining prior approval from the Underwriting Manager before an Insured Person can access a particular benefit.
35. **"Policy Year"** means the following:
    a. The first policy year shall be the period from the policy commencement date to 31 December of the same calendar;
    b. After the first policy year, the policy year is defined as the twelve (12) month period from 1 January to 31 December of each calendar year.
36. **"Waiting Period"** means the period from the policy commencement date or the date an Insured Person is added to this policy, until benefits become payable under this policy.
37. **"Medicine formulary"** is a list of prescription medication, both generic and brand name, approved by the Underwriting Manager.
38. **"Company, we, our or us"** means Constantia Life and Health Assurance Limited, Registration no. 1952/000379/06, a Registered Life Insurer in terms of the law of the Republic of South Africa.
39. **"You/your/yours/yourself"** means the insured person/s stated in the schedule.

Scope of cover

1. Persons covered by the MediGuard Plan

The persons who are covered in this Policy are those whose names appear on the Policy Schedule, which has been prepared by, or revised by, Constantia Life and Health Assurance.

Nominated family members may only include the Principal Insured Person and their Adult and Eligible Child dependants.

Nominated Family Members are covered if they are individually named on the Policy Application form, original Policy Schedule or have been added to the Policy Schedule by DuePoint's Client Service team upon your request, prior to any claimable event.

You may add children to the policy at any time, for example on the birth of another child. You must do this by notifying DuePoint's Client Service team in writing by sending an email to info@duepoint.net. Family Members will be subject to the normal waiting periods as outlined in this document before they come under cover. Constantia Life and Health Assurance Limited may request additional information in this regard.

2. Defined Events

Claims may be submitted in the event of the following:

1. Where an Insured Person suffering an Insured Incident and Medical Treatment is provided by a Service Provider from the following list:
    a. Medical consultation with a Network general practitioner, Network Nurse or Specialist;
    b. Medication as prescribed or dispensed by a Network general practitioner, Network Nurse, Specialist or Network dental practitioner;
    c. Diagnostic pathology, provided such pathology was specifically requested by a Network general practitioner or Network dental practitioner;
    d. Diagnostic radiology, provided such radiology was specifically requested by a Network general practitioner or Network dental practitioner;
    e. Basic and emergency dental treatment or surgery, enacted by a Network dental practitioner or Network dental therapist;
    f. Wellness assessment and telephonic advice provided by a Service Provider;
    g. Optometric wellness examination and/or the necessity for eyeglasses approved by a network optometrist;
    h. Following an Emergency:
        i. Emergency transportation services;
        ii. Medical treatment in a Hospital emergency unit for stabilisation before being transferred to a public facility. Any surgical procedure not specifically required for stabilisation is excluded.
        iii. Inter-hospital transportation to a public hospital following such treatment for stabilisation.

2. Where an Insured Person suffered an Accident and Medical Treatment is provided by one of the following Service Providers:
    a. In-hospital treatment including all hospitalisation (institution) costs, associated services, medicines and materials and whilst hospitalised as an inpatient;
    b. If necessary inter-hospital transportation should the need arise for any medical reason whatsoever; and

c. Treatment in a hospital emergency unit, or hospital casualty unit where treatment does not require admission to a Hospital as an inpatient.

3. The death of the Principal Insured Person and / or Spouse of the Principal Insured Person as a result of an Accident.

3. General Exceptions

The Company shall not be liable for hospitalisation, bodily injury, sickness or disease directly or indirectly caused by, related to or in consequence of:

1. Nuclear weapons or nuclear material or by ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel. For the purpose of this exception combustion shall include any self-sustaining process of nuclear fission;
2. Investigations, treatment or surgery for obesity or its sequel or cosmetic surgery or surgery directly or indirectly caused by or related to or in consequence of cosmetic surgery other than as a result of an Insured Incident;
3. Suicide, attempted suicide or self-inflicted injuries unless such injuries are sustained in an attempt to preserve another human life;
4. Routine physical or any other procedure of a purely diagnostic nature or any other examination where there are no objective indications of impairment in normal health and laboratory diagnostic or X-ray examinations except in the course of a medical condition or disability established by prior call or attendance of a Medical Practitioner;
5. All costs which are in the opinion of the Underwriting Manager's clinical review team:
    a) Not medically necessary or clinically appropriate or do not meet the healthcare needs of the Insured Person;
    b) Not consistent in type, frequency and duration of treatment;
6. Procedures performed in doctors' rooms that are not listed in the list of tariff code descriptions;
7. Any accident where the initial accident event occurred prior to the Insured Person's commencement date with this policy;
8. The taking of any drug or narcotic unless prescribed by and taken in accordance with the instructions of a registered Medical Practitioner (other than the Insured Person) or any illness caused by the use of alcohol;
9. Any medical transportation service for non-emergency purposes;
10. Drug addiction;
11. The supply of medication that is not listed on the Underwriting Manager's formulary list;
12. An event directly attributable to the Insured Person having an alcohol content exceeding zero point zero five (0.05) grams per one hundred (100) millilitres of blood or the Insured Person suffering from alcoholism;
13. Artificial insemination, infertility treatment or contraceptive;
14. Robotic surgery, specialised mechanical or computerised appliances equipment or all related Service Providers;
15. Contact lenses;
16. Participation in:
    a) Active military duty, police duty or police reservist duty;
    b) Aviation other than as a passenger;
    c) Any Competitive or Professional Sport or Activity;
    d) Any form of race or speed test (other than on foot or involving any non-mechanically propelled vehicle vessel craft or aircraft).
17. External prosthesis or appliances such as artificial limbs.

18. Any activity prohibited by law.
19. Any benefit requiring pre-authorisation where no authorisation was requested or approved.

