momentum

Health4Me

Health4Me

Accident and emergency cover group policy

2024

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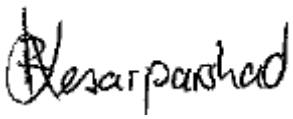
Accident and emergency cover group policy

Policy no: As per the Schedule

This Policy is effective from the Commencement Date.

Momentum Metropolitan Life Limited undertakes on payment of the stipulated premiums to provide Benefits in respect of the Members in accordance with the conditions of this Policy.



AUTHORISED SIGNATORY FOR
MOMENTUM METROPOLITAN LIFE LIMITED

1. DEFINITIONS

1.1. Definitions used in this Policy

1.1.1. In this Policy, certain words and expressions have specific meanings assigned to them and will have the same meaning throughout the Policy.

1.1.2. Capital letters are used to show where a defined word or expression is used in the Policy with the meaning listed below.

1.1.3. **Accident** shall mean an Emergency that is an external, unexpected event that is not traceable, directly or indirectly, to a Member's state of mental or physical health prior to the event. Accidents include but are not limited to falls, fractures, burns, transport related Accidents, the breaking of limbs due to Accidental causes, etc. Natural causes are not included in this definition.

1.1.4. **Benefit** shall mean the Benefits as defined in the Policy and Contract Schedule.

1.1.5. **Benefit Grouping** shall mean, if applicable, one of the categories specified in the Schedule into which Members are classified.

1.1.6. **Child** shall mean a person under the Child Cover Age who is:

1.1.6.1. a Member's natural Child (born before or after the Member's death); or

1.1.6.2. a Member's legally adopted Child.

Provided that once a Child has ceased to qualify as a Child, he/she cannot qualify as a Child again for the purposes of this Policy at any future date, provided further that at any one time, a maximum of six Children may qualify for Cover under this Policy.

1.1.7. **Child Cover Age** shall mean the age of 18 years, provided that in the case of a Child who is in full-time education at an institution recognised by the Insurer for these purposes, or a Child who suffers from a defect of mind or body and is financially dependent on the Member, it shall be 26 years, and Cover shall cease on the last day of the month in which a Child attains the Child Cover Age.

1.1.8. **Commencement Date** shall mean the date specified as such in the Schedule.

1.1.9. **Cover** shall mean the Benefits provided in terms of this Policy subject to any restrictions and exclusions.

1.1.10. **Eligible Employee** shall mean an employee in Service:

1.1.10.1. who is 18 years or older; and

1.1.10.2. who satisfies any entry qualifications as set out in the Schedule.

1.1.11. **Emergency** shall mean the sudden and, at the time, unexpected onset of a medical condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a body organ or part, or would place the Member's life in serious jeopardy, and for the purpose of this Policy includes, and is limited to Accidents, heart attacks and strokes.

1.1.12. **Emergency Medical Transportation** shall mean the transportation of a Member in order that he/she may receive medical or surgical care.

1.1.13. **Emergency Room** is based in an accredited health care facility that is staffed and equipped to provide rapid and varied Emergency care for a Member who was involved in an Accident, or has had a heart attack or stroke. The Emergency area may use a triage system of screening and classifying patients to determine priority needs for the most efficient use of available personnel and equipment.

1.1.14. **Employer** shall mean the party designated as such in the Schedule.

1.1.15. **Entry Date** shall mean the Commencement Date for all Eligible Employees existing at the Commencement Date and shall mean the first day of employment for new Eligible Employees entering into the employment of the Employer after the Commencement Date.

1.1.16. **Hospital** shall mean an institution that:

1.1.16.1. is licensed in accordance with the applicable terms of the jurisdiction in which it is located;

1.1.16.2. is primarily engaged in providing, for compensation from its patients, diagnostic, medical and surgical facilities for the care and treatment of injured or sick persons;

1.1.16.3. has one or more physicians available at all times; and

1.1.16.4. has 24-hour-a-day nursing services by registered graduate nurses under permanent supervision of the physician in charge, maintains a daily medical record for each patient which is accessible to the medical doctor of the Insurer, but which is not (except coincidentally), one of the following:

1.1.16.4.1. a clinic, health resort, nursing home or similar institution, old age home, geriatric institution, an institution for the treatment of alcohol or drug addiction, a mental institution, a hydropathical clinic, a nature cure clinic or similar institution, a hospice or an institution for the long-term care of blind, deaf, mute, TB, HIV, cancer sufferers, terminally ill sufferers or any other disabled persons or home care.

