TRUSTCO life
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UNDERWRITTEN BY TRUSTCO LIFE LIMITED

Policy Contract

NEXT GENERATION Single

ADDITIONAL BENEFITS: DREAD DISEASE, HOSPITALISATION, INCOME PROTECTOR AND FUNERAL

This policy is not a stand alone insurance policy but is linked to your Legal Shield policy. The additional benefits that you have chosen under this policy are underwritten by Trustco Life Ltd and governed by the Long Term Insurance Act, Act 5 of 1998 as amended.

1. DEFINITIONS

1.2. "Effective date" shall mean the first day of the month following receipt of the first premium in the books of the Insurer.
1.3. "Main Member" shall mean the applicant in whose name the policy was issued.
1.4. "Namibia" shall mean the Republic of Namibia.
1.5. "Policy" shall mean this Policy document as amended from time to time by the Insurer including the schedule and the application form thereto.
1.6. "The Insurer" shall mean Trustco Life Ltd.
1.7. "The Insured" shall mean the person in whose name this policy is effected while he/she is normally resident in Namibia.
1.8. The Insured, in respect of clauses 2, 3 and 4 shall only enjoy cover under these clauses in the event that the Insured is under the age of 55 on joining.
1.9. The Insured, in respect of clause 5, shall only enjoy cover under this clause in the event that the Insured is under the age of 70 on joining.
1.10. "The Labour Act" shall mean the Labour Act, Act 11 of 2007, as amended or substituted from time to time
1.11. "Beneficiary"shall mean the person nominated by the Insured in writing as his/her beneficiary to receive the payment of the funeral benefit in terms of the Policy and whose particulars appear in the records of the Insurer.

2. DREAD DISEASE COVER (If applicable)

2.1. Definitions

"Serious Illness" means any of the following:

a) Heart Attack: The death of a portion of the heart muscle due to inadequate blood supply to the relevant area. The diagnosis must establish the existence of all of the following criteria:
   i) a history of typical chest pain,
   ii) new ECG changes,
   ii) elevation of cardiac enzymes,
   iii) sonographic or angiographic evidence of LV dysfunction with an ejection fraction less than 30%,
   iv) clinical signs of CCF that need multi drug medical treatment. This excludes angioplasty and/or any similar intra-arterial procedures.
b) Stroke: Any cerebrovascular occurrence or accident which produces neurological sequelae lasting more than 24 successive hours and including infarction of brain tissue, haemorhage, and embolisation from an extracranial source. Evidence of permanent neurological deficit must be produced.
c) Cancer: A disease manifested by the presence of malignant tumor characterized by the uncontrolled growth and spread of malignant cells, and the invasion of normal surrounding tissue. All cancers diagnosed and treated by primary biopsy only, that do not require any further surgical, medical (chemotherapy, etc) or radio therapy, or other modalities are excluded. The term "cancer" also includes Leukemia and Hodgkin's disease but excludes:
   i) All skin cancers;
   ii) Cancer-in-situ, including melanoma-in-situ;
   iii) Cancer must be diagnosed by conventional histological means and diagnosis must be confirmed through immuno-histochemical methods through a pathologist approved by the Insurer. Cytological diagnosis is excluded.
d) Kidney Failure: End stage renal failure presenting as chronic irreversible failure of kidneys to function, as a result of which regular renal dialysis must be instituted on a weekly basis for more than one month.
   Peritoneal dialysis and dialysis for acute renal failure excluded.
e) Organ Transplant: The human-to-human organ transplant from a donor to the Insured of one or more of the following organs. Kidney, Heart, Lung, Liver, Pancreas. The transplantation of all or other organs, parts of organs or any other tissue transplant is excluded.
f) Paraplegia: The total and irreversible loss of the use of both legs or both arms.
g) Blindness: The total and irreversible loss of vision in both eyes.
h) Amyotrophic lateral sclerosis or Motor Neuron Disease: is a serious neurological disease of the motor tracts of the lateral columns and anterior horns of the spinal chord causing progressive muscular atrophy, increased reflexes, fibrillary twitching and spastic irritability of muscles.

"Diagnosis" means: Diagnosis by two registered medical specialists supported by clinical, radiological, histological and laboratory evidence, acceptable to the insurer.