4. General Conditions

4.1 Waiting Periods

Each Insured Person will have the following waiting periods applied to their benefits:

a) Two (2) month waiting period applicable to all benefits, except emergency transportation and inpatient or outpatient hospital treatment due to an Accident or Emergency;
b) Twelve (12) month waiting period applicable to chronic medication and optometry benefits;
c) Nine (9) month waiting period applicable to pre-birth maternity benefits.

4.2 Claims

a) Following an Insured Incident, the Insured Person shall:
    1. Ensure that treatment for an Insured Incident is provided by a Service Provider. Where there is uncertainty if a Service Provider is an appointed Service Provider, then the Insured Person must contact the Underwriting Manager. The Underwriting Manager will provide a list of appointed service providers;
    2. As soon as possible, but no later than one-hundred-and-twenty (120) days from treatment for such incident, notify the Underwriting Manager in writing of any claim;
    3. Supply, in writing, any proof or other information as the Underwriting Manager may reasonably request;
    4. As often as required, provide authority for the Underwriting Manager to inspect all current and/or past medical or other information including the results of any blood tests and submit himself to a medical examination at the expense of the Underwriting Manager;
    5. Where the Insured Person is not a Principal Insured Person, the Principal Insured Person or legal guardian shall provide or obtain the necessary permission or consent to comply with paragraph a) 4. failing which all benefits in respect of any claims subject to this condition shall be void.
b) Where a claim is paid for an Insured Incident where such an incident is a motor vehicle accident, the Insured Person or their legal guardian shall authorise the Underwriting Manager to obtain all required documentation and information and to make and recover any such claims from the Road Accident Fund. The Insured Person or their legal guardian shall provide the Underwriting Manager with all required documentation and information to make such claims and recoveries, otherwise the claim is not valid under this policy.
c) Any claim, other than treatment for an Emergency for which treatment or advice was provided by a Non-Network Service Provider, shall not be payable as a valid claim under this policy.
d) Any claim in terms of this policy will prescribe after twelve (12) calendar months from the date of occurrence of the Insured Incident.
e) Where the Underwriting Manager rejects or disputes a claim or the quantum of a claim, or voids the policy, the Principal Insured has ninety (90) days (the representation period) from receipt of the Underwriting Manager's written notification to dispute the decision of the Underwriting Manager. Notification of the dispute must be in writing and addressed to:

The Complaints Officer – Christiene Brummer
Constantia Insurance Company Limited
Building B and Portion of Building A, Nicol Main Office Park,
2 Bruton Road, Bryanston, Johannesburg, 2191

Tel: 011 686 4304
Fax: 011 789 8828
Email: christieneb@constantiagroup.co.za

PO Box 3518, Cramerview, 2060

Alternatively, the Principal Insured person may contact:

The Ombudsman for Long Term Insurance
PO Box 32334, Braamfontein, 2017

Tel: 011 726 8900
Fax: 011 726 5501
Email: info@ombud.co.za

Should the dispute not be resolved to the satisfaction of the Insured Person after one or both of the above measures have been exhausted, the Company and the Insured Person agree that the Insured Person may commence legal process against the Company within a period of 180 (one hundred and eighty) days from the date of notification of the outcome of the relevant measure to the Insured Person.

4.3 Premiums

a) The Principal Insured Person shall bear the cost of the premiums required to provide the benefits under the policy and shall pay the premiums and any charges due to the Company.
b) The premiums required to secure an Insured Person's benefits shall be payable throughout the term of this policy.
c) All premiums and benefits due to or payable by the Company shall be paid in the lawful currency of the Republic of South Africa (ZAR).
d) No latitude, extension of time or other indulgence which may be given or allowed, whether by agreement or inadvertently by the Company to the Principal Insured Person in respect of the performance of any obligation in terms of this contract, shall under any circumstances be construed to be implied consent or operate as a waiver or a novation of, or otherwise affect any of the rights of the Company or stop the Company from enforcing, at any time and without notice, strict and punctual compliance with each and every obligation of the Principal Insured Person under this policy.
e) All premiums are payable monthly in advance.
f) If premiums, in whole or in part, are in arrears, then no claim shall be payable until all the arrears have been settled in full.
g) Additional premiums are payable for each insured person aged 56 or older at the commencement date of their policy with the company. If the insured person has had medical scheme or MediGuard insurance coverage for fifteen (15) or more years since the age of thirty-five (35), the additional premiums may be waived if the applicant can demonstrate previous coverage in writing.

4.4 Termination of cover

a) Either party may cancel this policy by giving the other party thirty-one (31) days' notice in writing.
b) Upon cancellation of the policy by either party, treatment for an Insured Incident will qualify if the treatment caused by such Insured Incident commences before the date of cancellation in which case all outstanding claims must be submitted to the Company within three (3) months after the date of cancellation.

4.5 Territorial Limits and Jurisdiction

a) Benefits shall only be payable for Insured Incidents that occur within the borders of the Republic of South Africa.
b) The policy shall be subject to the laws of the Republic of South Africa and only South African courts shall have jurisdiction in any matter arising out of this policy.

c) Where payment is to be made to or by the Company, it shall be made in the lawful currency of the Republic of South Africa (ZAR) at the Company's head office, unless the Company allows otherwise.

4.6 Commencement of cover

Cover in terms of this policy commences on the first day of the calendar month for which the premium has been paid by or for the Insured Person.

4.7 Amendments

The Company reserves the right to adjust the premiums by giving by thirty-one (31) days' written notice to the Principal Insured Person.

4.8 Open enrolment, community rating, and cross-subsidisation

This policy is subject to open enrolment, community rating, and cross-subsidisation. This means that anyone may join and premium rates are only differentiated by principal member, adult and child dependants.