1.1.17. **Hospitalisation** shall mean confinement of an Insured Life to a Hospital for a continuous period of more than 24 hours.

1.1.18. **In-patient** shall mean a patient that has been Hospitalised.

1.1.19. **Insured Incident** shall mean a Major Medical Event as a result of an Accident or Emergency that gives rise to the payment of a Benefit.

1.1.20. **Insured Life** shall mean a person Covered in terms of this Policy.

1.1.21. **Insurer** shall mean Momentum Metropolitan Life Limited (Registration Number 1904/002186/06), an authorised financial services provider (FSP 6406) and registered credit provider.

1.1.22. **Major Medical Event** shall mean a medical event that is serious in nature and has an adverse effect on the Member's physical health.

1.1.23. **Maximum Amount** shall mean the Maximum Amount specified in the Schedule.

1.1.24. **Member** shall mean an Eligible Employee, his/her Spouse and Children who are Covered under this Policy.

1.1.25. **Out-patient** shall mean a patient who has received treatment at a Hospital without being Hospitalised or admitted to the Hospital as an In-patient.

1.1.26. **Policy** shall mean the contract of insurance providing Cover as detailed in this document and read together with the Schedule.

1.1.27. **Policyholder** shall mean the party designated as such in the Schedule.

1.1.28. **Pre-Authorisation** shall mean the process (automated or through interaction with the health professional or his/her representative) where a request for an intervention or treatment is made by a health professional or his/her representative and where the intervention or treatment is then authorised or rejected for full or partial Benefit.

1.1.29. **Renewal Date** shall mean the date specified as such in the Schedule.

1.1.30. **Schedule** shall mean the Schedule attached to and forming part of this Policy titled "Momentum Health4Me Policy and Contract Schedule".

1.1.31. **Service** shall mean uninterrupted, active, permanent employment with any Employer for not less than twenty hours per week, subject to the provisions of clause 2.2.

1.1.32. **Service Provider** shall mean a health care Services Provider that is duly registered as such in accordance with the laws of the Republic of South Africa and who has entered into a contract with Momentum Metropolitan Life Limited to render health care services.

1.1.33. **Southern Africa** shall mean the Republic of South Africa, Botswana, Lesotho, Mozambique, Namibia, Swaziland and Zimbabwe.

1.1.34. **Spouse** shall mean a Member's lawful partner in any of the following types of partnerships:

1.1.34.1. a marriage in terms of the Marriage Act;

1.1.34.2. a civil partnership as described in the Civil Union Act;

1.1.34.3. a customary marriage as described in the Recognition of Customary Marriages Act;

1.1.34.4. a union recognised as a marriage by any Asiatic religion of the Member; or

1.1.34.5. a permanent life partnership (provided that the Insurer receives satisfactory proof that a permanent life partnership exists as well as proof that the partners in the relationship have been living together for at least the last six months).

A maximum of two Spouses may qualify for Cover under this Policy.

1.1.35. **Stabilisation** shall mean the provision of such medical treatment of the condition as may be necessary to ensure, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the individual from the facility.

1.1.36. **Suspension Period** shall mean a maximum period of three months commencing on the date a Member's Cover shall cease in terms of clause 4.3.3.

1.2. Policy document and alterations

1.2.1. This Policy constitutes the entire contract between the Insurer and the Policyholder and any alteration to this Policy shall be in the form of an endorsement signed by an authorised official of the Insurer.

