

Discovery Group Risk Life Plan Guide

Contents

Section 1	Welcome	1
Section 2	The Group Risk Life Plan	3
Section 3	The Life Fund	6
Section 4	The Life Cover Benefit and the Global Education Protector	7
Section 5	Income Continuation Benefit	12
Section 6	Capital Disability Benefit	24
Section 7	Severe Illness Benefit	26
Section 8	Funeral Cover Benefit	31
Section 9	Spouse benefits	33
Section 10	Mortgage Protector	34
Section 11	Continuation Option	36
Section 12	Discovery Group Risk Payback	38
Section 13	Rewards for managing your health through Vitality	40
Section 14	Premium payments	42
Section 15	Underwriting and the Free Cover Limit Multiplier	45
Section 16	How to claim and receive your benefits	47
Section 17	General legal provisions, definitions and rules	50
Section 18	Cession and beneficiaries	56
Section 19	Discontinuing the policy	57
.....		
Appendix 1	Disability benefits assessment	58
Appendix 2	Severe Illness Benefit assessment	66
Appendix 3	Early Cancer Benefit assessment	80
Appendix 4	Activities of Daily Living	81
Appendix 5	Group Risk Payback tables	85

Welcome

Welcome to Discovery Group Risk

We offer unique and innovative Group Risk assurance products that will assist in providing valuable risk benefits to scheme members and their families.

This document will help you to understand the finer details of the Discovery Group Risk policy.

The policy protects members and their families from any life-changing events. It is important that the policyholder (see definition under clause 17.1.1) and members (see definition under clause 17.1.2) fully understand the protection given to members by the benefits that have been chosen by the policyholder and which are fully described in this document.

Documents that make up your policy

The policy consists of this Discovery Group Risk Life Plan Guide, the accepted quotation document, the application form, the client and member benefit schedules and the general benefit limits document.

These documents must be read together when determining the policyholder's and Discovery Group Risk's obligations and rights under the policy. Even if additional benefits are described in this document or the quotation document, the members are only covered for benefits reflected in the application form and the client and member benefit schedules.

This Discovery Group Risk Life Plan Guide (version GRLPG01/17) provides comprehensive information on all potential benefits that we may offer to members. Details of the Discovery Group Risk benefits actually selected, and details of the members covered under this policy, appear on the client and member benefit schedules accompanying this Discovery Group Risk Life Plan Guide. It is important to read the schedules carefully to ensure that the benefits chosen are correctly shown.

This policy may be amended by Discovery Group Risk with 30 days' notice to the policyholder, unless an immediate change is required by law. It is important to remember that at the time of a claim event the latest version of the policy, which can be shown to have been emailed to the policyholder's or their representative's recorded email address, will be applied. Certification by an officer of Discovery Group Risk of a copy of the email containing the policy changes will be enough proof that the new policy was received by the policyholder or their representative.

In the case of disagreement between the policy and any other documents, the conditions of the policy will override any other documents or communications.

The policyholder can cancel this policy within 30 days

If, after studying the policy (including benefit and member schedules and this Discovery Group Risk Life Plan Guide), the policyholder is unhappy with the policy chosen, the policyholder can take advantage of a 30-day cooling-off period. The cooling-off period enables the policyholder to re-evaluate the policy purchased and cancel the policy by sending a written cancellation notice to Discovery Group Risk within 30 days of the policy being issued. Any premiums paid will be refunded after the deduction of any costs incurred and claims paid.

Contact us for more information on this policy

We will assist you in resolving any problems that you may have, and we encourage you to contact us if necessary. You are welcome to contact:

- Your financial adviser as indicated on the client benefit schedule
- Discovery Group Risk contact centre at 0860 0 47687
 - By email: groupinfo@discovery.co.za
 - By fax: 011 539 7288
 - By mail: Discovery Group Risk
PO Box 3888
Rivonia
2128
- Discovery Compliance Officer:
 - Telephone: 011 529 2980
 - Fax: 011 539 1887
 - Email: Compliance@discovery.co.za

How to lodge a complaint

If you have received too little information or unsatisfactory service or have complaints about the advice you have received, please contact the Complaints team at Group_Risk_Complaints@discovery.co.za or on 011 529 1523.

If Discovery Group Risk does not resolve your complaint to your satisfaction, you may contact the parties mentioned below for assistance.

The Ombudsman for Long-term Insurance

Postal address:	Physical address:	Telephone: 021 657 5000 or 0860 10 32 36
Private Bag X45	Sunclare Building	Fax: 021 674 0951
Claremont	3rd floor 21 Dreyer Street	Email: info@ombud.co.za
7735	Claremont	Website: www.ombud.co.za
	Cape Town	
	7700	

or

The FAIS Ombud

Postal address:	Physical address	Telephone: 012 762 5000 or 012 470 9080
FAIS Ombud	473 Lynnwood Road	Fax: 012 348 3447 or 086 764 1422
PO Box 74571	Ground Floor, Block B 473	Email: info@faisombud.co.za
Lynnwood Ridge	Sussex Office Park	Website: www.faisombud.co.za
0040	Lynnwood	
	0081	

or

The Pension Funds Adjudicator

Pretoria

Postal address:	Physical address:	Telephone: 012 346 1738 or 012 748 4000
PO Box 580	4th floor, Riverwalk Office	Cell: 086 693 7472
Menlyn	Park, Block A	Email: enquiries@pfa.org.za
0063	41 Matroosberg Road	Website: www.pfa.org.za
	Ashlea Gardens	
	Pretoria, 0081	

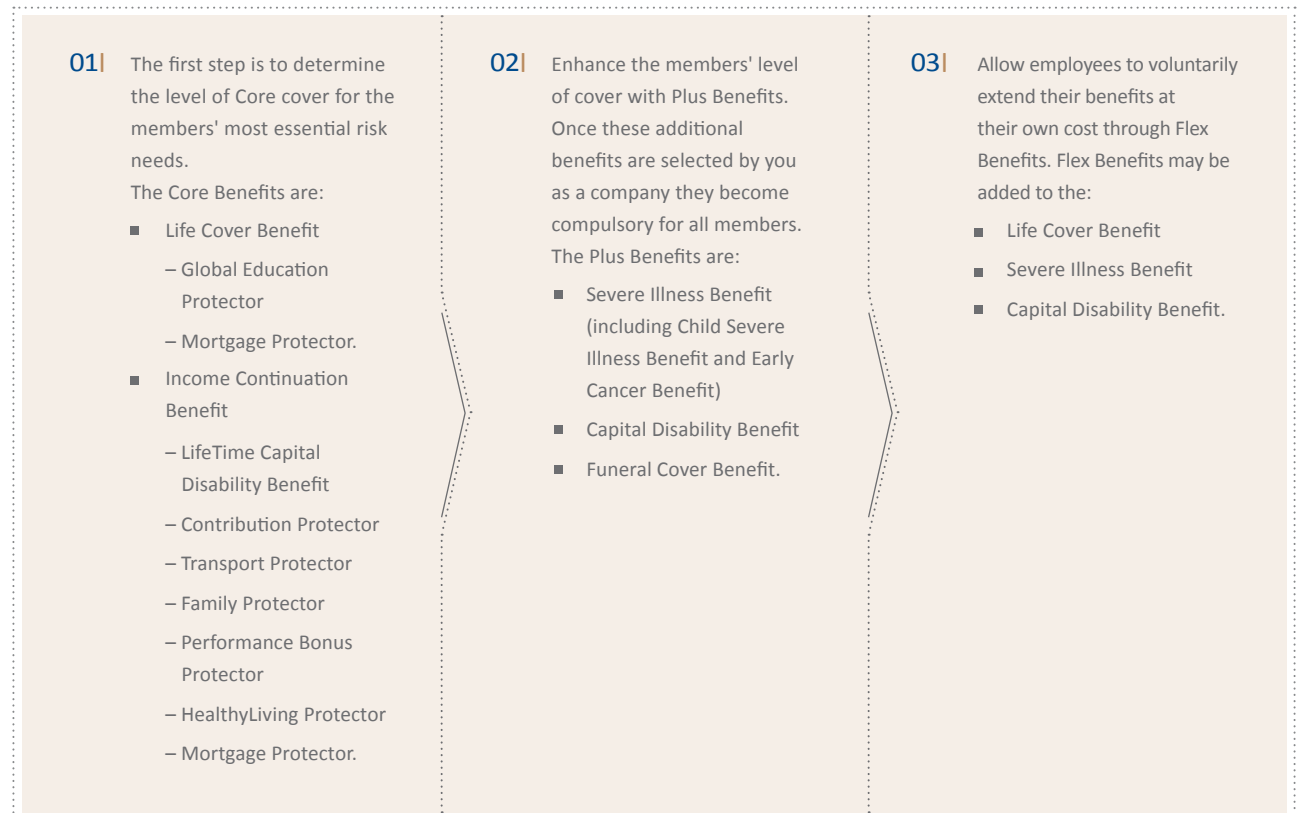
Johannesburg

Postal address:	Physical address:	Telephone: 011 783 4134
PO Box 651826	2nd floor, Sandown House	Fax: 011 884 1144
Benmore	Sandton Close 2	Email: enquiries@pfa.org.za
2010	2196	Website: www.pfa.org.za

The Group Risk Life Plan

The Group Risk Life Plan provides cover for life-changing events for the whole family. These life-changing events include death, severe illness and disability. To choose the best combination of benefits, policyholders can choose from the following options:

Determine the level of cover for members, with Core, Plus and Flex Benefits



Members may obtain rewards for managing their health through Vitality

Vitality

Subject to a minimum of 50% of members being on Discovery Health Medical Scheme, all members may join Vitality on a voluntary basis and engage in a state-of-the-art health and wellness programme. The more your members engage with Vitality the more the scheme will benefit.

Vitality is a wellness programme that empowers members to improve their health by giving them the knowledge, tools and motivation to set and meet health goals. The healthier members are, the more Vitality rewards them, and the greater their productivity in the workplace.

These options are outlined in the rest of this section and described in detail in the rest of this Discovery Group Risk Life Plan Guide.

2.1 Group Risk Life Plan benefit options available to the policyholder

The Group Risk Life Plan includes various combinations of benefits to be selected by the policyholder. These combinations assist the policyholder in providing members with benefits that meet their risk needs and provide additional access to unique and flexible products for the member on a voluntary basis. The policyholder must make two decisions:

1. Which Core and Plus Benefits to provide to members
2. Whether Flex Benefits should be made available to members.

Discovery Group Risk has established maximum benefit levels for Core, Plus and Flex Benefits. These limits are reviewed from time to time (see general benefit limits).

2.1.1 Core Benefits

Core Benefits are compulsory and applicable to all members. These benefits cover the most essential risk needs and ensure that all members enjoy a core level of protection.

Core Benefits include:

- The Life Cover Benefit
- The Income Continuation Benefit.

The policyholder will define the benefit structure for the selected benefits. Core Benefits are medically underwritten if cover for a member exceeds the free cover limit as determined by Discovery Group Risk from time to time.

2.1.2 Plus Benefits

In addition, the policyholder may select Plus Benefits, which then become compulsory and applicable to all members. These benefits cover additional member risk needs and ensure that all members enjoy an additional level of protection.

Plus Benefits include:

- The Capital Disability Benefit
- The Severe Illness Benefit
- The Funeral Cover Benefit
- The Spouse Life Cover Benefit.

The policyholder will define the benefit structure for the selected benefits. Plus Benefits (excluding the Funeral Cover Benefit) are medically underwritten if cover for a member exceeds the free cover limit as determined by Discovery Group Risk from time to time.

2.1.3 Flex Benefits

The policyholder may select Flex Benefits, which are not compulsory and may be selected by individual members depending on their risk needs. These benefits provide increased cover funded by the members to extend their compulsory benefits.

Flex Benefits may be added to:

- The Life Cover Benefit
- The Capital Disability Benefit
- The Severe Illness Benefit.

Flex Benefits are not available to spouses.

Flex Benefits have been predefined by Discovery Group Risk in terms of structure and benefit maximums.

The free cover for Flex Benefits is always zero.

Flex Benefits for members are medically underwritten on an individual basis. After initial underwriting on Flex Benefits, no further underwriting in respect of Flex Benefits is required for five years if:

- The original Flex multiple does not change (in other words, the multiple of the member's risk salary)
- The member's increase in risk salary is less than 15% per annum for the five years after underwriting.

Flex Benefits can only be added within:

- Three months of the Group Risk Life Plan commencement date
- Three months of entering the Group Risk Life Plan as a new member after commencement date
- Three months of the Group Risk Life Plan review date
- Three months of a major event such as marriage, divorce, death, birth or adoption of a child.

Flex Benefits may be removed or decreased within three months after a major event such as marriage, divorce, death, birth or the adoption of a child.

Flex Benefits may only be added after removal within:

- Three months of the Group Risk Life Plan review date
- Three months of a major event such as marriage, divorce, death, birth or adoption of a child.

2.1.4 Categorisation of membership

Members may be categorised into different categories with different benefits per category as chosen by the policyholder. If these categories are determined in such a way that the member has no direct control over the category into which they fall (for example, if categories based on level in the company, company unit, age, salary etc.) then no further underwriting requirements other than those already mentioned in this section will apply.

If categories are determined in a manner that allows the member to choose into which category they fall (for example, if categories based on different sums assured where the member can choose the category they desire), then the categorisation will be considered a Flex arrangement and will be priced as such, with the underwriting requirements described in 2.1.3 applying. In addition, other underwriting requirements may be included in the quotation for such a structure as considered by Discovery Group Risk to be appropriate to manage the benefit structure's risk.

Benefits where a member may choose their level of cover are best handled through Flex Benefits, which are designed to cater for this need.

2.2 Vitality

Members may join Vitality on a voluntary basis through one of the following channels:

- Membership of Discovery Health Medical Scheme
- Ownership of a Discovery Life Individual Life Plan
- If the Group Risk Life Plan policyholder has 50% or more of its members on Discovery Health Medical Scheme, then the remaining members, although not on Discovery Health Medical Scheme, may also become Vitality members through the Group Risk Life Plan.

See Section 13 for more details.

2.3 Standalone benefits

The following benefits may be selected on a standalone basis by the policyholder:

- The Life Cover Benefit
- The Income Continuation Benefit
- The Severe Illness Benefit
- The Funeral Cover Benefit.

2.4 What is the free cover limit?

The free cover limit is the maximum cover that Discovery Group Risk will provide to a member without the requirement of medical underwriting. This limit is determined by Discovery Group Risk at its sole discretion and may differ from benefit to benefit and from policyholder to policyholder. The free cover limit may be reviewed from time to time.

The Life Fund

3.1 The Life Fund is the financial foundation of the Group Risk Life Plan

The Group Risk Life Plan has as its basis a Life Fund for each member, which is the financial mechanism of the Group Risk Life Plan. The Life Fund is used to fund benefit payments for the benefits selected by the policyholder (except for the Income Continuation Benefit and its additional benefits, the Global Education Protector and the Funeral Cover Benefit).

3.2 The effect benefit payments have on the Life Fund

A life-changing event is defined as: Death or an illness or disability that is severe enough to affect a claimant's lifestyle or their ability to earn an income and so lowers their standard of living. Certain definitions have to be met to qualify for disability and serious illness benefits – see appendices.

If all premium payments are up to date, Discovery Group Risk may consider a claim in respect of a member under the Group Risk Life Plan. Benefits will be paid to nominated beneficiaries or the deceased estate or retirement fund (if approved), unless instructed otherwise by the policyholder.

Benefit payments are defined as: The proceeds of a claim under any of the benefits paid to the policyholder, member or third party as instructed by the policyholder.

Any benefit payment from a claimant's Life Fund reduces the value of the Life Fund by the amount of the benefit payment, subject to the Minimum Protected Fund (clause 3.3). If a member qualifies for benefit payments from more than one benefit as a result of the same life-changing event, the highest benefit payment will be processed first and the member's Life Fund will reduce by this benefit payment amount. Subsequent benefit payments related to the same event will then be processed against the reduced Life Fund value after the previous benefit payment has been deducted. The same effective date will apply for the assessment of benefit payment amounts for these multiple claims. This effective date is the date on which the life-changing event occurs. The benefit payment will be expressed as a percentage of the Life Fund and this is the amount by which the Life Fund will reduce.

Note: The Income Continuation Benefit, the Global Education Protector and the Funeral Cover Benefit do not reduce the Life Fund.

Example

Assume a member has a Life Fund of four times their annual risk salary and a Capital Disability Benefit of twice their annual risk salary (equivalent to 50% of the Life Fund). When a Capital Disability Benefit (Category A criteria of *Appendix 1*) payment is made, the Life Fund will be reduced by 50%.

3.3 The Life Fund can be protected using the Minimum Protected Fund

The Minimum Protected Fund option allows the policyholder to specify a minimum level for the Life Fund, subject to the survival period stipulated below.

The restoration of the Life Fund (to the level of the Minimum Protected Fund) will occur after a 14-day survival period from the occurrence of a life-changing event. The choice of a Minimum Protected Fund will affect the premiums charged. The extra premium will depend on the Minimum Protected Fund level and also on the cover selected for the various benefits. The Minimum Protected Fund option does not restore the Life Fund after death.

If this option has been selected, subject to the survival period, the balance in the member's Life Fund will never drop below the specified minimum balance, regardless of how many benefit payments have been made or what the monetary value of these payments was. The Minimum Protected Fund is expressed as a percentage of the Life Fund.

Example

Assume a member has a Life Fund of four times their annual risk salary and a Minimum Protected Fund of 50% of their Life Fund. No matter how many claims the member makes against their Life Fund, the balance left in the Life Fund will never be less than 50%.

3.4 The Life Fund can grow again even after a benefit payment has been made

The Life Fund will be reduced by the amount of the benefit payment. However, the remaining Life Fund will continue to grow by the annual salary increase percentage of the member.

3.5 How are the benefit amounts defined?

The client benefit schedule indicates the benefits selected by the policyholder. These benefits are usually defined as a multiple or percentage of the member's annual risk salary, a flat rand amount or a variation thereof, subject to Discovery Group Risk maximum benefits at date of claim (see general benefit limits).

The Life Cover Benefit and the Global Education Protector

4.1 The Life Cover Benefit

The Life Cover Benefit provides cover for members in the event of their death. If a spouse Life Cover Benefit has been selected, the death of the member's spouse will also be covered. On death of the member, the value of the Life Fund at the date of death is paid out. The value is determined as follows:

(i) Initial Life Fund (Core and Flex)

plus

(ii) Any amount by which the Life Fund has grown, due to salary increases, as well as any additional increases or decreases made by the member to their Flex Life Cover Benefit

less

(iii) Any benefit payments previously deducted from the Life Fund.

4.2 When does the Life Cover Benefit end?

The Life Cover Benefit ends at the earlier of:

- The end of the month in which the member reaches the benefit expiry age
- The member no longer being an eligible member (see clause 17.1.2)
- Termination of the Group Risk Life Plan
- Depletion of the Life Fund due to payment of claims.

The benefit expiry age is chosen by the policyholder and is generally the member's normal retirement age. This means that if the member dies in service before the benefit expiry age (and they were an eligible member at the time), the claim will be considered. Claims (in respect of life-changing events) after the benefit expiry age will not be accepted or considered. Premiums will not be charged for the Life Cover Benefit after the member reaches the benefit expiry age.

4.3 The Life Cover Benefit may continue when the member receives a disability income

The Life Cover Benefit could remain in place if the member becomes disabled and a valid Income Continuation Benefit claim is submitted, provided that the member has not been dismissed or retrenched by the employer and has not resigned as a result of their illness or injury, and Discovery Group Risk receives premiums for this member from the policyholder.

The level of the benefit will be the same as the level of the Life Cover Benefit at the date of disability. This benefit can be increased annually and the maximum increase will be restricted to the annual increase in the Income Continuation Benefit. The annual increase will be effected on the same date as the Income Continuation Benefit increase.

If the member becomes disabled, Discovery Group Risk must be notified if the Life Cover Benefit is to remain in place and if there are to be any annual increases. The Life Cover Benefit premium will still be paid to Discovery Group Risk for the disabled member. If the Life Cover Benefit increases, the increased premium will be paid to Discovery Group Risk. The Global Education Protector will remain in place if the Life Cover Benefit remains in place while the member receives a disability income.

4.4 The Life Cover Benefit can be increased to allow for tax payable when the benefit is received

If the policyholder is an approved retirement fund (see clause 17.1.1) and selects the option, the Life Cover Benefit can be increased by an amount approximated to cover tax payable on the benefit. This ensures that the full benefit chosen (before tax) will be payable to the policyholder. This option will increase the Life Cover Benefit premium.

The Global Education Protector

4.5 What is the Global Education Protector?

The Global Education Protector is automatically included with the Core Life Cover Benefit of the Group Risk Life Plan, provided that the Core Life Cover Benefit is equal to at least twice the member's annual risk salary. The Global Education Protector aims to ensure that the education of the member's children is not affected by the death of the member.

4.6 How does the Global Education Protector work?

The Global Education Protector provides indemnity cover for the education of a member's children in the event of the member's death. The Global Education Protector works on an indemnity basis. This means that, subject to clause 4.9, the education payments/fees for which the member was responsible, or which were actually being made by the member in the 12-month period before their death, or for which the member would have become responsible in the future, will be continued by the Global Education Protector.

In line with the indemnity principle, the Global Education Protector will pay the actual educational fees charged by the institution attended by the children at the time of the member's death. Such fees will exclude any fees that are paid separately or in addition to the normal standard education fees applicable to all the learners in the child's particular year/grade. Examples of such excluded fees are described, but are not limited to, those fees mentioned in clause 4.11. If the children attend a no-fees school or are exempted from paying fees, no benefit will be paid from the Global Education Protector, except for university fees.

Except in the case of the Private School Upgrade described in clause 4.16, upgrades to private schools are disallowed in general.

Example

If the member paid R2 000 per month for their child in Grade 3 at XYZ School, these payments would be continued after their death. For future years of education, the fees payable at XYZ School would be the fees paid under the Global Education Protector to indemnify the member, and would form the basis of future payments taking into account inflationary increases. This means that if a child has moved to a more expensive school, payments will be restricted to those that would have been payable at XYZ School.

The benefit payments are made annually, directly to the institution where the child is being educated. If any legislation or circumstances prevent funds being paid directly to the education facility, Discovery Group Risk reserves the right to pay the policyholder or the member's beneficiaries directly.

4.7 Who qualifies for the Global Education Protector?

To qualify for a benefit payment the child must be the biological or legally adopted child of the member or, subject to clause 4.7.1, the stepchild of the member, the existence of whom Discovery Group Risk has been notified at date of claim. Adoption will only be considered as valid if the date of adoption or the date of application for adoption is before the date of death of the member. A claim will only be considered if the member has not reached the benefit expiry age at time of claim.

4.7.1 Are stepchildren covered?

The stepchildren of the member may be covered if the following conditions are met:

- The member must be married to the stepchild's mother or father before the date of the event giving rise to a claim
- The member has notified Discovery Group Risk of the existence of the stepchild.

If the member divorces the mother or father of the stepchild, the benefit falls away for that stepchild.

4.8 What years of education will the Global Education Protector cover?

Benefit payments cover the following years of education:

- Pre-school (grade 0/R) – one year
- Primary school (grade 1 to 7) – seven years
- High school (grade 8 to 12) – five years
- Tertiary education:
 - Three-year undergraduate degree or recognised trade diploma/certificate
 - Five-year BDS (dental)
 - Six-year MBSc, MBChB (medical)

The Global Education Protector will only cover the number of years related to the degree for which the student initially applied after completion of grade 12. The benefit will not cover any additional years if a change is subsequently made to a longer degree.

Example

If the student begins a three-year undergraduate degree and then decides to change to a six-year medical degree, the benefit will only pay for three years.

All South African universities are included in this benefit, as well as universities of technology (technikons), recognised institutions providing for a trade (such as plumbing and electrical) and certain overseas universities.

4.9 Benefit payments for the Global Education Protector will end in the following instances

Benefit payments will be made until the earlier of:

- The child leaving school and not attending a tertiary institution immediately thereafter, subject to the allowance of a one-year break or gap year as described in clause 4.15
- The child leaving school with the intention of not returning
- The child completing a tertiary education subject to the benefit maximums described in clause 4.8
- The end of the education year in which the child turns 25
- The child not returning to school or university after the gap year described in clause 4.15
- The death of the child
- The child failing two successive years of primary or secondary education, until they progress to the next grade (clause 4.14)
- The child failing a year of tertiary education, until they pass that year (clause 4.14).

4.10 We will provide additional funding for certain fees at a tertiary educational level

Apart from the actual tuition fees, we will cover book fees and residence fees up to certain maximums (see general benefit limits). These payments are only made for tertiary level education.

- Book fees – The actual fees for books relating to the child’s chosen field of study or course, up to a maximum of 10% of the actual tertiary education fees
- University residence fees – The actual fees for university residence up to a maximum of 30% of the actual tertiary education fees.

The book fee and university residence fee are not included in the maximum benefit payable to an educational facility. These fee payments will not be made if the child does not attend a recognised education facility.

In the case of university, benefit payments will be based on education fees at a South African university, or a Discovery Group Risk-approved list of overseas universities, if the child is accepted at an overseas university on this list. The list of approved overseas universities may be changed by Discovery Group Risk from time to time. In the event of the spouse or the children emigrating from South Africa, benefits paid will be based on education fees for South African facilities, and not the rate of fees applicable to education in their new country of residence. If the child is enrolled in a university on Discovery Group Risk's select list of overseas universities, benefit payments for the overseas university will be paid in full, subject to the maximums applicable at the time (see general benefit limits).

4.11 The following expenses, among others, will not be covered by the Global Education Protector

- Any registration fees or administration fees for the school or institution in respect of the child
- Any book or residence fees for non-tertiary institutions or schools
- Any utensils or equipment required for studies
- Excursion fees
- Au pair fees
- Aftercare fees
- Extramural activity fees
- Fees that are paid separately or in addition to the normal standard education fees applicable to all the learners in the child’s particular year or grade, such as remedial fees or additional mathematics fees or fees for studies that do not form part of the school or institution’s normal curriculum.

4.12 How does Discovery cater for children who become eligible for benefits from the Global Education Protector before school-going age?

A child will be covered from grade 0/R subject to a maximum amount (see general benefit limits). When determining the fees applicable from grade 0/R, the fees paid in grade 00 will be taken into account. Discovery Group Risk will not be responsible for fees before grade 0/R.

A defined default fee will be paid (see general benefit limits), but Discovery Group Risk will consider the payment of private school fees under the Global Education Protector if before the member's death:

- The child was registered at or placed on a waiting list for a private school
- The child's elder siblings were already attending a private school.

4.13 What happens when education facilities are changed?

If a child changes their educational facility after the death of the member to a school or institution where fees are higher than the previous school or institution, Discovery Group Risk will, subject to the Private School Upgrade Benefit described in 4.16, continue making benefit payments at the rate applicable to the facility at the time of the member's death. Discovery Group Risk does not cover any additional cost of the new facility above the fees for the facility at the time of the member's death, as this is against the indemnity principle of the Global Education Protector.

If one child attends a Model C school or government school, and another child attends a private school, or is registered for a private school (if not of school-going age), the child attending the Model C or government school will not be allowed to upgrade to a private school, as this is against the indemnity principle of the Global Education Protector. If a child attends a free or low cost school, and wishes to upgrade to a Model C school, Discovery Group Risk does not cover any additional costs of the new facility above the fees for the facility at the time of the member's death, as this is against the indemnity principle of the Global Education Protector.

The same rule applies in the event of a child changing from a local tertiary educational facility they were attending at the time of the member's death, to a university on Discovery Group Risk's list of approved overseas universities or other local tertiary education facilities. It also applies if a child upgrades from, for example, a public to a private institution between primary and high school, where there will be no increase in payments to allow for the upgrade. The benefit does make allowance for fees to increase on normal transition from one schooling level to the next (for example, from primary to secondary, or from secondary to tertiary).

There are maximum increases in payments, up to the maximum benefit limits, which will be allowed as a child transitions between education levels as follows:

- Before school-going age (grade 000/00) until grade 0/R: Up to 100%
- From pre-school (grade 0/R) to primary school: Up to 100%
- From primary school to high school: Up to 20%
- If the child changes from a school with no fees to one with fees, Discovery Group Risk will pay the fees subject to a maximum amount (see general benefit limits).

4.14 What happens if a child fails a year of education?

For all the years up to the end of high school, the child may fail one year. In this case, Discovery Group Risk will only pay 33% of the relevant fees to repeat the year. If the child fails again, benefit payments will stop until the child progresses to the next grade of schooling.

In the event of failing a year of university, diploma, trade qualification, or similar tertiary qualification in full, Discovery Group Risk will not pay any benefit to repeat the year and benefit payments will stop until the child progresses to the next year of education. Discovery Group Risk regards failing two-thirds or more of the subjects in a year as failing the year in full. If the child progresses to the next year of education, having passed more than one-third of the previous year's subjects, Discovery Group Risk will continue to make benefit payments in full.

If a child has passed grade 12 and wishes to pass further subjects to get entry to a tertiary institution, a maximum of one-third of the actual fees payable during the matric year (or up to the benefit limit if no fees were paid), may be payable.

4.15 Can the child take a gap year?

Years of education must run consecutively. However, the child may take off one year between completing high school and starting university or similar tertiary education. No benefit payments will be made for this year. The rules on cessation of benefit payments will still apply, which may result in benefit payments ending before the child completes their education.

