FNB Short Term
5 First Place, 3rd Floor, Bank City
Cnr Pixley Ka Isaka Seme & Pritchard Streets
Johannesburg, 2001
PO Box 1153
Johannesburg, 2000
www.fnb.co.za

FNB Gap Cover Plan Terms and Conditions

VR: 20200528

FNB Gap Cover (the "Plan") is subject to the Terms, Conditions and Exclusions set out in this document and must be read with the Plan Schedule and, where applicable, your Customer Agreement. Please ensure that you understand all sections of your Plan Schedule and if you have any questions, please contact us. This Plan is exclusive to FNB / RMB Private Bank account holders. There are three different FNB Gap Cover Plan Types, the Essential, Comprehensive or Elite Gap Cover Plan. Each Plan Type has different benefits, limits and thresholds which are also confirmed in your Plan Schedule and in the terms and conditions below.

Who is the Insurer of the Plan?

The Gap Cover Plan is insured by FirstRand Short-term Insurance Limited and administered by FNB Short Term, a business unit of First National Bank, a division of FirstRand Bank Limited. Any reference to "we / us / our" means FNB Short Term and/or FirstRand Short-term Insurance Limited.

Who is insured under the Plan?

The Plan covers you and the members of your Family that are specified on your Customer Agreement and Plan Schedule. All Insured Persons must be South African citizens or permanent residents and be in possession of a bar-coded RSA ID book or a Smart ID Card. If the Insured Person is younger than 18 years, a valid birth certificate is acceptable.

Insured Persons may only include:

Plan Holder: The main Insured Person on the Plan who owns and pays the premiums for the Plan. For the purposes of this document, the Plan Holder will be referred to as "you, your, yourself".

Spouse: The person you are married to or have entered into a civil union with in terms of South African law, or your life partner with whom you live and have been residing with for at least 24 months, in a long-term, open and acknowledged personal relationship, capable of being registered under South African law. If you are married in terms of the Recognition of Customary Marriages Act to more than one spouse, only one of them can be covered as a Spouse.

Child(ren): Your or your Spouse's biological children, legally adopted children, grandchildren and stepchildren. A Child may only be covered until they reach the age of 26 years, thereafter the Child will no longer be eligible for cover under this Plan. When a Child reaches the age of 26 years, they may take up a new Plan in their own capacity, within thirty days of reaching the age of 26, without incurring any additional waiting periods or exclusions. The age limit is not be applicable to a Special Needs Child, as defined in this document, who remains a member of the Plan Holder 's Medical Scheme.

Children above the age of 21 must prove financial dependence, usually through virtue of being students, in order to be registered on the same Plan as their parents. Children above the age of 21 who are not financially dependent on their parents are required to seek cover under their own Plan.

Special Needs Child: A Child who relies on the Plan Holder for support and care beyond the age limitations specified under the definition of a "Child" because they are not able to support themselves financially due to a mental or physical disability.

Special Dependant: A dependant who not a Child of the Plan Holder but who is a dependant on the Plan Holder's Medical Scheme and has been explicitly accepted by us for cover under this Plan. If no explicit acceptance is provided by us, the Special Dependant is not covered, even though they are a dependant of the Plan Holder's Medical Scheme.

Family: Collectively the Plan Holder, Spouse, and up to three Children (or Special Dependants) as stated in the Plan Schedule. Additional Children, Special Needs Children or Special Dependants may be added at an additional cost and are only covered if stated in the Plan Schedule.

Medical Scheme membership: A Child may only be covered on your or your Spouse's Medical Scheme. All other Insured Lives must be members of your Medical Scheme. All Medical Schemes must be registered with the Council for Medical Schemes in South Africa.

When does the Plan and cover start?

Your cover starts on the day that we accept your application. We will notify you once the application is accepted. The contract will start on the Plan Start Date, as stated in your Plan Schedule. Cover for the Insured Persons starts on the date when they are accepted by us on the Plan, subject to the stated waiting periods.

This Plan is not a Medical Scheme and the cover is not a substitute for Medical Scheme membership.

What are you covered for?

There are multiple benefits provided by your FNB Gap Cover Plan depending on the type of Plan you chose. The total benefits you can claim for in a year (over a 12-month period from 1 July to 30 June) are limited and stated in your Plan Schedule. Your individual benefits may also be limited by the type of Plan you chose as stated in your Plan Schedule.