1.2.2. This Policy may be altered by the Insurer on one month's written notice to the Policyholder.

1.3. Benefits non-assignable

1.3.1. The Benefits under this Policy shall not be capable of being ceded, pledged or assigned in any way.

1.4. Surrender value

1.4.1. This Policy shall not have any surrender value.

1.5. Termination of Policy

1.5.1. The Policyholder and the Insurer may cancel this Policy or cancel the membership of any Member or Insured Life from the Policy by giving the other party one calendar month’s prior written notice (“the notice period”).

1.5.2. Should the Policyholder cancel the Policy without giving the Insurer one calendar month’s prior written notice, and a Benefit has been paid or claimed, or an insured event has occurred within the notice period, the Insurer in its sole and absolute discretion, may institute legal proceedings to recover from the Policyholder any outstanding contributions and/or Benefit paid or claimed.

1.5.3. The Policyholder may cancel the Policy within 30 days of receipt of the Policy or of the Policy summary provided in terms of section 48 of the Long-Term Insurance Act of 1998. The Insurer will refund all premiums paid in respect of the transaction, adjusted at the Insurer's discretion for any investment charges incurred, negative investment experience and reasonable, time-based fees for work performed. The Policyholder may not cancel the Policy in terms of this clause if a Benefit has been paid or claimed or an insured event has already occurred.

1.6. Outsourcing of Insurer’s functions

1.6.1. The Insurer shall, at its discretion, outsource any of its functions in terms of section 49A of the Long-Term Insurance Act No. 52 of 1998 and the regulations issued in terms of that Act and notify the Policyholder thereof in writing.

2. CONDITIONS FOR PROVISION OF COVER

2.1. Eligibility for membership

2.1.1. All Eligible Employees must be insured as Members under this Policy.

2.1.2. The Cover in respect of a Member shall, subject to compliance with clauses 2.1.3, 2.2 and 2.3, commence on his Entry Date, provided that the first premium is received by the Insurer.

2.1.3. Where an employee becomes a Member by the waiving of any entry condition, then the Cover for such employee shall not commence until the Insurer has agreed thereto in writing.

2.2. Actively at work

2.2.1. On the first working day on which an Eligible Employee's Cover is due to start, the Eligible Employee must be actively at work. This means that the Eligible Employee must be:

2.2.1.1. at work;

2.2.1.2. attending to his/her normal duties; and

2.2.1.3. capable of attending to the duties for which he/she is employed.

2.2.2. If an Eligible Employee is not actively at work as set out above, his/her Cover will only start when he/she returns to work, he/she is attending to his/her normal duties and is capable of attending to the duties for which he/she is employed.

2.2.3. If a Member's Cover increases because of a change in the Benefit structure, the restrictions set out above will also apply on the date that his/her Cover is due to increase. The restrictions will only apply to the amount of the increase, and not to the Member's existing Cover.

2.2.4. If the actively at work clause waiver is required in terms of the Schedule, the restrictions specified above will not apply to Cover that is less than the Cover that a Member enjoyed immediately prior to the Commencement Date under a previous group accident and emergency cover Policy effected by the Employer for the benefit of employees. Any Cover over this amount will be subject to the actively at work requirements.

2.3. Temporary absence

2.3.1. Should a Member be temporarily absent from the Service of the Employer, the Member may, at the Insurer's discretion, continue to be Covered at the level he/she enjoyed immediately before his/her absence, subject to the following conditions:

2.3.1.1. the Policyholder must notify the Insurer of the absence of the Member from Service in writing;

2.3.1.2. the Member must remain employed by the Employer; and

2.3.1.3. premiums must continue to be paid based on the Member's previous Cover levels even if the Member is receiving reduced or no remuneration during his absence.

2.3.2. This continued Cover will be granted for a maximum period of twelve months.

2.3.3. Absences from Service that are not separated by at least six consecutive months will be added together when calculating the maximum period of Cover allowed above.

2.3.4. The Policyholder may request permission from the Insurer for a Member to be absent from Service for longer periods. If the Insurer agrees to this in writing, such Member will be regarded as being temporarily absent subject to such conditions as the Insurer may require.

2.3.5. A Member whose Cover has ceased because he/she exceeded the maximum period allowed for temporary absence will be treated as a new Member if he/she returns to Service.