4.16 Can the child's education be upgraded to a private school?

A child may apply to Discovery Group Risk to upgrade from their current school to a private school on the following conditions:

- At the date of the member's death, the member's Vitality status must have been at Bronze or higher
- Application for the upgrade must occur within 12 months of the death of the member
- The child must have been accepted by the private school.

Payment of the benefit for a private school is limited to a maximum term of 12 years. Fees for private school education are limited to a maximum amount set by Discovery Group Risk from time to time (see general benefit limits).

4.17 How does the Global Education Protector affect the tax paid by a member?

The Global Education Protector is offered on an unapproved basis only (see clause 17.1.1).

Members may pay fringe benefit tax on the Global Education Protector premium, based on the deemed premium, as set by Discovery Group Risk for the benefit. These premiums for the Global Education Protector will increase annually at a rate determined by Discovery Group Risk.

Members are advised to seek appropriate guidance from a tax professional or from their authorised financial services providers for the correct tax treatment of the Global Education Protector payments and premiums.

4.18 What other legal provisions will apply to the Global Education Protector?

- Both the actively-at-work and the pre-existing conditions clauses (clauses 17.8 and 16.4), will automatically apply to the Global Education Protector, whether or not Discovery Group Risk has waived these clauses for other benefits. These clauses will be waived automatically for this benefit if, immediately before moving to Discovery Group Risk the member enjoyed equivalent benefits at their previous underwriter and met these conditions at that underwriter, and only to the extent that the previous benefits were at the same level as those provided by Discovery Group Risk.
- If a member has other individual or group life policies that also provide education benefits, Discovery will reduce its benefit payments in the ratio of the potential Discovery payment to the total payment received from all policies.
- The Global Education Protector cannot be ceded.
- If both parents are members of different Group Risk Life Plans insured by Discovery Group Risk and then both die, no additional payments will be made in excess of the actual costs of the child's education.
- The Global Education Protector will not be paid on the death of a spouse.
- Benefit payments from the Global Education Protector will have no impact on the Life Fund.

4.19 What information is required for the payment of the Global Education Protector?

The burden of proof of eligibility for the Global Education Protector is that of the policyholder, or whomever they direct to provide this information. Discovery Group Risk will determine the information required as proof of eligibility, and if the claim is accepted the benefit payment will only take place when all the requested information has been received. At least an unabridged birth certificate for the child and proof of payment by the member for the child's school fees over the 12 months before the member's death will be required.

For subsequent years of education, Discovery Group Risk will require proof of enrolment, proof of fees and the previous year's education results. If there are no nominated child beneficiaries at the date of death or notified to Discovery Group Risk within six months from date of death, no benefits will be admitted for payment.

Income Continuation Benefit

5.1 What is the Income Continuation Benefit?

The Income Continuation Benefit pays a regular income if the member experiences a loss of income as a result of being unable to perform their defined work functions due to injury or illness.

The member's Income Continuation Benefit sum assured is calculated using the benefit scale as indicated in the client benefit schedule. All benefits paid in terms of the Income Continuation Benefit, including additional benefits, may be subject to overall maximum benefit limits set by Discovery Group Risk (see general benefit limits).

There are various additional value-adding benefits included in the Income Continuation Benefit, depending on whether the policyholder chooses the Core Option or Comprehensive Option. These benefits are outlined in the table below, and described in more detail in the rest of this section.

	Core ICB option	Comprehensive ICB option
Recommended basic monthly ICB scale structure ² (up to maximum benefit each month, see general benefit limits)	Calculated using a sliding scale, as determined by Discovery Group Risk (see general benefit limits), which is applied to the monthly risk salary. The net after-tax salary limit ¹ does not apply.	
Any other basic monthly ICB structure including flat percentage structures (up to maximum benefit per month, see general benefit limits)	Yes, but the benefit combined with any Retirement Fund Waiver and upgrade on permanent disability is limited to net after-tax salary ¹	
Upgrade on permanent disability (up to maximum of 100% of net after-tax salary ¹ , when combined with the basic monthly ICB payment and any Retirement Fund Waiver unless cover is on the recommended scale structure, in which case the net after-tax salary limit ¹ does not apply)	No	Yes ³
Retirement Fund Waiver (up to maximum benefit per month, see general benefit limits)	Yes, limited to net after-tax salary limit ¹ when combined with basic benefit, unless the recommended basic monthly ICB scale structure is used, in which case net after-tax salary limit ¹ does not apply	
Discovery Group Risk Payback ^{5 and 6} This benefit requires both membership of Vitality and qualifying medical schemes administered by Discovery Health (up to maximum benefit each year).	Yes, if a member has a Life Cover Benefit of at least two times their yearly income and any ICB benefit. See section 12 below.	
LifeTime Capital Disability Lump-sum Benefit ² (up to capital disability maximum, see general benefit limits)	Yes, if selected (up to 18 times basic monthly ICB sum assured)	Yes (up to 36 times basic monthly ICB sum assured)
Performance Bonus Protector ^{2 and 5}	Yes ³ (up to 50% of annual risk salary)	Yes ³ (up to 75% of annual risk salary)
Family Protector ²	No	Yes (50% of basic monthly ICB sum assured for three months)
Contribution Protector ² (up to 33% of basic monthly ICB sum assured)	Yes (up to 12 months)	Yes ⁴ (up to 24 months)
HealthyLiving Protector ^{2 and 5} (up to 20% of basic monthly ICB sum assured)	No	Yes ³
Transport Protector ^{2 and 5} (up to 20% of basic monthly ICB sum assured)	No	Yes (up to two unrelated claims per year, limited to maximum claim amounts and periods, see general benefit limits)
Mortgage Protector ^{2 and 5} (up to 30% of monthly risk salary)	Yes	
SmartClaims ⁶	Yes	

¹ Net after-tax salary = Cost to company minus PAYE on cost to company, with the limit applied to the combined Income Continuation, Retirement Fund Waiver, and Upgrade Benefits payable

² Not included in the net after-tax salary limit

³ Claimant must satisfy Category A criteria of Appendix 1 (permanent disability)

⁴ Claimant must not satisfy Category A criteria of Appendix 1 (temporary disability)

⁵ Requires membership of Vitality

⁶ Requires membership of a qualifying medical scheme administered by Discovery Health

Since the Income Continuation Benefit is no longer taxable after the claimant receives it, the recommended scale is designed to approximate a flat benefit of 75% of risk salary, which under the previous tax regime was taxable on payment.

a flat benefit of 75% of risk salary, which under the previous tax regime was taxable on payment.

Benefits calculated using the recommended scale, whether or not they include the upgrade on permanent disability, are not subject to a maximum net after-tax salary limit. All benefits calculated using other scales, including flat percentage scales, will have a maximum limit of 100% of the member's net after-tax salary as defined in clause 14.1 at date of disability applied to the combined Income Continuation, Retirement Fund Waiver and upgrade benefits.

5.2 How is disability assessed for members?

Disability refers to injury, illness or disease that has resulted in a member being unable to function properly. Disability is assessed on objective medical criteria. Loss of access to gainful employment for reasons unrelated to the member's medical condition or disability will not be taken into consideration, for example, retrenchment or redundancy.

For an initial period of 12 months of disability from the date of disability determined in clause 5.4, the member will be assessed in terms of the effect that the disability has on their functionality and on their regular defined work functions. The assessment will take into account the reasonable continuity by which the member is no longer able to perform the material and substantial duties of their regular job with their own employer or any other suitable job that the employer can offer in terms of the principles set out in the Labour Relations Act.

Thereafter, Discovery Group Risk will assess the member's disability based on their inability to perform with reasonable continuity the material and substantial duties of their own or any job with their own or any employer (including self-employment), which the member could reasonably be expected to be qualified for or suited to, taking into account the degree of disability as well as the knowledge, training, education, ability, experience and age of the member.

5.3 How is disability assessed for members who are licensed pilots?

If a member's employment depends on them being in possession of a valid pilot's licence and no loss of licence clause is applicable and endorsed by Discovery Group Risk, no disability claim will be considered unless it renders them incapable of engaging in any occupation for remuneration or profit. This means that a pilot will be assessed not only for their own job with their own employer, but any occupation, with any employer. This definition is applicable from the date of disability determined in clause 5.4 and any period thereafter.

If a member's employment depends on them being in possession of a valid pilot's licence and the loss of licence clause is applicable and endorsed by Discovery Group Risk and is quoted and priced for, the loss of licence disability definition will apply for an initial period of 24 months of disability from the date of disability determined in clause 5.4.

Definition of disability for loss of licence: A pilot will be regarded as disabled if, in the opinion of Discovery Group Risk, injury or disease has rendered them incapable of performing the duties of their occupation or any other suitable job that their employer can offer. Disability will be deemed to include any condition, be it from injury or illness, that results in the loss of licence (CPL/ATP) by a competent Civil Aviation Authority (CAA) Medical Board and corroborated by Discovery Group Risk's Chief Medical Officer with objective medical evidence.

After the initial period, which includes the waiting period, the pilot's continued disability will be assessed in terms of the member's functionality for their own or any occupation with their own or any employer (including self-employment).

5.4 How is the date of disability determined for the Income Continuation Benefit?

The date of disability means the date upon which the member was last able to perform with reasonable continuity the material and substantial duties of their regular job with their employer, as medically assessed by Discovery Group Risk, based on objective, recognised and valid medical evidence received.

5.5 What waiting period is applied before disability benefits are paid?

Payment of the Income Continuation Benefit begins after the member has been continuously disabled due to injury or illness for a certain period of time, after the date of disability. This period is known as the waiting period. Payment will only begin after the expiration of the waiting period and only for periods after the waiting period. The waiting period may be one month, three months, six months or 12 months as selected by the policyholder. Please refer to the client benefit schedule for the waiting period that applies to members for the Income Continuation Benefit.

If the member recovers or is rehabilitated and claims again for the same cause within three months of recovery, the waiting period will be waived for this subsequent claim. This is known as the off-period. The benefit payment will revert to the benefit amount before the off-period.

Benefit payments are made on or before the last business day of each calendar month. Each monthly payment will be prorated according to that portion of the month for which the member qualifies for a benefit payment. The member's premium for the Income Continuation Benefit will be waived from the end of the waiting period until benefit payments stop.

5.6 What is the maximum income amount payable in the event of disability?

Before allowing for a benefit increase from the Performance Bonus Protector and the Contribution Protector described below, the monthly income amount paid on disability is subject to the overall maximum benefit limits set by Discovery Group Risk (see general benefit limits). In addition, the income will be reduced by any earnings (excluding earnings from passive income like interest, rent and dividends from JSE type shares etc.) and similar benefits from other insurers calculated on a monthly basis and received by the member, notwithstanding their disability. Dividends issued from an employer, partnership, close corporation or part-ownership of a company will be deemed income for this purpose. Discovery Group Risk must be informed if the member has any other disability benefits or any other earnings, as defined in this clause.

All income disability benefits will be aggregated to ensure compliance with the maximum benefit levels determined by Discovery Group Risk from time to time (see general benefit limits). If these maximums are exceeded, Discovery Group Risk may adjust the amount payable under its benefit proportionately. Discovery Group Risk will not incorporate Capital Disability Benefit amounts into the disability aggregation benefit calculation. The method for aggregating Income Continuation Benefits will be determined by Discovery Group Risk from time to time at its sole discretion.

Formula for aggregation:

$$\frac{(\text{Discovery Group Risk Income Continuation Benefits})}{(\text{All income disability benefits})} \times 100\% \text{ of net after-tax salary}$$

The general method for aggregating at claim stage is:

- Add up (aggregate) all income replacement benefits from whatever source
- Determine if this sum exceeds 100% of pre-claim net after-tax income
- If total benefits do exceed 100% of pre-claim net after-tax income, reduce all benefits payable from each source proportionately to their share of the total benefits so that the sum of benefits actually paid to the claimant does not exceed 100% of pre-claim net after-tax income.

In its aggregation calculations, Discovery Group Risk only takes into account income replacement benefits due to the claimant that are similar to its Income Continuation Benefit in both form and purpose. These benefits:

- Replace a certain portion of pre-claim income (normally 75% to 100%)
- Are paid from date of disability to the earlier of recovery or the end of the period for which the claimant would have received an income but for the disability (normally the claimant's company's normal retirement date)
- Have the main purpose of compensating the claimant for the income they lose because of their inability to work, for a long-term period until they receive pension income from a retirement vehicle
- Are referred to as income replacement, disability income, permanent health income, salary continuance etc benefits
- Include any rider benefits connected to income replacement benefits that have the main purpose of replacing lost income over the same period as the basic income replacement benefit
- Are provided by both group risk and individual life underwriters, but not by short-term insurance providers (who may provide some of the benefits below, which are excluded by Discovery Group Risk in its aggregation calculations).

For aggregation of its Income Continuation Benefit, Discovery Group Risk takes into account both its basic Income Continuation Benefit and the upgrade on meeting the Category A criteria of *Appendix 1*, if applicable (since the upgrade has the same form and purpose as the basic benefit).

Discovery does not aggregate benefits related to disability that do not have the same form or purpose as the income replacement benefits described above. Therefore, among others, Discovery does not aggregate:

- Capital Disability Benefits that are paid in the form of a lump sum
- Temporary disability benefits used to replace income for a period that covers a short-term waiting period before a Capital Disability Benefit is admitted or paid (normally less than 36 months)
- Sickness benefits that replace a portion of income for shorter periods of sickness that are not expected to last for a long term (normally less than 24 months)
- Any rider benefits connected to income replacement benefits that do not have the main purpose of replacing lost income over the same period as the basic income replacement benefit.

Discovery aggregates income replacement benefits to a level of 100% of the claimant's pre-claim net after-tax income (see clause 14.1) at the date of disability.

5.7 Are there any other factors that affect the monthly income amounts?

When the member recovers and monthly income payments end, the Income Continuation Benefit amount will revert to the benefit amount that would have applied immediately before the claim. In other words, it will revert to the originally selected Income Continuation Benefit amount before the claim, plus any escalation in the benefit amount for the benefit payment period.

Discovery Group Risk will pay the stated Income Continuation Benefit amount on the member's benefit statement as it was requested by the policyholder at activation or renewal date. Any claim submitted within six months of the claimant receiving or being awarded an increase of risk salary of more than 20% will be considered only on the earlier risk salary.

If the employer's industry or the member's or spouse's occupation or pastime pursuits change, which could be deemed by Discovery to fall into a higher risk category, it is important that Discovery Group Risk is informed of such a change as this may affect the continuance of cover for the member or the premium rating. Failure to notify may lead to Discovery Group Risk terminating a benefit or adjusting premiums.

5.8 Retirement Fund Waiver

The policyholder may choose to have a percentage of the member's risk salary (the Retirement Fund Waiver) paid to fund the employer's or employee's contribution towards retirement funding if the member becomes disabled. The Retirement Fund Waiver will be paid as long as the member receives an Income Continuation Benefit payment, where a member, at date of disability, was a member of a retirement fund or retirement vehicle (for example, a retirement annuity).

The Retirement Fund Waiver paid will be the lesser of:

- The Retirement Fund Waiver reflected in the client benefit schedule
- The actual contribution to the retirement fund or retirement vehicle
- The maximum Retirement Fund Waiver amount set by Discovery Group Risk from time to time (see general benefit limits).

5.9 Partial Disability Benefit

A member will qualify for a Partial Disability Benefit if:

- During the period of disability the member is capable or partially capable (with workplace modification or assistance) of performing the functions of their own job and the member's earnings are less than the benefit level selected
- The member earns an income (as defined in clause 5.6) while eligible for a benefit payment in terms of the definition of disability.

Calculation of the Partial Disability Benefit amount:

$$\text{Partial Disability Benefit} = \text{Income Continuation Benefit} \times \frac{(\text{Pre-disability earnings} - \text{current earnings})}{(\text{Pre-disability earnings})}$$

Where:

- **Pre-disability earnings:** Average risk salary provided in the six months before disability, used in the initial Income Continuation Benefit payment calculation.
- **Current earnings:** Average monthly earnings from an alternative occupation and any monthly income received (as defined in clause 5.6), or an amount that could be earned, based on the definition of disability.

A member must notify Discovery Group Risk if they start earning an income while a claim is in payment. If Discovery Group Risk determines that it was not notified of this while a claim was in payment, Discovery Group Risk may recover any amount that was paid in excess of the amount that would have been paid if the member had notified Discovery Group Risk that they were earning an income.

5.10 How does the pre-disability earnings amount increase?

The pre-disability earnings amount will be increased annually if an escalation in claim benefit was chosen by the policyholder. The payment will increase by Core CPI, limited to a maximum of the escalation percentage selected by the policyholder (the annual increase will never exceed the chosen percentage, even if Core CPI is above this percentage, but the annual increase might be lower than the chosen percentage if Core CPI is less than the chosen percentage).

Once the monthly income payments start, they will remain level unless the policyholder has chosen for them to increase annually (and this is reflected in the client benefit schedule). The payments will increase annually by Core CPI limited to a percentage maximum chosen by the policyholder. The options available for the maximum are 0%, 3%, 5%, 7%, 7.5% or 10%. Discovery Group Risk will use the Core CPI figure released by Statistics South Africa two months before the in-claim escalation anniversary. These increases will be effective after each 12-month period from the date at which benefit payments started.

5.11 Rehabilitation

If, at the sole discretion of Discovery Group Risk, the claimant is deemed able to be rehabilitated, Discovery Group Risk may request that the claimant undergoes rehabilitation. The purpose of the rehabilitation is to assist the claimant to achieve a level of performance to enable them to perform any gainful employment or occupation. This rehabilitation does not replace medical aid schemes and primary rehabilitation offered in clinics, hospitals and homes.

Discovery Group Risk may ask for frequent rehabilitation reports.

A Discovery Group Risk-appointed board of medical professionals will determine the feasibility of the rehabilitation programme. On acceptance of the programme, the claimant and the employer will be required to sign a written undertaking to indicate the claimant's genuine intent to follow the rehabilitation programme. The cost of the rehabilitation programme will be paid directly to the service provider by Discovery Group Risk and will be limited to a maximum determined by Discovery Group Risk from time to time (see general benefit limits).

This benefit will end on the occurrence of:

- The claimant being deemed rehabilitated by Discovery Group Risk
- The claimant failing to comply with the requirements detailed in the rehabilitation programme
- Discovery Group Risk deciding at its own discretion that the rehabilitation programme is not effective.

To remove any doubt, this Rehabilitation Benefit will not pay for any form of formal higher education or training (for example, undergraduate or postgraduate degrees or diplomas, or NQF level training). It will pay for short courses (for example, short admin or computer courses) designed to assist a claimant to achieve a minimum level of functionality, which enables them to gain suitable employment.

5.12 When do Income Continuation Benefit payments end?

The payment or partial payment of the Income Continuation Benefit will end if the claimant:

- No longer meets the applicable definition of disability in clause 5.2 or 5.3
- Earns an income that is equal to or more than their pre-disability income level, notwithstanding their injury or illness
- Unreasonably refuses to undergo recommended medical treatment or rehabilitation to reduce their disability or illness
- Fails or refuses to provide Discovery Group Risk with satisfactory proof of their disability or medical evidence within 30 days of being requested to do so, and if they fail to undergo a physical examination and tests at Discovery Group Risk's request and expense
- Reaches the benefit expiry age as shown in the client benefit schedule
- Dies.

5.13 How do income benefit payments affect the Life Fund?

Benefit payments for the Income Continuation Benefit and its additional benefits have no impact on the Life Fund.

5.14 When can the Income Continuation Benefit be upgraded?

The monthly Income Continuation Benefit for a member may be increased at the date of disability in the following circumstances:

- The member is covered by the benefits under the Comprehensive Option
- The member has satisfied the Category A criteria of *Appendix 1* at date of disability.
- The member satisfies the Category A criteria of *Appendix 1* at any other subsequent assessment performed after the date of disability, while the Income Continuation Benefit is still being paid.

The increase is calculated for both full and partial benefits as follows:

$$\text{Basic Income Continuation Benefit at date of disability} \times \frac{4}{3} \text{ capped at the member's net after-tax salary as defined in clause 14.1 at date of disability, unless cover is on the recommended scale structure in which case the cap does not apply.}$$

The upgrade only applies to the basic Income Continuation Benefit cover. All other benefits such as the Retirement Fund Waiver, Mortgage Protector, HealthyLiving Protector and Contribution Protector are excluded from this benefit increase.

Once an Income Continuation Benefit claim is in payment, the upgraded benefit will increase annually in line with the escalation rate selected by the policyholder. The waiting period referred to in 5.5 will be waived if a member qualifies for the upgrade.

If a member's cover is capped at the free cover limit (including the Free Cover Limit Multiplier, if applicable) or due to an underwriting decision, the total benefit payable, including the upgrade, will be capped at this level.

Example

If a member's monthly risk salary is R50 000, the Income Continuation Benefit sum assured is calculated using a benefit scale of 75% of monthly risk salary.

Then the member's basic Income Continuation Benefit sum assured will be R37 500 ($R50\ 000 \times 0.75$) per month.

If the member satisfies the Category A criteria of *Appendix 1* and is on the Comprehensive Option, the revised benefit will be the lesser of R50 000 ($R37\ 500 \times 4 \div 3$) and the member's net after-tax salary defined in clause 14.1.

If the member's cover is capped at a R30 000 free cover limit (including the Free Cover Limit Multiplier, if applicable), then the claim amount including the upgrade will be capped at R30 000.

The maximum monthly benefit including the upgrade is determined by Discovery Group Risk from time to time (see general benefit limits).

5.15 What is the Limited-term Income Continuation Benefit?

This benefit may be selected instead of the Income Continuation Benefit. A policyholder cannot select both the Income Continuation Benefit and the Limited-term Income Continuation Benefit for the same group of members.

The Limited-term Income Continuation Benefit pays a regular income for a limited term if the member experiences a loss of income after an injury or illness leaves them incapable of performing the normal requirements and duties of their job. A benefit term between six and 36 months can be selected. The maximum number of monthly income payments will be the benefit term less the waiting period.

The Limited-term Income Continuation Benefit can be selected on a standalone basis or together with a Capital Disability Benefit. When this benefit is selected together with a Capital Disability Benefit, a waiting period on the Capital Disability Benefit will apply. This waiting period will be the same as the Limited-term Income Continuation Benefit term.

A final decision on acceptance or rejection of the Capital Disability Benefit claim will only be made at the end of the Limited-term Income Continuation Benefit term if the member is still receiving this benefit at the end of the term. Medical information in support of the Capital Disability Benefit claim may be called for by Discovery Group Risk's underwriters at any time after the notification of acceptance of the initial Limited-term Income Continuation Benefit claim.

The following clauses in the Income Continuation Benefit section of the Discovery Group Risk Life Plan Guide relevant to the Income Continuation Benefit Core Option apply to the Limited-term Continuation Benefit:

- Clause 5.1 as it relates to the Core Option basic monthly sum assured structures, Retirement Fund Waiver, Contribution Protector, Performance Bonus Protector and SmartClaims only
- Clauses 5.2 and 5.3 (assessment of disability)
- Clause 5.4 (date of disability)
- Clause 5.5 (waiting period)
- Clause 5.6 (maximum income amount payable)
- Clause 5.7 (other factors)
- Clause 5.8 (Retirement Fund Waiver)
- Clause 5.9 (Partial Disability Benefit)
- Clause 5.10 (escalation in claim)
- Clause 5.11 (rehabilitation)
- Clause 5.12 (termination of benefit payment), with the added condition that benefit payments will end at the end of the limited benefit term
- Clause 5.13 (effect on Life Fund)
- Clause 5.19 (Contribution Protector), except that the Contribution Protector is payable for the maximum period of the lesser of 12 months and the Limited-term Income Continuation Benefit term less the waiting period
- Clause 5.20 (Performance Bonus Protector), except that the Performance Bonus Protector percentage of the claimant's annual risk salary is capped at 50% and is payable for the maximum period of the lesser of 24 months and the Limited-term Income Continuation Benefit term less the waiting period
- Clause 5.22 (SmartClaims).

The following clauses in the Income Continuation Benefit section of the Discovery Group Risk Life Plan Guide do not apply to the Limited-term Income Continuation Benefit:

- Clause 5.14 (no upgrade for Category A disability)
- Clause 5.16 (no LifeTime Capital Disability Lump-sum Benefit)
- Clause 5.17 (no Family Protector)
- Clause 5.18 (no Transport Protector)
- Clause 5.21 (no HealthyLiving Protector).

To qualify for a recurring Limited-term Income Continuation Benefit claim, the member's benefit payments must have terminated due to the member returning to work and:

- **Claim from the same cause:** If the claim is submitted within three months of returning to work, the waiting period will not apply and Discovery will pay the benefit for the remaining benefit term (six to 36 months less the waiting period, less the number of months paid under previous claims). The claim will be treated as a continuation of the previous claim. If the claim is submitted after three months, the waiting period will apply. Benefit payments made in respect of the same cause of disability cannot exceed the maximum benefit term (six to 36 months less the waiting period).
- **Claim from a different cause:** Discovery will treat the claim as a new claim. All conditions for a new claim, including the waiting period and maximum benefit term, will apply. The member will qualify for the full benefit term.

Example

A member with a 15-month benefit term and a three-month waiting period, claims for a certain cause of disability. After nine months' benefit payments (which started payment after the three-month waiting period) the member returns to work. Two months later the member claims for the same cause of disability. Discovery will only pay for an additional maximum of three months (15 months' benefit term less three-month waiting period less nine payments already made). If the member returns to work after receiving payments for these three months and claims again for the same cause of disability, no benefit payments will be made.

5.16 LifeTime Capital Disability Lump-sum Benefit

The LifeTime Capital Disability Lump-sum Benefit will pay a lump sum of up to 36 times the claimant's monthly Income Continuation Benefit basic sum assured if they meet the Category A criteria of *Appendix 1* at date of disability or they meet the Category A criteria of *Appendix 1* at any other subsequent assessment performed after the date of disability, while the Income Continuation Benefit is still being paid. The LifeTime Capital Disability Lump-sum Benefit is optional on the Core Option (up to 18 times basic monthly Income Continuation Benefit sum assured) and compulsory on the Comprehensive Option (up to 36 times basic monthly Income Continuation Benefit sum assured). The lump sum paid depends on the claimant's LifeTime Impact Category. The calculation of the LifeTime Impact Category is set out in *Appendix 1*.

The lump sum will be calculated as follows:

Multiple of Income Continuation Benefit		
Lifetime Impact Category	Core Income Continuation Benefit Option	Comprehensive Income Continuation Benefit Option
1	0	0
2	1.5	3
3	3	6
4	4.5	9
5	6	12
6	9	18
7	12	24
8	18	36

The lump sum will be paid with the first month's Income Continuation Benefit payment. This benefit will only pay once per life-changing event.

If a member claims under the Income Continuation Benefit the first time, they may qualify for the LifeTime Capital Disability Lump-sum Benefit based on the LifeTime Impact Category of the disability suffered. If the member returns to work later on and then claims again under the Income Continuation Benefit for the same life-changing event as their first claim, the LifeTime Capital Disability Lump-sum Benefit will not pay out again. However, if the second claim is due to a new life-changing event, the claimant will be reassessed and the LifeTime Capital Disability Lump-sum Benefit may be paid based on the claimant's new LifeTime Impact Category.

To qualify for more than one LifeTime Capital Disability Lump-sum Benefit payment (due to a new life-changing event), the member needs to return to work between the two life-changing events, premiums need to be paid for the period the member did not receive Income Continuation Benefit payments and the member needs to be continuously at work for at least three months after the Income Continuation Benefit payments ended.

The maximum LifeTime Capital Disability Lump-sum Benefit will be capped at the Capital Disability Benefit maximum benefit (see general benefit limits).

The LifeTime Capital Disability Lump-sum Benefit will not affect the Life Fund.

5.17 Family Protector

This benefit will pay 50% of a member's basic monthly Income Continuation Benefit sum assured, for up to three months, if their spouse or children suffer a severe illness (Severity A or B, as defined in *Appendix 2*). Claim payments will remain level and will not be increased by the member's benefit escalation rate or in-claim escalation rate while this benefit is being paid. The Family Protector is only available on the Income Continuation Benefit Comprehensive Option.

A maximum of three payouts (subject to benefit and claim payment expiry below) for any related severe illness conditions or conditions in the same body system will apply. The member can, however, claim for subsequent claims if the condition is unrelated to the previous claim and is in a different body system and will be entitled to a further maximum of three payouts. Payments for severe illness will only be made if the member's severely ill spouse or child is alive at the time of payment.

The Family Protector benefit does not require the member to be in receipt of an Income Continuation Benefit payment before a Family Protector claim will be paid, only that they are covered for an Income Continuation Benefit, including the Family Protector.

The waiting period does not apply to this benefit. Claim payments will start as soon as the claim has been accepted, and irrespective of the chosen waiting period.

A spouse is defined in 17.1.3. A child is defined in 17.1.4.

This benefit and all claim payments will expire on the earlier of the:

- Member reaching the expiry age of the Income Continuation Benefit
- Date the member leaves the service of the employer and is no longer an eligible employee
- Member's death
- Child's death
- Spouse's death
- Member's child reaching age 19
- Member's spouse no longer meeting the definition of spouse
- Spouse reaching the benefit expiry age, or age 65, or dies, whichever occurs first.

The cover for the member's spouse and each child in the family is provided without medical underwriting, but excludes pre-existing medical conditions affecting the spouse or child that the member, spouse or child knew about or sought medical attention for or ought reasonably to have known about at any time in the past, before the member joined the fund.

A maximum of three spouses and five children will be covered.

All claims must be submitted within three months of the date of the event.