The primary purpose of the benefits is to cover the gap between the incurred medical costs and the amount paid by the Medical Scheme. The benefits that you may qualify for are:

Benefit	Description	Benefit Specific Exclusions
Medical Expense Shortfall Benefit:	Shortfalls are covered for all service provider charges up to your Shortfall Percentage of the Medical Scheme tariff (stated on your Plan Schedule). This benefit covers shortfalls for all service providers such as Surgeons, Radiologists, Pathologists and Physiotherapists and includes cover for Prescribed Minimum Benefits. The benefit will only be paid for services that occur during hospitalisation and the defined Out-of-hospital events that are provided, and charged for, by an individual Medical Practitioner. The shortfall cover amount is calculated as the Medical Practitioner's charges less the Medical Scheme's tarrif (limited to the Medical Scheme tariff multiplied by your percentage cover).	

	Example for a customer on a Comprehensive Gap Cover Plan (500% Medical Expense Shortfall Benefit): *If a Medical Scheme has committed to covering a maximum of 100% of the Medical Scheme Tariff then they must pay expenses at the defined Medical Scheme Tariff. This means if the Medical Scheme Tariff for a given procedure is R2 000 (100%) then the maximum that the Medical Scheme will pay is R2 000 (100%).* *If the specialist performing the procedure charges more, e.g. R10 000, this is 5 times (500%) of the Medical Scheme Tariff.* *The maximum benefit payable by us for this procedure is therefore:* R10 000 — the fee charged by the specialist -R2 000 — less the benefit paid by medical scheme =R8 000 — equals your benefit	
Co-Payment Benefit:	The benefit covers the costs when a Medical Scheme requires a co-payment (or deductible) before undergoing the defined In- and Out-of-hospital medical procedures, diagnostic procedures, or basic in-patient dentistry. The costs of the co-payment will only be refunded after they are settled by you or deducted from the Medical Scheme savings account.	This Plan will not pay for co-payments applied: • For the voluntary use of a non-network hospitals, day clinic or service provider that does not form part of the Medical Scheme's network. • For medication.
Sub-limit Benefit:	The benefit provides cover when the Medical Scheme issues a Rand-value limit (also known as a sub-limit or annual limit) from which you can claim for the defined medical procedures, diagnostic procedures, or basic in-patient dentistry. The benefit covers services or devices such as internal prostheses, MRI, CT or PET scans, cornea or lens transplants, pacemakers, and cochlear implants. This benefit will only be paid for hospital events where the charges for the service have exceeded the relevant sub-limit benefit of your Medical Scheme. The amount payable under the Sub-limit Benefit is the shortfall between the cost of these services and the amount paid by your Medical Scheme. The maximum claim for this benefit is stated in your Plan Schedule.	**This benefit is not available on the Essential Gap Cover Plan Type.** The Sub-Limit Benefit does not cover service providers' accounts: • When the Medical Scheme applied a sub-limit or annual limit to in- or out-of-hospital medical procedures, treatment or investigations except for Internal Prostheses, Non-PMB Day Procedures, Renal Dialysis and MRI & CT Scans, where applicable. • Where the Medical Scheme's sub-limit or annual limit is exhausted at the time of hospitalisation and the Medical Scheme did not pay a portion towards the service provider's account unless the Sub-Limit Benefit specifically makes provision for the cover. • Renal Dialysis treatment costs not approved by the Medical Scheme as part of the initial or ongoing dialysis treatment plan, or where the Plan Holder or Insured Person has not followed the Medical Scheme rules or voluntary use of a non-network hospitals, day clinic or service provider.
Non-Network Benefit:	The benefit pays for the penalty charged by the Medical Scheme due to the voluntary use of a hospital that is not part of the Medical Scheme's hospital network. This benefit will pay a fixed value penalty or a percentage of the penalty (up to 30% of the total cost of treatment) whichever is the lesser. The benefit is limited by the Plan you chose as stated in your Plan Schedule. The benefit is limited to a single hospital event per Plan ,per year (1 July to 30 June).	**This benefit is not available on the Essential Gap Cover Plan Type.**
Cancer Benefit:	The benefit provides cover when the Medical Scheme only pays a portion towards the approved oncology treatment (such as radiotherapy, chemotherapy, basic and specialised radiology, pathology, specialist consultations, registered oncology facility fees, biological or specialised medication). Benefits will only be paid for treatment, that has been approved by your Medical Scheme, for the purposes of treating cancer (malignant neoplasm). The Benefit covers the following: • **Shortfalls:** The Benefit provides your **Shortfall Percentage** of the Medical Scheme rate, to cover oncology treatment shortfalls of service providers. • **Co-payment benefit:** If your Medical Scheme charges a co-payment for cancer related treatment (after using up the specific limit or threshold defined in your Medical Scheme) that you must pay, then this benefit will cover this amount subject to a maximum co-payment of 25% of the costs of treatment, for any claim per insured person in any one year (1 July to 30 June). This cover can be used for general and specialised treatment and biological drugs. • **Sub-limit benefit:** (covers 25% of the remaining costs after the cancer limit is reached): When your Medical Scheme imposes a cancer treatment cost limit and where no further treatment is funded by the Medical Scheme, this benefit will pay 25% of the ongoing treatment costs (the Benefit is equal to no more than 25% of the charged amount, less the amount paid by the Medical Scheme). This cover can be used for general and specialised treatment and biological drugs.	

