TRUSTCO life | Plus
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UNDERWRITTEN BY TRUSTCO LIFE LIMITED

# Policy Contract

**1. DEFINITIONS**

1.1. "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.
1.2. "Consultant" shall mean an employee of Trustco Life Limited.
1.3. "Effective Date" shall mean the day on which the first premium has been received in the books of the Insurer.
1.4. "The Insured" shall mean a person, ordinarily a resident in Namibia who has applied for cover while between the ages of 15 and 65 years, in respect of whom cover has been extended and in whose name the policy is effected.
1.5. "The Insurer" shall mean Trustco Life Ltd.
1.6. "Namibia" shall mean the Republic of Namibia.
1.7. "Policy" shall mean this Policy document which may be amended from time to time by the Insurer including the application form and schedule hereto.
1.8. "Inflation Rate" shall mean the rate of inflation as determined by the insurer from time to time.

**2. THE INDEMNITY OF THE INSURED**

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, the Insured being diagnosed with a dread disease or being occupationally disabled, as the case may be, to the insured, beneficiary or the estate of the Insured the benefit as per the policy schedule.

**3. 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.

**4. INSURED MATTER**

4.1. Upon the death of an Insured in whose name the policy is effected, the Insurer shall pay the amount indicated in the schedule of insurance, as calculated in accordance with the lifestyle indicators in the said schedule, subject to 4.3 to 4.8 to the nominated beneficiary or the estate of the Insured as the case may be.
4.2. In the event that the Insured is of the opinion that his/her lifestyle indicators have improved, the Insured must provide written proof thereof to the Insurer within 30 days of obtaining such proof in order that the Insurer can adjust the cover extended to the Insured in accordance with the improved lifestyle indicators.

**EXCLUSIONS AND WAITING PERIODS**

4.3. Provided that when the death of the Insured occurs within thirty six (36) months of the Effective Date and the death is as a result of HIV/AIDS or any HIV/AIDS related diseases, the Insurer shall only be obliged to pay the following benefits, subject to 4.4, to the beneficiary:
4.3.1. When the death occurred within six (6) months after the effective date of the policy - no benefit payable.
4.3.2. When the death occurred within six (6) to twelve (12) after the effective date of the policy - 10% of the amount indicated in the schedule of insurance, as calculated in accordance with the life style indicators in the said schedule.
4.3.3. When the death occurred twelve (12) to eighteen (18) months after the effective date of the policy - 20% of the amount indicated in the schedule of insurance, as calculated in accordance with the life style indicators in the said schedule.
4.3.4. When the death occurred eighteen (18) to twenty four (24) after the effective date of the policy - 40% of the amount indicated in the schedule of insurance, as calculated in accordance with the life style indicators in the said schedule.
4.3.5. When the death occurred twenty four (24) to thirty (30) months after the effective date of the policy - 60% of the amount indicated in the schedule of insurance, as calculated in accordance with the life style indicators in the said schedule.
4.3.6. When the death occurred (30) to thirty six (36) months after the effective date of the policy - 60% of the amount indicated in the schedule of insurance, as calculated in accordance with the life style indicators in the said schedule.
4.3.7 When the death occurred (30) to thirty six (36) months after the Effective Date of the policy, the full amount indicated in the schedule of insurance, as calculated in accordance with the life style indicators in the said schedule.
4.4. HIV/AIDS or HIV/AIDS related deaths will be excluded unless proof can be submitted to the insurer of:
4.4.1. Blood test results confirming a viral load count of less than 1000 copies/ml at any time during the 6 (six) month period preceding the death of the Insured. OR
4.4.2. Blood test results confirming a CD-4 count of not less than 300 cells/mm3 during the 6 (six) month period preceding the death of the Insured. AND
4.4.3. Regular use of Anti-retroviral treatment by the Insured as prescribed by a medical practitioner for the twelve (12) month period preceding the death of the Insured.
4.5. The Insurer shall not be liable indemnify the Insured in the event that the illness causing the death of the Insured or any of its symptoms manifested itself prior to the Effective Date.
4.6. The maximum cover extended under this policy for HIV cover is N$600,000.
4.7. 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.
4.8. The Insurer shall not be liable to indemnify the insured in the event that the death of the Insured is as a result of his/her participation
in a dangerous sport or activity, which is an activity or sport in which there exists an inherent risk or possibility of serious injury or death.
4.9. The onus of proof shall be upon the Beneficiary or the executor of the estate to show that an of the exceptions above were not present or did not contribute to the cause of death.