The maximum amount per claim will be subject to the maximum spouse or child Severe Illness Benefit (see general benefit limits).

The Family Protector will not affect the spouse's Life Fund.

5.18 Transport Protector

The Transport Protector is only available if the policyholder selected the Income Continuation Benefit Comprehensive Option.

If a member is booked off work for a period exceeding the waiting period, they will have access to the services of our preferred transport provider up to specified rand limits (see general benefit limits) for a period of 60 days following the admission of the claim. After 60 days, the benefit falls away, whether or not the full benefit amount has been used.

Payments under the Transport Protector will be subject to a maximum of 20% of the monthly basic Income Continuation Benefit sum assured. In addition, the payments will be subject to maximums set by Discovery Group Risk from time to time (see general benefit limits). The member will need to pay for the extra amount if the total cost of using the preferred transport provider exceeds the maximum benefit amount.

Discovery Group Risk reserves the right to change the:

- Preferred transport provider
- Methods used to provide the benefit, including cash payments if necessary
- Term at which the benefit payment will expire
- Total maximum payment.

A member may only claim for the Transport Protector up to two times per calendar year for unrelated claims, and no payments will be made from the Transport Protector for a claim submitted during the off period.

The Transport Protector will expire at the earlier of the:

- Member reaching expiry age of the Income Continuation Benefit
- Member receiving a Transport Protector payment for a Category A claim
- Member's death.

The Transport Protector may only be used in areas where the preferred transport provider operates. The preferred transport provider may also require the claimant to have access to certain technology before being able to use their services.

See general benefit limits for more details on the preferred transport provider and claim maximum amounts.

5.19 The Contribution Protector

The Contribution Protector will pay the member's premiums as principal member, for the following Discovery products (if applicable), during the Income Continuation Benefit claim period:

- The Individual Discovery Life Plan
- The Discovery Retirement Optimiser
- The Discovery Health Plan in force at the date of disability
- Any Discovery Retirement Plan
- Discovery Insure
- Vitality
- Contributions to other health plans or medical schemes in force at the date of disability will also be covered subject to the benefit maximums determined by Discovery from time to time (see general benefit limits).

No upgrade to a higher Discovery or other health plan will be allowed.

The Contribution Protector is separate from the Income Continuation Benefit payout. The Income Continuation Benefit claim period is only used to set a maximum timeframe for the consideration of payments of the Contribution Protector.

The Contribution Protector will be paid subject to the selected waiting period if the member has qualified for the Income Continuation Benefit and they enjoy the benefits of:

- The Core Option
- The Comprehensive Option, but have not qualified for the Upgrade (see clause 5.14) on the Income Continuation Benefit (in other words, they do not satisfy the Category A criteria of *Appendix 1*).

The Contribution Protector will be paid for a maximum period of 12 months under the Core Option and for a maximum of 24 months under the Comprehensive Option, after which it will expire.

The Contribution Protector expires if the member enjoys the benefits under the Comprehensive Option and they qualify for the upgrade for the Income Continuation Benefit (in other words, if they do satisfy the Category A criteria of *Appendix 1*).

The Contribution Protector is limited to 33% of the basic monthly Income Continuation Benefit sum assured that the member is receiving.

5.19.1 What legal provisions apply to the Contribution Protector?

Both the actively at work and the pre-existing condition clauses (clauses 17.8 and 16.4) automatically apply to the Contribution Protector, whether or not Discovery Group Risk has waived these clauses for other benefits. These clauses will be waived if, immediately before moving to Discovery Group Risk, the members enjoyed equivalent benefits at their previous underwriter and met these conditions at that underwriter, and only to the extent that the previous benefits were at the same level as those provided by Discovery Group Risk.

If the member has other individual or group life policies that also provide this kind of benefit, Discovery will reduce its benefit payments in the ratio of the potential Discovery payment to the total payment received from all other policies or contracts.

5.19.2 What about the tax treatment of the Contribution Protector premiums and proceeds?

Members may pay fringe benefit tax on the Contribution Protector premiums. Members are advised to seek appropriate guidance from a tax professional or from their authorised financial services provider for the correct tax treatment of the Contribution Protector payments and premiums. The relevant legislation applicable will apply as an overriding factor.

5.20 The Performance Bonus Protector

The Performance Bonus Protector pays a portion of the member's past bonuses in addition to the monthly disability income. Bonus refers to the member's net after-tax bonus.

The Performance Bonus Protector will be payable if the claimant has satisfied the Category A criteria of *Appendix 1* and is a member of Vitality at date of disability.

The Performance Bonus Protector is paid for a maximum of 24 months.

The Performance Bonus Protector is paid only while the claimant receives an Income Continuation Benefit payment. This benefit will end on the earlier of the expiration of 24 months or the termination of the Income Continuation Benefit.

The payment is calculated with reference to the:

- Average bonuses the claimant received over the three years before the member satisfied the Category A criteria of *Appendix 1*
- Bonus as a percentage of the member's annual risk salary being capped at 50% on the Core Option and 75% on the Comprehensive Option
- Member's Vitality status at the time of claim as per the following table:

Vitality status at date of claim event				
Blue	Bronze	Silver	Gold	Diamond
10%	20%	50%	75%	100%

For the purposes of this benefit, bonus is defined as participation in any incentive or bonus scheme that is paid in money, from time to time, at the discretion of the claimant's employer, and is measured and paid in terms of published and defined criteria on the condition that the incentive is not an entitlement and is not automatic.

Participation in a scheme where a bonus is paid by way of share options or phantom share options is specifically excluded. For schemes where bonuses are paid part share options and part money, only the money portion will be taken into consideration when calculating the Performance Bonus Protector amount.

Example

Calculating the bonus percentage

Consider a member earning the following income over the past three years:

Year	Basic salary	Bonus	Bonus percentage
Year one	R250 000	R37 500	15%
Year two	R275 000	R13 750	5%
Year three	R300 000	R75 000	25%

The average bonus would be calculated as $(15\% + 5\% + 25\%) \div 3 = 15\%$ (which must then have the Vitality percentage applied to it and be limited to 50% of annual risk salary on the Core Option, and 75% of annual risk salary on the Comprehensive Option).

The benefit will be paid monthly regardless of the frequency of the performance bonus. The onus will be on the member to prove past bonuses.

Members who have not earned past performance bonuses for whatever reason will not qualify for this benefit. This rule will apply even if a member has recently joined a performance incentive scheme, but has not yet received a performance bonus. Similarly, members in their first year of work will not qualify for this benefit.

The average bonus will be calculated over a three-year period even if the member did not receive bonuses in some of these years. This rule will apply even if a member has taken a sabbatical year.

Example

Calculating the performance bonus benefit

Scenario 1: At date of disability the member's monthly income is R27 500, the member is on Bronze Vitality status and has an Income Continuation Benefit of R18 500 with a 15% bonus percentage:

Core Option: The monthly Performance Bonus Protector would be $R27\,500 \times 15\% \times 20\% = R825$

Comprehensive Option: The monthly Performance Bonus Protector would be $R27\,500 \times 15\% \times 20\% = R825$

Scenario 2: At date of disability the member's monthly income is R27 500, the member is on Gold Vitality status and has an Income Continuation Benefit of R18 500. This member has received bonuses equal to 100% of salary over the past three years.

Core Option: The monthly Performance Bonus Protector would be $R27\,500 \times 50\% \times 75\% = R10\,312.50$

Comprehensive Option: The monthly Performance Bonus Protector would be $R27\,500 \times 75\% \times 75\% = R15\,468.75$

5.21 The HealthyLiving Protector

Vitality's HealthyLiving Protector benefit is made up of the HealthyFood, HealthyGear and HealthyCare benefits. Under each of these benefits Vitality may refund up to 25% of a member's spend on certain items in partner stores. Vitality may change the amount of the refund as well as the partner stores from time to time.

The HealthyLiving Protector will pay the claimant's average HealthyFood, HealthyGear and HealthyCare cash back that they received in the six months or portion thereof before the disability event, for every month while the claimant receives the Income Continuation Benefit. This will be paid in addition to the monthly disability income.

The average cash back will be calculated by looking at the period six months before the disability event. A six-month period will always be used, regardless of when any of the HealthyLiving benefits were actually activated. If a member's Vitality HealthyLiving benefit was not activated for some of the six months before the disability event, R0.00 will be used for these months when determining the average cash back.

The monthly HealthyLiving Protector amount will be capped at 20% of the claimant's Income Continuation Benefit basic sum assured and is subject to the maximum HealthyLiving Protector amount set by Discovery Group Risk.

To qualify for this benefit, the claimant must at time of claim:

- Be on the Income Continuation Benefit Comprehensive Option
- Have Vitality with the HealthyLiving benefits activated
- Have satisfied the Category A criteria of *Appendix 1* at date of disability
- Or at any other subsequent assessment performed after the date of disability, while the Income Continuation Benefit is still being paid.

The HealthyLiving Protector and its payments will expire on the earlier of the:

- Member no longer receiving Income Continuation Benefit payments for any reason
- Member reaching expiry age of the Income Continuation Benefit
- Member's death.

Example

HealthyFood, HealthyGear and HealthyCare were all activated six months before the disability event. During the six months preceding the disability event, the combined cash back for HealthyFood, HealthyGear and HealthyCare was: R100, R250, R500, R120, R0 and R1 000. So the average monthly cash back over the six months before disability is:

$(R100 + R250 + R500 + R120 + R0 + R1\ 000) \div 6 = R328.33$.

The client will receive R328.33 (increasing annually with the Income Continuation Benefit escalation rate) until the claimant stops receiving payments for the Income Continuation Benefit.

If the Income Continuation Benefit sum assured was R1 200 per month, a monthly cap of $25\% \times R1\ 200 = R300$ will apply, so the client will get R300 (increasing annually with the Income Continuation Benefit escalation rate) instead of R328.33 per month.

5.22 SmartClaims

With Discovery's Claims Concierge service, all claimants who are also members of Discovery Health will have access to a high-touch, compassionate and comprehensive claims experience, tailored to their individual needs. This unique service assists claimants to navigate the healthcare system while providing the link between the claimant, their doctor, their family and Discovery Health, and ensuring a highly specialised, client-centric approach to claims management when the claimant and their family need it most.

This service will cease if the member is no longer a Discovery Health Medical Scheme member.

5.23 Transitional arrangements

If a policyholder with existing Income Continuation Benefits with Discovery Group Risk on 1 April 2015 chooses not to upgrade to the enhanced Income Continuation Benefit set out in this section, their benefits will remain as they were on 1 April 2015.

This Discovery Group Risk Life Plan Guide (GRLPG01/17) will apply to these benefits, except that the following clauses will not apply:

- Clause 5.16 (no LifeTime Capital Disability Lump-sum Benefit)
- Clause 5.17 (no Family Protector)
- Clause 5.18 (no Transport Protector)
- Section 12 (no Corporate Integrator)

For the avoidance of doubt, all schemes with existing Income Continuation Benefits on 1 April 2015, for which the policyholder chooses to remain on those benefits, will nevertheless be subject to the net after-tax salary limitations on the combined Income Continuation, Retirement Fund Waiver and Upgrade Benefits as set out in this Discovery Group Risk Life Plan Guide (GRLPG01/17).

All existing schemes that choose to convert to the enhanced Income Continuation Benefit on or after 1 April 2015, and all schemes not currently assured by Discovery Group Risk, quoted for on or after 1 April 2015, will be subject to all the terms and conditions of this Discovery Group Risk Life Plan Guide (GRLPG01/17).

An existing scheme becomes subject to the terms and conditions of this Discovery Group Risk Life Plan Guide (GRLPG01/17) 30 days after receipt of this document by the policyholder or their recorded representative as set out in Section 1.

Capital Disability Benefit

6.1 What is the Capital Disability Benefit?

The Capital Disability Benefit pays a lump-sum amount in the event of the member or spouse having a permanent medical impairment as defined in *Appendix 1*.

6.2 How is the date of disability determined for the Capital Disability Benefit?

Discovery Group Risk will determine the date on which the life assured became disabled on the basis of objective medical evidence. This date is referred to as the date of disability. The disability benefit will not become payable if the date of disability occurs before the life assured becomes eligible for a disability benefit or after the life assured ceases to be eligible for a disability benefit.

6.3 How does Discovery Group Risk assess qualification for a claim?

The Capital Disability Benefit is assessed on the severity of the medical impairment – no matter what work is performed to generate an income, by reference to the criteria listed in *Appendix 1*.

By focusing on the effect of the medical impairment, Discovery Group Risk has developed an evaluation system that is objective and fair.

Discovery Group Risk has developed detailed protocols that describe every anatomical and physiological system disorder in the body, using objective medical criteria. This allows Discovery Group Risk to be completely objective when evaluating claims. Please refer to *Appendix 1* for these protocols.

6.4 What benefit payments are made under the Capital Disability Benefit?

The Capital Disability Benefit provides a lump-sum payment in the event of a medical impairment or illness satisfying the criteria of the benefit described in this section as well as in *Appendix 1*.

The lump-sum benefit is defined as a multiple of annual risk salary and expressed as a percentage of the Life Fund. Benefit payments will reduce the Life Fund.

Example

A member is provided with a Capital Disability Benefit equal to twice their annual risk salary. The member has a Life Fund of four times their annual risk salary. Therefore the Capital Disability Benefit is equivalent to 50% of the Life Fund.

The benefit may also be priced for loss of licence (see clause 5.3) for licensed pilots. The Capital Disability Benefit is assessed on the severity of the medical impairment – no matter what work is performed to generate an income. The loss of licence clause, if quoted and priced for, will allow consideration of the claim if all of the conditions mentioned below are met:

- The injury or illness has rendered the member totally incapable of engaging in their own occupation
- The member's pilot's licence is permanently removed by the Civil Aviation Authority (CAA) on medical grounds due to injury or illness. Discovery Group Risk must be provided with a copy of the certificate issued by the CAA confirming the terms and conditions relative to the loss of licence.

6.5 An objective and fair system is used to assess the severity of the disability

Payments are evaluated on how severely the disability affects the life assured. This benefit rates severity in two categories:

Category A – Pays 100% of the benefit if the disability satisfies the criteria for Category A.

Category B – Pays 50% of the benefit if the disability satisfies the criteria for Category B.

Please refer to *Appendix 1* for details on how the criteria used to establish severity ratings will determine which category will apply.

The benefit cover is defined as a multiple of the member's risk salary (expressed as a percentage of the Life Fund), subject to the benefit maximums determined by Discovery Group Risk from time to time (see general benefit limits).

Example

A member has a Capital Disability Benefit equal to 50% of their Life Fund. The member is assessed as having a Category B severity claim. The benefit amount payable will be calculated as follows:

Benefit amount = Severity level percentage × (benefit expressed as a percentage of the Life Fund × Life Fund) = 50% × (50% × Life Fund)

6.6 The effect of a benefit payment through an approved fund

If the policyholder of the Group Risk Life Plan is an approved fund, the member must be informed that, to receive a Capital Disability Benefit, based on the rules of the retirement fund, they will be required to retire from the fund. The member will not be able to receive the benefit if they remain a member of the approved fund.

6.7 How many benefit payments can be made under the Capital Disability Benefit?

The Capital Disability Benefit may not fall away after the first benefit payment.

As long as there are enough funds remaining in the Life Fund to fund additional benefit payments, multiple claims are allowed. The member may claim subsequent benefit payments for any life-changing event covered, irrespective of:

- The body system claimed for with any previous benefit payments.
- Whether the severity of the subsequent claim is higher, lower or equal to the severity of the previous claim.

The member may qualify for multiple claims within or across any body systems as a result of the same life-changing event. In this case, the claim with the highest severity would be paid first, with a second claim being paid six months later, provided that the second disease process is still present at the time. An example would be paraplegia and kidney failure as a result of a motor vehicle accident.

Once the member has satisfied the criteria for a subsequent benefit payment, the amount of the benefit payment is determined by whether the illness is of a progressive nature or a new life-changing event, and on the balance of the Life Fund.

- **Progressive illnesses:** At the time of the first claim, Discovery Group Risk will evaluate the severity of the disability according to the categories defined in *Appendix 1*. If the disability becomes more severe at a later date, Discovery Group Risk will reassess its severity category. If the severity of the disability increases, an additional payment will be made for the difference between the lower and increased severity category. If the disability progresses from Category B to Category A within a 90-day period, the additional benefit payment will place the member in the same financial position in which they would have been, had the original benefit payment been assessed on the higher category.

Example

Grade 3 retinopathy is classified as Category B, while grade 4 retinopathy is classified as Category A. Therefore, 50% of the benefit will be paid for grade 3 retinopathy and then an additional 50% of the benefit will be paid when grade 4 retinopathy occurs.

- **New life-changing event:** A subsequent claim may occur that is not regarded as a progression of previous claims. In this case, the benefit payment for the subsequent claim will be treated independently of any previous claims. The benefit payment will be based on the category of the subsequent claim and not the difference in categories between the subsequent claim and the previous claim. Any condition or disability that exists or arises co-morbidly with, or is a consequence of another condition or disability, will not be regarded as a new life-changing event.

Example

If a claimant has upper and lower digestive tract disease at Category B (50%), followed later by liver and biliary disease at Category A (100%), where the second claim is not a progression of the first claim, the benefit payment for the second claim would be 100% and not the difference in Category between the first and second claims (100% minus 50%).

The medical definitions for each severity level are documented in *Appendix 1*. The severity levels are judged using objective medical criteria provided by the member's treating specialist. The Discovery Group Risk medical panel, in conjunction with the treating specialist, will determine the severity level.

6.8 Other factors that influence the Capital Disability Benefit

Discovery Group Risk assesses the risk and sets the member's and spouse's Capital Disability Benefit premium according to the information supplied on the Discovery Group Risk application form and at the request for medical evidence. This information includes the industry of the employer, the expected occupation and the pastime pursuits of the member or spouse.

If the employer's industry or the life assured's occupation or pastime pursuits change, it is important that Discovery Group Risk is advised of such change to ensure that the life assured remains covered at all times. If this information is not supplied within two months of a change, the disability cover may lapse.

Severe Illness Benefit

7.1 What is a severe illness?

A severe illness is an illness or disorder that significantly affects a person's lifestyle. Definitions of medical impairments are listed in *Appendix 2*.

7.2 What benefit payment is provided by the Severe Illness Benefit?

The Severe Illness Benefit provides a lump-sum payment to an insured member who is diagnosed with one of the defined severe illnesses listed in *Appendix 2*. This lump-sum payment provides the necessary financial assistance to ensure that the insured member's lifestyle can be maintained or supported.

The lump-sum benefit is defined as a multiple of annual risk salary or as a flat rand amount, subject to the benefit maximums determined by Discovery Group Risk from time to time, including the three times annual risk salary maximum if lower than the flat rand amount (see general benefit limits), and expressed as a percentage of the Life or Impairment Fund. Benefit payments will reduce the Life Fund or Impairment Fund.

Example

A member is provided with a Severe Illness Benefit that is equal to twice their annual risk salary. The member has a Life Fund of four times their annual risk salary. Thus, the Severe Illness Benefit is equal to 50% of the Life Fund.

7.3 Early Cancer Benefit

The Early Cancer Benefit is automatically included in the Severe Illness Benefit. This benefit provides cover for qualifying in situ cancers and precancerous prostatic lesions. Please refer to *Appendix 3* for the full set of definitions covered.

Claims under the Early Cancer Benefit will be subject to an overall maximum benefit amount. Multiple payments are possible, subject to this overall maximum. This maximum will be reviewed annually (see general benefit limits).

Example

Discovery Group Risk stipulates that the maximum claim amount under the Early Cancer Benefit is R100 000. In this example, a client is covered by a Group Risk Life Plan with a Comprehensive Plus Severe Illness Benefit of R2 000 000. She later claims for a severity E (15% payout) in situ cancer.

The payout will work as follows: $\text{Minimum } (15\% \times R2\,000\,000, R100\,000) = \text{Minimum } (R300\,000, R100\,000) = R100\,000$

Additionally, claims under the Early Cancer Benefit will be treated as part of the normal progressive claims process as described in clause 7.7. Furthermore, when paying out a claim in a set of progressive cancer claims, where one of the previous claims was an early cancer claim, the severity percentage of the early cancer claim may be adjusted to allow for the fact that the full severity percentage may not have been paid out (due to the maximum claim amount).

Example

Ten months later, in the example above, the client's cancer progresses to Severity A (100% payout).

Her payout will work as follows:

Second payout: $(100\% - [R100\,000/R2\,000\,000]) \times R2\,000\,000 = (100\% - 5\%) \times R2\,000\,000 = 95\% \times R2\,000\,000 = R1\,900\,000$

If the Severe illness Benefit is accelerated, the Early Cancer Benefit claim will reduce the Life Fund. If a non-accelerated Severe Illness Benefit option is selected, claims under the Early Cancer Benefit will reduce the Impairment Fund.

No claims will be payable for any in situ cancer diagnosis in the first six months following the commencement of Severe Illness Benefit cover for a member. This will apply to any new benefits, additional cover, and reinstatements

7.4 How is the date of impairment determined for the Severe Illness Benefit?

Discovery Group Risk will determine the date on which the life assured was diagnosed for the medical condition, in relation to the severity level applicable, on the basis of objective medical evidence. This date is referred to as the date of impairment. The Severe Illness Benefit will not become payable if the date of impairment occurs before the life assured becomes eligible for a Severe Illness Benefit or after the life assured ceases to be eligible for a Severe Illness Benefit.

7.5 How are the severe illnesses categorised?

Discovery Group Risk's Severe Illness Benefit covers a wide range of medical conditions, from life-changing events to terminal illnesses, as listed in *Appendix 2*. This benefit is family-focused and allows the selection of the Severe Illness Benefit to suit the member's and their family's needs.

The Severe Illness Benefit provides cover for all of the following:

- Heart and Artery Benefit
- Cancer Benefit
- Nervous System Benefit
- Respiratory Diseases Benefit
- Gastrointestinal Benefit
- Urogenital Tract and Kidney Benefit
- Connective Tissue Diseases Benefit
- Advanced AIDS/Accidental HIV Benefit
- Eye Benefit
- Ear, Nose and Throat Benefit
- Endocrine and Metabolic Diseases Benefit
- Musculoskeletal Benefit.

7.6 How the severity levels affect benefit payments

The Severe Illness Benefit is designed so that benefit payments are in proportion to the severity of the illness itself. The assessment of the severity levels that apply to specific medical conditions is detailed in *Appendix 2* and is based on objective medical definitions and criteria.

There are seven severity levels used to determine benefit payments. These levels have been set to ensure that benefit payments provide enough cover for the impact that the severe illness is expected to have on the member's lifestyle.

The severity levels are as follows:

Severity A	Pays 100% of the benefit cover	
Severity B	Pays 75% of the benefit cover	
Severity C	Pays 50% of the benefit cover	
Severity D	Pays 25% of the benefit cover	
Severity E	Pays 15% of the benefit cover	
Severity F	Pays 10% of the benefit cover	
Severity G	Pays 5% of the benefit cover	



Cover may be selected for severity levels A to D (Comprehensive) or severity levels A to G (Comprehensive Plus). Irrespective of the option chosen, the Early Cancer Benefit, applies to both the Comprehensive and Comprehensive Plus options.

The Severe Illness Benefit is defined as a multiple of the member's annual risk salary (expressed as a percentage of the Life or Impairment Fund), subject to the benefit maximums determined by Discovery Group Risk from time to time (see general benefit limits). Even if the policyholder selects a flat rand benefit, the maximum multiple of the member's annual risk salary still limits the maximum benefit if the multiple provides a benefit less than the chosen rand benefit.

Example

A member has a Severe Illness Benefit equal to 50% of their Life Fund. The member is diagnosed with stage 2 cancer (Severity Level C). The benefit amount payable will be calculated as follows:

Benefit amount = Severity level percentage × (benefit expressed as a % of Life Fund × Life Fund) = 50% × (50% × Life Fund)

7.7 How many benefit payments can be made under the Severe Illness Benefit?

The Severe Illness Benefit does not fall away after the first benefit payment.

As long as there is enough Life or Impairment Fund remaining to fund additional benefit payments, multiple claims are allowed.

The member may claim subsequent benefit payments for any life-changing event covered irrespective of:

- The body system claimed for with any previous benefit payments
- Whether or not the severity of the subsequent claim is higher, lower or equal to the severity of the previous claim.

The member may qualify for multiple claims within or across any body systems as a result of the same life-changing event. In this case, the claim with the highest severity would be paid first, with a second claim being paid six months later, provided that the second disease process is still present at the time. An example would be paraplegia and kidney failure as a result of a motor vehicle accident.

Once the member has satisfied the criteria for a subsequent benefit payment, the amount of the benefit payment is determined by whether the illness is of a progressive nature or a new life-changing event, and on the balance of the Life or Impairment Fund, taking into account the Minimum Protected Fund option if applicable.

Progressive illnesses: At the time of the first claim, Discovery Group Risk will evaluate the severity of the illness according to the severity rating scale defined in *Appendix 2*. If the illness becomes more severe at a later date, Discovery Group Risk will reassess its severity rating. If the severity of the illness increases, an additional payment will be made for the difference between the lower and increased severity ratings. If the illness progresses from one severity to a higher severity within a 90-day period, the additional benefit payment will place the member in the same financial position in which they would have been, had the original benefit payment been assessed on the higher severity level.

Examples of illnesses that are often progressive include cancer, many of the chronic neurological diseases (for example, multiple sclerosis), many of the connective tissue diseases, chronic lung diseases (for example, emphysema), chronic liver diseases, progressive blindness or deafness and chronic kidney diseases.

Example

Stage 1 cancer is classified as Severity D, while stage 2 cancer is classified as Severity C. Therefore, 25% of the benefit will be paid for stage 1 cancer and then an additional 25% of the benefit will be paid when stage 2 cancer occurs.

New life-changing event: A subsequent claim may occur that is not regarded as a progression of previous claims. In this case, the benefit payment for the subsequent claim will be treated independently of any previous claims. The benefit payment will be based on the full severity level of the subsequent claim and not the difference in severity level between the subsequent claim and the previous claim. Any condition or illness that exists or arises co-morbidly with or is a consequence of another condition or illness will not be regarded as a new life-changing event.

Example

If a member has a heart attack at Severity C (50%), followed later by a subsequent heart attack at Severity B (75%), where the second claim is not a progression of the first claim, the benefit payment for the second claim will be 75% and not the difference in severity between the first and second claims (75% minus 50%).

The medical definitions for each severity level are documented in *Appendix 2*. The severity levels are judged using objective medical criteria provided by the member's treating specialist. The Discovery Group Risk medical panel, in conjunction with the treating specialist, will determine the severity level.

7.8 When will the Severe Illness Benefit expire?

The Severe Illness Benefit expires at the earlier of the member reaching the expiry of the benefit or age 65. This means that claims submitted in respect of life-changing events that arose before the expiry of the benefit will be assessed, but claims in respect of a life-changing event date after the expiry of the benefit will not be accepted. Premiums will not be charged for the Severe Illness Benefit after the member reaches the age at which the benefit expires (see general benefit limits). The Severe Illness Benefit also expires when the member is no longer an eligible member.

7.9 Other factors that influence the Severe Illness Benefit

Discovery Group Risk assesses the risk and sets the member's and spouse's Severe Illness Benefit premium according to the information supplied on the Discovery Group Risk application form and at the request for medical information. This information includes the industry of the employer, the expected occupation and the pastime pursuits of the member or spouse.

If the employer's industry or the life assured's occupation or pastime pursuits change, it is important that Discovery Group Risk is advised of such change to ensure that the life assured remains covered at all times. If this information is not supplied within two months of the change, the disability cover will lapse.

7.10 What is the Child Severe Illness Benefit?

If the member or spouse is covered for the Severe Illness Benefit, an amount of severe illness cover is automatically included for their children.

The automatic cover for each child in the family is provided free of medical underwriting, but excludes pre-existing medical conditions that the parents knew about or ought reasonably to have known about, or for which they sought medical attention before the inception of the benefit.

This cover expires when the child reaches the age of 18.

To qualify for a benefit payment the child must be the biological child of the member or must have been legally adopted before the life-changing event giving rise to the claim.

A claim for any child is limited to 10% of the member's sum assured for the Severe Illness Benefit, up to the benefit limit per claim event (see general benefit limits). Claims for children have no impact on the Life or Impairment Fund.

Under this benefit, Discovery Group Risk covers all body systems included in the main Severe Illness Benefit described in *Appendix 2*, including organ transplants, abnormalities of the heart requiring major surgery, severe brain damage following trauma, and some severe infections that can permanently affect the child. The Activities of Daily Living (see *Appendix 4*) measure of the Severe Illness Benefit does not apply to the assessment of claims for the Child Severe Illness Benefit.

7.11 Global Treatment Benefit

The Global Treatment Benefit is automatically included in the Severe Illness Benefit and provides the member with access to a range of authorised Discovery Health hospitals in the United States of America included in the hospital network used by Discovery Group Risk or Discovery Health at the time.

If a claim arises under the Severe Illness Benefit, the member may choose whether to have their medical treatment performed in South Africa or at the authorised network of hospitals in the United States of America. This choice, which affects their benefit payment amount, is defined in options 1 and 2 described below:

Option 1: The member chooses to have all treatment performed in South Africa

The member will receive the normal benefit payment amount defined under paragraph 7.6, which is dependent on the severity of the illness.

Option 2: The member chooses to have treatment in the United States of America

The member will receive the following benefit payment:

- A lump sum equal to 80% of what they would have received under option 1
- An amount equal to the actual cost of the treatment at the overseas facility, subject to a maximum of the benefit amount that would have been paid under option 1, less a deductible, which is defined as the amount payable by Discovery Health, had the treatment been performed in South Africa (in rand terms).