Casualty Benefit:	Your Medical Scheme may not cover at all, or may only partially cover, if you are treated in the emergency room at a registered hospital casualty facility. This Benefit will cover the cost of the emergency services that are provided within the casualty ward of a registered hospital (even if the costs are paid from the Medical Scheme's savings account) less any amount paid by your Medical Scheme from risk pool benefits, subject to the maximum amount as determined by the level of Plan chosen, per event, per year (1 July to 30 June). No benefit is payable for services that are related to an illness, services or procedures that are not provided within a casualty ward of a registered hospital or that do not require immediate treatment. Any medication required after the initial visit and subsequent follow-ups to the casualty ward, or the cost of any prosthetic products such as crutches, limb guards, braces or any fees charged by Prosthetists or Orthotists will not be covered. In order to qualify for this benefit in the case of an accident you must use the casualty facility within 48 hours.	The Casualty Benefit does not cover service providers' accounts for: • A casualty event that was not due to a medical event requiring immediate treatment for a physical injury, condition or illness that is, in our opinion, severe or life-threatening. • When the Medical Scheme provided a casualty benefit and paid the accounts in full, from the Medical Scheme's hospital benefit. • Treatment on dates other than the date of hospitalistion, except for return visits to the registered medical facility where follow-up treatment is required as a result of the initial hospitalisation. • Medication that is prescribed or provided to be taken home.

Waiting Periods

Once cover starts, the Insured Persons are covered immediately for hospitalisation because of an accident. Cover for any other reason will only start when the waiting periods listed in the table below have expired:

Cause of Claim	Waiting period for the Insured Person/s*
All causes other than Accidents	3 months
Maternity	12 months
Specific Pre-Existing Conditions	12 months

**Or any reduced waiting period we have agreed to and communicated to you in writing.*

Any claim that starts during the above Waiting Periods, will not be covered, even if it extends beyond the Waiting Periods. If you upgrade your cover or add an Insured Person to your Plan, the above Waiting Periods will apply to the upgraded cover or additional Insured Person from the date of upgrade or when the Insured Person was added to your Plan.

General Exclusions

There will be no cover if:

- The terms and conditions of the Plan are not met.
- Any information provided to us is materially incorrect, fraudulent, misrepresented or omitted. We also reserve our right to recover any amount paid on a claim, which later transpires to have been a fraudulent claim.
- You or any Insured Person is found to be abusing or committing fraud on the Plan. We also have the right to cancel the Plan immediately.
- You or any Insured Person participates (or attempts to participate) in any illegal or criminal activities, war, invasion, hostilities or war-like operations (whether war has been declared or not), civil war, military uprising, usurped power, martial law, insurrection, rebellion or revolution.
- You or any Insured Person under this Plan are not members of a Medical Scheme. In this case, it is your responsibility to inform us so we can cancel or update your Plan.
- If your annual limits have been reached, you will not be able to claim for any more events that occur in that 12-month period. You will only be able to claim again for events that occur in the following 12-month period. Benefits are not carried over from year to year.

Dual Insurance (Similar Insurance Plans):

This is where an Insured Event is covered for the same or similar Events by more than one independent insurance Plans. It is lawful to obtain double insurance, and the Plan Holder can make claim to both insurers in the event of a loss because both are liable under their respective Plans. The Plan Holder, however, cannot profit (recover more than the loss suffered) from this arrangement because the insurers are law bound only to share the actual loss in the same proportion, they share the total premium.

General Medical Exclusions

There will be no cover for the following:

- Any claim for which the Medical Scheme has not paid a portion or has not contributed towards an individual line item on the account from the Medical Scheme's Hospital Benefit.
- When all costs are paid by the Medical Scheme in full, where no shortfall exists or where the Medical Scheme paid a claim on an ex-gratia basis.
- Consultations prior to or following hospitalisation, except for Out-of hospital benefits.
- When the Medical Scheme paid a portion of, or the full amount of the account from the Medical Scheme's saving account or day-to-day benefit. This is not applicable to the Co-payment or Casualty Benefit as explicitly stated.
- Events, fees and accounts payable while you or an Insured Person are in the Medical Scheme's self-payment gap.
- For Allied Healthcare Providers unless allowed for within the Medical Scheme benefits.
- For claims where the Insured Persons failed to obtain pre-authorisation or appropriate service provider referral or other authorisation as required by the Medical Scheme.
- When the Insured Person has not followed the Medical Scheme rules (not including the use of non-network hospitals). Examples of these penalties are amounts due to not obtaining pre-authorisation from the Medical Scheme for a procedure, or as a result of consulting a specialist without first obtaining a referral from a General Practitioner.
- Upfront (or private) co-payments or fees to healthcare providers that cannot be claimed back from the Medical Scheme (sometimes referred to as Split Billing). This is a separately identifiable fee, in excess of the Medical Scheme Tariff and is not considered refundable. For Gap Cover to be assessed, the account needs to reflect and be assessed by the Medical Scheme.
- Upfront co-payments to healthcare providers that are more than the co-payment amounts imposed by the Medical Scheme.
- Dental Implants, Orthodontic, Prosthodontic or Cosmetic Dentistry.
- Hospitalisation is in any institution, hospital or clinic which is primarily a rest or convalescent (recovery) facility, or a place for custodial care.

- Cosmetic surgery except where reconstructive cosmetic surgery is necessitated, in the sole opinion of FNB Short Term Insurance, as a direct result of Trauma or other essential, non-elective treatment or medical procedure.
- When the medical event is due to:
  - Treatment for depression, mental or stress-related conditions.
  - Mental and behavioural disorders or the consequences thereof.
  - Self-inflicted injuries, including suicide, attempted suicide, or wilful injury to oneself.
- For any illness or dependency syndrome which resulted from the use of drugs or alcohol. Injuries resulting from accidents that are due to the use of drugs or alcohol will be covered once, and not for subsequent incidents.
- Any physical examinations, investigations and operations where there are no objective indications or impairments.

Our Claims Process

The decision to pay any claim for any benefit is made by us only and stands independent from the opinion expressed by the Specialist, Medical Practitioner or Medical Scheme of the Insured Persons. Our decision will be based on the assessments of any medical specialist, clinical information, hospital records, Medical Scheme statements and any other information relevant to the claim, including clinical guidelines and benchmarks regarding diagnosis or hospitalisation.

Claim Event Date is the date of discharge from hospital, or the date on which a procedure or surgery is performed, treatment is provided, or an investigation is conducted, where applicable.

When requested to provide additional or supporting documentation, such as a Medical Scheme pre-authorisation letter, medical report or blood test results, a submission period of 90 days will be granted to submit such documents, at your own expense.

We reserve the right to negotiate a discounted rate with the relevant service providers on your behalf, to ensure that a favourable risk profile is maintained. If granted, payment may be made directly into the respective service provider's bank account. Where you or any Insured Person has received a discount on their service providers' accounts, the latest account reflecting the discount must be submitted and we will only be liable to pay the outstanding amount.

In the event that a Medical Expense Shortfall being claimed is identified as a Prescribed Minimum Benefit (PMB), you or any Insured Person agree to allow us to investigate the reason(s) for the shortfall directly with the Medical Scheme. You or any Insured Person may be requested to sign a Letter of Undertaking which enables us to investigate these reason(s). We may agree to proceed with the claim and settle the applicable shortfall amount and thereafter conduct an investigation.

Definitions

Accident means any injury caused solely and unexpectedly, directly and independently of all other causes, sustained by external, violent or physical means, during the cover of this Plan. For example, a car crash.

Allied Healthcare Providers are healthcare providers associated with a medical event but who are not Doctors or Specialists.

Basic Dentistry is defined as the following dental treatment: cleaning, extractions (including wisdom teeth), fillings, inlays, bonding, root canal treatment, and treatment for pain and abscess.

Deductible or Co-payment means a defined, fixed amount specified in Rands by the Medical Scheme that is subtracted from the Medical Scheme benefit when undergoing defined Medical Procedures or hospitalisation. For the purposes of this definition, it explicitly excludes any deductible or co-payment that is specified by the Medical Scheme as a percentage of costs and not a specified Rand amount.

Diagnostic Procedures means Cystourethroscopy, Colonoscopy, Proctoscopy, Sigmoidoscopy, Gastroscopy, Cystoscopy, Hysteroscopy, CT Scan, MRI Scan or PET Scan

Hospitalisation/Hospitalised means an admission to a Hospital, as a result of an injury, illness or condition ("Hospitalisation Event") which requires an overnight stay in a medical facility. The Hospitalisation and duration of stay must be supported by a relevant Specialist following the recognised clinical guidelines. Objective signs and symptoms, as well as test results which support the diagnosis, must exist for the duration of the Hospitalisation.