2.4. Waiting periods

2.4.1. A waiting period may be applied by the Insurer depending on its underwriting requirements. Such waiting periods will be advised, in writing, to the Policyholder by the Insurer, in the Schedule.

2.4.2. Premiums are payable during a waiting period.

2.5. Exclusions

2.5.1. No Benefit will be payable for any claim if it is in any direct or indirect way caused by, related to, or a result of:

2.5.1.1. any nuclear reaction or nuclear radiation;

2.5.1.2. active participation in war, invasion, act of foreign enemy, hostilities or warlike operations (whether war has been declared or not), civil war, military uprising, military or usurped power, martial law, insurrection, rebellion or revolution;

2.5.1.3. active participation in any mutiny, riot or civil commotion that assumes the proportions of or amounts to a popular uprising;

2.5.1.4. any act of terrorism or action taken in controlling, preventing, suppressing or in any way relating to any act of terrorism, even if there are other causes or events that contribute to the claim at any stage. In this Policy terrorism means an act, the threat of an act, or any preparation for an act:

2.5.1.4.1. which may or may not involve violence or the use of force by any person or group (whether they are acting alone or on behalf of or in connection with any organisation, regime or any constitutional or practicing government);

2.5.1.4.2. that is, or appears to be, intended to intimidate, harm or influence any government, the public, or a section of the public, or to disrupt any segment of the economy; or

2.5.1.4.3. from its nature or context appears to be done in connection with political, social, religious, ideological or similar causes or objectives;

2.5.1.5. excessive use of intoxicating liquor, wilful inhalation of gas or taking of poisons, drugs or narcotics (except under proper medical direction);

2.5.1.6. any violation of the criminal law by the Member, or any event occurring whilst the Member is in violation of the criminal law;

2.5.1.7. mining or using explosives unless as part of an occupation for commercial purposes;

2.5.1.8. any hazardous activity, including but not limited to motorised racing/speed contests, speed trials, boxing (including kickboxing) or fighting of any kind, except in self-defence;

2.5.1.9. any risky or dangerous activities which, in the opinion of the Insurer, may expose the Insured Life to a higher-than-average risk of injury; or

2.5.1.10. attempted suicide or any self-inflicted injury, whether the Member is sane or insane, and whether by the Member's own hand or not.

2.6. Cessation of Cover

2.6.1. A Member's Cover shall cease on the earliest of the following:

2.6.1.1. the absence of the Member from Southern Africa for a period of twelve consecutive months (unless the Insurer decides to extend this period at its sole discretion);

2.6.1.2. cessation of Service;

2.6.1.3. the Member reaching the termination date;

2.6.1.4. the Member's death;

2.6.1.5. cessation of payment of premiums, subject to clause 4.3;

2.6.1.6. termination of this Policy by the Insurer or the Policyholder; or

2.6.1.7. if the Member no longer satisfies the eligibility criteria for Cover under the Policy.

2.7. Membership Changes

2.7.1. Benefit option changes

2.7.1.1. New Members who are added to the Policy, either from the Policy inception date, or ad-hoc, will have a three-month window period from the inception date of Cover, in which they will be permitted to exercise a Benefit option change, provided that more than one Benefit option has been selected by the Policyholder.

2.7.1.2. Option changes not exercised withing the window period stated above will only be allowed under the following circumstances:

2.7.1.2.1. effective 1 January of every year; or

2.7.1.2.2. an option change will be permitted during a Benefit year upon a Member's annual salary increase, provided that proof is supplied to Momentum (annual salary increase letter).

2.7.2. Addition of dependants

2.7.2.1. New Members who are added to the Policy, either from the Policy inception date, or ad-hoc, will have a three-month window period from the inception date of Cover, in which they will be permitted to add dependants, provided that dependant Cover has been selected by the Policyholder.