In addition:

- If the member is a member of Discovery Health Medical Scheme, the deductible under option 2 will be equal to the amount they will receive from their particular Discovery Health Plan had the treatment been performed in South Africa.
- If the member is not a member of Discovery Health Medical Scheme, the deductible will be equal to the Discovery Health Rate for the treatment had it been done in South Africa, whether or not they receive payment from a medical scheme.
- If the costs of treatment at the overseas facility exceed the amount payable under the Global Treatment Benefit, the excess will be for the member's account.
- The Global Treatment Benefit assists in funding the overseas treatment costs only. Discovery Group Risk will not provide funding for any treatment performed in South Africa which precedes or is subsequent to the treatment at the overseas facility.
- The member must satisfy the criteria under Severity A, B, C or D of the Severe Illness Benefit to qualify for option 2.
- Only treatment approved by the American Medical Association and medicine approved by the Food and Drug Administration in the United States of America are covered.

- Additional therapy, for example physiotherapy, occupational therapy or equivalent, is excluded.
- The Global Treatment Benefit does not cover travel and accommodation costs relating to the overseas treatment.
- The member must notify Discovery Group Risk of their choice between option 1 and option 2 at the time of claim notification under the Severe Illness Benefit.
- Apart from organ transplants, the overseas medical treatment must take place within three months of claim notification. In the case of organ transplants, the member must be placed on an organ transplant waiting list within six months of claim notification.
- If their treatment does not occur within these time periods, Discovery Group Risk will pay the policyholder the remaining 20% of their lump sum due under option 1. The Global Treatment Benefit will not be available thereafter for the event that led to the claim under the Severe Illness Benefit.
- Discovery Group Risk does not accept any legal responsibility for the quality of medical procedures, treatment or advice provided to the life assured.
- Irrespective of the amount paid out to the member under option 2 of the Global Treatment Benefit, the amount deducted from their Life or Impairment Fund will be the amount that would have been paid to them under option 1.
- The Global Treatment Benefit allows the member to have multiple treatments overseas. Irrespective of the number of times they are treated overseas, the maximum payout for treatment of a particular or related illness is capped at the benefit amount under option 1, less the deductible. The maximum payout for all life-changing events is capped at 2.5 times initial Severe Illness Benefit sum assured and increased by the annual risk salary increase percentage of the member.
- The payout for treatment of a progressive illness will be based on the severity of the illness at the time of the treatment, less any payout for prior treatment at a lower severity.
- The Global Treatment Benefit is available on the Comprehensive and Comprehensive Plus Severe Illness Benefit options, including the automatic cover for children.
- The premium for the Global Treatment Benefit is included in the premium for the Severe Illness Benefit and is annually reviewable based on claims experience.

The Global Treatment Benefit expires at the earlier of reaching age 65 and the benefit expiry age of the Severe Illness Benefit, as indicated in the client benefit schedule.

7.12 What is the Impairment Fund?

The Severe Illness Benefit reduces the Life Fund in the event of an accepted claim. However, the Severe Illness Benefit may be selected as a standalone benefit. In this case, the Impairment Fund becomes the financial mechanism of the Group Risk Life Plan and is used to fund Severe Illness Benefits.

The Impairment Fund operates in the same way as the Life Fund, except that it may only be reduced by severe illness claims. All other features applicable to the Life Fund are also applicable to the Impairment Fund. This includes the Minimum Protected Fund and Vitality.

7.13 Transitional arrangements

If a policyholder with existing Severe Illness Benefits with Discovery Life Group Risk at 1 January 2017 chooses not to upgrade to the Early Cancer Benefit set out in this section, and the enhanced Severe Illness Benefit assessment criteria contained in *Appendix 2*, then their benefits will remain as they were on 1 January 2017.

This Discovery Group Risk Life Plan Guide (GRLPG01/17) will apply to these benefits, except that the following clause and appendix will not apply:

- Clause 7.3 (Early Cancer Benefit)
- *Appendix 2* of this Discovery Group Risk Life Plan Guide (GRLPG01/17) is replaced with *Appendix 2* of the previous version of the Discovery Group Risk Life Plan Guide (GRLPG09/15).

All existing schemes that choose to convert to the Early Cancer Benefit and the enhanced Severe Illness Benefit assessment criteria on or after 1 January 2017 and all schemes not currently assured by Discovery Group Risk, quoted for on or after 1 January 2017, will be subject to all the terms and conditions of this Discovery Group Risk Life Plan Guide (GRLPG01/17).

An existing scheme becomes subject to the terms and conditions of this Discovery Group Risk Life Plan Guide (GRLPG01/17) 30 days after receipt of this document by the policyholder or their recorded representative as set out in Section 1.

Funeral Cover Benefit

8.1 Funeral Cover Benefit

The policyholder may select Funeral Cover Benefits, which then become compulsory and applicable to all eligible members.

8.2 How are benefits defined?

The client benefit schedule indicates the benefits selected by the policyholder. The Funeral Cover Benefit is subject to maximums set by Discovery Group Risk from time to time (see general benefit limits), and is defined as a sliding scale based on the age of the life assured.

8.3 What is the Funeral Cover Benefit?

A lump-sum benefit is paid to cover the cost of a funeral for the member only or for the member and their spouse and children. Two benefit options are available:

- Member-only Funeral Cover Benefit
- Family (member, spouses and children) Funeral Cover Benefit.

The Funeral Cover Benefit is provided to all members on a compulsory basis if selected by the policyholder. No medical evidence is required for the Funeral Cover Benefit.

8.4 How are spouses and children defined for the family Funeral Cover Benefit?

A spouse is defined in 17.1.3. A maximum of three spouses will be covered under the Family Funeral Cover Benefit.

A child is defined in 17.1.4. A maximum of five children will be covered under the Family Funeral Cover Benefit.

In addition to the general definition of a child, for the Family Funeral Cover Benefit:

- A child of the member who studies full-time at a recognised educational institution and who has not reached the age of 24 years is considered a child.
- No age limit will apply to a child who is incapacitated by mental or physical infirmity and unable to maintain themselves, provided that such child is wholly dependent on the member for support and maintenance.

Once a child has become independent of the member for support and maintenance, dependency cannot be revived at a later date and they will not be considered a child for the purposes of the Family Funeral Cover Benefit at any future date.

8.5 What benefit payments are provided by the Funeral Cover Benefit?

Member-only funeral cover: Upon the death of the member, a benefit payment equal to the amount of the Funeral Cover Benefit will be considered.

Member and family funeral cover: Upon the death of the member, spouses or children, a benefit payment equal to the amount of the Funeral Cover Benefit will be considered.

If all premium payments are up to date, Discovery Group Risk will consider payment of the Funeral Cover Benefit as set out in the client benefit schedule in respect of a deceased life assured, and if accepted, pay the benefit amount to the member, or to the beneficiary in the case of the death of the member (or another party if requested by the member). In addition to the necessary forms and protocols required, the policyholder will be required to provide Discovery Group Risk with the date and cause of death within six months of the date of death.

8.6 When does the Funeral Cover Benefit expire?

The Funeral Cover Benefit expires at the selected benefit expiry age. The benefit expiry age is selected by the policyholder and is generally the age at which the member would reach normal retirement age.

This means that if the member dies in service before the benefit expiry age, the claim will be assessed and considered, but claims after the benefit expiry age will not be accepted. Premiums will not be charged for the Funeral Cover Benefit after the member reaches the benefit expiry age.

The Family Funeral Cover Benefit will expire:

- At the earlier of the date that the member reaches the benefit expiry age, age 70 or dies. Premiums will not be charged for the Family Funeral Cover Benefit after the member reaches the benefit expiry age, age 70 or dies
- At the date that the member is no longer an eligible member
- For the spouses or children, if they no longer meet the definition of spouse or child as defined in clauses 17.1.3, 17.1.4 and 8.4
- For the spouses the earlier of the date the spouse reaches the benefit expiry age, age 70 or dies.

8.7 Extended Family Funeral Cover Benefit

If this option is chosen by the policyholder, additional family members, as defined in clause 8.7.1, may be included as lives assured under the Extended Family Funeral Cover Benefit. All other terms and conditions applicable to the Funeral Cover Benefit and the Family Funeral Cover Benefit will apply as appropriate to the Extended Family Funeral Cover.

8.7.1 Terms and conditions of the Extended Family Funeral Cover Benefit

- The maximum entry age to the policy is the last day of the month in which the extended family member reaches 70 years of age and 65 years of age for the principal member.
- Family members who may be covered are those who are dependent on the principal member for financial assistance towards funeral and related costs. These may include parents, parents-in-law, uncles, aunts, brothers, sisters, nephews, nieces, grandparents and children of the principal member, who are over age 21. A maximum of 10 extended family members per principal member will be covered.
- A waiting period of six months will apply from the date of commencement of cover for the extended family member. If the extended family member leaves the scheme for a period of one month or more and subsequently rejoins the scheme, then the six-month waiting period will apply again. If, immediately before moving to Discovery Group Risk, the extended family members enjoyed equivalent benefits at their previous underwriter and proof of this can be provided to Discovery Group Risk then the six-month waiting period may be waived.
- The monthly premium will be determined on the extended family member's age and amount of cover selected.
- The Extended Family Funeral Cover Benefit will expire on the last day of the month in which the extended family member attains 100 years of age or the principal member reaches the lesser of the benefit expiry age or age 65.
- An up-to-date member schedule must be supplied to Discovery Group Risk by the last working day of each month in respect of members enjoying cover for the following month and the premium paid to Discovery Group Risk must correspond to this member schedule. The member schedule must contain the following information:
 - Principal member's details
 - Extended family member's relationship to principal member
 - Extended family members' names and surnames
 - Extended family members' dates of birth and ID numbers
 - Date that extended family members joined the benefit
 - Extended family members' genders.
- In the event of a death, notification of the death and the relevant supporting documents must be submitted in writing to Discovery Group Risk within six months from the date of death. Failure to do so within this notification period will result in the benefit being forfeited.
- Discovery reserves the right to request further documentation or information as it may deem necessary to accurately assess a claim.
- If both spouses enjoy funeral cover under Group Risk Life Plans insured by Discovery Group Risk and they both have common relations insured under the Funeral Cover Benefit, Family Funeral Cover Benefit or Extended Family Funeral Cover Benefit, the total benefit paid for lives assured in common (including themselves) will not exceed the maximum sums assured set by Discovery Group Risk from time to time (see general benefit limits). If these maximums are breached on the death of a particular life assured, then the benefits payable under each spouse's cover will be proportionately reduced so that the total benefit paid does not breach the maximums.

Spouse benefits

9.1 Spouse benefits

The policyholder may select spouse's benefits.

The Group Risk Life Plan offers the following benefits to spouses:

- Spouse Life Cover Benefit
- Spouse Capital Disability Benefit
- Spouse Severe Illness Benefit.

The spouse benefits are defined as a fixed rand amount or a multiple of the member's annual risk salary, and are subject to maximums set by Discovery Group Risk from time to time (see general benefit limits). The policyholder may choose the spouse benefits, provided the spouse benefits are compulsory for all members who have a spouse.

If a member has more than one spouse, the spouse, as defined in clause 17.1.3, to whom the member has been married for the longest period will be deemed the spouse for all spouse benefits, excluding the Funeral Cover Benefit.

9.2 The payment of the spouse benefits

On the death of the spouse, a benefit payment equal to the amount of the spouse Life Fund will be made to the policyholder.

The following applies to the payment of spouse benefits:

- The standard terms and conditions that apply to member benefits will apply to spouse benefits
- The spouse Life Cover Benefit does not reduce the Life Fund of the member, unless specifically requested by the policyholder
- Any benefit payment made in terms of the spouse Capital Disability Benefit and spouse Severe Illness Benefit will reduce the spouse Life Fund.

On the death of the spouse, a benefit payment equal to the amount of the spouse Life Cover Benefit will be made to the policyholder.

The amount of this benefit payment is calculated as follows:

(i) Initial Life Fund (Core)

plus

(ii) Any amount by which the Life Fund has grown, due to risk salary increases

less

(iii) Any benefit payments previously deducted from the Life Fund.

9.3 When do the spouse benefits expire?

Excluding the Funeral Cover Benefit, the spouse benefits expire in any of the following circumstances:

- At the date the member or the spouse reaches the benefit expiry age, age 65 or dies, whichever occurs first. Premiums will not be charged for the spouse benefits after the member reaches the benefit expiry age, age 65 or dies. However, it remains the responsibility of the employer to inform Discovery Group Risk that no premiums should be charged for such a spouse.
- At the date that the member is no longer an eligible member.
- The spouse no longer meets the definition of spouse as defined in clause 17.1.3.

Mortgage Protector

10.1 Mortgage Protector

The Mortgage Protector will pay a fixed number of monthly instalments into a member's bond account if the member is disabled and their claim qualifies for the Income Continuation Benefit, or who dies, and at date of death or disability:

- Is on a Group Risk Life Plan that provides a Life Cover Benefit and an Income Continuation Benefit
- Is a member of Vitality
- Has a registered bond in their own name (as mortgage holder) registered over the member's primary residence with an outstanding balance, with a recognised financial institution.

The number of monthly Mortgage Protector instalments and their value are calculated taking into account:

- The Vitality status of the member at the time of the claim as per the table below
- The average of the member's last 12 home loan instalments.

Vitality status at date of claim event

Blue	Bronze	Silver	Gold	Diamond
3 months	6 months	9 months	12 months	24 months

Example

Average monthly home loan instalment over the past 12 months was R10 000; Vitality status = Silver.

Benefit = R10 000 per month for nine months on disability of member, or R90 000 (9 × R10 000) paid on death.

Additional home loan repayments over and above the contractual monthly instalments are not included in the calculation of the average home loan instalment.

The monthly instalment is capped at 30% of the member's monthly risk salary.

The Mortgage Protector is separate from the Income Continuation or Life Cover Benefit payout. These benefits are only used to create the event for the payment of the Mortgage Protector. The Mortgage Protector will only pay when claiming for one of the benefits (it pays once only on the Life Cover Benefit or Income Continuation Benefit. Once the Mortgage Protector has paid out on one of these benefits, no further payment will be made).

Example

If the member claims for the Income Continuation Benefit and then dies, the benefit will only pay for the Income Continuation Benefit event.

Properties held in companies, trusts and close corporations (CCs) are not eligible for this benefit. The benefit is only offered if the property and home loan are held in the member's name or in the name of the member and their spouse (in other words co-ownership between member and their spouse).

To qualify for the Mortgage Protector payment on disability the member must qualify for the Income Continuation Benefit. The Mortgage Protector payments on disability will be paid monthly.

The Mortgage Protector benefit will expire:

- At the earlier of the expiration of the fixed benefit payment term as per the Vitality table above or the termination of the Income Continuation Benefit
- On the member's death, whether or not while in receipt of the Mortgage Protector due to disability, in which case a lump-sum amount will be paid, calculated by multiplying the number of qualifying months (per the Vitality table above) by the average monthly instalment less any instalments already paid.

10.2 Taxation of the Mortgage Protector

Members may pay fringe benefit tax on the premium for the Mortgage Protector. The premiums for the Mortgage Protector are not guaranteed and will be reviewed annually. Members must get appropriate guidance from a tax professional or from their authorised financial services provider for the correct treatment of the Mortgage Protector payments and premium.

10.3 What legal provisions apply to the Mortgage Protector?

Both the actively at work and the pre-existing conditions clauses (clauses 17.8 and 16.4) automatically apply to the Mortgage Protector, whether or not Discovery Group Risk has waived these clauses for other benefits. These clauses will be waived if immediately before moving to Discovery Group Risk the members enjoyed equivalent benefits at their previous underwriter and met these conditions at that underwriter, and only to the extent that the previous benefits were at the same level as those provided by Discovery Group Risk.

Continuation option

The continuation option may be selected by the policyholder to enable members to apply for an individual Discovery Life Plan for the same benefits they enjoyed under the Group Risk Life Plan. Conversion to an individual Discovery Life Plan will be governed by the rules, terms and conditions applicable to an individual Discovery Life Plan as defined by Discovery Life, at the time of the conversion.

The application for an individual Discovery Life Plan through the continuation option will not be subject to the standard underwriting requirements applied by Discovery Group Risk, save only that the applicant undergoes a human immunodeficiency virus (HIV) screening, the result of which will determine whether or not the application will be accepted.

11.1 When may a member exercise the continuation option?

For the Core Life Cover Benefit:

- As a result of the member leaving service of the policyholder or ending employment with the policyholder for any reason on or before age 65.

For the Global Education Protector:

- As a result of the member leaving service of the policyholder or ending employment with the policyholder for any reason on or before age 55.

For the Core Income Continuation Benefit, Capital Disability Benefit and Severe Illness Benefit:

- As a result of the member leaving service of the policyholder or ending employment with the policyholder for any reason on or before age 60.

For the Funeral Cover Benefit:

- As a result of the principal member leaving service of the policyholder or ending employment with the policyholder for any reason on or before age 65.

In addition, a member may also exercise the continuation option when the policyholder ends the provision of risk benefits to its members completely, due to its insolvency or liquidation. This provision does not apply if the cover offered under this Group Risk Life Plan is replaced partially or fully, whether by means of group risk or individual life cover, and whether with Discovery or an alternate insurer.

11.2 Conditions for exercising the continuation option

- The member must be employed by or belong to the policyholder for a continuous period of 12 months before any continuation option may be exercised.
- If at the date of exercising the option a claim is being considered under the Group Risk Life Plan and the payment for the claim would have the effect of reducing the Life Fund, the benefits under the individual Discovery Life Plan will be the same as those that the applicant would enjoy under the Group Risk Life Plan after the payment of the claim. In other words the applicant would be offered an individual Discovery Life Fund as reduced by the claim under the Group Life Plan (subject to the Minimum Protected Fund if applicable).
- If a member wants to apply for cover in excess of the benefits enjoyed under the Group Risk Life Plan or for any other benefits not included under the Group Risk Life Plan, these additional benefits will be subject to the normal underwriting requirements in force at the time.
- A member must apply to Discovery Life for an individual Discovery Life Plan in terms of this continuation option within 60 days of the member's termination of employment or termination of participation in the Group Risk Life Plan. If the member has not applied within this time limit the continuation options fall away and are no longer available. The member may apply to Discovery Life after this, but their application will be subject to the normal underwriting requirements in force at the time.
- The standard terms and conditions of the individual Discovery Life Plan will apply.
- The rates and premiums applicable under the individual Discovery Life Plan for the benefits applied for under the continuation option will differ from those under the Group Risk Life Plan.
- Any pre-existing condition provisions and underwriting decisions, loadings or exclusions that applied to the Group Risk Life Plan benefits will be transferred and continue to apply to the individual Discovery Life Plan benefits. The waiting period will not be shorter, and the maximum cover age will not be later than the age initially selected for the Group Risk Life Plan client benefit schedule.
- An applicant will not enjoy cover under an individual Discovery Life Plan (subject to the terms and conditions of the individual Life Cover Benefit) in the period between the termination of employment or termination of participation in the Group Risk Life Plan and the acceptance of risk by Discovery Life. The member will, however, continue to enjoy cover under the Group Risk Life Plan for a period of 30 days after termination of employment or participation in the Group Risk Life Plan, provided that an application for an individual Discovery Life Plan in terms of this continuation option has been made.

- The individual Discovery Life Plan policy maximum ages, if below those of the Discovery Group Risk scheme maximums, will apply.
- Premiums will terminate when the member reaches the benefit expiry age as shown in the client benefit schedule.
- If a member otherwise qualifies for a continuation option on any benefit, but they continue to receive cover for that benefit, then the option falls away for those benefits, but is reinstated when that continued cover is no longer provided (and all other conditions for the continuation option are still met).

11.3 Continuation option for disability claimants

A disability claimant may only exercise the continuation option as detailed below.

For the Core Life Cover Benefit:

- As a result of the claimant leaving the service of the employer on or before the earlier of normal retirement date or age 65.

Discovery Group Risk Payback

Employees on a Discovery Group Risk policy that qualify for Group Risk Payback and who are members of qualifying medical schemes administered by Discovery Health, can earn a payback of up to 15% of the value of their Group Risk premiums once they have attended a Discovery Wellness Experience or completed their Vitality Health Checks. The Group Risk Payback applies to both approved and unapproved risk benefits. Employees qualify for this payback primarily because of their employer or their retirement fund (pension or provident fund) participating in the Group Risk scheme.

The percentage payback earned in a year depends on the employee's health plan (for qualifying schemes administered by Discovery Health), total health claims amount and Vitality status.

The payback accrued each year is limited to a maximum amount determined by Discovery Group Risk from time to time (see below).

12.1 How is Discovery Group Risk Payback activated?

The payback is available to employees of employers with more than 20 employees who:

- Are covered through their employer's Discovery Group Risk policy, with Life cover of at least twice their yearly income and any Income Continuation Benefit (basic monthly Income Continuation Benefit scale structure and any other basic monthly Income Continuation Benefit structure)
- Are members of Discovery Group Risk and a qualifying medical scheme administered by Discovery Health that qualifies for the Group Risk Payback for at least 12 months
- Have attended a Discovery Wellness Experience or completed a Vitality Health Check and
- Are engaged with the Vitality or Vitality Move programme through any channel, including through their own main membership of the medical scheme or through that of their spouse.

12.2 How does the Discovery Group Risk Payback work?

The payback is yearly and specific to each employee (with the first year being extended if the employee qualifies in the course of the year). Qualifying employees receive a payback depending on their applicable health plan, their total amount of health claims for the year and their Vitality status. The qualifying health plans and the percentage of premium paybacks earned are shown in Appendix 5.

Qualifying employees who do not attend a Discovery Wellness Experience or complete a Vitality Health Check in the year will not earn a payback amount.

The payback is based on the gross Discovery Group Risk premiums for all benefits (including Flex Benefits).

The payback earned each year is limited to a current maximum of R10 000.

12.3 Retirement Funds boost to reinvested Group Risk Paybacks?

Qualifying employees who are also members of the Discovery Retirement Funds* have their Group Risk Paybacks earned automatically reinvested in the Funds (as a member's additional voluntary contribution) unless the members choose to receive the paybacks in cash. If their paybacks are reinvested into the Discovery Retirement Funds*, Discovery Life Limited will boost the reinvested payback amounts by 100%. Refer to the Discovery Retirement Funds Guide for more information.

12.4 How will the Group Risk Payback be paid out?

If an employee chooses to receive their payback in cash, payment is as set out below:

- The Discovery Group Risk Payback is paid directly into the member's bank account as registered with the medical scheme, by 31 March after the end of the year in which these become due.
- The amounts due are paid at the end of March following the year in which these are due, to ensure that the employee's Vitality status has been updated with all points earned.

12.5 How does tax affect the Group Risk Payback?

The payback has the following tax considerations:

- If an employee chooses to have their payback in cash instead of reinvesting it in the Discovery Retirement Funds*, the payback is considered income when the employee receives it and will be subject to income tax. An IT3(a) certificate will be issued by Discovery Group Risk. The employee must disclose the amount received in their income tax returns for the tax year of assessment in which the payback is paid out.
- If the payback earned by the member is reinvested (as a member's additional voluntary contribution) in the Discovery Retirement Funds* the member can claim the amount reinvested in the Funds as part of the allowed contribution deduction limit (currently the greater of 27.5% of remuneration or taxable income capped at R 350 000) for the tax year in which it is reinvested.

*The Discovery Retirement Funds refer to the Discovery Life Pension Umbrella Fund and Discovery Life Provident Umbrella Fund.

12.6 What happens if the member ends their membership?

If the member or employer ends either their Discovery Group Risk policy, their membership of a qualifying scheme administered by Discovery Health or their Vitality membership, they forfeit their payback.

If the member changes employers and joins an employer where they continue being a member of a qualifying medical scheme administered by Discovery Health (including Vitality) and of a Discovery Group Risk scheme, within two months of joining the new employer, they will keep the payback they earned under the previous employer.

If participating schemes or member groups fall below 20 members, they no longer qualify for the Discovery Group Risk Payback for future accrual. If participation in the Discovery Group Risk Payback ends solely due to the 20-membership requirement not being met, the accrued payback will not fall away. It is paid out as cash or reinvested in the Discovery Retirement Funds at the end of March following the year in which participation ended, as long as all other requirements are met.

12.7 What can change over time?

From time to time we may review and change any of the following:

- 1 The qualifying health plan types, the mapping of the health plans, health claim amount ranges and the criteria for valid health claims
- 2 The qualification criteria and conditions for the Group Risk Payback
- 3 The payback percentages when there are changes to the Vitality programme, as well as any other changes within the Discovery Group.
- 4 The maximum payback earned each year.

Example

James is 34 years old and has diabetes. He has a family of three. He works for a consulting engineering firm. James is a member of Discovery Health Medical Scheme under the Family Saver health plan type. His firm joins Discovery Group Risk on 1 July 2018 and participates in the Vitality programme. James has attended the Discovery Wellness Experience this year, where it was found that all his relevant risk measures were within a normal range.

Since he is required to be a member of both Discovery Health Medical Scheme and Discovery Group Risk for 12 months, his payback will be calculated up to December 2019. He will therefore get 18 months' worth of payback, which will only pay out in March 2020 due to the required updating of his Vitality points and final assignment of his Vitality status for the year.

Going forward, James's payback will be calculated for the full 12 months up to the end of December, with payment occurring in March.

James, who pays an annual Group Risk Life Plan premium of R12 000, progresses from Bronze to Silver Vitality status over the period and has all his Vitality Health Checks completed for the period. He sent in health claims amounting to R1 500 in the first year and R6 000 in the second year. He will receive the following annual paybacks for 2018, 2019 and 2020:

December 2019 Payback	$= 1.5 \text{ years} \times \text{Bronze Vitality status (with R1 500 health claims)} \times \text{yearly premium}$ $= 1.5 \times 6\% \times \text{R12 000}$ $= \text{R1 080}$
December 2020 Payback	$= 1 \text{ year} \times \text{Silver Vitality status (with R6 000 health claims)} \times \text{yearly premium}$ $= 1 \times 6\% \times \text{R12 000}$ $= \text{R720}$

12.8 Vitality Move for non-Vitality members

All members of the Discovery Group Risk scheme with the Group Risk Payback feature who are not Vitality members can access to Vitality Move. Based on the members' engagement in the Vitality Move programme, they will be mapped to a column in the payback tables related to their health plan type as follows:

Vitality Move engagement	Appropriate column in the Group Risk Payback table (See Appendix 5)
Completed all Vitality Health Checks	Blue status column
Body Mass Index in range	Bronze status column
All Vitality Health Checks measures in range	Silver status column

Rewards for managing health through Vitality

13.1 Rewards for managing health

The Group Risk Life Plan is a living policy, which, while it compensates members and their families for events that influence their quality of life, also rewards members for responsibly managing and improving their health while they are able-bodied. This is achieved through a wellness programme administered by Discovery Vitality (Pty) Ltd ("Vitality"), which has been enhanced to form a valuable foundation to the Group Risk Life Plan.

13.2 How can members join Vitality?

Vitality is not available on a standalone basis. Vitality is available to members who qualify for membership through at least one of the following channels:

- They are members of Discovery Health Medical Scheme
- They have an individual Discovery Life Plan
- If the Group Risk Life Plan policyholder has 50% or more of its members on Discovery Health Medical Scheme, then the remaining members, although not on Discovery Health Medical Scheme, may also become Vitality members through the Group Risk Life Plan.

The Vitality membership for the member and their dependants can only be activated through one of these three options and applies to the whole family.

There is a monthly contribution payable for this benefit. Vitality discounts its membership premiums by up to 25% (dependent on membership size) if all employees of an employer are on Vitality. This discount works as follows:

Number of employees	Vitality discount for eligible employers
20 - 200	15%
201 - 500	20%
501+	25%

Vitality members who qualify and opt for Vitality membership through membership of a Group Risk Life Plan may have their Vitality contributions paid:

- By their employer, in which case the contribution is billed with the Discovery Group Risk premiums
- By the member, in which case the member will be billed separately (this being the only payment method for approved funds).

Vitality is designed to encourage members to look after their health and wellness lifestyle. By improving their health, they reduce their long-term healthcare costs.

Please refer to the Vitality portfolio for complete details of the programme. Information is updated with the quarterly Vitality statement.

13.3 Members and spouses can earn Vitality points for preventive measures

Members and spouses who are not members of Discovery Health Medical Scheme can still receive Vitality points for preventive measures by posting a copy of the results of such measures to:

Discovery Vitality
PO Box 786722
Sandton
2146

Members and spouses may also contact Vitality by calling **0860 66 55 44**.

13.4 The Vitality membership can expire

Members' Vitality membership will expire if:

- The policyholder's qualifying level for Vitality membership on the Group Risk Life Plan falls below the 50%
- On termination of the Group Risk Life Plan
- If the member is no longer an eligible member and does not enjoy Vitality through Discovery Health Medical Scheme or an individual Discovery Life Plan
- Children covered through their parent's Vitality membership, reach the age of 18.

13.5 Corporate wellness

Discovery Health Medical Scheme pays for Wellness Days and voluntary counselling and testing for members who are on Discovery Health Medical Scheme. Discovery Group Risk will pay for these Wellness Days and voluntary counselling and testing for members who are not on Discovery Health Medical Scheme, but covered by a Group Risk Life Plan, provided that 50% of members are covered by the Discovery Health Medical Scheme. The Group Risk Life Plan must have both the Life Cover and Income Continuation Benefits. Discovery Group Risk will pay for a maximum of 250 non-Discovery Health Medical Scheme members.