2.2. INDEMNITY TO THE INSURED

In the event that the Insured is diagnosed during the currency of this Policy as suffering from a Serious Illness as defined herein, the Insurer shall pay to the Insured the sum of money stated in the Schedule to this policy, provided however that such Serious Illness or any symptom or symptoms associated with the Serious Illness did not manifest itself directly or indirectly prior to the Effective Date of this policy. The Insurer shall be obliged to compensate only once per Serious illness per Policy.

2.3. EXCLUSIONS: DREAD DISEASE

The Insurer shall not be liable to pay compensation as envisaged in clause 2.2 for diagnosis of an Illness in respect of any Insured:

2.3.1. As a result of the influence of alcohol or drugs or narcotics upon an Insured unless prescribed by and taken in accordance with the directions of a member of the medical profession (other than the Insured).
2.3.2. Where the medical/clinical state of the Insured is attributable to or caused by the Human Immunodeficiency Virus (HIV related Illness) or Acquired Immunity Destruction Syndrome (AIDS) including derivatives or variations thereof howsoever caused and Tuberculosis or Pulmonary Pneumonia.
2.3.3. The onus of proof shall be upon the Insured to show that any exemption is not applicable.
2.3.4. Where the Insured does not survive for more than thirty days after the diagnosis.
2.3.5. When the Insured does not persist with the monthly payments while a claim is being processed.

3. HOSPITAL BENEFIT (If applicable)

3.1. INDEMNITY TO THE INSURED

3.1.1. The Insurer will, subject to the terms and conditions contained in this policy, pay to the Insured the benefits stated in the schedule to this policy if the insured is hospitalized for an uninterrupted period of seven days or more as a result of illness or an accident.
3.1.2. The benefit shall be payable for the entire period of hospitalization subject to Clause 3.1.4
3.1.3. The benefit will be payable if the Insured is hospitalized in a registered hospital in Namibia or the Republic of South Africa.
3.1.4. The Insurer's liability to pay the benefit shall be limited to a maximum of sixty (60) days hospitalization in every cycle of five (5) years calculated from the effective date. In the event that an Insured is hospitalized prior to the completion of the five (5) year cycle, the benefits shall be calculated on a pro-rata basis.
3.1.5. The Insurer shall only be obliged to pay the benefit in the event that a registered medical practitioner certifies in writing that the hospitalization of the Insured was a necessary consequence of the illness or accident.

3.2. EXCLUSIONS: HOSPITALISATION

The Insurer shall not be liable to pay compensation as envisaged in clause 3.1 if the hospitalization is caused by:

3.2.1. Obesity or any related illness.
3.2.2. Cosmetic surgery, fertility, impotence and frigidity related claims.
3.2.3. Any illness existing prior to the effective date.
3.2.4. Diseases related to drug or alcohol abuse.
3.2.5. Sexually transmitted diseases and HIV/AIDS including derivatives and variations thereof howsoever caused
3.2.6. Mental, psychological and psychiatric disorders.
3.2.7. Influenza.
3.2.8. Chronic fatigue syndrome/myalgia
3.2.9. Diseases related to stress syndromes.
3.2.10. Maternity related illness or condition.
3.2.11. Self inflicted injuries

3.3. WAITING PERIOD

3.3.1. There shall be a waiting period of six months from the Effective Date in respect of claims under the hospital benefit.

4. INCOME PROTECTION (If applicable)

4.1. INDEMNITY TO THE INSURED

In consideration of the Insured having paid the agreed premium as reflected in the Schedule of Insurance and subject to the terms, conditions and exclusions herein, the Insurer undertakes to pay to the Insured the amount reflected in the Schedule of Insurance, or any portion thereof, in the event that the Insured suffers a loss of income due to sickness for an uninterrupted period of at least thirty (30) days and provided that such payment:

(i) in the case of an Insured who is employed and receives a salary or wage, shall not exceed the Gross remuneration which would have been paid to the Insured as remuneration by his employer; or
(ii) in the case of the self-employed Insured, shall not exceed the gross amount being withdrawn by the Insured as remuneration from his/her business, farming or profession as reflected on the latest personal income tax return of the Insured.