2.7.2.2. Addition of dependant changes not exercised withing the window period stated above will only be allowed under the following circumstances:

2.7.2.2.1. effective 1 January of every year; or

2.7.2.2.2. within three months of either the date of birth of a new Child, or the date of the official adoption of a new Child; or

2.7.2.2.3. within three months of the marriage date to a new Spouse; or

2.7.2.2.4. an addition of dependants will be permitted during a Benefit year upon a Member's annual salary increase, provided that proof is supplied to Momentum (annual salary increase letter).

2.7.3. Termination of membership

2.7.3.1. If the membership of a Member is terminated during the course of a Benefit year, the Member in question will only be permitted to be placed back on Benefit effective 1 January of the upcoming year, should they wish to continue with Cover, unless there was a break in service in terms of the membership of the employee.

3. BENEFITS

3.1. Payment of Benefits

3.1.1. The Benefit offers two Benefit options. The Benefits Covered by each Benefit option are subject to an overall annual limit. In accordance with the following Benefit tables, certain restrictions apply to specific Benefits.

3.1.2. The Insurer will provide Benefits in accordance with the Benefit option chosen as detailed in the Schedule.

3.1.3. All Benefits under this Policy will be forfeited if a claim is found to be fraudulent in any respect or if a medical condition is intentionally exaggerated.

3.2. Base option

Base option	
Benefit	**Benefit description**
Accident and emergency cover	**Accident cover:** Emergency transportation, stabilisation and treatment cost paid in case of an accident that requires immediate medical treatment An accident shall mean a medical emergency that is an external, unexpected event that is not traceable, directly or indirectly, to a member's state of mental or physical health prior to the event

Base option (continued)	
Benefit	**Benefit description**
Accident and emergency cover (continued)	Up to R30 000 per event (casualty benefit) and up to R500 000 per event (in-hospital benefit) covered at a private hospital for accidents that fit the qualifying criteria **Emergency (heart attack or stroke) cover:** Emergency transportation, stabilisation and treatment cost paid in case of an emergency (heart attack or stroke) that requires immediate medical treatment Up to R30 000 per event (casualty benefit) and up to R250 000 per event (in-hospital benefit) covered at a private hospital for emergency (heart attack or stroke) events that fit the qualifying criteria A maximum of R5 000 000 is payable on accident and emergency cover per member per year If the benefit limit is exceeded, and further treatment is required, the member will be transported to a state hospital for further care and treatment Medical emergencies that do not fit the qualifying criteria will warrant transportation, stabilisation and treatment at a state facility Accident and emergency cover includes emergency transportation, stabilisation and treatment cost, and includes the cost of diagnostic scans (like MRI and CT scans), take-home medication, internal and external prosthetics, orthotics and assistive devices, rehabilitation services (like step-down services, wound care, physiotherapy and occupational therapy), subject to both clinical approval and the respective per event limits

3.3. Standard option

Standard option	
Benefit	**Benefit description**
Accident and emergency cover	**Accident cover:** Emergency transportation, stabilisation and treatment cost paid in case of an accident that requires immediate medical treatment An accident shall mean a medical emergency that is an external, unexpected event that is not traceable, directly or indirectly, to a member's state of mental or physical health prior to the event Up to R30 000 per event (casualty benefit) and up to R1 500 000 per event (in-hospital benefit) covered at a private hospital for accidents that fit the qualifying criteria **Emergency (heart attack or stroke) cover:** Emergency transportation, stabilisation and treatment cost paid in case of an emergency (heart attack or stroke) that requires immediate medical treatment Up to R30 000 per event (casualty benefit) and up to R500 000 per event (in-hospital benefit) covered at a private hospital for emergency (heart attack or stroke) events that fit the qualifying criteria A maximum of R5 000 000 is payable on accident and emergency cover per member per year If the benefit limit is exceeded, and further treatment is required, the member will be transported to a state hospital for further care and treatment Medical emergencies that do not fit the qualifying criteria will warrant transportation, stabilisation and treatment at a state facility Accident and emergency cover includes emergency transportation, stabilisation and treatment cost, and includes the cost of diagnostic scans (like MRI and CT scans), take-home medication, internal and external prosthetics, orthotics and assistive devices, rehabilitation services (like step-down services, wound care, physiotherapy and occupational therapy), subject to both clinical approval and the respective per event limits

4. ADMINISTRATION

4.1. Provision of information

4.1.1. The Policyholder shall provide to the Insurer all information regarding the Members as required by the Insurer on a monthly basis.