Premium payments

14.1 What is a risk salary?

A member's salary is the determinant of benefits:

- **“Risk benefit salary”** is the definition of salary used to determine a particular scheme's benefit sums assured, and **“risk premium salary”** is the definition of salary used to determine a particular scheme's premiums.
- Where both the risk benefit salary and risk premium salary are based on the same definition, the common definition is referred to as the **“risk salary”**. For the majority of schemes both definitions are the same.
- The details of a member's actual salary and the definitions of salary to be used for calculating benefit sums assured and premiums are provided by the policyholder to Discovery Group Risk. Discovery Group Risk will apply the salary definition as provided in the membership data.
- The most common definitions of risk salary used by policyholders for group risk plans are:
 - Pensionable salary
 - A percentage of cost to company salary (up to a maximum of 100%)
 - Gross salary (this includes certain items of the employee's package that may not necessarily be pensionable)
 - Basic salary plus a certain portion of fluctuating emoluments
 - Running average salary
 - Net salary.
- A member's risk salary may not exceed the member's actual salary.
- If the policyholder failed to inform Discovery Group Risk of an increase of more than 20% in the member's annual risk salary, Discovery reserves the right to request a motivation of salary increase from the policyholder if such an increase occurred within six months of a claim being lodged.

The salary used for determining the maximums for the combined Income Continuation Benefit and Retirement Fund Waiver (if applicable), and the individual limits for its associated benefits (if applicable), is a member's net after-tax salary, which is defined as:

Net after-tax salary = Cost to company - PAYE on cost to company

The net after-tax salary maximum limit does not apply to the Income Continuation Benefit (including the upgrade if applicable) or to the Retirement Fund Waiver if the Income Continuation Benefit is based on the recommended scale benefit.

14.2 Risk salary for commission earners

The risk salary for commission earners is calculated using a running average. The risk salary is calculated by adding the salary and commission that the member received in the period before the life-changing event that gave rise to the claim and which period will not be less than six months. The total is then divided by the months in the period. The policyholder will need to ensure commission or wage earners' risk salary definition is agreed to at the onset of the scheme.

Example

If we assume a commission earner generated the following monthly income:

January R15 000	February R25 000	March R12 000	April R22 000	May R21 000	June R23 000	July R18 000
-----------------	------------------	---------------	---------------	-------------	--------------	--------------

In this example the period selected for the calculation of the running average salary is six months. The risk salary used for determining benefits would be calculated as follows:

June risk salary = $(23\ 000 + 21\ 000 + 22\ 000 + 12\ 000 + 25\ 000 + 15\ 000) \div 6 = 19\ 667$

July risk salary = $(18\ 000 + 23\ 000 + 21\ 000 + 22\ 000 + 12\ 000 + 25\ 000) \div 6 = 20\ 167$

14.3 Premiums

Premiums and premium rates are determined at commencement of the Group Risk Life Plan and will apply until the policy anniversary (“premium term”), after which they may be amended by Discovery Group Risk. The premiums and premium rates may thereafter be amended at every policy anniversary.

14.3.1 When may premiums be amended

Premiums and premium rates may be amended during the premium term (before policy anniversary) or in the period between acceptance of a quotation and installation of the scheme, at the sole discretion of Discovery Group Risk, if:

- There is a change in membership (of the Group Risk Life Plan) of more than 15%
- The policyholder is amalgamated, taken over or takes over another entity
- The policy is amended by the policyholder
- The policyholder’s business activities change and the new activities are deemed by Discovery Group Risk to fall into a higher risk category
- The policyholder has furnished incorrect member or other information.

14.3.2 When must premiums be paid and what factors affect the premium rating?

The policyholder must pay the premiums when they become due. Premiums may be paid in advance or in arrears as determined in the client benefit schedule. Premiums and premium rates are determined by reference to the following factors, among others:

- Age of lives assured
- Gender of lives assured
- Occupation of lives assured
- Nature of industry in which the lives assured operate
- Previous claims experience
- Region in which lives assured operate
- Previous medical claims information of the lives assured, if they are Discovery Health Medical Scheme members
- Any other factors that Discovery Group Risk, at its sole discretion, considers will affect the risk associated with the lives assured.

The policyholder must supply Discovery Group Risk with accurate member information for purposes of premium rating. Failure to provide accurate information will entitle Discovery Group Risk to cancel the policy or to revise the terms and conditions (including premiums). The policyholder has an ongoing duty to tell Discovery Group Risk if the nature of their industry changes, as per clause 17.15.

14.3.3 How the Discovery Group Risk premiums and benefits increase

The initial Life Fund and other benefits are expressed as a multiple of the member’s annual risk salary. The Life Fund increases as each member receives a salary increase. This typically occurs at the group plan anniversary, although it may occur at any stage. Discovery Group Risk must be informed if a member’s salary increases. Discovery Group Risk reserves the right to request a motivation of salary increase from the policyholder if such increases exceed 20% and occurred within six months of a claim being submitted. Benefits increase as each member receives a salary increase, provided that Discovery Group Risk is notified in writing, and may be subject to underwriting if those benefits exceed the free cover limit.

If the benefits are specified as a flat rand amount of cover rather than as a multiple of risk salary, the benefits will remain level or flat, unless otherwise requested by the policyholder.

Premium rates are recalculated on each policy anniversary date. Factors that will be taken into consideration are the factors mentioned in clause 14.3.2.

14.3.4 Premiums may increase or decrease

The policyholder may at any time request the addition or removal of Core, Plus or Flex Benefits, or the addition or removal of members. Such changes will result in the increase or decrease of premiums. The changes may be subject to medical underwriting.

14.3.5 What happens if the policyholder does not pay premiums?

If a premium is not paid when it becomes due, the policyholder will be informed of this by Discovery Group Risk in writing. Discovery Group Risk allows the policyholder 30 days (known as the grace period) from the date when the premium became due to pay the arrear premium. If an insured event happens during the grace period, Discovery Group Risk will consider a claim (subject to the terms of the policy), but only on receipt of the arrear premium.

If a second premium is not paid when it becomes due (the policyholder has failed to pay two premiums or the Group Risk Life Plan is two premiums in arrears) the policy will be suspended. If an insured event occurs while the policy is two premiums in arrears, no claim will be paid in this period even if the arrear premiums are paid thereafter, unless Discovery Group Risk waives the requirements of this paragraph, at its sole discretion, in writing.

If a third premium is not paid when it becomes due, the policy will be terminated.

14.3.6 The client benefit schedule provides the details of the members' cover

The client benefit schedule provides details of the benefits for the members, including premiums and any applicable exclusions. The policyholder will receive a client benefit schedule from Discovery Group Risk at inception and at the annual revision of the policy. If any of the policy details change, Discovery Group Risk will send a new client benefit schedule detailing the changes.

Underwriting and the Free Cover Limit Multiplier

15.1 What medical information is required?

All Core and Plus Benefits under the policy are granted free of underwriting up to the free cover limit. The free cover limit is determined by Discovery Group Risk at their sole discretion and will vary from policy to policy. Any benefits required in excess of the free cover limit are subject to underwriting. Cover in excess of the free cover limit (the excess portion) will only commence on acceptance of risk by the Discovery Group Risk underwriters. The underwriters may accept or decline the excess portion or impose any terms or conditions that they deem necessary.

The period from date of application for the excess portion to the earlier of the expiration of a maximum of 90 days or the acceptance of risk by our underwriters is known as the medical evidence period. This is the period during which the member must fulfil any underwriting requirements that Discovery Group Risk's underwriters may deem necessary.

If an advance cover decision was granted during the medical evidence period, subsequent increases (on the excess portions) limited to an annual maximum of 20% for a period of five years, will not be subject to any further underwriting.

Discovery Group Risk will cover the costs of the medical underwriting required, up to Discovery Group Risk's maximums. If the member disagrees with the underwriting decision, any further evidence will be for the member's account.

There is no free cover limit for Flex Benefits and no accident cover is provided for Flex Benefits during the medical evidence period.

For certain plans Discovery Group Risk may at its sole discretion determine that no medical evidence period applies or that the medical evidence period is limited to a shorter period than 90 days.

15.2 Is accident cover available during the medical evidence period?

During the medical evidence period, Discovery Group Risk will provide cover below the free cover limit for a member at the standard rates, terms and conditions of the Group Risk Life Plan.

During the medical evidence period, if applicable, Discovery Group Risk will provide accident cover (Core and Plus) to the extent of the excess portion, as follows:

- For Capital Disability and Severe Illness Benefits limited to claims arising due to an accident only
- For Life Cover Benefit claims, provided that the cause of death is directly caused by an accident during the medical evidence period.

Accident cover in excess of the free cover limit will terminate on the earlier of the expiry of the medical evidence period and the member being advised of Discovery Group Risk's underwriting decision.

Accident cover can be introduced, removed or reintroduced at installation, renewal or benefit change stages.

Accident cover will only be valid for the first three months from policy inception or if the member previously went for underwriting and a decision was issued by Discovery Group Risk.

Accident cover will not be granted if a member has been restricted previously due to not submitting all the requested medical evidence within the medical evidence period.

Accident means death or injury or illness to a member arising directly or indirectly from a sudden and unexpected event that happens at a known time and place and has visible, violent and external cause.

The accident cover will exclude claims as a result of:

- A suicide, attempted suicide or any self-inflicted injury
- A member or their dependants being under the influence of alcohol, drugs or narcotics, unless a registered medical practitioner has prescribed the drugs or narcotics. The member and their dependants may not perform the role of registered medical practitioner
- The claim being a result of wilfully and deliberately breaking any law, a wilful act of war, riot or acts of public hostility
- Participating in any type of aviation or airborne pursuit, except as a passenger travelling in, or a pilot piloting a registered passenger aircraft that is owned and operated by a licensed airline or air-transport company, or in a military passenger aircraft. The aircraft must be flown on a recognised route between licensed airfields, and the pilot must hold a current commercial pilot's licence
- Participating in hazardous pursuits.

15.3 What is the Free Cover Limit Multiplier?

Members on Vitality qualify for an increased free cover limit, depending on their Vitality status as per the following table:

Vitality status on the date medicals are requested:

Blue	Bronze	Silver	Gold	Diamond
0%	10%	20%	30%	40%

The following conditions apply to the Free Cover Limit Multiplier:

- The percentages in the above table are adjustments applicable to Vitality members only, and only while they are Vitality members.
- The Free Cover Limit Multiplier is based on the member's Vitality status at the date that the medicals are requested.
- Members who have had benefits declined or loaded above a certain free cover limit may not increase the Free Cover Limit Multiplier by improving their Vitality status.
- Maximum free cover limits after allowing for the Free Cover Limit Multiplier apply (see general benefit limits).

Example

If a plan has a free cover limit of R2 000 000, a Bronze Vitality member will qualify for a free cover limit of $R2\,000\,000 \times 110\% = R2\,200\,000$.

If a member's cover is medically declined or restricted the scheme's free cover limit will apply.

How to claim and receive benefits

16.1 How to claim a benefit

If a member or life assured experiences a lifestyle-changing event for which a claim may be payable, they must contact their financial adviser or the Discovery Group Risk contact centre on 0860 54 33 22. Discovery Group Risk will then provide the necessary forms and protocols needed for consideration of the claim.

16.2 Payment of benefits to the policyholder

Discovery will pay benefits to the policyholder or to any party if so directed by the policyholder on its behalf.

16.2.1 Payment of the Life Cover Benefit

Discovery Group Risk will pay the death benefit as set out in the client benefit schedule for a deceased life assured to the policyholder (or to any party so directed by the policyholder on its behalf). In addition to the necessary forms and protocols required, the policyholder will be required to provide Discovery Group Risk with the date and cause of death.

16.2.2 Payment of Capital Disability, Severe Illness and Income Continuation Benefits

On the disability or severe illness of a member or life assured, Discovery Group Risk will pay, after the waiting period (if applicable), the benefit set out in the client benefit schedule for Core, Plus and Flex Benefits, to the policyholder (or to any party so directed by the policyholder on its behalf). This benefit may be subject to benefit maximums as advised by Discovery Group Risk from time to time (see general benefit limits).

In addition to the necessary forms and protocols required, the claimant must submit the necessary medical evidence or any other information required by Discovery Group Risk to establish whether or not the claim is valid in terms of the policy within 90 days. Failure to submit the necessary medical evidence or any other information required by Discovery Group Risk within this time limit may cause the claim to be rejected.

The cost of obtaining medical information required by Discovery Group Risk must be paid by the claimant. Discovery Group Risk may defer the assessment of the claim until all the medical evidence has been produced. In respect of ongoing claims, Discovery Group Risk may request the claimant to submit further medical information from time to time. The claimant is responsible for submitting any further or other information requested. Failure by the claimant to provide such medical evidence may result in the termination of the benefit payment.

If the policyholder requests a review of a claim decision it must do so within 90 days of the initial claim decision. If the policyholder remains dissatisfied after the review it may within six months approach the Ombudsman for Long-term Insurance for assistance or may seek legal assistance.

The costs of the review will be borne by the policyholder or claimant. Discovery Group Risk will have the final discretion in deciding whether or not a claim should be admitted and will communicate its final decision to the policyholder in writing.

16.2.3 When can an Income Continuation, Capital Disability or Severe Illness Benefit claim be declined?

Discovery Group Risk reserves the right to decline claims when:

- The disability or severe illness of the claimant was self-inflicted
- Material information, for cover above the free cover limit, about physical disabilities or medical conditions that affect the claimant at the time that cover commences was not disclosed or was misrepresented
- The claim arose from participation in a hazardous occupation that was not disclosed to Discovery Group Risk and is not normally associated with the industry in which the claimant is employed
- Discovery Group Risk did not receive enough medical evidence from the claimant or treating medical practitioner to fulfil the criteria to make a benefit payment
- The claimant fails to provide medical evidence within 90 days in order for a claim to be considered
- The policyholder failed to inform Discovery Group Risk of an increase of more than 20% in the member's annual risk salary. Discovery reserves the right to request a motivation of salary increase from the policyholder if such an increase occurred within six months of a claim being lodged
- If a life-changing event occurs during a period in which Discovery Group Risk has not received premiums for the claimant.

Furthermore, Discovery Group Risk reserves the right to refuse claims if the disability or severe-illness claim was a result of:

- Breaking of any law or involvement in any riot, insurrection, usurpation of power, martial law or war
- Intentional and negligent consumption of poisons, alcohol, drugs or narcotics, unless prescribed by a registered medical practitioner. Neither the member nor their dependants may perform the role of a registered medical practitioner in these circumstances
- Excessive consumption of alcohol.

Discovery Group Risk will not be legally responsible for any claim under this policy if:

- The policyholder, member or life assured commits any act of dishonesty or fraud relating to any provisions contained in this policy
- The claimant declines or neglects to undergo reasonable medical treatment when there is a reasonable likelihood that the medical treatment would improve the medical impairment
- The benefits applied for under the Group Risk Life Plan have been increased, or the waiting period for the Income Continuation Benefit has been reduced, from those enjoyed under the previous plan with another insurer where:
 - The member is medically impaired during the 12-month period immediately following the alteration
 - The member's medical impairment, in the opinion of Discovery Group Risk's medical panel, is directly or indirectly attributable to an injury or illness for which they sought medical advice, or which they knew about or could reasonably be expected to have known about during the six-month period before the effective date of the alteration.

16.4 What pre-existing conditions may affect the claim?

Any claim during the first 12 months of a member joining the Group Risk Life Plan, excluding claims for the Life Cover Benefit and the Funeral Cover Benefit, that in the opinion of the medical panel of Discovery Group Risk is directly or indirectly attributable to any physical defects, illnesses, bodily injuries or diseases that the member suffered from, was aware of (or ought reasonably to have been aware of), or had sought medical advice or treatment for within six months before the date of the member joining the plan, will be excluded.

16.5 Waiver of the pre-existing exclusion clause

At the commencement of a Group Risk Life Plan, the pre-existing conditions clause (clause 16.4) is automatically waived if immediately before moving to Discovery Group Risk (without a break in insurance cover) the members enjoyed equivalent benefits at their previous underwriter and met this condition at that underwriter, and only to the extent that the previous benefits were at the same level as those provided by Discovery Group Risk.

For new schemes (not previously insured), new benefits and benefits higher than those enjoyed under the previous underwriter, the pre-existing conditions clause (clause 16.4) is not automatically waived. It may only be waived through request at the quotation stage, which request Discovery Group Risk may approve or decline at its sole discretion. In this case if Discovery Group Risk approves the waiver, the waiver must be stipulated in the quotation document. Waiving the pre-existing conditions clause in these circumstance may be accompanied by an increase in premiums at Discovery Group Risk's discretion.

If the pre-existing conditions clause (clause 16.4) is waived either automatically or by request in terms of this clause, then the waiver operates as follows:

- The waiver only applies to members who were employed by the policyholder or were members of the policyholder immediately before commencement of the Group Risk Life Plan and were members of a group life insurance plan providing either the same benefits as the Group Risk Life Plan immediately before the Group Risk Life Plan commences, or for new schemes, new benefits or benefits higher than those enjoyed under the previous underwriter if waived in writing in the accepted quotation document.
- The pre-existing conditions clause (clause 16.4) cannot be waived for any member who was not employed by or a member of the policyholder immediately before the commencement of the plan.

16.6 War, riot and terrorism exclusion

Discovery Group Risk will not pay any Life Cover, Income Continuation, Capital Disability, Severe Illness or Funeral Cover Benefits in the event that the claim arises directly or indirectly as a consequence of:

War and riot exclusion

- The war and riot exclusion includes: War or civil war, which includes active or passive participation therein
- Invasion, which includes invasion of the state by its enemies (foreign or otherwise), and land or property invasions on state or private property, by anyone
- Acts by enemies of the state (foreign or otherwise)

- Hostilities, warlike operations (whether or not war is declared)
- Riots
- Strikes
- Labour disturbances
- Rebellion
- Revolution
- Insurrection
- Civil commotion
- Civil unrest or disturbance of the peace, including active or passive participation therein
- Any activity associated with the investigation or containment of the foregoing by any security force.

Furthermore, this exclusion includes any loss or damage caused by the overthrowing or influencing of any government by terrorism or any violent means, or to create chaos, fear, alarm or dependency among the citizens of the state.

Partial waiver of the war, riot and terrorism exclusion

On request from the policyholder, Discovery Group Risk will provide written confirmation whether or not the passive war, riot, and terrorism clause has been partially waived. The inclusion of this waiver will be defined in the client benefit schedule. If the partial waiver is granted, then the premium will increase to allow for the partial waiver.

This partial waiver will cover members for death, disability, severe illness, and funeral benefits where the cause can be directly or indirectly attributed to passive participation in an act of war, riot, or terrorism.

This waiver will exclude a claim that is a consequence of direct or indirect active participation in war, riot, or terrorism.

Discovery Group Risk may cancel the partial waiver of the passive war, riot and terrorism exclusion, by giving the policyholder 24 hours' notice if:

- Discovery Group Risk is no longer able to reinsure this cover
- The Republic of South Africa is involved in armed conflict with another country or is occupied by a foreign power.

This waiver will be subject to whether or not suitable reinsurance can be obtained. If this is not available, the waiver will automatically be withdrawn.

If Discovery Group Risk alleges that by reason of this exclusion, any loss, damage or expense is not covered under this policy, the burden of proof to the contrary will lie with the policyholder.

Atomic, biological and chemical war and terrorism

Discovery Group Risk will not pay any death, disability, severe illness or funeral benefits in the event that the claim arises directly or indirectly as a consequence of:

- Use of nuclear, biological or chemical weapons, or any radioactive contamination
- Attacks on or sabotage of facilities (including nuclear power plants, reprocessing plants, final repository sites and research reactors) and storage depots, which lead to the release of radioactivity of nuclear, biological or chemical warfare agents, whether or not any of the aforesaid has been performed with the specific use of information technology.

In particular, cover will not exist when the attacks and sabotage have been performed with the specific use of information technology.

The exclusion for atomic, biological and chemical war and terrorism may not be waived.

General legal provisions, definitions and rules

17.1 Definitions

17.1.1 Who is the policyholder of this policy?

The policyholder of this policy may be:

- A retirement fund (normally sponsored by the employer) registered under the Pension Funds Act and approved by the Receiver of Revenue to receive certain tax exemptions in terms of the Income Tax Act. In this case the retirement fund is referred to as an “approved” fund and this policy only provides approved assurance benefits to the fund
- An employer (who may also be the sponsor of a retirement fund for their employees) of the employees covered by this policy.

Throughout this policy, “policyholder” is used to refer to the owner of this policy, whether they are an approved retirement fund or an employer. The approved or unapproved nature of the benefits covered by this policy appear in the client benefit schedule.

17.1.2 Who is a member of the Group Risk Life Plan, eligible for cover under this policy?

Eligible employee means a permanent, active, full-time employee (not a temporary employee, contractor or part-time employee, unless otherwise agreed in writing by Discovery Group Risk) who has not reached the benefit expiry age, who is employed for no less than 25 hours a week and who was actively at work on the date of the commencement of the plan or on the date of commencement of employment with the employer (unless the actively at work clause 17.8 is waived in terms of clause 17.9).

A member of the Group Risk Life Plan who is covered under this policy, refers to:

- For unapproved benefits – an eligible employee who is employed by the employer who is the policyholder of this policy
- For approved benefits – an eligible employee who also belongs to the retirement fund that is the policyholder of this policy.

Membership is compulsory for every eligible employee of the employer or fund. In the event of an employee not being a member of the plan (which non-membership must be agreed to by Discovery Group Risk in writing), such employee may apply for membership at a later stage, but such application will be subject to full underwriting. No free cover limit will apply in respect of such an employee.

Any member who becomes eligible after the commencement date will become a member on the first day of the month they become eligible if they became eligible on that day, or on the first day of the next month if they become eligible during a month. No member may resign or end membership as long as they remain in service of the employer or belong to the retirement fund and are under the benefit expiry age.

17.1.3 How is a spouse defined?

A spouse is defined as the person to whom the member is legally married and includes:

- A party to a customary union according to South African indigenous laws
- A union recognised as a marriage under the tenets of any Asiatic religion
- A person living with the member in the manner of a spouse, in a relationship of mutual dependence, running and sharing a common household.

17.1.4 How is a child defined?

A child is defined as an unmarried person who is financially dependent on the member and is described as:

- A natural child of the member under the age of 21 years
- A dependent stepchild of the member, under the age of 21 years
- A foster child of the member, under the age of 21 years
- A child under the age of 21 years, legally adopted by the member
- A stillborn child (death of the foetus after the 26th week of pregnancy) of the member
- A grandchild being a child of the member’s children, where both the child’s parents are deceased and the child is dependent on the member. Proof of dependency must be submitted to Discovery Group Risk.

17.1.5 Who is the life assured?

- The life assured is the person for whom a benefit is paid when they experience a life-changing event (death, disability or severe illness). In most case cases the life assured is the member of the Group Risk Life Plan. For certain benefits (spouse Benefits, Funeral Cover Benefits, Child Severe Illness Benefits and the Family Protector) where a benefit is paid when a life-changing event occurs to a relation of the member (spouse, child or extended family member), that relation is the life assured.

17.2 Documentation to be received

This Discovery Group Risk Life Plan Guide, read in conjunction with the accepted quotation document, the client and member benefit schedules, the general benefit limits document, and any endorsement signed by Discovery Group Risk and the policyholder, constitutes the entire agreement between Discovery Group Risk and the policyholder. Other than changes reflected in the member and client benefit schedules sent to the policyholder by Discovery Group Risk from time to time, alterations to these documents will only have force if formatted as an endorsement and signed by an authorised official of Discovery Group Risk and by the policyholder.

17.3 Risk salary used for calculating benefits

Unless otherwise stated in this document, or recorded in the accepted quotation or member or client benefit schedules, the benefit payable on death, disability or impairment will be calculated using the risk salary of the member as at date of death, disability or impairment (see clause 14.1).

17.4 Currency and law

Benefit payments and premiums are payable in the lawful currency of the Republic of South Africa. Any questions of law arising under this policy will be decided according to the laws of the Republic of South Africa.

17.5 Definition of age

All ages in this Discovery Group Risk Life Plan Guide refer to the end of the month in which those ages are reached.

17.6 Maximum entry ages

For Core, Plus and Flex Benefits, members must be between the ages of 15 and 65. However, the maximum entry age for members who were not covered under another compulsory group scheme is 65 for Life Cover Benefits, and five years before the benefit expiry age for Capital Disability and Severe Illness Benefits.

The maximum age at which a member may select Flex Benefits is 55.

All members must meet the requirements of the Basic Conditions of Employment Act.

17.7 Benefit expiry age

The benefit expiry age for Core, Plus and Flex Benefits will be selected by the policyholder and is generally the age at which the member would reach normal retirement age. The ages that may be selected are 60, 63 and 65.

Discovery Group Risk is able to provide life and funeral cover to a maximum benefit age of 70 years, if so requested by the policyholder and provided that the member is still an eligible employee. The benefit expiry age selected will be detailed per benefit in the client benefit schedule.

17.8 Actively at work

A member must be actively at work, attending to, or capable of fulfilling their normal daily duties on the first working day on which their cover commences. If the member was not actively at work at the time of the commencement of cover, cover for that member under the policy will only commence after eight consecutive weeks of uninterrupted service is completed.

A member who is on annual leave at commencement will have this clause waived, provided that they did not receive medical treatment for a condition that lead to their disability or severe illness within eight weeks of their intended date of return to work.

A member who is on maternity leave at commencement will have this clause waived, provided that she did not receive medical treatment for a condition unrelated to her pregnancy that lead to her disability or severe illness within eight weeks of her intended date of return to work.

Members who are on sabbatical leave, whether or not still employed by the employer, will not be covered for any benefits while they are on sabbatical leave.

When will the actively at work clause apply?

- On commencement of a Group Risk Life Plan for all members who did not enjoy group risk cover previously with the same employer
- To the increased benefits only for an existing group plan where any benefit amounts have increased
- Where there has been an amendment to the benefits or definitions of benefits selected
- Always to the Global Education Protector, Contribution Protector, and Mortgage Protector, unless specifically waived for those benefits in terms of clauses 4.18, 5.19.1 or 10.3
- For new entrants into an existing group plan
- From the commencement date of any new benefit additions.

17.9 Waiver of the actively at work clause

At the commencement of a Group Risk Life Plan, the actively at work clause (clause 17.8) is automatically waived if immediately before moving to Discovery Group Risk (without a break in the policies) the members enjoyed equivalent benefits at their previous underwriter and met this condition at that underwriter, and only to the extent that the previous benefits were at the same level as those provided by Discovery Group Risk.

For new schemes (not previously insured), new benefits and benefits higher than those enjoyed under the previous underwriter, the actively at work clause (clause 17.8) is not automatically waived. It may only be waived through request at the quotation stage, which request Discovery Group Risk may approve or decline at its sole discretion. In this case if Discovery Group Risk approves the waiver, the waiver must be stipulated in the quotation document. Waiving of the actively at work clause in these circumstance may be accompanied by an increase in premiums at Discovery Group Risk's discretion.

If the actively at work clause (clause 17.8) is waived either automatically or on request, in terms of this clause, then the waiver operates as follows:

- The waiver only applies to those members who were employed by the policyholder or were members of the policyholder immediately before commencement of the Group Risk Life Plan and were members of a group life insurance plan providing either the same benefits as the Group Risk Life Plan immediately before the Group Risk Life Plan commences, or for new schemes, new benefits or benefits higher than those enjoyed under the previous underwriter if waived in writing in the accepted quotation document.
- The actively at work clause (clause 17.8) cannot be waived for any member who was not employed by or a member of the policyholder immediately before the commencement of the plan.

17.10 Cover for members receiving disability income benefits

Discovery Group Risk will continue to cover a member for the Life Cover Benefit, the Global Education Protector and the Funeral Cover Benefit if the member receives disability income benefits under any disability income policy taken out by the employer, as long as the member remains on the monthly membership schedule, is still an employee of the employer and premiums for their death benefits continue to be paid.

Cover for any disability claimants from previous disability income policies, who meet these criteria at the date cover begins with Discovery Group Risk will only be covered if these claimants were notified to Discovery Group Risk at the quotation stage and included in the accepted quotation documentation, otherwise they will be excluded from this cover.

The Life Cover Benefit will be based on the risk salary as reflected on the monthly membership schedule. This risk salary may not exceed the risk salary applicable on the day before the established date of disability of the member. Discovery Group Risk will allow a disability income benefit claimant's risk salary in respect of the Life Cover Benefit to increase annually, if the disability income claimant remains covered for the death benefit.

The risk salary will increase at the benefit escalation rate (limited to a maximum escalation rate of 10%) and on the increase date at which the disability income claimant receives this escalation under the policy for the disability income benefit. After the increase in risk salary the premium for the death benefit will be calculated on the increased risk salary.

Conditions applicable:

- Discovery Group Risk must be notified of the current disability income claimants at quotation stage
- These disability income benefit claimants must be included in the quotation when pricing the plan
- These disability income benefit claimants must be placed in a separate category to the actively at work employees
- All information required for other members for the processing of the applicable premium rate must be provided
- Discovery Group Risk must accept the take-over of disability income benefit claimants in writing in the quotation document
- At any stage if the Life Cover Benefit exceeds the free cover limit, such excess benefits will be underwritten for a disability income benefit claimant. This applies whether before, at or after the disability income benefit claim event
- All free cover limit changes will be applied to the Life Cover Benefit
- The death benefits will only be applicable to the disability income benefit claimant until the earlier of age 65, normal retirement age, death, or termination of the policy by the policyholder
- The claimant must be receiving disability income benefit payments
- The policyholder is responsible for the premium payments for the disability income benefit claimant's death benefits.