Hospital Network means a list of hospitals specified by the Insured Person's Medical Scheme, as the designated service provider of one or more benefit options of the Medical Scheme.

Illness means any physical disease or sickness which manifests in an insured but is not a disease or sickness which is of such a nature as to be incapable of diagnosis by objective evidence.

Maternity means pregnancy and giving birth, including treatment, conditions or complications directly or indirectly related. Any hospitalisation related to maternity in the 12-month maternity waiting period is excluded.

Medical Practitioner means a qualified medical practitioner, who is registered with the Health Professions Council of South Africa and is authorised to practice in the Republic of South Africa.

Medical Procedure means any procedure defined under the National Health Reference Price List (NHRPL). If any procedure or operation is not listed on the NHRPL, FNB Short Term will calculate, at their sole discretion, an appropriate benefit to be paid.

Medical Scheme means a Medical Scheme as registered under the Medical Schemes Act No 131 of 1998.

Medical Scheme Tariff means a specific amount that your Medical Scheme has committed to paying for a specific procedure. Your Medical Scheme calculates this amount based on what it can afford to pay for the procedure, not on the actual costs to the Medical Practitioner for performing the procedure.

Out-of-hospital-benefits are only provided where specified. The following Out-of-hospital procedures may be covered. These are performed in day clinics or doctor's rooms:

- Urology - Cystoscopy, orchidopexy, prostate biopsy, vasectomy,
- Ear, nose, throat - Adenoidectomy, Direct Laryngoscopy, Grommets, Myringotomy, Sinus Surgery and Tonsillectomy
- Orthopaedic - Arthroscopy, Bunionectomy, Carpal Tunnel Release, Ganglion Surgery
- Radiology - Cat, MRI And Pet Scans, Nuclear Radiology, Varicose Vein Removal, X-Rays
- Gastro-intestinal - Closure of Colostomy, Colonoscopy, Endoscopy, Gastroscopy, Laparoscopy, Oesophagoscopy, Haemorrhoidectomy
- Gynaecology - Cervical Laser Ablation, Dilatation and Curettage, Hysteroscopy, Tubal Ligation
- Cardiovascular - Coronary Angioplasty and Angiogram
- Ophthalmology - Cataract Removal, Pterygium Removal, Trabeculectomy
- General surgery - Hernia repairs and certain Biopsies

Penalty means any co-payment, deductible, exclusion or reduction, applied against the benefits of an Insured Person's Medical Scheme, that would otherwise not have been applied had the authorisation rules of that Medical Scheme been adhered to or the benefits had been attained from the Medical Scheme's designated service provider or Hospital Network.

Qualifying Hospital means an institution which is licensed as a hospital under the laws of the Republic of South Africa with accreditation from the Board of Healthcare Funders of Southern Africa.

Shortfall Percentage The percentage of shortfall cover that you have on your chosen Plan.

Specialist means a Medical Practitioner, as defined in the Health Professions Act 56 of 1974, who has undergone further medical education in a specific field of medicine relevant to your diagnosis, by completing a multiple year residency and practices and is registered as such at the Health Professions Council of South Africa.

Specific Pre-Existing Waiting Period means a period in which you or an Insured person is not entitled to claim in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within a period of 12 months preceding the day on which cover commenced.

Specific Pre-Existing Conditions means any of the following injuries, illnesses or conditions that the Insured Person has (or should reasonably have) received, or has been recommended to receive, medical advice, diagnosis, care or treatment within 12 months before the Start Date of their cover.

These include:

1. Chronic Conditions (Diabetes, Hypertension, Epilepsy, Anaemia, Autoimmune Conditions, Tuberculosis, Gout, Congenital Conditions);
2. Digestive System (Gastrointestinal Tract Infections, Gastritis, Gastric Ulcers, Gastroesophageal Reflux Disease [GORD], Hernia, Irritable Bowel Syndrome, Hepatitis);
3. Heart Conditions (Heart Attack/Myocardial Infarction, Heart Failure, Angina, Cardiomyopathy, Heart Valve Disorders, Arrhythmias, Ischaemic Heart Disease);
4. Back Problems (Back Pain, Neck Pain, Muscle Spasms, Spondylosis, Spinal Stenosis, Intervertebral Disc Disorders/Diseases);
5. Bone and Joint Disorders (Arthritis, Fractures, Joint Replacements, Joint Dislocations, Joint Contractures, Tendon Injuries);
6. Male and Female Reproductive System Disorders (Abnormal Uterine Bleeding, Uterine Fibroids, Pelvic Inflammatory Disease (PID), Endometriosis, Prostatitis, Prostatic Hypertrophy, Orchitis, Erectile Dysfunction);
7. Lung Conditions (Asthma, Pneumonia, Tuberculosis, Chronic Obstructive Pulmonary Disease [COPD], Emphysema);
8. Kidney or Bladder Diseases (Chronic Kidney Disease, Kidney Failure, Urinary Tract Infections, Kidney Stones, Nephritis);
9. Brain and Nerve Disorders (Strokes, Paralysis, Meningitis, Neurodegenerative Disorders, Nerve Injuries); and
10. Infections (Cellulitis, Septicaemia, Skin Ulcers/Abscesses, Bed/Pressure Sores, Herpes Zoster/Shingles, Tonsillitis, Sinusitis, Ear Infections)
11. Venous Conditions (Varicose Veins, Venous Ulcers, Deep Vein Thrombosis)