Table of Benefits

5.1 MediGuard Benefits

Access to Network General Practitioners

Access to Network general practitioners, at the consulting rooms of the general practitioner (including specified procedures which can be performed in the consulting rooms) during the normal consulting hours of Network general practitioners. The number of consultations per Insured Person per Policy Year is not limited, but Pre-authorisation is required for ten (10) or more general practitioner or nurse consultations per Insured Person per Policy Year.

Procedures performed in doctors' rooms

Tariff Code	Description
0206	Intravenous treatment/infusion: chargeable once per twenty-four-hour (24-hour)
0244	Repair of 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 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
, per stick (irrespective of the number of tests on 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

Nurse Consultations

Access to a network of Nurse practitioners, during the normal consulting hours at approved pharmacy clinics for minor ailments. The number of consultations per Insured Person per Policy Year is not limited, but Pre-authorisation is required for ten (10) or more general practitioner or nurse consultations per Insured Person per Policy Year. In many practices' nurses can provide scripts for minor ailments for up to schedule two (2) medications.

Specialist Visits

Access to a specialist medical practitioner is limited to one thousand two hundred rand (R1 200) per visit with an overall annual limit of two thousand five hundred rand (R2 500) per family per Policy Year. Referral by a Unity Health Network general practitioner and pre-authorisation is required.

Access to Acute Medication

Medicines dispensed or prescribed by a Network general practitioner for acute illnesses at one or more of the consultations referred to above, if required, and subject to the medicine formulary approved by the Underwriting Manager for acute illnesses and formulary reference pricing (FRP), as amended from time to time and available through approved pharmacies or dispensing Network general practitioners.
The benefit for prescribed acute medication is not limited.

Access to Chronic Medication

Medicines for the following specific chronic conditions:

8 Listed "high impact" Conditions:

Asthma;	Chronic Obstructive Pulmonary Disorder;
Diabetes Type 1&2;	Epilepsy;
HIV/AIDS;	Hyperlipidaemia;
Hypertension;	Tuberculosis.

Subject to the medicine formulary approved by the Underwriting Manager for chronic illnesses and formulary reference pricing (FRP), as amended from time to time and available through approved pharmacies and subject to registration of the specified chronic condition through the Underwriting Manager.

Access to Basic and Emergency Dentistry

This service is to be provided by a Network dental practitioner or Network dental therapist appointed by the Underwriting Manager for basic and emergency dental treatment for pain and sepsis, including extractions, up to one thousand two hundred rand (R1 200) per person per incident. Access is further subject to a list of dental procedures approved by the Underwriting Manager. The list of dental procedures approved by the Underwriting Manager includes:

Tariff Code	Emergency Dentistry - List of dental procedures	
8104	Specific consultation	(maximum one per visit)
8107	X-rays	(maximum of two per visit)
8112	X-rays	(maximum of two per visit)
8145	Local anaesthetic	(maximum one per visit)
8110	Sterile tray	(maximum one per visit)
8109	Gloves and masks	(maximum two per visit)
8132	Emergency root canal	(maximum two per visit)
8201	Extraction (Max 1 per quadrant the second and additional extractions must be claimed under code 8202)	
8202	Extraction (Max 1 per quadrant the second and additional extractions must be claimed under code 8202)	
8131:	Non-specified emergency treatment	(maximum one per visit)
8731:	Incision and drainage of abscess – intraoral	(maximum one per visit)
9011:	Incision and drainage of abscess – intraoral – pyogenic	(maximum one per visit)
9013:	Incision and drainage of abscess – intraoral – pyogenic	(maximum one per visit)

Basic Dentistry - List of dental procedures

8101	Full Mouth Examination, Charting and Treatment Planning (maximum two per annum – once every six months)	
8104	Examination or specific consultation not requiring charting and treatment planning (maximum one per visit)	
8107	Intraoral radiographs, per film	(maximum two per visit)
8112	Intraoral radiographs, per film	(maximum two per visit)
8109	Infection control	(maximum two per visit)
8110	Provision of heat or vapour sterilised and wrapped instrumentation (maximum one per visit)	
8132	Emergency root canal treatment, adults only	(maximum two per visit)
8145	Local anaesthetic per visit	(maximum one per visit)
8159	Scaling and polishing	(once per annum)
8162	Fluoride treatment, adults only	(once per annum)
8201	Extraction single tooth	
8202	Extraction each additional tooth in the same quadrant	

Restoration – List of dental procedures

8341	Amalgam – one surface
8342	Amalgam – two surfaces
8343	Amalgam – three surfaces
8344:	Amalgam – four or more surfaces
8351	Resin – one surface
8352	Resin – two surface
8353	Resin – three surface
8354	Resin – four surface

Pre-authorisation is required for all dental fillings

Access to Basic Optometry

Access to an optometrist approved by the Underwriting Manager for an annual optometric wellness examination, and when required a basic pair of frames and clear plastic single vision or bifocal lenses approved by the Underwriting Manager, every twenty-four (24) months per Insured Person subject to qualifying norms (including an unaided visual acuity of worse than 6/9 on the Snellen Scale for distance vision and near vision; a refraction requirement exceeding zero point five (0,5) dioptre sphere and /or zero point five (0,5) dioptre cylinder on distance vision and one point two five (1,25) 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), subject to terms and conditions agreed by the Underwriting Manager with the approved optometrist Service Provider.