4.1.2. At each Renewal Date the Policyholder is required to provide the Insurer with full membership details, including identity/passport numbers and date of births, mobile phone numbers, salary information, Benefit Grouping selections, Benefit option selections, and all other information requested by the Insurer to determine Cover, Benefits and premiums.

4.1.3. In addition, the Policyholder shall provide to the Insurer any information requested by the Insurer which it considers relevant to the determination of Cover, Benefits and premiums in terms of this Policy.

4.1.4. In the event that any information requested by the Insurer is not provided within six weeks of the Insurer requesting it, and the information is material to the Insurer's ability to perform its obligations in terms of the Policy, the Insurer will give the Policyholder two weeks' written notice of its intention to terminate the performance of services and any Cover provided under the Policy. On the expiry of the two-week notice period, the performance of services and the provision of Cover will cease unless the Insurer has before then received the requested information or has agreed otherwise in writing.

4.1.5. The Insurer shall not be liable to any person in respect of any misrepresentations, errors or omissions contained in the information provided to the Insurer by the Policyholder.

4.1.6. The Insurer must have satisfactory proof of an Insured Life's age before any Benefit is paid for that Insured Life. If the date of birth previously notified to the Insurer in respect of an Insured Life proves to be incorrect, the Insurer shall, after consulting with the Policyholder, calculate the premiums that should have been paid and adjust the premiums retrospectively to the date on which the Member became entitled to Cover in terms of this Policy or make such adjustment to the Cover as it considers appropriate.

4.1.7. Should any amount owed to the Insurer as a result of such premium adjustment not be paid by the Policyholder to the Insurer within thirty days of the Insurer's written request to do so, the Insurer will reduce the Cover as it considers appropriate by reference to the premiums actually received in respect of the Member.

4.1.8. The Insurer shall keep a register of Members and shall record therein the information supplied by the Policyholder.

4.1.9. The Insurer shall be entitled, at all reasonable times, to enable it to fulfil its obligations in terms of the Policy, to inspect and make copies of the payrolls and other records of the Employer.

4.1.10. The Insurer shall have the right to call for an auditor's certificate at the expense of the Policyholder, to certify any information relating to a claim or the Cover or Benefits provided under this Policy.

4.1.11. The Insurer shall not be liable for any claim under this Policy should the Policyholder, Member or Employer commit any act of dishonesty or fraud in relation to any provision contained in this Policy.

4.2. Claims

4.2.1. The Policyholder should notify the Insurer as soon as possible of any potential claim or of any occurrence that could lead to a claim.

4.2.2. Formal written notification of a claim in respect of a Benefit shall be lodged with the Insurer within four months of the Insured Incident, failing which the claim shall not be admitted.

4.2.3. All documentation required by the Insurer, shall be lodged with the Insurer within four months of the Insured Incident, failing which, the claim shall not be admitted.

4.2.4. Should the Insurer request any additional information or supporting documents over and above the standard, prescribed requirements, these must be provided to the Insurer within four months of the Insured Incident, failing which, the claim shall not be admitted.

4.2.5. The Insurer will assess the claim and, on the satisfaction of the provisions of this Policy, shall pay the Benefits to the Policyholder or such other person as the Policyholder may direct in accordance with the provisions of this Policy, within a reasonable time period of receiving all required documentation.

4.2.6. If the Insurer receives a notification of a claim in respect of a Benefit, but the date of the claim event falls within the Suspension Period in terms of clause 4.4, the claim shall not be admitted.

4.2.7. In the event of a claim being declined it is the responsibility of the Member to settle all claims with the Service Provider directly.

4.3. Payment of premiums

4.3.1. Premiums shall be payable either in advance or arrears as elected by the Employer as specified in the Schedule.

4.3.2. Premiums must be paid based on a Schedule of Members Covered which must be updated on a monthly basis by the Policyholder. The Policyholder must submit this Schedule to the Insurer by the 25th of the month.