These disability income benefit claimant members will not be entitled to any further disability or severe illness benefits.

These disability income benefit claimant members will not be allowed to exercise the continuation option in Section 11, and therefore this benefit will not be applicable to this category of members.

Discovery Group Risk will not automatically waive the actively at work condition for any claimant receiving disability income benefits.

Discovery Group Risk will notify disability income claimant members of premium rates, terms, conditions and exclusions on which they will provide the Life Cover Benefit, the Global Education Protector and the Funeral Cover Benefit, including any underwriting requirements.

17.11 Take-over of existing plans

The medically underwritten cover of members who are actively at work in the existing plan will be taken over on the same terms and conditions as those applied by the previous underwriter, subject to any maximum limits determined by Discovery Group Risk and on receipt of written proof of the medically underwritten cover from the previous underwriter. Cover levels that were not medically underwritten under the previous plan will not be taken over automatically. The policyholder must notify Discovery Group Risk of the cover they want Discovery Group Risk to take over and Discovery Group Risk will let the member know under what rates, terms and conditions they will take over the cover, including any underwriting requirements.

Where Discovery Group Risk takes over cover for an existing plan, there may be current disability income benefit claimants that are in receipt of a disability income benefit from the previous insurer. Discovery Group Risk will consider these disability income benefit claimants for the Life Cover Benefit, the Global Education Protector and the Funeral Cover Benefit if they meet all criteria set out in clause 17.10, and on the terms and conditions set out in that clause.

Discovery Group Risk will not take over Severe Illness Benefit cover for members who have already claimed for the same or a similar benefit under a previous insurer.

17.12 Particulars of the lives assured

The policyholder will be required to provide Discovery Group Risk with all documentation and proof of the particulars of the lives assured as required from time to time to determine the benefits and premiums. If it transpires that any of this information is incorrect, Discovery Group Risk will be entitled to make appropriate benefit and premium adjustments or correct the cover.

17.13 Evidence of age

Discovery Group Risk will request evidence of the member's age before making a benefit payment. If the date of birth previously provided to Discovery Group Risk by a member is incorrect, Discovery Group Risk will determine the premiums that should have been paid and adjust the premiums retrospectively to the date on which the member became entitled to the cover in terms of this policy. Any adjustment of premium will be reflected in the next premium statement to the policyholder.

17.14 Temporary absence

If an employee is temporarily absent from the service of the employer other than by reason of disability or illness, the following provisions apply:

- Provided that payment of premiums continues, the cover will be provided for a period of six months without notification
- The policyholder may apply for an extension in excess of six months, which Discovery Group Risk may grant at its sole discretion, and if the extension is granted payment of premiums must continue
- The maximum period of absence is 24 months, with benefits ceasing thereafter, or at any time if premiums are not paid
- If the member resumes active employment after cover has ended, they will be treated by Discovery Group Risk as a new member.

17.15 Duties of the policyholder

If the policyholder failed to inform Discovery Group Risk of an increase of more than 20% in the member's annual risk salary, Discovery reserves the right to request a motivation of salary increase from the policyholder if such an increase occurred within six months of a claim being lodged.

The policyholder must provide Discovery Group Risk with the following:

- Accurate and up-to-date information when required, including at claim stage
- A list of members of whom the policyholder is aware that will not qualify for a benefit under the Group Risk Life Plan
- If the membership changes by more than 15% (increase or decrease) at any time, in which case Discovery Group Risk has the right to revise the rates, free cover limits and terms and conditions of the plan at their sole and absolute discretion
- If the nature of the policyholder's industry changes
- Information relating to any ongoing claimants at any previous or other insurers.

17.16 Territorial limitations

Members and lives assured must be resident in the Republic of South Africa. If a member or life assured is temporarily absent from the Republic including as a result of secondment to a foreign country, the following provisions apply:

- The policyholder will continue payment of premiums and the member or life assured will continue to be covered for the assurance for a period of six consecutive months
- If the absence, including secondment, continues in excess of six consecutive months, then the cover will end, unless Discovery Group Risk, at its sole discretion, approves up to a further 18 consecutive months' absence, in writing, after receiving the following data for each member or life assured:
 - Name of member or life assured
 - Occupation
 - Description of work
 - Date of secondment start
 - Term of secondment
 - Country of secondment.
- After twenty-four consecutive months' absence from the Republic of South Africa, the member's or life assured's cover will automatically terminate, unless Discovery Group Risk approves a further extension at its sole discretion
- Upon return to the Republic of South Africa by the member or life assured after the cover has ended as described above, the member's or life assured's cover will recommence as if they were a new member or life assured
- For the avoidance of doubt, it should be noted that the war, riot and terrorism exclusion (clause 16.6) continues to apply while a member or life assured is absent from the Republic of South Africa, whether for reasons of work or otherwise. If requested by the policyholder and priced for in the accepted quotation, the partial waiver (related to passive participation) of the war, riot and terrorism exclusion also applies while absent from the Republic of South Africa, but only until Discovery Group Risk is no longer able to reinsure this cover, at which point the partial waiver may be withdrawn with 24 hours' notice.

17.17 Alterations to the policy

Policy alterations are subject to one month's written notice from either the policyholder or Discovery Group Risk unless a shorter period is agreed upon in writing. If the amendment is the result of changes to legislation or regulations, which require implementation within less than one month, Discovery Group Risk may alter the policy from the effective date of the change without giving notice to the policyholder. Alterations by the policyholder will be binding on all members for the Core, Plus and Flex Benefits.

17.18 Notification of claims

Claims must be submitted in writing to Discovery Group Risk within three months of the date of the event that caused the member's or life assured's disability or severe illness and within six months of the member's or life assured's death. Discovery Group Risk may also request other documents or medical evidence to assess the claim. All documents required to assess a claim must be submitted within six months of the date of the event that caused the member's or life assured's disability or severe illness and within nine months of the member's or life assured's death. Discovery Group Risk will reject a claim for failure to submit the claim and all documents required to assess a claim within these time periods.

17.19 Consent to disclosure – policyholder

The policyholder must consent to the exchange of information, including medical information, between Discovery Group Risk, any medical practitioner consulted, any other life office, Discovery Health, Discovery Health Medical Scheme and Vitality. The policyholder gives Discovery Group Risk permission to access this information on the application form.

17.20 Consent to disclosure – members

The members must consent to the exchange of information, including medical information, between Discovery Group Risk, any medical practitioner they have consulted, any other life office, Discovery Health, Discovery Health Medical Scheme and Vitality. The policyholder gives Discovery Group Risk permission to access this information on the application form. Failure by the member to provide such consent or withdrawal of such consent may entitle Discovery Group Risk to reject or refuse a claim.

17.21 Precedent

No decision by Discovery Group Risk with regard to any matter concerning the policy may be interpreted as a precedent.

17.22 Misrepresentation

The information given to Discovery Group Risk for quotation purposes or in the application form, or any other documents that were provided in support of the application, forms the basis upon which the policy is issued.

If the member or policyholder fails to disclose any information, or provides false information or distorts information when applying for the policy or during the life of the policy or membership, Discovery Group Risk will be entitled to suspend their cover from the inception date of the policy. In addition to this, Discovery Group Risk will also be entitled to:

- Refuse to pay out any current or future claims that are related to the misrepresentation or non-disclosure
- Adjust the premium from the date of the misrepresentation or non-disclosure
- Recover monies already paid to the members for claims that relate to the misrepresentation or non-disclosure
- Cancel certain benefits or the entire policy with immediate effect, and keep any premiums paid to Discovery Group Risk as penalty.

17.23 Fraud

The conditions under the misrepresentation clause (clause 17.22) also apply in case of fraud where the policyholder or member:

- Submits a fraudulent claim
- Uses any fraudulent means or devices to make claims
- Provides false information in order to obtain a benefit
- Knowingly allows anyone acting on their behalf to provide false information to obtain a benefit
- Deliberately and wilfully conspires to cause the illness or disability that gives rise to a claim.

Cession and beneficiaries

18.1 Unapproved Life Cover Benefits may be ceded as security

Unapproved Life Cover Benefits provided through the Group Risk Life Plan may be ceded as security.

Discovery Group Risk will pay the Life Cover Benefit as set out in the client benefit schedule for a deceased member or life assured to the policyholder or another party if requested by the policyholder.

For the cession to apply, the policyholder needs to take out an unapproved policy and agree that the life cover may be ceded as security to a lending institution controlled by the National Credit Act. The member needs to complete the relevant documentation, which may include a beneficiary nomination form, as well as a cession form, ceding the life cover to the institution.

The institution and the policyholder need to accept the cession.

18.2 Approved Life Cover Benefits are not suitable for cession

In the case of approved policies, the policyholder is the retirement fund. The payment of the death benefit is regulated in terms of Section 37C of the Pension Funds Act No 24 of 1956. The trustees of the fund will therefore formulate a trustee resolution for the distribution of the death benefit, taking into account any dependants, beneficiaries and nominees, in this order. The life cover provided by a retirement fund is designed to provide for dependants and beneficiaries and lastly for nominees. A nominee could be an institution (such as a bank). However, because of the regulation of approved life cover through the Pension Funds Act, it is not suited to be ceded to a bank, as this does not guarantee payment to the nominee.

18.3 Unapproved policies benefit distribution

Unapproved Life Cover Benefits are distributed according to the beneficiary nomination form.

The payment of these benefits from an unapproved policy is regulated by the relevant insurance policy provisions, which determine that the benefit must be paid in terms of the beneficiary nomination form. The member's rights are therefore enforced against the policyholder. Therefore, where proceeds are paid by Discovery Group Risk in accordance with the signed beneficiary nomination form dealing with such unapproved risk, Discovery Group Risk acts according to the policyholder's instruction to pay the beneficiary directly.

In instances where any nominated beneficiary is below the age of 18 years, the proceeds in respect of such person will be paid to a beneficiary trust, beneficiary fund, or to the policyholder. Any amount below R20 000 per beneficiary younger than 18 years may be paid to a beneficiary trust, beneficiary fund, the policyholder, the minor's guardian or into the minor's personal bank account. The policyholder will need to provide an instruction in writing to Discovery Group Risk regarding the selected payment avenue.

In the light of the aforementioned, and in the event that there is no unapproved beneficiary nomination form, or if the nominated beneficiary doesn't accept the benefit, the proceeds of the benefits must be paid to the policyholder, or to the deceased estate directly if the employer so directs. On the written instruction from the policyholder, Discovery Group Risk will act as a conduit for such proceeds due and pay such parties as instructed by the policyholder in the event where no unapproved benefit beneficiary nominations exist.

Discovery Group Risk will pay the death benefit as set out in the client benefit schedule for a deceased member or life assured in one of the following ways:

- Pay the policyholder
- Pay as per the unapproved beneficiary nomination to the nominated beneficiaries
- Pay as per the policyholder's written instruction to process payment as instructed by the policyholder if no beneficiary nomination exists
- Pay the deceased estate in the absence of beneficiary nominations.

18.4 What are the responsibilities of the parties involved?

The policyholder is responsible for keeping the beneficiary nomination forms in safe custody and in the event of the death of the member instructing the insurer on the payment of the death benefit.

The member is responsible for completing the beneficiary nomination form and keeping it up to date.

Discovery Group Risk is responsible for paying the death benefit as instructed by the policyholder on the death of the member or life assured, which may include a payment to an institution to which the benefit or part thereof was ceded. The remainder of the death benefit (if any) will be paid to the member's or life assured's beneficiaries.

Discontinuing the policy

19.1 If the policyholder discontinues the policy

The policyholder must give Discovery Group Risk one calendar month's written notice if the policyholder wishes to discontinue the plan. If this occurs, the policyholder will not be entitled to resume premium payments and all benefits will end at the expiry of the notice period unless otherwise agreed by Discovery Group Risk in writing.

19.2 If a member's benefits are discontinued

The benefits in respect of a particular member and their dependants may be fully or partially discontinued as soon as any of the following events occur:

- Full or partial discontinuance of premium payments in respect of the particular member
- The member reaching any benefit expiry age
- The member ceasing to be an eligible member
- The admission by Discovery Group Risk of a claim for a death benefit.

19.3 If Discovery Group Risk discontinues the policy

Discovery Group Risk has the right to discontinue the benefits provided to members and dependants in terms of this policy if:

- The policyholder is placed under judicial management or liquidation, or has been liquidated, or effects a compromise with its creditors
- There is any material non-compliance by the policyholder regarding any of the provisions of this policy.

This policy will automatically be discontinued on the date of termination of the last remaining member's participation in this policy or on the discontinuance of all benefits for whatever reason.

Disability benefits assessment

General provisions

1. Calculation of the LifeTime Impact Category used for determining the level of the Lifetime Capital Disability Lump-sum Benefit

All changes reflected in *Appendix 1* must be permanent despite treatment according to recognised medical protocols. These new life-changing events must have occurred since the date of commencement of the policy.

The LifeTime Impact Category is determined by the total LifeTime Impact score as follows:

Total LifeTime Impact score	LifeTime Impact Category
0 – 4	1
5 – 9	2
10 – 14	3
15 – 19	4
20 – 24	5
25 – 29	6
30 – 34	7
35 – 39	8

The total LifeTime Impact score is determined by adding the score for the various LifeTime Impact factors set out in the remainder of this appendix, for Category A disability only, to an additional age-based score for conditions where the score is marked by a degree sign (°).

The age-based scores added to LifeTime Impact factors are:

Age at claim	Additional score
<30	30
31 – 40	22
41 – 50	14
51 – 55	8
56 – 60	4
61+	0

2. Cardiovascular

This benefit covers conditions of the heart and arteries as specified below.

Only one payment will be made per coronary event. A single coronary event is defined as incorporating all cardiac pathologies or procedures that occur within 30 days of each other.

The diagnosis must be confirmed by a cardiologist, cardiothoracic surgeon, neurosurgeon, vascular surgeon or specialist physician. Relevant special investigations such as ECGs, echocardiograms, other imaging studies and blood tests must confirm the diagnosis.

Chronic diastolic heart failure is defined as New York Heart Association (NYHA) class 4 and irreversible restriction demonstrated on Doppler echocardiography.

Permanence of the ejection fraction impairment will be established in two measurements taken three months apart unless otherwise proven to the satisfaction of Discovery Group Risk.

Disease	Category A	LifeTime Impact Score	Category B
Heart failure due to myocardial infarction or valvular heart disease or cardiomyopathy or cardiac arrhythmias or congenital heart disease or hypertensive heart disease	NYHA III and EF less than 40%	7	Maximum METs achieved on effort ECG less than 5
	Maximum METs achieved on effort ECG less than two	7	EF less than 45%
	EF less than 35%	7	NYHA III and confirmed with raised proBNP levels according to age bands (age below 50: proBNP more than 450 pg/ml; age 50 and above: proBNP more than 900 pg/ml)
	Awaiting cardiac transplantation	7	
	NYHA IV and confirmed with raised proBNP levels according to age bands (age below 50: proBNP more than 450 pg/ml; age 50 and above: proBNP more than 900 pg/ml)	7	
Hypertension	Cardiac end-organ damage as defined by an estimated LV mass Males: more than 255 g (greater than 131g/m ²) Females: more than 193g (greater than 113g/m ²) or Inter-ventricular septum or posterior wall thickness of more than 17mm	4	
Constrictive pericarditis	Constrictive pericarditis as confirmed on transthoracic echocardiography with all of the following: dilatation of the inferior vena cava and hepatic veins , calcifications, abnormal septal wall motion and atrial enlargement.	7	Constrictive pericarditis as confirmed on transthoracic echocardiography with two of the following: dilatation of the inferior vena cava and hepatic veins. calcifications, abnormal septal wall motion and atrial enlargement.
Peripheral arterial disease	Permanent ABI less than 0.4 following vascular surgery unless surgery is medically contra-indicated or Gangrene of a limb or Amputation of a limb or Arterial ulceration	8	Severe claudication defined as an inability to complete a treadmill exercise stress test due to claudication with a post-exercise ankle systolic pressure of less than 50mmHg
Peripheral venous disease			Non-healing venous ulcer for more than three months with evidence of deep venous insufficiency as confirmed by duplex ultrasonography with a reflux time that is more than 0.5 seconds in duration at the level of the ulcer

3 Respiratory system

This benefit covers specified conditions of the respiratory system. The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations such as lung function tests, blood tests, histology or imaging.

The claimant must be treated by a pulmonologist, registered as such with the Health Professions Council of South Africa. Lung function tests should be performed by a pulmonologist. The test should include pre- and post-dilatation measurements and show less than 5% variation between three successive FVC or FEV1 readings. Two DCO tests must be done with results within three units. Corrections must be made for anaemia and carboxyhaemoglobin on the DCO test.

Disease	Category A	LifeTime Impact Score	Category B
Chronic obstructive airways disease (chronic bronchitis emphysema) or asthma or restrictive or mixed lung disease	FVC less than 40% of predicted* or FEV1 less than 40% of predicted* or Dco less than 40% predicted* or constant use of prescribed oxygen due to blood oxygen saturation levels below 88%	10	FVC 40% - 49% of predicted* or FEV1 40% - 49% of predicted* or Dco 40% - 49% predicted*
Lung cancer	See cancer table		See cancer table

* Pulmonary function tests – including post-bronchodilatation testing – should be performed by a pulmonologist, and show less than 5% variation between three successful readings. These tests must be technically acceptable to the treating specialist as well as to Discovery Group Risk's medical panel.

4 Mental and behavioural disorders

After a Capital Disability Benefit claim for Category A or B has been made, future claims for mental and behavioural disorders will only be considered if the criteria for a Category A claim in respect of mental and behavioural disorders as listed below are met:

Disease	Category A	LifeTime Impact Score	Category B
Mood disorders	Permanent inability to perform at least four Activities of Daily (ADL) Living from four different ADL categories. The categories include Self-care ADLs, Communication ADLs, Physical ADLs and Advanced ADLs. ADL failure must be present despite ongoing medical treatment by a psychiatrist with evidence of all of the following: 1) Demonstrable compliance to at least a combination of antidepressant at maximal dosages or mood stabilisers or anti-psychotic medication for more than two years or 2) two or more in-patient admissions of longer than two weeks or 3) A complete in-patient course of ECT therapy unless medically contraindicated**	13	
Schizophrenia and other psychotic disorders	Permanent inability to perform at least four Activities of Daily Living from four different ADL categories. The categories include Self-care ADLs, Communication ADLs, Physical ADLs and Advanced ADLs. ADL failure must be present despite demonstrable compliance with adequate trials of at least two different anti-psychotic regimes for at least one year**	13	
	Permanent legal institutionalisation for a psychiatric disorder*		Legal institutionalisation for at least six months for a psychiatric disorder*

* Excluding institutionalisation for drug or alcohol abuse or a violation of South African criminal law.

** Sensory Function ADLs and Hand Function ADLs are excluded.

5 Nervous system

The claimant must be treated by a neurologist or neurosurgeon, registered as such with the Health Professions Council of South Africa. This benefit covers specified conditions of the brain, spinal cord nerves and arteries to the brain.

Stroke is defined as death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in neurological deficit lasting longer than 24 hours, confirmed by neuro-imaging investigation and appropriate clinical findings by a specialist neurologist.

Category A	LifeTime Impact Score	Category B
Total and permanent loss of speech	11	Loss of speech as confirmed by abnormal strobovideolaryngoscopy
Total and permanent loss of comprehension of language	11	Permanent inability to perform two out of six Activities of Daily Living
Permanent inability to perform four or more out of six Activities of Daily Living	11	Permanent inability to perform two Self-care Activities of Daily Living
Permanent inability to perform three or more Self-care Activities of Daily Living	11	Permanent bilateral hemianopia
Persistent vegetative state for more than three months	11	Complete blindness* defined as best corrected binocular Snellen rating of less than 20/125
Permanent loss of memory recall or orientation to person, place and time, confirmed by a persistent MMSE score of less than 21	11	Complete loss of sight in one eye
Permanent non-progressive cognitive impairment with a MMSE score of less than 21	11	Greater than 75% binaural hearing impairment
Dementia or progressive neurocognitive disorders with a permanent CDR score of 2 or more	11	Persistent monoplegia
		Hearing loss* of 70dB in both ears measured over the frequencies (500, 1000, 2000, 3000 Hz) in two measurements over six months with a hearing aid
Persistent quadriplegia, hemiplegia or paraplegia	11	Total hearing loss or deafness in one ear*
Complete blindness* defined as best corrected binocular Snellen rating of less than 20/200	6°	Three generalised epileptic attacks per week despite optimal therapy confirmed by long-term EEG monitoring. Non-epileptic seizures are excluded.
70% visual acuity impairment**	6°	50% visual acuity impairment*
Hearing loss* (deafness) of 90db or more in both ears measured over the frequencies (500, 1000, 2000 Hz) in two measurements over six months with a hearing aid	6°	Permanent visual field defect of at least 25% in each eye resulting from a scotoma

All changes must be permanent

* All measurements are with appropriate aids

** AMA Guides to the Evaluation of Permanent Impairment: Latest Edition

Neuropsychological and any other appropriate testing must be done to demonstrate permanency and pathology with regard to soft neurological signs.

Functional psychiatric disorders are excluded.

All definitions to be confirmed by corresponding findings on specialist investigation.

6 Digestive system

This benefit covers specified conditions of the liver, pancreas, biliary system, and upper and lower gastrointestinal system. Conditions related to drug or alcohol abuse are not covered under this benefit. The claimant must be treated by a specialist physician, gastroenterologist or surgeon, registered as such with the Health Professions Council of South Africa. The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations, such as blood tests, histology or imaging.

Disease	Category A	LifeTime Impact Score	Category B
Upper and lower digestive tract disease	Anatomical loss and alteration in the gastrointestinal tract with medical evidence of established gastrointestinal pathology and weight loss of more than 25% below the lower limit of normal BMI or BMI of less than 14	9	Anatomic loss of alteration in gastrointestinal tract with medical evidence of established gastrointestinal pathology and weight loss of more than 15% below the lower limit of normal BMI or BMI less than 16
	Faecal incontinence defined as permanent, continuous uncontrolled passage of faecal material. Colostomies and ileostomies are not covered under this definition	9	
	Permanent disturbance of bowel function resulting in a malabsorption syndrome with evidence of any two of the following: 1) Steatorrhea or more than 20g of fat in the stool 2) Refractory anaemia of Hb less than 9g/dl 3) Refractory hypoalbuminaemia of less than 28g/l	9	
	Irreparable hernia with previous bowel obstruction and the permanent inability to perform four or more out of six Activities of Daily Living.	9	
	Permanent inability to swallow due to an anatomical or neurological abnormality as confirmed by abnormal oesophageal manometry or imaging studies	9	
Liver and biliary disease	Chronic liver disease classified as Child-Pugh class C	11	Chronic liver disease classified as Child Pugh B
	Primary sclerosing cholangitis	11	
	Primary biliary cirrhosis	11	
	Awaiting liver transplant on a recognised SA or international transplant list	11	

Functional disorders with no demonstrable gastrointestinal pathology are excluded under this benefit.

7 Renal system

This benefit covers specified conditions of the urogenital tract and kidneys. Surgery for gender reassignment is not covered under this benefit.

The claimant must be treated by a specialist nephrologist or urologist, registered as such with the Health Professions Council of South Africa. The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations, such as blood tests, histology or imaging.

Category A	LifeTime Impact Score	Category B
Permanent kidney dysfunction with a GFR of less than 15ml/min/1.73m ² according to the MDRD study equation	14	Permanent kidney dysfunction with a GFR of less than 30ml/min/1.73m ² according to the MDRD study equation
Ongoing peritoneal dialysis or haemodialysis	14	
Total or continuous permanent urinary incontinence	14	

8 Endocrine system

This benefit covers specified conditions of the thyroid, pituitary or adrenal gland.

The claimant must be treated by a specialist endocrinologist or surgeon, registered as such with the Health Professions Council of South Africa. The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations, such as blood tests, histology or imaging.

Disease	Category A	LifeTime Impact Score	Category B
Diabetes mellitus	Claims as a result of type 1 or type 2 diabetes mellitus with evidence of end-organ damage are assessed under the relevant body systems	13	Claims as a result of type 1 or type 2 diabetes mellitus with evidence of end-organ damage are assessed under the relevant body systems
Cushing's syndrome, pheochromocytoma, syndrome of inappropriate anti-diuretic hormone secretion (SIADH), chronic adrenal insufficiency, parathyroid associated chronic hypo- or hypercalcaemia, chronic hyperaldosteronism	Claims as a result of any endocrine disease are assessed under the relevant body systems		Claims as a result of any endocrine disease are assessed under the relevant body systems

9 Other

Category A	LifeTime Impact Score	Category B
Permanent inability to perform four out of six Activities of Daily Living or Permanent inability to perform three Self-care activities of Daily Living	6°	Permanent inability to perform two or more Activities of Daily Living or Permanent inability to perform two Self-care Activities of Daily Living

10 Haematology

Category A	LifeTime Impact Score	Category B
A permanent treatment-resistant pancytopenia (anaemia leukopenia, thrombocytopenia) resulting in ongoing monthly transfusions of at least four units of blood or blood products This excludes cancer-related pancytopenias	6°	A permanent treatment-resistant anaemia or leukopenia or thrombocytopenia resulting in ongoing monthly transfusions of at least four units of blood or blood products This excludes cancer-related anaemias, leukopenia or thrombocytopenia

11 Advanced AIDS

This benefit covers advanced AIDS and accidental HIV seroconversion as specified below. A positive human immunodeficiency virus antibody test and confirmatory polymerase chain reaction test is required to confirm the diagnosis.

The diagnosis of the specified AIDS-defining conditions must be supported by compatible signs and symptoms and confirmed by relevant special investigations, such as blood tests, antibody test and histology or imaging.

Category A	LifeTime Impact Score
Despite optimal treatment and full adherence to prescribed antiretroviral therapy, a permanent CD4 count less than 50 and a positive PCR Or Despite optimal treatment and full adherence to prescribed antiretroviral therapy, a CD4 cell count of less than 200 and a positive PCR And At least one of the following diseases must be diagnosed: <ol style="list-style-type: none"> 1) Kaposi's sarcoma 2) Pneumocystis jirovecii pneumonia (PJP) 3) Confirmed progressive multifocal leukoencephalopathy 4) Active extra-pulmonary tuberculosis 5) Cryptococcosis 6) Disseminated non-tuberculous mycobacteria infection 7) Confirmed diagnosis of any other condition as defined as stage 4 on the World Health Organization (WHO) clinical criteria list 	7

12 Cancer

Cancer is a malignant tumour characterised by the uncontrolled growth of cells, invasion of normal tissue and spread to distant organs. The term malignant tumour includes leukaemia, lymphoma and sarcoma.

Pre-malignancy and carcinoma in situ tumours, except for carcinoma in situ of the breast treated by mastectomy, are not covered under this benefit. Brain tumours are covered under the Nervous System Benefit. Specified neuroendocrine tumours are covered under the Endocrine and Metabolic Diseases Benefit.

A current internationally recognised staging system will be used to assess the claim.

A report from the treating specialist, including the histology and stage of the cancer, the relevant imaging reports and other tests must confirm the diagnosis. A specialist is a person registered as such with the Health Professions Council of South Africa in a relevant speciality.

Category A	LifeTime Impact Score
Stage IV cancer	8
Stage III cancer scoring 4 on the ECOG performance scale continuously for a period of over six months	8
Leukaemia scoring 4 on the ECOG performance scale continuously for a period of over six months	8
Brain tumour WHO Grade III or IV	8
Stage III multiple myeloma	8

13 Musculoskeletal system

This benefit covers specified conditions of the muscle, bones, joints and nerves. The claimant must be treated by a specialist, registered as such with the Health Professions Council of South Africa. The diagnosis must be supported by the relevant investigations and reports.