Access to Basic Radiology

Access to black and white diagnostic X-rays on referral by a Network general practitioner at one or more of the consultations referred to above, if required, and subject to a list of X-ray procedures approved by the Underwriting Manager, available through a radiologist identified by the Underwriting Manager. The list of X-rays approved by the Underwriting Manager includes:

Tariff Code	
30110	Chest, two views, anteroposterior (AP) and lateral
64100	Forearm – left
64105	Forearm – right
65130	Wrist – left
65135	Wrist – right
65100	Hand – left
65105	Hand – right
65120	Finger
65140	Scaphoid – left
65145	Scaphoid – right
62100	Humerus – left
62105	Humerus – right
63100	Elbow – left
63105	Elbow – right
72100	Knee, one or two views – left
72105	Knee, one or two views – right
72120	Knee including patella – left
72125	Knee including patella – right
72140	Patella – left
72145	Patella – right
71100	Femur – left
71105	Femur – right
73100	Lower leg – left
73105	Lower leg – right
74100	Ankle – left
74105	Ankle – right
74120	Foot – left
74125	Foot – right
74130	Calcaneus – left
74135	Calcaneus – right
74145	Toe

Access to Basic Pathology

Access is limited to diagnostic pathology tests on referral by a Network general practitioner at one or more of the consultations referred above, if required, and subject to a list of basic pathology tests approved by the Underwriting Manager, available through a pathologist Identified by the Underwriting Manager. The list of pathology tests approved by the Underwriting Manager includes:

Tariff Code	
3743	Erythrocyte sedimentation rate
3755	Full blood count (including items 3739, 3762, 3783, 3785, 3791)
3762	Haemoglobin estimation
3785	Leucocyte total count
3797	Platelet count

3816	T and B-cells EAC markers (limited to one marker only for CD4/8 counts)
3865	Parasites in blood smear
3883	Concentration techniques for parasites
3885	Direct Prep. AFB (TB Micro)
3916	Mycobacterial culture
3947	C-Reactive protein
3948	LgG specific antibody titer ELISA/EMT per Ag
4001	Alkaline phosphate
4009	Bilirubin total
4025	Cholesterol, HDL/LDL, triglycerides
4027	Cholesterol total
4032	Creatinine
4057	Glucose quantitative (blood)
4026	LDL cholesterol (chemical determination)
4027	Cholesterol Total
4028	Lipogram – HDL Cholesterol
4032	Creatinine
4049	Glucose tolerance STD 2hrs 75
4052	Glucose tolerance test (3 specimens)
4053	Oral glucose tolerance test (OGTT)
4064	Glycated haemoglobin Chromatography / HBA1C
4113	Potassium
4114	Sodium
4130	Aspartate aminotransferase (AST)
4131	Alanine aminotransferase (ALT)
4139	Adenosine deaminase, (ADA) CSF / Fluid / Serum
4147	Triglyceride
4151	Urea
4188	Urine dipstick, per stick (irrespective of number of tests on stick)
4352	Occult blood monoclonal antibodies
4559	Liquid based cytology
4566	Vaginal or cervical smears

Pre-Birth Maternity Benefits

Access to a gynaecologist is limited to 2 (two) visits and 2 (two) ultrasound scans per Policy Year, subject to a maximum benefit of three thousand rand (R3 000) per Family per Policy Year. This benefit is only payable if Pre-authorisation is requested and approved.

5.2 Medical Emergency Benefits

Specific Memorandum

The Medical Emergency Benefit shall be delivered by the Service Provider as appointed by the Underwriting Manager. The Medical Emergency Benefit is comprised of the following:

a) A twenty-four-hour (24-hour) medical information hotline, which shall include the necessary medical personnel, including paramedics, nurses and doctors, 24 (twenty four) hours a day to provide general medical information

and advice and to guide the Insured Person through a medical crisis situation, by providing emergency advice or by enabling the Insured Person to receive the required support;

b) A twenty-four-hour (24-hour) emergency medical response to the scene of an Emergency shall be available. Emergency medical response shall include appropriate road and/or air response, utilising an ambulance, and/or rapid response vehicle and/or helicopter and/or a fixed wing aircraft (all of which are manned by appropriately qualified and experienced emergency care practitioners, paramedics or medical doctors), dispatched to the site of the Emergency. Where appropriate, lifesaving support will be provided to the Insured Person and where relevant, the Insured Person will be stabilised before transfer is provided to the closest appropriate medical facility;

c) Twenty-four-hour (24-hour) medical transportation in the event of an Insured Person's involvement in an Emergency. The Service Provider will provide emergency medical transportation by road and/or by air ambulance, under appropriate medical supervision, if necessary, to the nearest medical facility capable of providing adequate care. Medical considerations, the degree of urgency, the Insured Person's state and fitness to travel and other considerations, including, but not limited to, airport availability, weather conditions and distance to be covered as assessed by the contact centre doctor and support staff will determine whether transport will be provided by medically equipped aircraft, helicopter, regular scheduled flight, rail or road. The Company will cover all the costs of the medical transfer;

d) Repatriation of mortal remains within the Republic of South Africa shall be limited to seven thousand five hundred rand (R7 500) per Insured Person.

5.3 Casualty Benefit

A benefit equal to the cost of outpatient hospital treatment in a casualty ward or hospital emergency unit will be available, provided that such treatment is in the event of an Accident. The benefit shall be limited to six thousand rand (R6 000) per Insured Person per Insured Incident. This benefit is only payable if Pre-authorisation is requested and approved.

5.4 Emergency Stabilisation Benefit

A benefit equal to the cost of treatment in a hospital emergency unit, provided that such treatment is in the event of an Emergency. The benefit shall be limited to twenty-two thousand rand (R22 000) per Insured Person per Insured Incident. Inter-hospital transfer in an appropriate road and/or air response will be undertaken utilising an ambulance, and/or rapid response vehicle, and/or helicopter and/or a fixed wing aircraft (all of which are manned by appropriately qualified and experienced emergency care practitioners, paramedics or medical doctors). No limitation applies to inter-hospital transfers. This benefit is only payable if Pre-authorisation is requested and approved.

5.5 MRI And CT Scan Benefit

When an Insured Person has been admitted as an inpatient as a result of an injury sustained due to an accident, the actual cost of an MRI or CT scan that is necessitated due to the injuries sustained. This benefit is limited to sixteen thousand rand (R16 000) per Insured Person per Policy Year. This benefit is only payable if Pre-authorisation is requested and approved.