**5. PREMIUMS, SCHEDULE OF INSURANCE, PAYMENT**

5.1 The following shall be reflected in the Schedule of Insurance:
i) The monthly premium.
ii) The minimum limit of indemnity from time to time.
iii) The lifestyle indicators used to calculate the benefit.
5.2. Liability is limited to cover in accordance with the schedule of insurance.

**6. COMMENCEMENT, DURATION OF INSURANCE AND PAYMENT OF PREMIUMS**

6.1. The insurance shall commence only after the insurer has notified the insured in writing of acceptance of the application and upon receipt of the first premium by the Insurer. The insurance shall be effective, subject to 6.6, until the death of the Insured or canceled by the Insurer or the Insured in writing; in which event cover shall cease at 00h00 on the last day of the month for which premiums have been paid.
6.2. 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.
6.3. Subject to clause 19, if this policy is canceled at any time for any reason, the Insured shall not be entitled to a refund of premiums paid.
6.4. No person or company is authorised to receive premiums from the Insured except on written authority from the Insurer to do so.
6.5. The parties may cancel the policy at any time upon one month's written notice in which case
the provisions of clause 6.1 and 6.3 will be applicable.
6.6. In the event of non-payment of premiums by the Insured, the policy shall be lapsed in accordance with the Long Term Insurance Act No 5 of 1998.

**7. OCCUPATIONAL DISABILITY (If Applicable)**

7.1. Occupational disability is being permanently unable, due to injury or illness, to perform the functions of any occupation that the Insured could reasonably be expected to follow taking into account the Insured's level of education, experience and employment history.
7.2. In the event that the Insured is permanently occupationally disabled, the Insurer shall pay the full benefit contained in the Policy Schedule subject to the terms and conditions of this policy.

**8. EXCLUSIONS FOR OCCUPATIONAL DISABILITY**

8.1. The Insured is over the age of 65
8.2. The occupational disability is self-inflicted
8.3. The occupational disability is as a result of a mental disorder (including psychological and psychiatric condition)
8.4. Stress related conditions
8.5. The occupational disability is as a result of alcohol or drug abuse
8.6. The occupational disability is HIV related
8.7. The Insured does not survive for a period of thirty days (30) from occurrence
8.8. The insured fails and/or refuses to follow reasonable medical advice or to undergo reasonable medical treatment to improve his/her condition
8.9. The occupational disability is as a result of participation in a dangerous activity or sport, which is an activity or sport in which there exists an inherent risk or possibility of serious injury or death.
8.10. The illness and/or injury, or the symptoms thereof, causing the Occupational Disability manifests itself, directly or indirectly, prior to the Effective Date.

**9. DREAD DISEASE COVER (If Applicable)**

9.1.1. 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 benefit contained in clause 9.1.2
9.1.2 Only one successful claim per Serious Illness will be entertained for the duration of the policy. Each Serious Illness is indemnified for 12.5% of the total Dread Disease cover reflected in the Schedule. 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.
9.2. "Serious Illness" means any of the following:
a) Heart Attack: The death of a portion of the hear 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;
iii) Elevation of cardiac enzymes;
iv) Sonographic or angiographic evidence of LV dysfunction with an ejection fraction less than 30%
v) Clinical signs of CF 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, haemorrhage, and embolisation from an extra cranial source. Evidence of permanent neurological deficit must be produced.
c) Cancer: A disease manifested by the presence of malignant tumour characterised 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 by a pathologist. 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 and 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 cord causing progressive muscular atrophy, increased reflexes, fibrillary twitching and spastic irritability of muscles.