4.2. SICKNESS DEFINED

For purposes of this policy "sickness" shall mean any somatic illness or ailment which a registered medical practitioner certifies, and confirmed in writing by the appointed medical practitioner of the Insurer, which is of such a nature that the Insured is not able to perform the work he is required to perform in terms of his conditions of employment or which is of such a nature that a self-employed person is not able to manage his business, farming or profession for the period so determined by the said medical practitioners, or that the Insured required to be hospitalized in respect of hospital benefit claims.

4.3. SICK LEAVE AND OTHER BENEFITS

No payment shall be made:

4.3.1. while the Insured who is employed and receives a salary or wage, entitled to sick leave; or
4.3.2. in the case of a self-employed Insured, a period of at least thirty (30) days have lapsed from the date on which the illness causing the incapacity was diagnosed.
4.3.3. The amount payable by the Insurer shall be reduced by the amount payable to the Insured in terms of any other statutory provision
4.3.4. Each period of 30 days or portion thereof shall constitute a new claim and shall be dealt with in provisions of this clause.

4.4. LIMITATIONS AND EXCEPTIONS

The Insurer shall not be obliged to make any payment in terms of this Policy if any sickness is caused by:

4.4.1. Obesity or any related illness.
4.4.2. Cosmetic surgery, fertility, impotence and frigidity related claims.
4.4.3. Any illness existing prior to the effective date.
4.4.4. Diseases related to drug or alcohol abuse.
4.4.5. Sexually transmitted diseases and HIV / AIDS including derivatives and variations thereof howsoever caused
4.4.6. Mental, psychological and psychiatric disorders.
4.4.7. Influenza.
4.4.8. Chronic fatigue syndrome/myalgia
4.4.9. Diseases related to stress syndromes.
4.4.10. Maternity related illness or condition.
4.4.11. For the first six months from the effective date of the policy the Insurer shall only be obliged to make payment where the illness is a result of an accident of any kind.
4.4.12. There shall be an 18 month waiting period for sexually transmitted diseases and HIV/Aids in the event that the Insured has chosen the HIV inclusive option for the income protector.

4.5. LIMIT OF INDEMNITY

4.5.1. The Insured shall be obliged to make payment to a limit of six (6) months for the first completed cycle of 36 months calculated from the Effective Date.
4.5.2. Provided that a period of 36 months have elapsed calculated from the Effective Date or a total of 36 premiums were received in the books of the Insurer whichever is the latest the obligation of the Insurer shall be extended to a limit of 12 months.

4.6. CESSATION OF INCOME PROTECTOR BENEFIT

This Income Protector Benefit shall cease in the event that the Insured becomes unemployed or retires from business, farming or profession for a period of at least two (2) months because:

4.6.1. The Insured is dismissed by his Employer in terms of Section 33 of the Labour Act.
4.6.2. His employment is terminated in accordance with the provisions of Section 30 of the Labour Act.
4.6.3. The Insured is retrenched in terms of Section 34 of the Labour Act.
4.6.4. The Insured attains the age of 65 years or retires from employment.
4.6.5. The contract of employment terminates due to any of the events mentioned in Section 32 of the Labour Act.

4.6.6. Employment is terminated for any other reason whatsoever.
4.6.7. Business, farming or profession is terminated, alienated or disposed of.
4.6.8. The Insured shall be deemed unemployed irrespective of whether his termination or dismissal is disputed by the Insured and irrespective of whether proceedings were instituted by the Insured for his reinstatement.
4.6.9. A business, farming or profession shall be deemed to have been terminated, alienated or disposed of irrespective whether the termination, alienation or disposal are disputed by a third party and irrespective of whether legal proceedings were instituted by or against the Insured.