5.6 Physiotherapy and Occupational Therapy Benefit

Physiotherapy and Occupational therapy following an inpatient hospitalisation due to an accident. The benefit shall only be payable during the three (3) month period following the discharge from an inpatient hospitalisation due to an

accident and shall be limited to three thousand rand (R3 000) per Insured Person per Policy Year. This benefit is only payable if Pre-authorisation is requested and approved.

5.7 Personal Accident Benefit

A benefit equal to the cost of inpatient hospital treatment, provided that such treatment is in the event of an Accident. The benefit shall be limited to one million, one hundred thousand rand (R1 100 000) per Insured Person per Insured Incident. Inter-hospital transfer in an appropriate road and/or air response will be undertaken utilising an ambulance, and/or rapid response vehicle, and/or helicopter and/or a fixed wing aircraft (all of which are manned by appropriately qualified and experienced emergency care practitioners, paramedics or medical doctors). No limitation applies to inter-hospital transfers. This benefit is only payable if Pre-authorisation is requested and approved.

5.8 Accidental Death Benefit

A benefit equal to ten thousand rand (R10 000) is payable in the event of the death of the Principal Insured Person and/or the spouse of the Principal Insured Person due to an Accident. The benefit is limited to one spouse only. The Principal Insured and/or spouse needs to nominate a beneficiary to whom the benefit amount will be paid to in the event of accidental death. If a beneficiary is not nominated the benefit amount will be paid to the estate of the deceased.

5.9 Overall Annual Limit

The overall annual limit for all hospitalisation benefits: The Casualty Benefit, Emergency Stabilisation Benefit, Physiotherapy, and Occupational Therapy Benefit, MRI and CT scans Benefit, Personal Accident Benefit and Accidental Death Benefit is not limited per Family per Policy Year.

5.10Wellness Programme

The overall annual limit for all hospitalisation benefits: The Casualty Benefit, Emergency Stabilisation Benefit, Physiotherapy, and Occupational Therapy Benefit, MRI and CT scans Benefit, Personal Accident Benefit and Accidental Death Benefit is not limited per Family per Policy Year.

Health screenings at approved pharmacies
Limited to one per Insured Person per policy year. Wellness screenings are limited to: blood pressure, cholesterol, glucose levels, body mass index (BMI), waist circumference, HIV and pre- and post-test counselling.

Pap smears
This benefit is only available from approved pharmacies and Network general practitioners and shall be limited to one Pap Smear every three (3) years after the age of twenty-one (21).

Prostate-specific antigen (PSA) screening
Available at approved pharmacies once every 2 years after the age of fifty (50).

Vaccination Programme
The following vaccinations are available from approved pharmacies:
Influenza: This benefit is available annually and only payable if administered by 31 May in each Policy year.

Tetanus: This benefit is available once every ten (10) years.
Hepatitis A & B: This benefit is available once per Insured Person during their lifetime.
Pneumococcal: This benefit is available once every five (5) years for Insured Persons aged sixty (60) or older and for Insured Persons with severely compromised immune systems.

Assistance Programme
Unlimited telephonic counselling services are provided by registered counsellors who follow specific procedures and clinical protocols. The service is available 24/7 and includes counselling for: critical incidence/trauma counselling, HIV counselling, legal advice, financial advice.

5.11Pro-ration of Benefits

The Company reserves the right to pro-rate benefits in a manner determined by the Company for Insured Persons joining during the Policy Year.

5.12Pre-authorisation and Patient Management

The Underwriting Manager may require another opinion in respect of proposed treatment or medicine which may result in a claim for benefits. The relevant Insured Person shall consult a provider nominated by the Underwriting Manager at the cost of the Company. In the event that another opinion proposes a different treatment or medicine, the Underwriting Manager may in its discretion require that the alternative treatment plan or medicine be followed for claims to be payable.

To ensure optimal patient management and care the Underwriting Manager may require Pre-authorisation to access benefits in respect of any Service Provider at any time for a particular Insured Person.

5. Cancellation and Termination

Constantia Life and Health Assurance Limited may at any time and by providing 31 (thirty one) days written notice, cancel this Policy and all benefits.

You may, within 31 days from the date of receiving the Policy, cancel the Policy by providing written notice to DuePoint at info@duepoint.net. If the cancellation notice reaches the Company within 31 days after you have received the Policy Schedule, or within 31 days after it reasonably can be accepted that you should have received the Policy Schedule, your policy will end when Constantia Life and Health Assurance Limited receives your notice.

If your cancellation notice reaches us after the 31 days, the policy will end at the end of the month in which Constantia Life and Health Assurance Limited received it.

6. Transfer or Cash In

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

7. Change in Details Supplied

Should there be any changes to the original details supplied by any Assured at the time of application for the policy and/or specified in the policy schedule, the Assured must notify Constantia Life and Health Assurance Limited in writing (info@duepoint.net) or call its Client Service team (010 020 4500) within 30 (thirty) days of such change occurring.

Should the Assured not notify Constantia Life and Health Assurance Limited of such change, Constantia Life and Health Assurance Limited reserves the right to reject liability in respect of a claim or to cancel this policy.

8. Misrepresentation, Misdescription or Non-Disclosure

If there are false or incomplete statements in the application form or recorded verbal declaration where the Client Service team is contacted directly, of this Policy, or if there is any false or incomplete statements when submitting a claim, Constantia Life and Health Assurance Limited reserves the right to cancel the Policy or to reject a claim.

Misrepresentation, misdescription or non-disclosure of any material fact or circumstances in connection with this policy, a claim in terms of this policy or the application for this policy may result in this policy being cancelled, a claim rejected or the policy voided from inception.