Where a medical procedure is claimed for, the underlying diagnosis or cause of the resulting procedure will be used to consider whether it is a pre-existing condition or not.

Treatment means any form of diagnosis, treatment or care provided by a Medical Practitioner during a hospital event for the purpose of treating or monitoring the medical condition of an Insured Person.

What and when must you pay?

You must pay the premium amount stated in the Plan Schedule. Premiums are payable monthly in advance. Partial payment of premium will not be accepted. You authorise us to collect your premium each month by debit order on your chosen premium collection date. Premiums must be debited from your FNB/RMB transactional account.

If your chosen debit order day is within seven days after the Plan's Start Date, your first debit date will only be the following month on your chosen debit order day. However, changes requested within four days from the next debit date will only be applied from the following month.

If we are not able to collect your premium, we will attempt to debit a double premium on your next premium collection date. If you do not have enough money in your account for us to debit the premium(s), our electronic tracking service may continue to check your account. The unpaid premium(s) can be debited should there be enough money in your account.

If the debit order date falls on a Sunday or South African public holiday, we will debit your premium on either the business day before or after your chosen date. You can ask us to change your debit order date at any time. If we agree, the new date will become your premium debit order date. Every December, your premium may be debited on your salary date if this is different to the rest of the year.

If you cancel or dispute the debit order, your Plan and cover will also end. You will not receive a refund of the premiums you have already paid because you were covered for the months that you paid premiums. You authorise us to debit up to four times your initial premium to allow for future cover and premium increases. If we transfer the Plan to another Insurer, then the mandate that you have given to us to debit your account will also be transferred to the new Insurer.

What happens if I miss a premium?

You can at any time be up to two premiums in arrears and still be covered. If you are in arrears (missed a premium payment), we will debit your account with up to two premiums every month until you are no longer in arrears.

Your Plan will lapse when you are three premiums in arrears, and we are unable to collect a premium 30 days after the last unpaid premium. If there is a successful claim, while in arrears, we will recover any missed premiums from the claim payment. To keep your cover and prevent the Plan from lapsing, we may contact you to change your debit date to the date you receive your salary.

Premium and benefit reviews: The premium and cover amount will be reviewed annually on the 1st of July.

When will the cover and Plan end?

The Plan and all cover ends:

- When the Plan is cancelled;
- For Insured Persons, on the day they are removed from the Plan;
- If you do not pay the premiums as agreed;
- If you dispute or cancel your debit order; or
- On your death if the continuation option is not exercised.

Reviews & Cancellations:

You can end the Plan telephonically or in writing at any time. We will refund any premiums paid if you cancelled within 2 months from the Plan's Start Date (this is known as the "**cooling-off period**") and if you haven't claimed, otherwise no premiums will be refunded. This Plan does not have any surrender or paid-up value. We can review the Plan with 31 days' notice or cancel it with 90 days' notice, including cancellation due to a high-risk claim history or the product no longer remaining financially feasible for the Insurer.

We may immediately cancel this Plan or place it on hold, refuse any transaction or instructions, or take any other action that we consider necessary:

- to obey the law and prevent or stop undesirable or criminal activity,
- ensuring he Insurer's reputation remains intact and/or is not compromised
- if we detect any fraudulent activity or attempt to commit fraud.

How and when to make a claim?

Notification and submission: You need to notify us as soon as possible once you become aware of a claim, but not later than 60 days after the Insured Person has been discharged from hospital or undergone the medical treatment. Contact us on phone number 087 736 7772 or by email: fnblifeclaims@fnb.co.za.

If the claim is approved, then the full benefit will be paid:

- After the Insured Person is discharged; or
- If the Insured Person is hospitalised for more than 30 days,

The claim will be paid to you into your FNB / RMB transactional account, where this Plan's premium is paid from, unless we pay directly to the Service Provider's account.