4.7. INSURED TO NOTIFY

The Insured shall forthwith notify the Insurer in writing if any of the events mentioned in clause 4.6 occurs:

4.7.1. The Insured shall notify the Insurer in writing if the Insured takes up employment, business, farming or a profession different from that held by the Insured on the Effective Date in which event the Insurer shall be entitled to re assess the risk underwritten and to adjust the premium payable in accordance with the terms and conditions this Policy.
4.7.2. The Insured shall advise the Insurer in writing of all or any salary increases. A self-employed insured shall advise the amount of all or any increase in remuneration withdrawn from the business, farming or profession.
4.7.3. Failure to comply with the provisions may mean that the amount reflected in the schedule shall not be adjusted by the Insurer

5. FUNERAL BENEFIT (if applicable)

5.1. THE INDEMNITY OF THE INSURED

5.1.1. In consideration of the Insured having paid the agreed premium to the Insurer and subject to the terms, conditions and exclusions herein, the Insurer hereby undertakes to pay upon the death of the Insured,
to the Beneficiary or the estate of the Insured the funeral benefit of the Insured.
5.1.2. A member has the option to add a parent(s) or parent(s)-in-law to the policy to be covered under the terms and condition of this policy for an additional fee per parent or parent-in-law who is under the age of 85 at the time he/she is added.

5.2. INDEMNITY TO THE INSURER

Neither the Insurer nor any employee, agent or Consultant shall be liable for any damage caused by any act, advice, negligence or otherwise.

5.3. INSURED MATTER

5.3.1. Upon the death of the Insured in whose name the policy is effected, the Insurer shall pay the amount indicated in the schedule of insurance to the nominated Beneficiary or the estate of the Insured as the case may be.
5.3.2. In the event of the Beneficiary having pre-deceased the Insured, the benefit shall be paid to the estate of the Insured in whose name the policy is effected.

5.4. EXCLUSIONS AND WAITING PERIODS

5.4.1. The Insurer shall only be liable to compensate during the first twelve (12) months calculated from the Effective Date in the event that the cause of death can be deemed to be an accidental death.
5.4.2. Notwithstanding the above, the Insurer shall not be liable to compensate when the death was caused by suicide in the event that such suicide is committed within a period of 24 months calculated from the Effective Date.
5.4.3. The onus of proof shall be upon the Beneficiary or the executor of the estate to show that any of the exceptions above were not present or did not contribute to the cause of death.
5.4.4. Claims for the funeral benefit will be paid within 72 hours of successful assessment by the Insurer.

6. PREMIUMS, SCHEDULE OF INSURANCE, PAYMENT

6.1. The following shall be reflected in the Schedule of Insurance:
6.1.1. the monthly premium;
6.1.2. cover amount

7. COMMENCEMENT, DURATION OF INSURANCE AND PAYMENT OF PREMIUMS

7.1. Subject to clause 7.2, the Insurance shall commence on the Effective Date, and, provided that the Insured continues to pay the monthly premium, shall be effective until cancelled by the Insurer or the Insured in writing; in which event cover shall cease at 24h00 on the last day of the month for which premiums have been paid.
7.2. Premiums are payable monthly in advance before the first (1st) day of the month for which cover is required. The onus is on the Insured to ensure that the premiums are duly paid timeously. In the event that the premiums are payable by debit order, the Insurer shall have the right to resubmit the debit order in the event that the debit order is returned unpaid. In the event that the preferred date of the month indicated on the application form is a Sunday or Public Holiday, the debit order may be submitted on an earlier date.
7.3. If arrear premiums are received in the books of the Insurer, the Insurer shall have the right to indemnify the Insured or to regard the Policy as having been cancelled and to refund the arrear premiums received.
7.4. The parties may cancel the Policy at any time upon one month's written notice in which case the provisions of clause 7.1 will be applicable.
7.5. Subject to clause 13 if this policy is cancelled at any time for any reason the Insured shall not be entitled to a refund of premiums paid.
7.6. No person or company is authorized to receive premiums from an Insured except on written authority from the Insurer to do so.
7.7. The Insurer shall have the right to increase the monthly premium from time to time. Such increase shall be decided by the Insurance Investee Executive Committee taking into consideration the inflation rate, economic conditions and sustainability.
7.8. The Insurer reserves the right to cancel the Policy if, in the opinion of the Insurer, the Insured is an insurable risk, in which case the provisions of clauses 7.1 and 7.5 will be applicable.