In the event that a benefit is paid to the Assured as a result of any misrepresentation, non-disclosure, misdescription or fraudulent action by the Assured, the Assured shall be obliged to repay or return the benefit the Assured has received under this policy and Constantia Life and Health Assurance Limited shall be entitled to take legal action against the Assured to recover the benefit and/or any costs associated with such legal action.

9. Fraud

If any claim or part thereof under this policy is in any way fraudulent, or if any fraudulent means or devices are used by the Assured or anyone acting on the Assured's behalf to obtain any benefit under this policy, or if any of the events assured against under the policy are occasioned by the Assured's intentional conduct or any person acting on behalf of or with the connivance of the Assured, all benefits afforded in terms of this policy in respect of such claim, and premiums paid in respect of such policy shall be forfeited, and this policy may be avoided or cancelled as from the date of the fraudulent conduct, at Constantia Life and Health Assurance Limited's discretion.

10. Territory Covered

The territorial limits are restricted to the Republic of South Africa. Any Assured ordinarily resident in the Republic of South Africa shall be covered in terms of this policy during a visit lasting less than 3 (three) months outside the territory covered.

11. Constantia Life and Health Assurance Limited's Liability

Despite what this policy stipulates elsewhere, Constantia Life and Health Assurance Limited shall not be liable to make any payment unless the premium has been received and satisfactory proof of a claim has been submitted as required by Constantia Life and Health Assurance Limited.

Payment by Constantia Life and Health Assurance Limited of the benefits provided for in this policy will be a full and effective discharge by the Company of its liability and obligations in terms of this policy.

12. Treating Our Customer Fairly

Should these Policy Terms, Conditions and Notices not be completely clear to you, you may call us on 010 020 4500, visit our website at www.duepoint.net or email us at info@duepoint.net. Or contact the TCF or Compliance offices as listed under the Disclosure Schedule below section 1.5.

13. Requests for Policy Service

Please call 010 020 4500 or send an email to info@duepoint.net.

Disclosure Schedule

NOTICE TO LONG-TERM INSURANCE POLICYHOLDERS DISCLOSURE AND OTHER LEGAL REQUIREMENTS - PLEASE READ CAREFULLY

(This notice does not form part of the assurance contract or any other document)

As a Long-Term Assurance Policyholder, or prospective Policyholder, you have the right to the following information:

1. About the Insurer

a) Name, physical address and telephone number:

Constantia Life and Health Assurance Limited, a member of the Constantia Insurance Group, is a registered Long-Term Insurance Company.

Company Registration Number	:	1952/000379/06
PO Box Address	:	PO Box 2215, Cape Town, 8000
Physical Address	:	Building B, Nicol Main Office Park, 2 Bruton Road, Bryanston 2191
Contact number	:	011 686 4200

Constantia Life and Health Assurance Limited

DuePoint Customer Services
Corner Main,
2 Payne Road,
Bryanston,
Sandton
Telephone: 010 020 4500
Email: info@duepoint.net

b) Legal status and any interest in the Insurer:
The Insurer is a public company with limited liability.

c) Whether in possession of professional indemnity insurance:
This Insurer is in possession of professional indemnity insurance.

d) Contact details of the Public Officer, TCF Compliance Officer and Complaints Department of the Insurer:

Public Officer	Contact Number	Email address

Peter Todd	010 020 4500	info@duepoint.net
TCF and Compliance Officer		
Christiene Brummer	011 686 4200	Christieneb@constantiagroup.co.za
Market Conduct Officer		
Mrs Astrid Baynes	011 686 4200	Astridb@constantiagroup.co.za
Complaints Department		
Brendan Benfield	010 020 4500	complaints@duepoint.net

e) Ambledown's Compliance Officer

Compliance Officer: Mr. Paul Makwea
Physical Address: Ambledown House, Eton Office Park East, c/o Sloane & Harrison Streets, Bryanston
Postal Address: PO Box 1862, Cramerview, 2060
Telephone: 086 126 2533
Email: compliance@ambledown.co.za

f) Underwriting Manager Details

Name: Ambledown Financial Services (Pty) Limited
Telephone: 0861 366 006
Fax No: 011 706 5568
Registration No: 2004/006271/07
FSP No: 10287
Website Address: www.unityhealth.co.za
Physical Address: First Floor Right Wing, Ambledown House, Eton Office Park, c/o Sloane and Harrison Streets, Bryanston, 2191
Email Address: info@unityhealth.co.za
Postal Address: PO Box 1862, Cramerview, 2060

Should you be dissatisfied with any aspect of your insurance contract, service received as part of a general disclosure, how to lodge a complaint or of Unity Health's compliance with the FAIS Act, please refer the matter to info@unityhealth.co.za.

Underwriting Managers Compliance Officer: Moonstone Compliance, Telephone No: 021 883 8000

a. Ambledown Financial Services has an agreement with Constantia Insurance Company Limited authorising Ambledown Financial Services to act as an underwriting manager whereby marketing, underwriting, policy documentation administration, and claims handling is administered for Health & Accident insurance business.
b. Ambledown Financial Services has in the last 12 months earned more than 30% of its remuneration from Constantia Insurance Company Limited.
c. Ambledown Financial Services has both Professional Indemnity and Fidelity Guarantee Cover.

g) Premium Payment:

Details of your Premium obligations are contained in the policy's schedule of insurance and include administration fees, commissions and total amount due, payment dates and payment conditions.

h) Claim Notification Procedures:

- Please note that for potential claims under your policy Insured Persons are required to contact the Underwriting Manager in order to establish the appointed service provider. If you fail to pre-authorise your claim it may be repudiated due to the absence of the notification.
- Any claim that does not require pre-authorisation must be submitted to the underwriting manager or intermediary within 120 (one-hundred-and-twenty) days from the date of happening of the event giving rise to your claim. If you fail to notify your claim timeously it may be repudiated due to such late notification. Furthermore, you may be required to complete a claim form and may also be required to produce documentary proof substantiating your claim.