If the claim is not submitted in time, we will not accept the claim and we will not be liable to pay any benefits under this Plan for such claim.

If the claim is rejected: If we reject the claim or any portion of it, you have 90 days to ask us in writing for a review of the decision. We will review the claim decision when we receive that request and tell you of our reviewed decision in writing.

If you are still not satisfied upon receiving our reviewed decision and do not serve a summons on us within 180 days from the day when we tell you of our final decision, we will then be relieved of our liability and your claim will prescribe. The 180-day period is in addition to the 90 days referred to above.

If we still reject your claim and you are not satisfied with the reason that we give for the rejection, or if you have any unresolved dispute about this Plan, you may refer the matter to the **Ombudsman for Short-term Insurance**:

First Floor, Block B, 1 Sturdee Avenue, Cnr. Bolton and Baker Roads, Rosebank.
P. O. Box 32334, Braamfontein, 2017.
Tel: (011) 726-8900 Fax: (011) 726-5501.
Email: info@ombud.co.za; www.ombud.co.za.

What documentation is required to claim?

The following documents are required for every claim:

- A copy of your Medical Scheme Statement which confirms all your medical costs and everything that the Medical Scheme has paid for your claim event.

The following documents may be requested by us to further investigate any claim:

- A completed claim form (can be requested from the claims department on the number above);
- A copy of the Hospitalisation record that you received from the hospital when you were discharged;
- The medical report from the consulting specialist;
- A copy of all the relevant medical service provider's accounts; and
- Copies of any tests or investigations to support a diagnosis.

You and the relevant Insured Person, where applicable, must:

- Work with us by giving us any extra evidence or information we may need at any time or to decide on a claim. This includes any documents, history, records, reports, examinations, opinions, certificates, test results and other information, from any Specialist, Medical Practitioner, hospital, medical institution, employer or any other person who may be in possession of such evidence, concerning the claim of an Insured Person;
- If we require any further consent from any of the insured lives to enable us to gain access to (or communicate) the required information or evidence, you must ensure that we receive it. If we cannot acquire the necessary consent, we will not be able to pay the claim; and
- Pay for the costs of getting this evidence and information.

What if you cannot claim under certain circumstances, who will we pay?

If you cannot submit a claim, due to you being incapacitated or because of your death, we may, in our sole discretion, pay the proceeds to the person responsible for your care or affairs.

Reinstatement

If your Plan lapses after we have received at least one premium, it can be reinstated (with no additional waiting periods) within 31 days of it lapsing, if all the unpaid or missed premiums are paid-up. If you wish to continue the cover but did not reinstate the Plan within the time specified above, a new Plan based on prevailing pricing and new waiting periods will have to be taken up. There will be no cover between the time your Plan was lapsed or cancelled and then subsequently reinstated.

Waiver and Continuation Option

In the event of your death, and if a nominated Insured Person (who is older than 18 years) was insured under the Plan, the Plan will remain in force for three more months without requiring any person to make premium payments. The nominated Insured Person (who is older than 18 years) may decide within the three months, if they want to continue with the cover as the new Plan Holder and continue paying the Plan's premiums for the remaining insured lives.

Changes to the cover or Insured Persons

You may upgrade or downgrade your cover, as well as add or remove Insured Persons on the Plan. All cover changes (cover amount increases or changes to Insured Persons) will be subject to the waiting periods and the same eligibility criteria as for a new Plan. The Start Date of the increased cover or the cover for the new Insured Persons will be the date we load it, which will be noted on the Plan Schedule. You can cancel a change to the Plan within two months of making it, we will refund any additional premium paid as a result of that change (if you have not yet claimed).

General Terms and Conditions

You cannot borrow money under this Plan or use it as security for a loan.

We may collect information from you directly or from any third parties or share with any third party (including but not limited to Astute, Home Affairs, Credit Bureaus, Hospitals, Medical Scheme and other Medical Institutions, etc.) for underwriting, issuing of policies, assessment of claims and all other insurance-related purposes.

Legal issues: Any legal issues will be decided in accordance with South African Law. This contract is based on the written, digital and/or telephonic disclosures and information that you have provided to us. At times, we may be lenient in enforcing the Terms and Conditions of the contract or the rights that we have in terms of it, if it is to your benefit. Such leniency will not prevent us from being able to enforce any existing or future right we have under the Plan.