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

**9.3. EXCLUSIONS**

The Insurer shall not be liable to pay compensation as envisaged in clause 9.1.1 and 9.1.2 for dlagnosls of a Serous Illness In respect of any Insured:

9.3.1. Where the serious illness is as a result of the influence of alcohol or drugs or narcotics unless prescribed by and taken in accordance with the directions of a member of the medical profession (other than the Insured).

9.3.2. Where the medical/clinical state of the Insured is attributed 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. The onus of the proof shall be upon the insured to show that any exemption is not applicable.

9.3.3. Where the Insured does not survive for more than thirty (30) days after the diagnosis.

**10. NO CLAIM BONUS**
**(If Applicable)**

10.1. In the event that the insured chooses this option and does not submit a claim for a period of 15 years from the Effective Date of the policy, all premiums received by the Insurer will be paid back to the Insured subject to clauses 10.2 to10.4.

10.2. The Insured will only receive a premium back bonus in the event that all premiums are paid timeously and the policy is fully paid up for a period of fifteen (15) years.

10.3. The premium back bonus is not assignable or transferable. Payment of the premium back bonus shall only be made to the Insured.

10.4. The projected premium back bonus contained in the Policy Schedule is a projection and the premium back bonus shall be calculated on completion of the 15 year period on the actual premiums received by the Insurer.

**11. CLAIMS PROCEDURE**

11.1. Within ninety (90) days after the event, the Insured, a beneficiary or Executor of the estate of the Insured, as the case may be, shall claim the benefit in writing on the prescribed claim form.

11.2. The Insurer will not be liable to indemnify unless:

a) A proper death certificate indicating the cause of death of the Insured has been submitted; and/or

b) A medical report (obtainable at any Trustco office) completed and signed by the attending medical practitioner.

c) Any other information reasonably necessary for assessment of the claim and requested by the Insurer has been submitted.

**12. DOCUMENTS TO BE SUBMITTED TO THE INSURER**

12.1. The beneficiary or executor of the estate shall be obliged to furnish to the Insurer all such documents as may be requested to assess a claim.

12.2. All documentation requested by the Insurer is to be provided at no cost to the Insurer.

12.3. The Insured hereby grants Power of Attorney to the Insurer to obtain from any coroner, medical practitioner, public authority, third party or other institution any documentation or information pertaining to the claim.

**13. WHOLE AGREEMENT**

13.1. The Application for Insurance shall be the basis of and form part of this Policy.

13.2. The Policy and amendments thereto, the Application and the Schedule of Insurance shall constitute the sole agreement between the parties.

13.3. No contrary representation or agreement to amend 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.

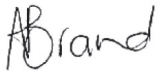
**14. REPUDIATION OF CLAIMS, CONFLICT AND DISPUTE**

14.1. 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.

14.2. The repudiated claim and the request for reassessment will be considered by the Reassessment Committee of the Insurer.

14.3. 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.

**Signed on behalf of Trustco Life Ltd**



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**Annette Brand**
CEO: Trustco Life Ltd.

14.4. 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.

**15. PREMIUM INCREASE**

Various premium increase options are available depending on the option chosen by the Insured. The following options are available and the Insured's chosen option is indicated in the Schedule of Insurance:

15.1. No premium increase shall be applied for the duration of the policy and the life cover shall remain constant and not increase;

15.2. The premium shall increase annually by the applicable inflation rate and the life cover shall remain constant and not increase:

15.3. The premium shall increase annually by the applicable inflation rate and the life cover shall increase;

15.4. The Insurer may from time to time amend the administrative fee payable monthly on the policy.

**16. REACTIVATION**

In the even that a Trustco4Life Plus policy in the name of the policy holder was cancelled for any reason, an administrative fee equal to one (1) monthly premium shall become payable as a first charge.

**17. DISCLOSURE OF RISK**

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) months premium shall be become payable as a first charge on the new policy.

**18. 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.

**19. COOLING-OFF PERIOD**

In the event that the Insured cancels his/her policy within two months of application for cover by the Insured, the Insurer shall refund all premiums received from the Insured less the cost of any risk cover enjoyed by the Insured, including the cost of any medical testing of the Insured paid by the Insurer.