i) Manner of payment of premium and due date of premium:
Monthly premiums, payable by debit order, due each month on your salary / agreed pay date. Should your pay date fall on a Saturday, Sunday or recognised South African public holiday, you authorise the Insurer (or its nominee) to debit your account at its discretion on the following or previous ordinary business day.

j) Consequences of non-payment:
Subject to any relevant deferred benefit periods, your policy will come into force once the Policy Commencement Date as shown on the Policy Schedule has been reached and the first premium has been received by us on or before that date and will remain in force so long as all subsequent premiums are received by us when due or within 15 days thereof and the policy has not been cancelled. If your monthly premium is not received or only partially received within 15 days of due date, your policy will lapse, on notifying you, and all policy benefits and cover will cease. A lapsed policy may be re-instated at the option of the Insurer upon the receipt of all future premiums when due, but the extent of the benefits and cover will be subject to the re-commencement of any deferred benefit periods.

2. Other Matters of Importance

a) You must be informed of any material change to the information provided above.
b) If the information above was given to you verbally, it must be confirmed to you in writing within 30 days.
c) A polygraph or lie detector test is not obligatory in the event of a claim and the failure thereof may not be the sole reason for repudiating the claim.
d) You are entitled to a copy of the policy document free of charge.
e) The Insurer must give you written reasons for repudiating a claim.
f) The Insurer may not cancel your policy without giving you 31 days notice in writing.
g) Your Insurer may not cancel your assurance merely by informing your Intermediary. There is an obligation on the Insurer to make sure the notice has been sent to you.

3. Warning

Although the application for this policy may have been completed online, remember never to sign any blank or partially completed form and to complete all forms in ink. Keep all documents handed to you. Make notes as to what

is said to you. Don't be pressurised to buy the product. Incorrect or non-disclosure by you of relevant facts may influence an Insurer on claims arising from your contract of assurance.

4. Policy Claims and Administration

Constantia Life and Health Assurance Limited	
Building B, Nicol Main Office Park, 2 Bruton Road, Bryanston 2191	Telephone 010 020 4500

Particulars of the Ombudsman for Long-Term Insurance who is available to advise you in the event of claim problems that are not satisfactorily resolved by Constantia Life and Health Assurance Limited:

Ombudsman for Long-Term Insurance	
Private Bag X45 Claremont 7735	Telephone 021 657 5000 Fax 021 674 0951

Financial Sector Conduct Authority	
P.O. Box 35655 Menlo Park 0102	Telephone 012 428 8000 Fax 012 346 6941

5. Customer Responsibility

It is important that all of the information provided by you or on your behalf or on behalf of an assured person, is complete and accurate. Should this not be so, the possible consequences of incomplete, misrepresented or non-disclosed information associated with your application include the cancellation of the products applied for and the forfeiture of any monies paid to date, the repudiation of all claims irrespective of their cause or nature, and the possible institution of criminal action against you.

Whilst reasonable steps would have been taken to ensure that the products applied for by yourself are suitable for providing cover appropriate to the purchase you have made, no analysis of your financial needs or risk profile has or will be undertaken, and no advice has been given by the Insurer or those associated with it. It is therefore vital that you take particular care to ensure that the product or products you have purchased are appropriate and adequate for your needs.

6. Claims and Complaints Procedures

When a claim arises, please refer to the accompanying policy documentation for details of the procedures to be followed.

a) In the case of dissatisfaction with services received, you have the right to lodge a complaint through:

Complaints Officer:	Mr. Paul Makwea
Physical Address:	Ambledown House, Eton Office Park East, c/o Sloane & Harison Streets, Bryanston
Postal Address:	PO Box 1862, Cramerview, 2060
Telephone:	(086) 126 2533
Email:	complaints@ambledown.co.za

A full Complaints Resolution Policy may be requested from the Compliance Officer as per details below.

In the case of dissatisfaction with services received, you have the right to lodge a complaint with Constantia Insurance Company Limited through:

Complaints Officer:	Mrs. Astrid Baynes
Physical Address:	Building B and Portion of Building A, Nicol Main Office Park, 2 Bruton Road, Bryanston, Johannesburg, 2191
Postal Address:	PO Box 3518, Cramerview, 2060
Telephone:	011 686 4200
Email:	complaints@constantiagroup.co.za

b) For complaints relating to the Insurer's conduct, contact the Ombud for Financial Service Providers at:

Ombud for Financial Service Providers		
Physical Address	Postal Address	Telephone
Ground Floor, Block B	P.O. Box 74571	012 470 9080
Sussex Office Park	Lynnwood Ridge	Fax
473 Lynnwood Road	0040	012 348 3447
Cnr Lynnwood Road & Sussex Ave		Email
Lynnwood Ridge		info@faisombud.co.za
0081		Website
		www.faisombud.co.za

In order to complain to the Ombud for Financial Service Providers you must lodge a Complaints Registration Form that may be downloaded from the FAIS Ombud's website (www.faisombud.co.za/howtocomplain) or obtained from the FAIS Ombud (contact details as above). You must read the form carefully, gather the necessary information, complete the form, sign the form and return the form to the FAIS Ombud's office at one of the above addresses including supporting documents (for instance, correspondence, policy documents, application forms and contact details).

7. Further Information in Compliance with the Protection of Personal Information Act

In terms of the Protection of Personal Information Act of 2013 you are notified that the information provided and obtained in order to issue this policy is mandatory and is collected, held and processed mainly to improve the service provided to you and to provide you with access to the services and products of the Insurer.