8. CLAIMS PROCEDURE

8.1. Within 60 days after the occurrence of an event, which may give rise to a Dread Disease, Hopitalisation or Income Protector claim in terms of this policy, the Insured shall advise the Insurer in writing on the prescribed claim form.
8.2. Within 90 days after the death of the Insured, the Beneficiary shall submit a claim in writing on the prescribed claim form together with a proper death certificate indicating the cause of death, a medical report (obtainable at any Trustco office) completed and signed by a medical practitioner and any other information reasonable necessary for the assessment of the claim.
8.3. The Insurer will not be liable to indemnify unless:
8.3.1. The Insurer has issued written confirmation of cover subsequent to a claim being received and,
8.3.2. The Insured continues to pay the monthly premium while the claim is
in progress.

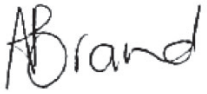
9. DOCUMENTS TO BE SUBMITTED TO THE INSURER

9.1. The Insured shall be obliged to furnish to the Insurer such documents as may be requested, at no cost to the Insurer.
9.2. The Insured hereby grants Power of Attorney to the Insurer to obtain from any Public Authority or third party any document or information pertaining to a claim.

10. WHOLE AGREEMENT

10.1. The application for insurance shall be the basis of and forms part of this Policy.
10.2. The Policy and amendments thereto, the Application and the Schedule of Insurance shall constitute the sole agreement between the parties.
10.3. No contrary representation or agreement to vary the Policy shall be of any force or effect unless reduced to writing and signed by someone specifically authorized thereto in writing by the Insurer.

Signed on behalf of Trustco Life Ltd



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Annette Brand
CEO: Trustco Life Ltd.

11. REPUDIATION OF CLAIMS, CONFLICT AND DISPUTE

11.1. In the event of a repudiation by the Insurer of a claim, or portion of a claim, the Insured must submit a written request for reassessment within thirty (30) days of being notified of the repudiation.
11.2 The repudiated claim and the request for reassessment will be considered by the Reassessment Committee of the Insurer.
11.3 In the event of the Insured not agreeing with the decision of the Reassessment Committee, the Insured shall notify the Insurer within thirty (30) days of being notified of the decision.
11.4 Within ninety (90) days of being notified of the decision of the Reassessment Committee, the Insured shall institute legal action against the Insurer by way of having summons served on the Insurer. Should this not be done, the Insured's claim against the Insurer prescribes.

12. NAWA BONUS

12.1. A Nawa Bonus is payable in the event that the policy holder has kept all monthly premiums up to date during the said period and that the Policy is not otherwise in arrears. The Nawa Bonus shall be an amount as reflected in the Schedule.
12.2. There shall be a six month waiting period from the payment of the first premium as reflected in the books of the Insurer or the receipt of an arrear premium before a Nawa Bonus can be claimed.
12.3. A thirty (30) day notice must be given of the Insured's intention to claim the Nawa Bonus.
12.4. Payment of the Nawa Bonus shall be in terms of the applicable policy and procedures of the Insurer.

13. COOLING – OFF PERIOD

In the event that the Insured cancels his/her policy within two months of the application for cover by the Insured and provided that the Insured did not prior to such cancellation submit any claim in terms of the policy, the Insurer shall refund all premiums received from the Insured.

14. REACTIVATION

In the event that a similar additional benefit in the name of the main member had previously been cancelled for any reason, an administrative fee equal to one (1) monthly premium shall be become payable as a first charge on the new policy.

15. DISCLOSURE OF RISK

The Insured acknowledges that he is obliged to disclose to the Insurer any fact or circumstance which may arise while this policy is valid and which may affect the risk Insured. Failure to do so may result in the repudiation of any claim submitted.

16. COMMUNICATION

The Insurer is entitled to address any written communication with the Insured in the manner it deems most expedient by way of either mail, facsimile, smart fax, short message service or electronic mail. For purposes of communicating any amendment of the terms and conditions of this policy, the Insured expressly consents to the Insurer notifying the Insured of any such amendment by means of short message service to the mobile telephone number nominated by the Insured from time to time or as reflected in the Insurer's records. Any communication by the Insurer to the Insured by means of short message service to the mobile telephone number nominated by the Insured from time to time or as reflected in the Insurer's records shall be deemed as having been received by the Insured. For this purpose, the Insured acknowledges that it is the Insured's sole and exclusive duty to notify the Insurer of any change of the Insured's contact details.