Disease	Category A	LifeTime Impact Score	Category B
Hand	Total loss of use of hand at the level of the wrist. Manual occupation: Failure of the hand function ADLs, as assessed by an occupational therapist, as follows: All three of the following hand function impairments: 1) grip strength below 2 standard deviations of average age and gender values (Mathiowetz) and 2) pinch strength below 2 standard deviations of average age and gender values (Mathiowetz) and 3) co-ordination/dexterity below norm according to coordination test, OR completely unable to perform 2 of the following three hand function Activities of Daily Living: 1) grasping and holding 2) pinching 3) coordination/dexterity	7°	Loss of use of more than three fingers, one of which includes either thumb or index finger
Upper limb	80% impairment of dominant upper limb** or 100% impairment of non-dominant upper limb** or bilateral upper limb impairment equivalent to 48% WPI** Manual occupation: 50% impairment of either upper limb, or a bilateral upper limb impairment equivalent to a 30% WPI**	7°	60% impairment of dominant upper limb** or 90% impairment of non-dominant upper limb** or bilateral upper limb impairment equivalent to 36% WPI** Manual occupation: 30% impairment of either upper limb or a bilateral upper limb impairment equivalent to a WPI of 18%**
Lower limb	80% impairment of lower limb** manual occupation: 50% impairment of lower limb or bilateral lower limb impairment equivalent to a 20% WPI**	8°	60% impairment of lower limb** Manual occupation: 30% impairment of lower limb or bilateral lower limb impairment equivalent to a 12% WPI**
Upper and lower limb	Combined upper and lower limb impairment equivalent to a 50% WPI** or manual occupation: Combined upper and lower limb impairment equivalent to a 35% WPI**	7°	Combined upper and lower limb impairment equivalent to a 40% WPI** Manual occupation: Combined upper and lower limb impairment equivalent to a 25% WP**
Spine	Cauda equina syndrome or loss of bowel or bladder integrity or paraplegia or quadriplegia or cervical spine impairment resulting in 30% WPI after surgery unless surgery is medically contra-indicated, or thoracic spine impairment resulting in 22% WPI after surgery unless surgery is medically contra-indicated, or lumbar spine impairment resulting in 33% WPI after surgery unless surgery is medically contra-indicated, or permanent inability to perform three Self-care Activities of Daily Living	9°	Radiculopathy and significant extremity impairment as indicated by atrophy, loss of reflexes, dermatomal sensory loss or loss of spine motion integrity as documented by neurological or motor compromise** or cervical spine impairment resulting in 24% WPI after surgery unless surgery is medically contra-indicated, or thoracic spine impairment resulting in 16% WPI after surgery unless surgery is medically contra-indicated or thoracic spine impairment resulting in 16% WPI after surgery unless surgery is medically contra-indicated, or lumbar spine impairment resulting in 24% WPI after surgery unless surgery is medically contra-indicated, or permanent inability to perform two Self-care Activities of Daily Living
Soft tissue	Severe facial disfigurement as per AMA guide Class four or 25% body surface area full thickness burns resulting in contractures with 50% WPI**	6°	Severe facial disfigurement or distortion as a result of trauma or accidental injury of 25% of the face with involvement of the nose, eye, ear or mouth or 15% body surface area full thickness burns resulting in contractures with 30% WPI**

Manual occupation greater than 20% very heavy, 30% heavy, or 40% moderate manual labour job description or profession requiring manual dexterity.

* Disorders include muscle, bone, nerve or joint impairments

** Based on AMA guides to the Evaluation of Permanent Impairment; latest edition – examining doctor will be provided with specific valuating protocols

*** The coordinated use of both hands to perform Activities of Daily Living or work WPI – Whole-person impairment

Severe Illness Benefit assessment

General provisions

- The life-changing event must have occurred after the commencement of the benefit.
- Symptoms and signs must be compatible with the diagnosis, and the relevant specialist investigations (including blood tests, imaging, histology and other tests) must confirm the diagnosis.
- Inability to perform Activities of Daily Living must be due to and compatible with the diagnosis of the life-changing event.
- Psychiatric illness, chronic fatigue syndrome (and synonyms) and fibromyalgia (and synonyms) and related terms are not covered under the Severe Illness Benefit.
- Major organ transplant claims include being on an official South African or international transplant waiting list for the relevant transplant.
- Specialist reports are required to assess all claims. A specialist is a medical practitioner registered as a specialist with the Health Professions Council of South Africa.
- The claims definitions in the Discovery Severe Illness Benefit are compliant with the Standardised Critical Illness Definitions Project (SCIDEP). The document is available at <https://www.asisa.org.za/asisadocs/Standards/SCIDEP>. The Discovery Group Risk Disclosure Grid (referred to in the document) is:

SCIDEP disclosure grid				
SEVERITY LEVEL	A	B	C	D
Heart attack	100%	75%	50%	25%
Coronary artery bypass graft (CABG)	75%	50%	50%	50%
Acute myelocytic leukemia	100%	100%	100%	50%
Stroke	100%	100%	100%	50%
Cancer	100%	100%	50%	25%

Note that the percentages shown in the table relate to the percentages of the benefit payment, payable under each severity level. Please refer to clause 7.6 for more details on how severity levels affect benefit payments.

- Activities of Daily Living (ADLs) are defined in Appendix 4.
- Please note that claims relating to conditions that may have been identified as a result of screening tests (for example, genetic tests), but where there are no medical symptoms of the disease, will not be covered under these definitions.

1. Cancer Benefit

Cancer is a malignant tumour characterised by the uncontrolled growth of cells, invasion of normal tissue and spread to distant organs. The term malignant tumour includes leukaemia, lymphoma and sarcoma.

Pre-malignancy and carcinoma in situ tumours, except for carcinoma in situ of the breast treated by mastectomy, are not covered under this benefit. However, a list of in situ cancers are covered in Appendix 3, under the Early Cancer Benefit. Brain tumours are covered under the Nervous System Benefit. Specified neuroendocrine tumours are covered under the Endocrine and Metabolic Diseases Benefit.

A current internationally recognised staging system will be used to assess the claim.

A report from the treating specialist, including the histology and stage of the cancer, the relevant imaging reports and other tests, must confirm the diagnosis. A specialist is a person registered as such with the Health Professions Council of South Africa in a relevant speciality.

Once a payment for a cancer listed under Severity A cancer has been made, further cancer claims will only be considered for unrelated cancers, as well as payments under the Cancer Relapse Benefit. An unrelated cancer is a cancer that is not regarded as being of the same tissue and the same organ. The unrelated cancer will be considered as a new life-changing event.

Where stem cell or bone marrow transplants are performed as treatment for cancer, only one Severity A claim will be paid. Only one bone marrow or stem cell transplant will be paid for during the lifetime of the policy.

If two cancers of two different tissue types are present and have manifested independently of each other, then, subject to the Minimum Protected Fund (if applicable) and the limits of the Life Fund, as well as the terms of the Essential and Classic Life Plan payment rules, each cancer will be considered as a separate life-changing event. These two claims will be regarded as claims within the same body system.

Severity A

Stage IV cancer

Stage III cancer unless specified elsewhere

Acute myelocytic leukemia

Chronic lymphocytic leukemia: Stage III or IV on the Rai classification system

Chronic myelocytic leukemia

Acute lymphoblastic leukemia

Bone marrow transplant or stem cell transplant

Severe aplastic anaemia as defined by the International Aplastic Anaemia Study Group

Multiple myeloma: Stage III on the Durie-Salmon scale or equivalent on an appropriate international staging system

Hodgkin's or non-Hodgkin's lymphoma: Stage III or IV on the Ann Arbor staging system or equivalent on an appropriate staging system

Prostate cancer T4N0M0 or with affected lymph nodes or distant metastases

Malignant melanoma stage III or IV

Neuroendocrine tumour stage III or IV

Carcinoid syndrome with evidence of liver metastasis

Borderline ovarian tumours stage III and IV

Pseudomyxoma peritonei with disseminated peritoneal adenomucinosis

Post-organ transplant lympho-proliferative disorders

Gastrointestinal stromal tumours stage III and IV

Dermatofibrosarcoma protuberans stage III and IV

Severity C

Stage II cancer unless specified elsewhere

Chronic lymphocytic leukemia: Stage II on the Rai classification system

Multiple myeloma: Stage 1 or 2 on the Durie-Salmon scale or equivalent on an appropriate international staging system

Hodgkin's or non-Hodgkin's lymphoma: Stage II on the Ann Arbor staging system or equivalent on an appropriate staging system

Prostate cancer T3N0M0

Malignant melanoma stage II

Basal cell carcinoma stage III

Neuroendocrine tumour stage II

Hairy cell leukemia with myelofibrosis transformation

Borderline ovarian tumours Stage II

Gastrointestinal stromal tumours stage II

Dermatofibrosarcoma protuberans stage II

Severity D

Stage 1 cancer unless specified elsewhere

Chronic lymphocytic leukemia: Stage 0 or I on the Rai classification system

Moderate chronic aplastic anaemia as defined by the International Aplastic Anaemia Study Group

Hodgkin's or non-Hodgkin's lymphoma: Stage I on the Ann Arbor staging system or equivalent on an appropriate staging system

Prostate cancer T1N0M0 with Gleason score higher than 6

Prostate cancer T2N0M0

Malignant melanoma stage 1

Mastectomy for carcinoma in situ

Prophylactic mastectomy

Hairy cell leukemia

Neuroendocrine tumour stage 1

Borderline ovarian tumours stage I

Gastrointestinal stromal tumours stage I

Severity E

Myelodysplastic syndrome

Myelofibrosis

Overlap myelodysplastic/myeloproliferative neoplasms according to WHO classification

Severity G

Basal cell carcinoma stage I or II treated with skin graft or skin flap or greater than 2cm

Squamous cell carcinoma stage I or II treated with skin graft or skin flap or greater than 2cm

Prostate cancer T1N0M0 with Gleason score of 6 or lower

Myeloproliferative disorders: Polycythemia vera, essential thrombocytosis

Mastectomy for carcinoma in situ

Prophylactic mastectomy

Hairy cell leukemia

Neuroendocrine tumour stage 1

Borderline ovarian tumours stage I

Gastrointestinal stromal tumours stage I

2. Heart and Artery Benefit

This benefit covers conditions of the heart and arteries as specified below.

Only one payment will be made per coronary event. A single coronary event is defined as incorporating all cardiac pathologies or procedures that occur within 30 days of each other.

One payment will be made for pacemakers and one payment will be made for permanent defibrillator implants.

The diagnosis must be confirmed by a cardiologist, cardiothoracic surgeon, neurosurgeon, vascular surgeon or specialist physician. Relevant special investigations such as ECGs, echocardiograms, other imaging studies and blood tests must confirm the diagnosis.

Permanence of the ejection fraction Impairment will be established in two measurements taken three months apart unless otherwise proven to the satisfaction of Discovery Group Risk.

Severity A

Bilateral carotid artery endarterectomy or bypass surgery

Coronary artery bypass graft to three or more vessels

Permanent ejection fraction of less than 40%

Severe myocardial infarction with an ejection fraction of less than 40% at least 14 days after the acute myocardial infarction

SCIDEP Level A heart attack

SCIDEP Level A coronary artery bypass graft

Heart transplant

Heart and lung transplant

Chronic diastolic heart failure NYHA class 4 with raised proBNP levels according to age bands. Ages under 50 years proBNP more than 450 µg/mL; ages 50 years and older proBNP more than 900 µg/mL

Heart valve replacement

Peripheral arterial disease with gangrene or amputation

Surgical repair of the aortic root

Surgical repair of thoracic or thoracoabdominal aortic aneurysm

Severity B

Peripheral arterial disease with absent doppler readings, persistent claudication and leg ulcers

Permanent ejection fraction between 40 and 50%

Myocardial infarction with an ejection fraction of less than 50% at least 14 days after the acute infarction

SCIDEP Level B heart attack

Surgical repair of an abdominal aortic aneurysm

Heart valve repair

Severity C

Coronary artery bypass graft to one or two vessels

Unilateral carotid artery endarterectomy or bypass

Aortoiliac occlusive disease

Moderate myocardial infarction of specified severity, as evidenced by any one of the following three criteria:

1. Compatible clinical symptoms and new pathological Q waves
2. Raised cardiac markers and compatible clinical symptoms
3. Raised cardiac markers and characteristic ECG changes defined as either pathological Q waves or ST segment and T wave changes indicative of myocardial ischaemia or myocardial infarction.

Under criteria 2 and 3, raised cardiac markers are defined as either:

- Troponin T of 1.0ng/mL or more (1000ng/L for high sensitivity troponin T), or equivalent
- CK-MB mass of more than two times the upper limit of normal in the acute presentation phase
- CK-MB mass of more than four times the upper limit of normal after intervention
- Total CPK elevation of more than two times the upper limit of normal with at least 6% being CK-MB

SCIDEP Level C heart attack

SCIDEP CABG Level B, C, D

Open heart surgery to correct a structural abnormality in the heart, for example, ventricular aneurysm, hypertrophic cardiomyopathy, atrial myxoma or radical pericardiectomy

Permanent defibrillator insertion

Severity D

Minimally invasive pericardiectomy

Surgical repair of an aneurysm of any of the following branches of the aorta: iliac, renal, splenic, subclavian, superior mesenteric artery

Surgical repair of a totally occluded major peripheral artery: iliac, femoral, popliteal, tibial, peroneal, renal, splenic, subclavian, superior mesenteric or brachial artery

Stenting of carotid artery stenosis in one or both carotid arteries

Permanent pacemaker insertion for documented arrhythmia

Mild myocardial infarction of specified severity, as evidenced by all three of the following three criteria:

1. Compatible clinical symptoms
2. Imaging or ECG evidence
3. Raised cardiac markers

Under criterion 2, imaging or ECG evidence is defined as either:

- Characteristic ECG changes, for example ST segment and T wave changes indicative of myocardial ischaemia or myocardial infarction
- Angiographic evidence of stenosis of 50% or more of a coronary artery treated with a stent
- Hypokinesia of the myocardium on echocardiogram.

Under criterion 3, raised cardiac markers are defined as either:

- Troponin T of 0.5ng/mL (500ng/L or more for high sensitivity troponin T), or equivalent
- CK-MB mass of more than the upper limit of normal up to two times the upper limit of normal in the acute presentation phase
- Total CPK elevation of more than two times the upper limit of normal with at least 6% being CK-MB

SCIDEP Level D heart attack

Heart attack with hsTrop T between 100 to 500 ng/L with angiographic evidence of coronary artery disease

Severity E

Acute rheumatic fever with three days, ICU or cardiac care unit stay due to cardiac complications

Endocarditis or pericarditis with more than three days, ICU or cardiac care unit stay

Acute heart failure with more than three days, ICU or cardiac care stay

Severity F

Acute coronary syndrome with hsTrop T of between 15 to 99ng/L and angiographic evidence of coronary artery disease. Coronary artery spasm without evidence of coronary artery disease is excluded from this definition

Percutaneous coronary intervention (Angioplasty with or without stent)

Minimally invasive cardiac surgery not specified elsewhere

Pathway ablation

Medically treated arteritis or endarteritis with more than five days, hospital stay

Surgical repair of symptomatic atrial or ventricular septal defect

Severity G

Electrical cardioversion

Chronic AF that persists despite electrophysiological intervention by cardiologist

Intravenous anti-arrhythmic therapy administered as medical emergency

Intravenous inotropic support for more than two days

Malignant hypertension with papilloedema and a diastolic pressure of higher than 120 mmHg on optimal treatment

3. Nervous System Benefit

The claimant must be treated by a neurologist or neurosurgeon, registered as such with the Health Professions Council of South Africa.

This benefit covers specified conditions of the brain, spinal cord nerves and arteries to the brain.

Stroke is defined as death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in neurological deficit lasting longer than 24 hours, confirmed by neuro-imaging investigation and appropriate clinical findings by a specialist neurologist.

Symptoms and signs, as well as imaging (computerised tomography or magnetic resonance imaging) must confirm a new stroke. Transient ischaemic attacks are specifically excluded.

A Severity D payment will be paid on receipt of objective medical evidence from the treating neurologist confirming the diagnosis of an acute stroke. A further assessment of the stroke claim will be made on receipt of a full specialist neurologist's report three months after the stroke.

Neurological deficits and ADL impairments must be compatible with the diagnosis and objective medical evidence.

Permanence will be established after 90 days, unless otherwise proven to the satisfaction of Discovery Group Risk.

Brain tumours are assessed according the World Health Organization's grading. Pituitary microadenomas are specifically excluded under this benefit.

Severity A

Stroke with permanent inability to perform one category of the Activities of Daily Living Score Sheet (as defined in Appendix 4)

Permanent inability to perform four or more categories of the Activities of Daily Living Score Sheet (as defined in Appendix 4)

Permanent inability to perform three or more of the Self-care Activities of Daily Living (as defined in Appendix 4)

Total permanent loss of speech including expressive or receptive aphasia

Quadriplegia

Paraplegia

Hemiplegia or diplegia

Glasgow Coma Scale of less than 8/15 lasting longer than 96 hours

Definite diagnosis of motor neuron disease

WHO grade III and IV brain tumours

Definite diagnosis of dementia with permanent MMSE score of 10/30 or less as confirmed by formal neuropsychometric testing

Severity B

The permanent inability to perform three categories of Activities of Daily Living

The permanent inability to perform two Self-care Activities of Daily Living

Extracranial monoplegia

Severity C

Stroke with permanent, minor neurological deficit, but still able to perform six categories of the Activities of Daily Living

The permanent inability to perform one Self-care Activity or two categories of the Activities of Daily Living

Craniotomy

WHO grade II brain tumours

Ventriculostomy or insertion of a shunt for the treatment of hydrocephalus

Definite diagnosis of dementia with permanent MMSE score of 20/30 or less as confirmed by formal neuropsychometric testing

Severity D

Definite diagnosis of an acute stroke

Depressed skull fracture with brain laceration

WHO grade I brain tumours

Subarachnoid haemorrhage not requiring surgery

Definite diagnosis of multiple sclerosis

Definite diagnosis of generalised Myaesthesia Gravis confirmed with positive serology and electrophysiological testing

Parkinson's disease confirmed with spect imaging

Parkinson-plus syndromes as confirmed by a neurologist under one of the following categories:

- Multiple system atrophy
- Progressive supranuclear palsy
- Dementia with Lewy bodies, or
- Corticobasal syndrome or
- Parkinsonism-dementia ALS complex

Intracranial endovascular procedures

Pituitary macroadenomas bigger than 10mm or hypophysectomy

Brain abscess

Severity E

Depressed skull fracture

Glasgow Coma scale less than 8/15 for longer than 72 hours but less than 96 hours

Severity F

Stereotactic radiosurgery

Bacterial meningitis

Severity G

Cerebral oedema

Intubation and ventilation for status epilepticus

4. Gastrointestinal Benefit

This benefit covers specified conditions of the liver, pancreas, biliary system, and upper and lower gastrointestinal system.

Conditions related to drug or alcohol abuse are not covered under this benefit.

The claimant must be treated by a specialist physician, gastroenterologist or surgeon registered as such with the Health Professions Council of South Africa.

The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations such as blood tests, histology or imaging.

Severity A

Chronic liver disease classified as Child-Pugh class C

Primary sclerosing cholangitis

Fulminant hepatic failure

Liver transplant

Pancreas transplant

Portal hypertension with either varices, or refractory ascites and splenomegaly, or refractory pancytopenia

Primary billiary cirrhosis

Complete pancreatectomy

Severity B

Chronic liver disease classified as Child-Pugh class B

Permanent colostomy

Permanent ileostomy

Total colectomy

Severity C

Chronic liver disease classified as Child-Pugh class A

Chronic pancreatitis complicated by insulin-dependent diabetes mellitus or confirmed malabsorption syndrome

Confirmed diagnosis of portal hypertension

Repeated open surgical procedures to the small bowel or colon for Crohn's disease or ulcerative colitis. All procedures within 90 days will be considered as one event

Chronic persistent hepatitis (Knodel score of at least 13 out of 22)

Severity D

Partial hepatectomy of at least 1/3 of the organ

Partial pancreatectomy

Severity E

Loss of more than 1/3 of the tongue

Severity F

Tracheal oesophageal fistula

Chronic rectal fistula despite surgical repair

Severity G

Peritonitis due to bowel perforation

Drainage of pancreatic cyst or abscess

5. Connective Tissue Diseases Benefit

This benefit covers the following connective tissue diseases: progressive systemic sclerosis, seropositive rheumatoid arthritis, systemic lupus erythematosus (SLE), sarcoidosis, polyarteritis nodosa, giant-cell arteritis, Wegener’s granulomatosis, dermatomyositis and polymyositis, Ehlers-Danlos syndrome and pseudoxanthoma elasticum.

The claimant must be treated by a specialist rheumatologist registered as such with the Health Professions Council of South Africa. The diagnosis must be made in accordance with current internationally recognised criteria and supported by the relevant histology, serology and imaging.

Severity A

Permanent inability to perform four or more categories of the Activities of Daily Living Score Sheet due to a listed connective tissue disease

Permanent inability to perform three or more Self-care Activities of Daily Living due to a listed connective tissue disease

Multiple organ dysfunction meeting two defined Severity B criteria under two or more body systems due to a connective tissue disease

Severity B

Definite objective evidence of involvement of two or more organs excluding the skin as an organ

Permanent inability to perform two Self-care Activities of Daily Living

Severity C

Joint replacement or fusion or reconstruction as a result of a listed connective tissue disease

Permanent inability to perform one Self-care Activities of Daily Living

Severity D

Definite diagnosis of a listed connective tissue disease

Severity E

Pseudoxanthoma elasticum

Ehlers-Danlos syndrome

Behçet's disease

6. Urogenital Tract and Kidney Benefit

This benefit covers specified conditions of the urogenital tract and kidneys. Surgery for gender reassignment is not covered under this benefit.

The claimant must be treated by a specialist nephrologist or urologist registered as such with the Health Professions Council of South Africa.

The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations such as blood tests, histology or imaging.

Severity A

Chronic renal failure with ongoing, permanent haemodialysis or a GFR of less than 15ml/min/1.73m² according to the internationally recommended GFR equation

Renal transplant

Ongoing permanent peritoneal dialysis

Severity B

Chronic renal failure with a permanent GFR of less than 30ml/min/1.73m² and evidence of progressive renal failure as evidenced by sustained decrease of GFR of more than 5ml/min per year, according to the internationally recommended GFR equation

Severity C

Acute renal failure requiring more than five treatments of haemodialysis

Any disease or disorder requiring complete nephrectomy (donors excluded)

Total amputation of the penis

Any disease or disorder requiring complete cystectomy

Confirmed gross or confluent renal cortical necrosis involving more than 2/3 of the renal cortex

Severity D

Partial nephrectomy of at least 1/3 of the kidney

Partial cystectomy resulting in a loss of at least 1/3 of the functional capacity of the bladder

Partial amputation of the penis (circumcision is excluded)

Bilateral orchidectomy

Open kidney surgery for renal or renovascular disease or injury

Vesicovaginal or rectovaginal fistula

Severity E

Confirmed diagnosis of nephritic syndrome

Confirmed diagnosis of nephrotic syndrome with a proteinuria of 3g per 24 hours and a GFR of <60 mls per minute present for six months

Unilateral orchidectomy

Severity F

Urethral fistula

Chronic tubulointerstitial nephritis

Severity G

Renal abscess

Surgical repair of a stricture of the ureter or the urethra (one payment only)

7. Respiratory Disease Benefit

This benefit covers specified conditions of the respiratory system.

The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations such as lung function tests, blood tests, histology or imaging.

The claimant must be treated by a pulmonologist registered as such with the Health Professions Council of South Africa. Lung function tests should be performed by a pulmonologist. The test should include pre- and post-dilatation measurements and show less than 5% variation between three successive FVC or FEV₁ readings. Two D_{co} tests must be done with results within three units. Corrections must be made for anaemia and carboxyhaemoglobin on the D_{co} test.

Severity A

- Presence of irreversible cor pulmonale
- Confirmed diagnosis of pulmonary hypertension groups 1 to 5, including pulmonary veno-occlusive disease, with a pulmonary artery pressure of greater than 30mmHg
- Lung transplant
- Heart and lung transplant
- Chronic obstructive or restrictive lung disease with a permanent FEV1 or FVC or Dco of 40% or less than predicted
- Pulmonary thromboendarterectomy performed by sternotomy

Severity B

- Requiring removal of more than one lobe of the lung
- Pulmonary venous occlusive disease not specified elsewhere
- Chronic obstructive or restrictive lung disease with a permanent FEV1 or FVC or Dco of 41% to 45% of predicted

Severity C

- Veno-caval filter inserted for recurrent pulmonary emboli
- Chronic obstructive or restrictive lung disease with permanent FEV1 or FVC or Dco of 46% to 49% of predicted

Severity D

- Lung abscess
- Drainage of empyema
- Bronchopleural fistula
- Removal of one lobe of the lung

Severity E

- Confirmed diagnosis of pneumoconiosis
- Confirmed diagnosis of bronchiectasis with at least two impaired lung function readings, taken at least three months apart, with FEV1 of 60% of less
- Pleurectomy
- Decortication
- Idiopathic interstitial pneumonia excluding respiratory bronchiolitis-associated interstitial pneumonia (respiratory bronchiolitis) and bronchiolitis obliterans organising pneumonia (BOOP)
- Pulmonary embolus diagnosed on imaging

Severity F

- Drainage of pleural effusion
- Near drowning requiring full resuscitation with immersion syndrome, hypoxia, acidosis and pulmonary oedema and ventilatory support

Severity G

- Hyperbaric oxygen therapy for decompression sickness
- Mechanical ventilation for status asthmaticus

8. Advanced AIDS/Accidental HIV Benefit

This benefit covers advanced AIDS and accidental HIV seroconversion as specified below. A positive human immunodeficiency virus antibody test and confirmatory polymerase chain reaction test is required to confirm the diagnosis.

The diagnosis of the specified AIDS-defining conditions must be supported by compatible signs and symptoms and confirmed by relevant special investigations such as blood tests, antibody test and histology or imaging.

Severity A

- Advanced AIDS evidenced by positive blood tests as specified above, and a CD4 cell count of less than 50 while on antiretroviral therapy for at least three months

Advanced AIDS evidenced by positive blood tests as specified above, and a CD4 cell count of less than 200 while on antiretroviral therapy for at least three months and diagnosis of at least one of the following diseases :

- Kaposi's sarcoma
- Pneumocystis jirovecii pneumonia (PJP)
- Confirmed progressive multifocal leukoencephalopathy
- Active extra-pulmonary tuberculosis
- Cryptococcosis
- Disseminated non-tuberculous mycobacteria infection
- Confirmed diagnosis of any other condition as defined as stage 4 on the WHO clinical criteria list

Advanced AIDS evidenced by positive blood tests as specified above, and a CD4 cell count of less than 200 while on antiretroviral therapy for at least three months, with definite diagnosis of any three conditions defined as stage 3 AIDS on the WHO clinical criteria list

Accidental HIV as a result of:

- Accidental needlestick injury while rendering professional duties as a doctor, dentist, paramedic or nurse. A test confirming negative HIV status must be done within 24 hours of the needlestick injury
- A road traffic accident
- The transfusion of infected blood from a transfusion service recognised by Discovery Group Risk
- Receiving an organ transplant where the organ was previously infected with HIV
- Rape or criminal assault or any other violent crime. The case must have resulted in the opening of a criminal case by the police. A test confirming negative HIV status must be done within 24 hours of the assault and a medical examination performed directly after the assault

9. Musculoskeletal Benefit

This benefit covers specified conditions of the muscle, bones, joints and nerves.

The claimant must be treated by a specialist registered as such with the Health Professions Council of South Africa. The diagnosis must be supported by the relevant investigations and reports.

Severity A

More than 25% full thickness body surface area burns

Total and permanent loss of use or amputation of both lower limbs at the level of the ankle or higher (proximal to the ankle)

Total and permanent loss of use or amputation of both upper limbs at the level of the wrists or higher (proximal to the wrist)

Total and permanent loss of use or amputation of one upper limb above (proximal to) the wrist and one lower limb above (proximal to) the ankle

Severity B

Full thickness burns involving 15 to 25% of the body surface area

Total and permanent loss of use or amputation of a lower limb at the level of the ankle or higher (proximal to the ankle)

Total and permanent loss of use or amputation of the upper limb above (proximal to) the wrist or higher

Severity C

Total and permanent loss of use or amputation of a hand below (distal to) the wrist

More than 10% full thickness body surface area burns

Severity E

Reattachment surgery for a traumatic amputation of any limb (arm or leg)

Reconstruction surgery for Le Fort II or III facial fractures or any multiple facial fracture, including the orbit

Severity F

Chronic osteomyelitis

Reconstructive surgery to hands or feet involving bone graft and skin flap

Poliomyelitis resulting in permanent paralysis

Complete amputation of two or more full fingers or total toes

Suture of a major nerve to restore function to hand or limb

Severity G

Emergency spinal surgery or traction for spine instability within seven days of an accident

Complete replacement of any joint due to a chronic disease process

Definite diagnosis of Paget's disease

Complete amputation of a full finger or total toe

Osteoporosis resulting in collapse of more than one vertebra or hip fracture in ages under 65 years

Resurfacing of a knee, hip or shoulder joint (one payment only)

10. Eye Benefit

This benefit covers specified conditions of the globe, retina, optic nerve, cornea and orbit.

The claimant must be treated by an ophthalmologist registered as such with the Health Professions Council of South Africa. The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations such as visual acuity tests or imaging.

Severity A

Complete blindness

Severity B

Best corrected binocular Snellen rating of less than 20/125

Enucleation of eye

Severity C

Optic nerve atrophy

Permanent hemianopia

Complete blindness in one eye

Severity D

Confirmed diagnosis of retinitis pigmentosa

Severity E

Corneal transplant

Optic neuritis (only one payment will be made)

Permanent visual acuity loss of more than 50% in one eye

Severity F

Retinal detachment

Macular degeneration or dystrophy

Progressive panuveitis not responsive to pharmacological treatment

Severity G

Orbital abscess

11. Ear, Nose and Throat Benefit

This benefit covers specified conditions of the ear and neural pathways that relate to hearing as well as specified conditions of the nose, paranasal sinuses and venous sinuses of the brain.

The claimant must be treated by a specialist ear, nose and throat surgeon, registered as such with the Health Professions Council of South Africa.

The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations such as blood tests, histology or imaging.

Severity A

Hearing loss of 90dB or more in both ears, measured over the frequencies 500Hz, 1000Hz, 2000Hz and 3000Hz in two measurements six months apart, with a hearing aid

Severity B

Binaural hearing loss of more than 75% (as defined by the AMA guide)

Hearing loss of 70dB in both ears, measured over the frequencies 500Hz, 1000Hz, 2000Hz, 3000Hz in two measurements six months apart, with a hearing aid

Severity C

Dural sinus thrombosis including cavernous sinus thrombosis

Severity D

Acoustic neuroma

Cortical mastoidectomy

Binaural hearing loss of more than 60% (as defined by the AMA guide)

Cochlear implant

Severity E

Chronic petrositis

Osteomyelitis of sinuses

Severity F

Tympanosclerosis with hearing loss of 70dB in one ear, measured over the frequencies 500Hz, 1000Hz, 2000Hz, 3000Hz in two measurements six months apart, with a hearing aid

Hearing loss of 70dB in one ear, measured over the frequencies 500Hz, 1000Hz, 2000Hz, 3000Hz in two measurements six months apart, with a hearing aid

Otosclerosis

Severity G

Nose reconstruction as a result of a disease (trauma and cosmetic procedures excluded)

12. Endocrine and Metabolic Diseases Benefit

This benefit covers specified conditions of the thyroid, pituitary or adrenal gland. Only one payment will be made for each disease.