4.3.3. If the full amount of the premiums due and the Schedule of Members Covered is not received by the 7th day of the month in respect of which they are due, Cover will be suspended. If the full amount of premiums due and the Schedule of Members Covered is not received by the Insurer by the fifteenth day of the month following the month in respect of which they are due, all Cover shall cease from the last date in respect of which the full amount of premiums has been paid, unless it is agreed otherwise by the Insurer in writing.

4.3.4. The Insurer shall be entitled to charge the Policyholder interest on any overdue premium at the most recent call interest rate charged by First National Bank for the period from the expiry of the period of grace to the date of payment of the overdue premium.

4.4. Suspensions

4.4.1. If the premiums due are not received as set out in clause 4.3, the Member's Cover will cease and the Member's participation in the Policy will be suspended.

4.4.2. At the request of the Policyholder, the Member's participation in the Policy may be reinstated if agreed to by the Insurer, subject to the following conditions:

4.4.2.1. the reinstatement request must fall within the Suspension Period; and

4.4.2.2. the Member's Cover and participation in the Policy will be reinstated on the first day of the month for which the outstanding premiums are due, upon receipt of the outstanding premiums by the Insurer.

4.4.3. The Insurer shall not admit any claim received in respect of a Benefit, where the date of the claim event falls during the Suspension Period, but prior to the reinstatement of the Policy.

4.5. Rate guarantee

4.5.1. The premium rates and Benefits used to calculate premiums shall be guaranteed for the period from the Commencement Date until the following Renewal Date.

4.5.2. The Insurer may however alter the premium rates at any time on one month's written notice to the Policyholder, in the event that:

4.5.2.1. there is a change in Membership or categories of Members which in the opinion of the Insurer affects the risk under this Policy;

4.5.2.2. the business activities of the Employer change to such an extent that in the opinion of the Insurer it affects the risk under this Policy;

4.5.2.3. the Benefit structure under this Policy changes; or

4.5.2.4. the information or data provided to the Insurer for the purposes of calculating the premium rates is in any material respect incorrect, including but not limited to previous claims experience and Member information, which shall include the age, sex and occupation of the Member.

4.5.3. After the expiry of the period referred to in clause 4.5.1 above, the Insurer shall have the right to alter the premium rates and Benefits at any time during any Policy year upon one month's prior written notice to the Policyholder.

4.6. Currency and law

4.6.1. All amounts payable in terms of this Policy, either to or by the Insurer, are payable in the lawful currency of the Republic of South Africa at the registered office of the Insurer. Any question of law arising under this Policy shall be decided according to the laws of the Republic of South Africa.

4.7. Address and communications

4.7.1. The Insurer and the Policyholder will choose a physical address for all official written correspondence related to this Policy. Their chosen addresses are set out in the Schedule.

4.7.2. Either party may change its address by giving written notice of the new physical address to the other party. Until receipt of such amended address, the last notified address shall remain in force and of effect.

4.7.3. All communications in connection with this Policy shall be in writing.

4.8. Decisions not a precedent

4.8.1. No waiver of rights or latitude or indulgence granted by the Insurer in any instance shall create a precedent or be construed as a novation of this Policy.

4.9. Disputes

4.9.1. Should a dispute arise out of the interpretation or implementation of this Policy, such dispute shall be referred to the Ombudsman for long-term insurance for resolution.

4.9.2. Nothing in this Policy shall prevent any party to this agreement from applying for urgent or interdictory relief.

4.10. Fraud and dishonesty

4.10.1. The Insurer will not be liable for any claim if the Policyholder, Member or Employer commit any act of dishonesty or fraud in relation to this Policy.

4.10.2. The Insurer can investigate any circumstances where it suspects dishonest or fraudulent behaviour. Such investigation may include, but will not be limited to, the use of photographs, video and other recordings or documents that may be used as evidence for the purposes of the investigation, subject to the rules governing the law of evidence.