When submitting any personal information, the information that is received from you will be used only for the purpose for which the information is requested and to enable the Insurer to comply with its obligations or to comply with any legal requirements. You expressly consent to the collecting and processing of your personal information which may include, but is not limited to, the following:

- Carrying out the transaction you requested
- Underwriting the risk assured
- Assessing and processing claims
- Statistical analysis, research and communication with you
- For purposes of claims history
- For the detection and prevention of fraud, crime, money laundering or through this database which will assist the insurance industry to limit insurance fraud, to underwrite risks fairly and to assess every risk identified. The Insurer may therefore reveal or share your personal information in relation to the promotion of the aforesaid information sharing objectives thereby ensuring further that your policy is fairly underwritten. Such information sharing may also include storage in the SAIA (South African Insurance Association) database and the verification of such shared information against legally recognised databases.

With your consent the Intermediary may also supplement the information that you provide with information received from other affiliated Insurers, Reinsurers, Underwriting Managers and Agents (“UMA”) and Administrators in order to offer you a more consistent and personalised experience in your interactions with the Intermediary.

The Insurer's affiliated Insurers, Reinsurers, UMA and Administrators are subject to the same privacy regulations as the Insurer. Your personal information will not be disclosed to any other company or organisation unless required by law or where it is in the public interest that such disclosure is necessary or where you have expressly provided authorisation in this regard.

Failure to provide the information in a complete and accurate manner may lead to your policy not being issued, not coming into force, being cancelled or your claim being repudiated.

You have the right to access the personal information held on your behalf as set out above. You also have the right to ask the Insurer to update, correct or delete your personal information. All reasonable steps to confirm your identity will be taken before providing details of your personal information or making changes to your personal information. You can contact the Insurer at the numbers or addresses listed above.

8. Treating Customers Fairly Policy

Constantia Life and Health Assurance Ltd has a strong focus on customer satisfaction and is recognised for the fair treatment of its customers. Constantia Life and Health Assurance Ltd is fully committed to delivering service of the highest standard as its customers are its most valuable asset. Constantia Life and Health Assurance Ltd's Treating the Customer Fairly ("TCF") policy is structured according to the guidance provided by the Financial Sector Conduct Authority ("FSCA") to ensure it consistently delivers fair outcomes to its customers. In order to implement Constantia Life and Health Assurance Ltd's policies on TCF each of its affiliated Insurers, Reinsurers, UMAs, Administrators and employees are expected to understand and apply this policy and are bound thereto in terms of the standards of service delivery set out below.

9. Approach to Service Delivery

The Financial Sector Conduct Authority has outlined 6 key themes, which are central to the TCF initiative. DuePoint will comply with and contribute to these 6 TCF fairness outcomes viewed from the perspective of its customers as follows:

- Customers are confident that they are dealing with a provider where the fair treatment of customers is central to its culture
- Products and services marketed and sold in the retail market are designed to meet the needs of identified customer groups and are targeted accordingly
- Customers are given clear information and are kept appropriately informed before, during and after the time of contracting
- Where customers receive advice, the advice is suitable and takes account of their circumstances
- Customers are provided with products that perform as providers have led them to expect, and the associated service is both of an acceptable standard and what they have been led to expect
- Customers do not face unreasonable post-sale barriers to change or cancellation of products, submit a claim or make a complaint.

10. Conflict of Interest Requirements

- Ambledown Financial Services (Pty) Ltd has established a Conflict of Interest Management Policy which is available on request from our Compliance Officer.
- In order to meet regulatory requirements, financial or immaterial expenditure by and to our staff are monitored.
- Where potential Conflicts of Interest have been identified which do not have a direct impact on you, the insured, internal structures are in place to manage and control such circumstances.

11. Standards of Service Delivery

DuePoint aims to demonstrate through its behaviours and monitoring that it is consistently treating customers fairly throughout the stages of the product life cycle to which it can contribute. In order to achieve these service standards DuePoint and its employee members undertake to:

- Adhere to DuePoint's corporate culture of ensuring that customers fully understand the features, benefits, exclusions, risks and costs associated with the financial products they buy
- Ensure that customers are provided with clear, concise information and kept appropriately informed before, during and after the purchase of their products allowing them to make informed decisions
- Ensure that regular, clear and appropriate correspondence is maintained with customers at all times and that the relevant communication protocols are strictly followed
- Adhere to DuePoint's phone etiquette standards and to provide excellent service to the customer where the fair treatment of the customer is central to that service
- Follow the principle that customer service at all stages must meet customer expectations and that any promises or commitments made must be met
- NOT give any financial advice to customers but to direct them to the organisation's Key Individuals or Representatives where such advice is required or sought
- Ensure that any request from a customer is attended to without any unnecessary barriers or delays
- Fairly manage the customer's expectation at all times
- Leave the customer feeling pleased about their experience with the Company and confident that they are dealing with an honest, professional and ethical organisation where the fair treatment of clients is central to the company's culture
- Ensure all third parties contracted with are committed to treating our customers fairly.
- Complaints handling service standards:
  - We respond in a timely manner to our customers and prospective customer’s questions and queries, addressing any issues or concerns promptly
  - All customer complaints are dealt with and escalated appropriately in order to meet our obligations to our clients
  - Complaints are therefore handled fairly, promptly and impartially.
  - All valid claims are paid promptly
  - The principles of "fairness and equity" are applied in all decisions, always giving the customer the benefit of the doubt where information is not perfectly clear
  - In dealing with complaints DuePoint will 'treat like situations alike' and give careful consideration to whether an error might have affected a wider class of customers and what should be done to remedy this
  - DuePoint will investigate the root causes of complaints and obtain feedback from customers who have experienced our complaints process in order to improve the level of service that is provided.

Constantia Life and Health Assurance Company Limited | Reg No. 1952/001635/06 Vat No. 4330146871
Tel: 011 686 4200 | Facsimile: 011 789 8828 | 2 Bruton Road, Bryanston, 2191 | PO Box 3518, Cramerview, 2060 www.constantiagroup.co.za