The claimant must be treated by a specialist endocrinologist or surgeon registered as such with the Health Professions Council of South Africa.

The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations such as blood tests, histology or imaging.

Severity D

ICU or high-care admission for treatment of a thyroid storm

Hypophysectomy

Severity E

Diabetes insipidus

Acute adrenal crisis or diagnosis of Addison's disease

Sheehan's syndrome or Simmond's disease

Severity F

Diabetic coma (one event only)

Conn's syndrome

Cushing's syndrome

Phaeochromocytoma or insulinoma

Glycogen storage diseases

Lipid storage disease

Surgical removal of a benign neuroendocrine tumour

Adrenalectomy

Confirmed amyloidosis of any of the following organs: heart, kidneys, liver, spleen, tongue

Severity G

Acromegaly

Parathyroid tetany

13. Child Severe Illness Benefit

This benefit covers the specified conditions affecting children under the age of 18, as well as the specified conditions under the main Severe Illness Benefit.

The claimant must be treated by a paediatrician or paediatric surgeon registered as such with the Health Professions Council of South Africa.

The diagnosis must be supported by compatible signs and symptoms and confirmed by relevant special investigations such as blood tests, histology or imaging.

Childhood cancers must be diagnosed by a specialist and confirmed by the relevant investigations, for example, blood tests, histology or the relevant imaging, and treated with accepted oncology modalities, for example, surgery, chemotherapy, bone marrow transplant or radiotherapy.

Furthermore, children who suffer any of the specified cancers below will be paid out the higher of the corresponding Severity and the normal staging Severity under Section 1 above.

Severity A

Diagnosis of a condition, resulting in global developmental delay, confirmed by poor performance in two or more of the following developmental domains:

- Motor
- Speech and language
- Cognition and personal
- Social and daily living skills

Poor performance is defined as two standard deviations below the norm or equivalent.

Childhood cancer treated with chemotherapy, radiotherapy or stem cell transplant

Childhood cancer stage III or IV

Severity C

Surgical correction of congenital heart disease

Childhood cancer treated with surgery only

Severity E

Surgical repair of a congenital anomaly

Rheumatic fever with cardiac complications

Type 1 diabetes mellitus

Severity F

Poliomyelitis with permanent paralysis

Severity G

Juvenile rheumatoid arthritis, septic arthritis, osteomyelitis

Hirschsprung's disease

Surfactant therapy

Cleft lip or palate repair

Disorders of amino acid metabolism

Early Cancer Benefit assessment

The positive diagnosis with histological confirmation of the following are covered under this benefit:

Severity E

- Lobular carcinoma in situ of the breast with chemotherapy, lumpectomy or breast-conserving surgery
- Ductal carcinoma in situ of the breast with chemotherapy, lumpectomy or breast-conserving surgery
- Excision of recurrent (more than one clinical event) carcinoma in situ of the cervix, which includes cervical intraepithelial neoplasia III
- Carcinoma in situ of the ovary with excision
- Carcinoma in situ of the testis (intratubular germ cell neoplasia) with unilateral orchidectomy
- Carcinoma in situ or high-grade dysplasia of the oesophagus with excision, oesophagectomy or endoscopic (including ablation) therapy
- Bladder carcinoma in situ (Tis) with excision or partial or total cystectomy
- Carcinoma in situ of the stomach (intraepithelial tumour without invasion of the lamina propria) with radiotherapy, chemotherapy, excision or gastrectomy

Severity G

- Bladder carcinoma in situ (Tis) treated with intravesical bacillus Calmette-Guerin (BCG) treatment
- Carcinoma in situ of the uterus with excision or hysterectomy
- Carcinoma in situ of the fallopian tubes with excision
- Carcinoma in situ of the vagina or vulva with excision
- Carcinoma in situ of the testis (intratubular germ cell neoplasia) with chemotherapy radiotherapy or excision
- Histological presence of both high-grade prostate intraepithelial neoplasia (HGPIN) and atypical small acinar proliferation (ASAP)
- Carcinoma in situ of the penis with excision
- Carcinoma in situ of the lung with excision
- Carcinoma in situ of the kidney with excision
- Colon adenoma with increasing polyp size > 1 cm or high-grade dysplasia, treated with polypectomy or surgery
- Carcinoma in situ of the larynx with radiotherapy or excision
- Carcinoma in situ of the pharynx with radiotherapy or excision
- Carcinoma in situ of the nasal cavity with radiotherapy or excision
- Carcinoma in situ of the thyroid with radiotherapy or excision
- Melanoma in situ with excision
- Carcinoma in situ of the salivary glands or adenoid cystic carcinoma of salivary gland with excision
- Dermatofibrosarcoma protuberans (complete excision with clear margins would be considered as one event). Subsequent events will be subject to multiple claims rules

Activities of Daily Living

The Activities of Daily Living (ADLs) is an internationally used scoring system that assesses the functional ability of a person, including the physical, cognitive and interactive abilities. Discovery Group Risk uses the ADLs to assess functioning in both the Severe Illness and Capital Disability Benefits when objective criteria of impairment are needed – for example, when neurological and connective tissue diseases as specified in *Appendix 1* and *2* are assessed. Changes to the ADLs must be permanent, must have occurred after the date of commencement of the policy, and must be due to the condition, illness or event that is being claimed for.

Discovery Group Risk reserves the right to request an occupational therapist's or neuropsychologist's assessment of ADL functioning, using standardised assessment methods.

There are six categories of ADLs

- Self-care
- Communication
- Physical Activity
- Sensory Function
- Hand Function
- Advanced Activities

Scoring of the categories

The terms “no impairment”, “moderately impaired”, “severely impaired” and “very severely impaired” are used in the Advanced Activities category. The terms “independent”, “impaired”, “unable” are used in all the other categories. These terms are defined in the Activities of Daily Living Score Sheet at the end of this appendix.

Self-care

- If a person is **unable** to do **one** activity within this category, it is scored as the inability to perform the Self-care category of the ADL Score Sheet.
- If a person is **impaired** in doing **two** activities within this category, it is scored as the inability to perform the Self-care category of the ADL Score Sheet.

Communication

- If a person is **unable** to do **one** activity within this category, it is scored as the inability to perform the Communication category of the ADL Score Sheet.
- If a person is **impaired** in doing **two** activities within this category, it is scored as the inability to perform the Communication category of the ADL Score Sheet.

Physical Activity

- If a person is **unable** to do **three** activities within this category, it is scored as the inability to perform the Physical Activity category of the ADL Score Sheet.
- If a person is **impaired** in doing **six** activities within this category, it is scored as the inability to perform the Physical Activity category of the ADL Score Sheet.

Sensory Function

- If a person is **unable** to do **one** activity within this category, it is scored as the inability to perform the Sensory Function category of the ADL Score Sheet.
- If a person is **impaired** in doing **two** activities within this category, it is scored as the inability to perform the Sensory Function category of the ADL Score Sheet.

Hand Function

- If a person is **unable** to do **one** activity within this category, it is scored as the inability to perform the Hand Function category of the ADL Score Sheet.
- If a person is **impaired** in doing **two** activities within this category, it is scored as the inability to perform the Hand Function category of the ADL Score Sheet.

Advanced Activities

It is scored as the inability to perform the Advanced Activity category if:

- A person is **moderately impaired** in all **four** areas
- A person is **severely impaired** in **two** of the four areas
- A person is **very severely impaired** in **one** of the four areas

Activities of Daily Living Score Sheet

Self-care			
Activity	Independent	Impaired	Unable
Bathing	<ul style="list-style-type: none"> No assistance is required, or The client is able to perform bathing or showering independently with the aid of hand rails and a non-slip bath mat. 	<ul style="list-style-type: none"> Hands-on assistance is required, or Assistive devices such as electronic bath benches are required when getting in or out of the tub or shower, or The client generally baths himself/herself but needs some assistance with cleaning hard-to-reach areas. 	<ul style="list-style-type: none"> The client is totally dependent on others in all areas of bathing; the client would be at risk if left alone.
Grooming	<ul style="list-style-type: none"> No assistance is required. 	<ul style="list-style-type: none"> Hands-on assistance is required with some activities of personal hygiene. 	<ul style="list-style-type: none"> The client is totally dependent on others in all areas of grooming.
Dressing	<ul style="list-style-type: none"> No assistance is required, or The client may perform dressing with an adapted method (such as sitting to dress lower limbs). 	<ul style="list-style-type: none"> Hands-on assistance is required with some activities, or The client is unable to dress himself/herself completely (for example, tying shoes, zipping or buttoning) without the help of another person. 	<ul style="list-style-type: none"> The client is totally dependent on others in all areas of dressing.
Eating and feeding	<ul style="list-style-type: none"> No assistance is required, or The client is able to perform the activity independently with the aid of modified cutlery. 	<ul style="list-style-type: none"> Hands-on assistance is required, for example, help with cutting up food or pushing food within reach, or help with applying an assistive device (such as a universal cuff). 	<ul style="list-style-type: none"> The client is totally dependent on others in all areas of eating.
Toilet use and continence	<ul style="list-style-type: none"> No assistance is required with toilet use, and the client has no incontinence. 	<ul style="list-style-type: none"> Hands-on assistance is required with some activities, for example, transferring onto the toilet, but the constant presence of another person while toileting is not necessary, or Intermittent catheterising. 	<ul style="list-style-type: none"> The client is totally dependent on others in all areas of toileting, or The client has no control of bowel or bladder, or Permanent catheter, or Permanent colostomy.
Mobility in home	<ul style="list-style-type: none"> The client goes about the home independently. 	<ul style="list-style-type: none"> Walking and transferring requires the assistance of another person, or a railing, cane, walker or wheelchair. 	<ul style="list-style-type: none"> The client sits unsupported in a chair or wheelchair, but cannot propel himself/herself alone or transfer from bed to chair alone, or The client is bedridden.
Communication			
Activity	Independent	Impaired	Unable
Listening	<ul style="list-style-type: none"> The client is able to comprehend verbal communication in his or her first language. 	<ul style="list-style-type: none"> The client is significantly impaired to comprehend verbal communication in his or her first language. 	<ul style="list-style-type: none"> The client is permanently unable to comprehend verbal communication in his or her first language.
Speaking	<ul style="list-style-type: none"> The client is functionally able to communicate verbally in his or her first language. 	<ul style="list-style-type: none"> The client is significantly impaired to communicate verbally in his or her first language. 	<ul style="list-style-type: none"> The client is permanently unable to communicate verbally in his or her first language.
Reading	<ul style="list-style-type: none"> The client is able to comprehend written language in his or her first language. 	<ul style="list-style-type: none"> The client is significantly impaired to comprehend written language in his or her first language. 	<ul style="list-style-type: none"> The client is permanently unable to comprehend written language in his or her first language.
Writing	<ul style="list-style-type: none"> The client is able to complete personal information documents in his or her first language independently. 	<ul style="list-style-type: none"> The client requires assistance when completing forms in his or her first language. 	<ul style="list-style-type: none"> The client is permanently unable to write in his or her first language.
Keyboard use	<ul style="list-style-type: none"> The client can use a cellphone, keyboard, ATM and credit card machine independently. 	<ul style="list-style-type: none"> The client requires assistance when using a cellphone, keyboard, ATM or credit card machine. 	<ul style="list-style-type: none"> The client is permanently unable to use a cellphone, keyboard, ATM or credit card machine.

Physical activity			
Activity	Independent	Impaired	Unable
Standing	<ul style="list-style-type: none"> The client can stand independently for longer than 10 minutes. 	<ul style="list-style-type: none"> The client needs external support or assistive devices (such as a walking frame), to stand, or The client can stand independently, but not for longer than 10 minutes. 	<ul style="list-style-type: none"> The client is unable to stand independently and therefore requires hands-on support when standing; the client would be at risk if unassisted.
Sitting	<ul style="list-style-type: none"> The client can sit independently for longer than 20 minutes. 	<ul style="list-style-type: none"> The client needs support to sit, or The client can sit independently, but not for longer than 20 minutes. 	<ul style="list-style-type: none"> The client is unable to sit independently.
Walking	<ul style="list-style-type: none"> The client can walk independently (even though some difficulty or discomfort may be experienced) for six minutes, covering a distance of more than 300 metres. 	<ul style="list-style-type: none"> The client needs assistive devices (such as a walking frame) to walk, or The client can walk independently, but the distance covered in six minutes is less than 300 metres. 	<ul style="list-style-type: none"> The client is totally dependent on others for walking, or The client must be pushed in a wheelchair or gurney at all times.
Crouching	<ul style="list-style-type: none"> The client is able to assume and maintain the crouching position independently. 	<ul style="list-style-type: none"> The client requires external support getting in or out of the crouching position, or in maintaining the crouching position. 	<ul style="list-style-type: none"> The client is unable to assume the crouching position.
Squatting	<ul style="list-style-type: none"> The client is able to perform five repetitive knee squats. 	<ul style="list-style-type: none"> The client is able to perform repetitive knee squats, but is unable to perform five, or The client requires external support when squatting. 	<ul style="list-style-type: none"> The client is unable to perform a knee squat.
Kneeling	<ul style="list-style-type: none"> The client is able to assume and maintain the kneeling position independently. 	<ul style="list-style-type: none"> The client requires external support getting in or out of the kneeling position, or in maintaining the kneeling position. 	<ul style="list-style-type: none"> The client is unable to assume the kneeling position.
Reaching	<ul style="list-style-type: none"> The client is able to reach to full arm length (above head height). 	<ul style="list-style-type: none"> The client is able to reach past eye level height, but unable to reach to full arm length. 	<ul style="list-style-type: none"> The client is unable to reach past eye level height.
Bending	<ul style="list-style-type: none"> The client is able to bend forward independently. 	<ul style="list-style-type: none"> The client requires external support when bending forward. 	<ul style="list-style-type: none"> The client is unable to bend forward.
Carrying	<ul style="list-style-type: none"> The client is able to carry 4.5kg for 5 metres with both hands, and The client is able to carry 2kg with the left hand for 5 metres, and The client is able to carry 2kg with the right hand for 5 metres. 	<ul style="list-style-type: none"> The client is able to carry some weight with both hands but is unable to carry 4.5kg with both hands for 5 metres, or The client is unable to carry 2kg with the left hand for 5 metres, or The client is unable to carry 2kg with the right hand for 5 metres 	<ul style="list-style-type: none"> The client is unable to carry any weight.
Lifting	<ul style="list-style-type: none"> The client is able to lift (from floor to waist) 4.5kg with both hands, and The client is able to lift (from floor to waist) 2kg with the left hand, and The client is able to lift (from floor to waist) 2kg with the right hand. 	<ul style="list-style-type: none"> The client is able to lift some weight with both hands, but is unable to lift (from floor to waist) 4.5kg with both hands, or The client is unable to lift (from floor to waist) 2kg with the left hand, or The client is unable to lift (from floor to waist) 2kg with the right hand. 	<ul style="list-style-type: none"> The client is unable to lift any weight.
Stair use	<ul style="list-style-type: none"> The client is able to climb 20 steps independently, during which a handrail may be used and one step at a time is climbed. 	<ul style="list-style-type: none"> The client requires hands-on assistance when climbing stairs, or The client is unable to climb 20 or more steps. 	<ul style="list-style-type: none"> The client is unable to negotiate stairs.
Travel (driving, riding)	<ul style="list-style-type: none"> The client is able to drive a vehicle independently, or The client is able to use public transport independently. 	<ul style="list-style-type: none"> The client requires assistance when using public transport, or The client requires a driver if he/she had previously been able to drive a motor vehicle independently. 	<ul style="list-style-type: none"> The client is unable to travel.

Sensory function			
Activity	Independent	Impaired	Unable
Hearing	<ul style="list-style-type: none"> The client has functional hearing with or without the use of a hearing aid. 	<ul style="list-style-type: none"> The client's best corrected, permanent binaural hearing loss exceeds 50%. 	<ul style="list-style-type: none"> The client's best corrected, permanent hearing loss exceeds 70dB as measured over the frequencies 500Hz, 1000Hz, 2000Hz and 3000 Hz.

Seeing	<ul style="list-style-type: none"> The client has normal vision with or without correction. 	<ul style="list-style-type: none"> The client has a permanent visual field defect of 25% or more in one eye due to a scotoma. 	<ul style="list-style-type: none"> The client has a permanent visual field defect of 25% or more in both eyes due to scotomas or permanent quadrantanopia.
Tactile sensation	<ul style="list-style-type: none"> The client has normal sensory function (sensation of the hands is assessed under hand function). 	<ul style="list-style-type: none"> The client has impaired sensory function in a dermatome corresponding with objective pathology (sensation of the hands is assessed under hand function). 	<ul style="list-style-type: none"> The client has complete loss of sensory function in a dermatome corresponding with objective pathology (sensation of the hands is assessed under hand function).
Tasting and smelling	<ul style="list-style-type: none"> The client has normal ability to taste and smell. 	<ul style="list-style-type: none"> The client has significant Impairment to taste or smell as a result of an injury or disease. 	<ul style="list-style-type: none"> The client is permanently unable to taste, or permanently unable to smell, as a result of an injury or disease.

Hand function

Activity	Independent	Impaired	Unable
Grasping and holding	<ul style="list-style-type: none"> The client has grip strength better than two standard deviations below the average age and gender values (according to Mathiowetz normative data for adults). 	<ul style="list-style-type: none"> The client has grip strength weaker than two standard deviations below average age and gender values (according to Mathiowetz normative data for adults). 	<ul style="list-style-type: none"> The client is unable to grasp.
Pinching/Tip pinch	<ul style="list-style-type: none"> The client has pinch strength better than two standard deviations below average age and gender values (according to Mathiowetz normative data for adults) 	<ul style="list-style-type: none"> The client has pinch strength weaker than two standard deviations below average age and gender values (according to Mathiowetz normative data for adults) 	<ul style="list-style-type: none"> The client is unable to pinch
Coordination/Dexterity	<ul style="list-style-type: none"> This is better than two standard deviations below the norm according to standardised hand coordination tests (for example the Minnesota Rate of Manipulation). 	<ul style="list-style-type: none"> This is two standard deviations below the norm according to coordination test (for example the Minnesota Rate of Manipulation). 	<ul style="list-style-type: none"> The client is unable to perform percussive movements (finger touching or diadochokinesis).
Sensory discrimination/Tactile sensation	<ul style="list-style-type: none"> The client has normal sensory function in hands. 	<ul style="list-style-type: none"> The client has impairment of sensory function, but retained protective sensibility in the hands. 	<ul style="list-style-type: none"> The client has no sensation in hands.

Advanced activities

The following areas are assessed under this category:

- Concentration
- Memory
- Problem solving, judgement and reasoning
- Executive function, including planning, initiation, organising, error monitoring

The above four areas can be tested by a neuropsychologist and stratified according to percentiles.

Activity	No impairment	Moderately impaired	Severely impaired	Very severely impaired
Memory	<ul style="list-style-type: none"> Neuropsychological testing results fall above the 30th percentile, or higher than half a standard deviation below the norm. 	<ul style="list-style-type: none"> Neuropsychological testing results fall between the 15th and 30th percentile, or between half and one standard deviation below the norm. 	<ul style="list-style-type: none"> Neuropsychological testing results fall between the 5th and 15th percentile, or between one and two standard deviations below the norm. 	<ul style="list-style-type: none"> Neuropsychological testing results fall below the 5th percentile, or two standard deviations below the norm (or worse).
Concentration	<ul style="list-style-type: none"> Neuropsychological testing results fall above the 30th percentile, or higher than half a standard deviation below the norm 	<ul style="list-style-type: none"> Neuropsychological testing results fall between the 15th and 30th percentile, or between half and one standard deviation below the norm. 	<ul style="list-style-type: none"> Neuropsychological testing results fall between the 5th and 15th percentile, or between one and two standard deviations below the norm. 	<ul style="list-style-type: none"> Neuropsychological testing results fall below the 5th percentile, or two standard deviations below the norm (or worse).
Problem solving, judgment and reasoning	<ul style="list-style-type: none"> Neuropsychological testing results fall above the 30th percentile, or higher than half a standard deviation below the norm. 	<ul style="list-style-type: none"> Neuropsychological testing results fall between the 15th and 30th percentile, or between half and one standard deviation below the norm. 	<ul style="list-style-type: none"> Neuropsychological testing results fall between the 5th and 15th percentile, or between one and two standard deviations below the norm. 	<ul style="list-style-type: none"> Neuropsychological testing results fall below the 5th percentile, or two standard deviations below the norm (or worse).
Executive function, including planning, initiation, organising and error monitoring	<ul style="list-style-type: none"> Neuropsychological testing results fall above the 30th percentile, or higher than half a standard deviation below the norm. 	<ul style="list-style-type: none"> Neuropsychological testing results fall between the 15th and 30th percentile, or between half and one standard deviation below the norm. 	<ul style="list-style-type: none"> Neuropsychological testing results fall between the 5th and 15th percentile, or between one and two standard deviations below the norm. 	<ul style="list-style-type: none"> Neuropsychological testing results fall below the 5th percentile, or two standard deviations below the norm (or worse).

Group Risk Payback tables

Please note the following in respect of all the tables below:

- All figures were correct as at 1 July 2018.
- Health claims ranges are adjusted each year.
- Discovery Health Medical Scheme's KeyCare series and the equivalent plans on schemes administered by Discovery Health are excluded from the Group Risk Payback

The Group Risk Payback tables per qualifying health plan type are as follows:

Core health plan Group Risk Payback tables:

Main member: Core					
Health Claims (R)	Blue	Bronze	Silver	Gold	Diamond
0 to 500	5.0%	7.5%	10.0%	12.0%	15.0%
501 to 2 511	4.5%	6.0%	7.5%	10.0%	12.0%
2 512 to 5 400	4.0%	4.5%	6.0%	7.5%	10.0%
5 401 to 15 034	0.0%	0.0%	4.5%	6.0%	7.5%
Above 15 034	0.0%	0.0%	0.0%	4.5%	6.0%

Family: Core					
Health Claims (R)	Blue	Bronze	Silver	Gold	Diamond
0 to 500	5.0%	7.5%	10.0%	12.0%	15.0%
501 to 3 678	4.5%	6.0%	7.5%	10.0%	12.0%
3 679 to 11 180	4.0%	4.5%	6.0%	7.5%	10.0%
11 181 to 25 364	0.0%	0.0%	4.5%	6.0%	7.5%
Above 25 364	0.0%	0.0%	0.0%	4.5%	6.0%

The following list of qualifying health plans all receive paybacks according to the criteria in the Core health plan Group Risk Payback tables above:

Anglovaal Essential Core	Medisense Essential Core Plan
Classic Core – Max Medical Scheme	Retail Medical Scheme Essential Benefit Plan
Classic Core – Standard Plan	Select Core - Max
CLASSIC CORE PLAN	Select Core – Core Plan
CSIR CLASSIC CORE PLUS BENEFIT PLAN	SAAMMED Classic Core Benefit Plan
CSIR ESSENTIAL CORE	SAAMMED Essential Core Benefit Plan
CSIR ESSENTIAL CORE PLUS BENEFIT PLAN	Coastal Core – Core Plan
DISCOVERY FOR DOCTORS CORE	Classic Delta Core
DISCOVERY FOR DOCTORS CORE	Essential Delta Core
EDCON ESSENTIAL LIMITED	Remedi Classic Option
ESSENTIAL CORE – MAX MEDICAL SCHEME	Naspers Option Basic
ESSENTIAL CORE – CORE PLAN	ANGLO STANDARD CARE PLAN - CORE

Comprehensive health plan Group Risk Payback tables:

Main member: Comprehensive					
Health Claims (R)	Blue	Bronze	Silver	Gold	Diamond
0 to 500	5.0%	7.5%	10.0%	12.0%	15.0%
501 to 5 316	4.5%	6.0%	7.5%	10.0%	12.0%
5 317 to 15 049	4.0%	4.5%	6.0%	7.5%	10.0%
15 050 to 35 920	0.0%	0.0%	4.5%	6.0%	7.5%
Above 35 920	0.0%	0.0%	0.0%	4.5%	6.0%

Family: Comprehensive					
Health Claims (R)	Blue	Bronze	Silver	Gold	Diamond
0 to 500	5.0%	7.5%	10.0%	12.0%	15.0%
501 to 7 634	4.5%	6.0%	7.5%	10.0%	12.0%
7 635 to 22 375	4.0%	4.5%	6.0%	7.5%	10.0%
22 376 to 50 459	0.0%	0.0%	4.5%	6.0%	7.5%
Above 50 459	0.0%	0.0%	0.0%	4.5%	6.0%

The following list of qualifying health plans all receive paybacks according to the criteria in the Comprehensive health plan Group Risk Payback tables above:

Classic Comprehensive – Max Medical Scheme	LA Comprehensive (Plan)
Classic Comprehensive – Standard Plan	IBM Essential Comprehensive Plus Plan
CSIR Classic Comprehensive Plus Benefit Plan	Umed Classic Plan
CSIR Essential Comprehensive Plus Benefit Plan	Executive Plan
Discovery for Doctors Comprehensive	Classic Delta Comprehensive Plan
Discovery for Doctors Comprehensive	Essential Delta Comprehensive Plan
Essential Comprehensive – Max Medical Scheme	Altron Enhanced Plan
Essential Comprehensive – Standard	Remedi Comprehensive Option
Edcon Essential Comprehensive	Naspers Option Plus
IBM Classic Comprehensive Benefit Plan	Classic Comprehensive Zero MSA
IBM Select Comprehensive Benefit Plan	Malcor Plan A
Quantum Essential Comprehensive Plan	Malcor Plan B
Retail Medical Scheme Essential Comprehensive Benefit Plan	Malcor Plan C
Select Comprehensive - Max	WitsMed Plus
Select Comprehensive – Standard Plan	BankMed Plus
SAAMMED Classic Comprehensive Benefit Plan	Glencore
SAAMMED Essential Comprehensive Benefit Plan	Netcare
Tsogo Sun Classic Comprehensive Benefit Plan	SAB Comprehensive

Saver health plan Group Risk Payback tables:

Main member: Saver					
Health Claims (R)	Blue	Bronze	Silver	Gold	Diamond
0 to 500	5.0%	7.5%	10.0%	12.0%	15.0%
501 to 3138	4.5%	6.0%	7.5%	10.0%	12.0%
3 139 to 7 425	4.0%	4.5%	6.0%	7.5%	10.0%
7 426 to 21 300	0.0%	0.0%	4.5%	6.0%	7.5%
Above 21 300	0.0%	0.0%	0.0%	4.5%	6.0%

Family: Saver					
Health Claims (R)	Blue	Bronze	Silver	Gold	Diamond
0 to 500	5.0%	7.5%	10.0%	12.0%	15.0%
501 to 4 598	4.5%	6.0%	7.5%	10.0%	12.0%
4 599 to 15 374	4.0%	4.5%	6.0%	7.5%	10.0%
15 375 to 35 933	0.0%	0.0%	4.5%	6.0%	7.5%
Above 35 933	0.0%	0.0%	0.0%	4.5%	6.0%

The following list of qualifying health plans all receive paybacks according to the criteria in the Saver health plan Group Risk Payback tables above:

Edcon essential core	University of kwazulu-natal delta plan
Quantum essential saver	Classic saver delta
Tsogo sun classic saver	Altron basic plan
La core (plan)	Anglo managed care plan – saver
La active (plan)	Bmw medical aid plan – saver
La focus (plan)	Bankmed traditional
Classic saver	Bankmed core saver
Coastal saver	Smart plan (now called classic smart)
Essential saver	Essential smart
Classic delta saver	Sab essential
Essential delta saver	

Priority health plan Group Risk Payback tables:

Main member: Priority					
Health Claims (R)	Blue	Bronze	Silver	Gold	Diamond
0 to 500	5.0%	7.5%	10.0%	12.0%	15.0%
501 to 4 227	4.5%	6.0%	7.5%	10.0%	12.0%
4 228 to 11 237	4.0%	4.5%	6.0%	7.5%	10.0%
11 238 to 28 610	0.0%	0.0%	4.5%	6.0%	7.5%
Above 28 610	0.0%	0.0%	0.0%	4.5%	6.0%

Family: Priority					
Health Claims (R)	Blue	Bronze	Silver	Gold	Diamond
0 to 500	5.0%	7.5%	10.0%	12.0%	15.0%
501 to 6 116	4.5%	6.0%	7.5%	10.0%	12.0%
6 117 to 18 874	4.0%	4.5%	6.0%	7.5%	10.0%
18 875 to 43 196	0.0%	0.0%	4.5%	6.0%	7.5%
Above 43 196	0.0%	0.0%	0.0%	4.5%	6.0%

The following list of qualifying health plans all receive paybacks according to the criteria in the Priority health plan Group Risk Payback tables above:

Retail medical scheme essential plus benefit plan	Umed value plan
Classic priority plan	M-med plan
Essential priority plan	M-med plan
Mediclinic priority plan	Afrisam standard plan
Coastal priority plan	Bankmed comprehensive