It is your obligation to accurately and properly disclose all material facts. If any of the information or statements that you give us is materially incorrect, fraudulent, misrepresented or omitted, or if you did not give us the relevant information when starting, or changing your Plan, or submitting a claim, we have the right to:

- Change the Terms and Conditions of your Plan;
- Cancel your Plan from any date that we choose and to keep your premiums for the cover you had until the date of cancellation;
- Treat your Plan as if it had never started and refund your premiums, less any costs we have incurred (for example, administration costs);
- Not pay out any claims;
- Recover any amount paid on a claim, which later transpires to have been a fraudulent claim; and
- Recover from you any amounts that we have paid for previous claims.

You are entitled to a copy or written or printed record of any transaction requirement upon your request.

Product discontinuation: We have the right to discontinue this product line and cancel all such policies. In this event, your Plan may be cancelled, and we will tell you at least 90 days before it is cancelled.

Insurance Complaint Process & Regulatory Information:

Product Supplier and Underwriter: FirstRand Short-term Insurance Limited is a licensed non-life insurer, Registration No. 2018/234369/06. 3rd Floor 5 First Place, 9 Kerk Street, Johannesburg, 2000. PO Box 1153, Johannesburg, 2000. Tel: 087 736 7772.

Complaints: If you have any complaints about this Plan or a claim, please contact the Complaints Department. Tel: 087 575 9408. E-mail: care@fnb.co.za. You can also contact the Compliance Officer or request a copy of the FNB FAIS Conflicts of Interest Policy from the FSP at: Tel: 087 736 7772. Email: insurancepillarcompilance@fnb.co.za.

Financial Service Complaint Process and Regulatory Information:

FirstRand Short-term Insurance and FNB hold professional indemnity insurance. FNB is a registered financial services provider for this class and type of product. FNB takes responsibility for the actions of its authorised representatives insofar as they are providing financial services for this Plan. Representatives will inform you if they are providing services under supervision. FNB and FirstRand Short-term Insurance are associates in terms of the FAIS Act. A Financial Services Provider in terms S3A(2)(a) of the FAIS General Code of Conduct is required to have a Conflict of Interest Policy. A copy of the FirstRand FAIS Conflict of Interest Policy, that also covers this FSP, can be found at https://www.firstrand.co.za/investors/governance-and-compliance.

Financial Service Provider: First National Bank ("FNB"), a division of FirstRand Bank Limited, Registration No. 1929/001225/06. FSP No. 3071. 3rd floor, 1 First Place, Simmonds Street, Bank City, 2001. PO Box 1153, Johannesburg, 2000. visit the FNB website. Tel: 087 5759404. E-mail: fnblife@fnb.co.za

Unresolved Complaints: If after you have contacted FNB and you have an unresolved dispute about the financial service provided to you, you can contact the FAIS Ombudsman. Physical address: FAIS Ombudsman Kasteelpark Office Park, 2nd Floor, Orange Building, Cnr Nossob & Jochemus Streets, Erasmuskloof, Pretoria or PO Box 74751, Lynnwood Ridge, 0040. Tel: 012 470 9080 / 012 762 5000. Email: info@faisombud.co.za. Website: www.faisombud.co.za.

FirstRand Privacy Term and Privacy Notice

Your personal information (which, for the purposes of this clause includes special personal information) will be held by entities within the FirstRand Group.

To better understand the entities that form part of the FirstRand Group and how your personal information is treated, please refer to FirstRand's Privacy Notice which forms part of this privacy term. The Privacy Notice can be found on our Platform (for example our Banking App or website) or contact us to request a copy.

In this privacy term references to "we", "us" or "our" are references to the entities in the FirstRand Group, and all affiliates, associates, cessionaries, delegates, successors in title or third parties (authorised agents and contractors), when such parties are acting as responsible parties or operators in terms of applicable privacy laws, unless stated otherwise.

- By accepting these Terms and Conditions or by utilising any products or services ("Solutions") offered by us, you acknowledge that in order to:
  - Conclude and fulfil contractual terms or obligations to you;
  - Comply with obligations imposed by law; or
  - To protect or pursue your, our, or a third party's legitimate interests, solutions that best meet your needs, your personal information may be processed through centralised functions and systems across entities in the FirstRand Group and may be used for the purposes, in the manner, and with the appropriate controls as set out in our Privacy Notice.
- Where it is necessary to obtain consent for processing outside of this privacy term, we will explicitly seek your consent separately.
- We want to ensure that you fully understand how your personal information may be used. We have described the purposes for which your personal information may be used in detail in our Privacy Notice.
- We have also set out further information about accessing, correcting or objecting to the processing of your personal information in our Privacy Notice. We strongly advise that you read our Privacy Notice.

For the purposes of these Terms and Conditions the responsible party is the party with whom you are contracting a solution, as well as other entities in the FirstRand Group, which are listed in our Privacy Notice as responsible parties. For the contact details of these responsible parties, please see our Privacy Notice.