POLICY WORDING – TERMS AND CONDITIONS

This document sets out the terms and conditions, which govern our relationship and must be read as one document together with the policy schedule and any other disclosed documentation. This policy, however, shall not be invalidated on account of any incorrect statement made in good faith, unless the incorrectness of such statement is of such a nature as to be likely to have materially affected the assessment of the risk under the policy at the time the policy was issued. Please contact our Customer Care department should you require any information on any aspect of your plan, by calling 0860 765 223 or emailing info@solacebenefits.co.za.

If, at any time, you feel that your personal information has been processed by us without your consent or that your rights in terms of the POPI Act have been violated in any way, you may send a complaint through to our Information Officer at the following email address popi@solacebenefits.co.za, or you may submit your complaint directly to the Information Regulator.

1. DEFINITIONS

In this policy, the following words and expressions have the following meanings:

1.1. **Accident:** A sudden, unexpected, unforeseen, unintended injury caused solely and directly by a chance and uncertain event and by violent, external and visible means independently of any other cause, excluding suicide or attempted suicide, the result of which incident requires immediate medical attention.

1.2. **Admission**: A prolonged stay (overnight as an in-patient for more than 48 (forty-eight) consecutive hours) in a facility that meets the definition of a hospital; this does not include casualty wards.

1.3. **Child/Children:** Your biological, legally adopted, or step-child/children who are over the age of 6 (six) months and below the age of 18 (eighteen) years. You can register up to 5 (five) unmarried children to be covered under your Plan. Certified proof of birth, or adoption will be required before a claim is accepted.

1.4. **Congenital**: A condition existing at birth and often before birth or that develops during the first month of life.

1.5. **Contact Sport**: A high-risk sport, such as (but not limited to) football, soccer, hockey, rugby or boxing that involves physical contact between players as part of the normal play.

1.6. **Disability**: A life assured who has sustained an injury whereby they cannot perform ordinary tasks or occupations with the same ability as a person without such disadvantage or impairment.

1.7. **Grace Period:** The interval allowed for the payment of an outstanding premium. The grace period is 20 (twenty) days from the date you receive written notice of non-receipt of premium. In the event of a claim during the grace period, the outstanding premium may be deducted from the amount payable to you.

1.8. **Hospital**: An institution for health care which provides patient treatment by specialised staff and equipment, for sick or injured persons where they are given surgical or medical treatment and providing for longer-term patient stays. This excludes places of recovery and or rehabilitation, drug or mental institutions or upgrades to private wards.

1.9. **Illness**: Any unforeseen sickness, disease originating, contracted, commencing or first manifesting itself during the period of insurance. Should the illness reoccur within a 6 (six) month period, it will be deemed to be part of the initial illness and associated claim.

1.10. **Injury**: A visible, physical injury, cut, abrasion, bruise, burn or disfigurement, bodily harm, sickness or disease caused to a person by an unforeseen accident.

1.11. **Insurer**: Centriq Life Insurance Company Limited, a licenced life insurer and an authorised Financial Services Provider (FSP No. 7370.)

1.12. **Intermediary**: Legal and Tax Services (Pty) Ltd is authorised by the Insurer to market and administer your plan as the non-mandated intermediary. (Financial Services Provider No. 28566) "We" or "Us" may be used interchangeably.

1.13. **Life/Lives Assured:** This is any life listed on the policy schedule as being covered by the plan, and which satisfies the definitions of a policyholder, spouse and child.

1.14. **Natural Causes or Illness**: Any unforeseen sickness, illness or disease originating, contracted, commencing or first manifesting itself during the period of insurance. Should the illness reoccur within a 6 (six) month period, it will be deemed to be part of the initial illness and associated claim.

1.14 **Plan:** The healthcare insurance cover as well as any value-added services included in your product, which is either the Individual or Family plan as set out in your policy schedule.

1.15 **Policy**: This policy document, read together with the schedule, is your policy, which governs all aspects of our relationship.

1.16 **Policyholder:** The person reflected as the policyholder in the schedule. A legal entity cannot be the policyholder. The policyholder must be a South African permanent resident or be in possession of a valid work or other permit, which allows the policyholder to remain in South Africa on a long-term basis as required by the Immigration Act. "You" or "Your" may be used with the same meaning.

1.17 **Premium:** The amount you are required to pay monthly in order to enjoy the benefits of the plan. The premium is set out in the policy schedule.

1.18 **Pre-existing Condition**: A medical condition that was in existence prior to this policy's inception date, or in existence during the first 3 (three) months during the waiting period or that was newly diagnosed within the first 3 (three) months from the inception date of the policy, whether it was known or unknown.

1.19 **Professional Sport**: A life assured's participation in a sporting activity, from which most of the lives assured's income is earned.

1.20 **Policy Schedule**: The schedule to which this policy is attached. In addition to other important information, the schedule contains the name of the policyholder, the healthcare prestige cash benefit, and the amount of the premium.

1.21 **Spouse:** A partner in marriage, legally recognised civil union or customary marriage concluded in accordance with the applicable South African laws, religion or tradition, which may be subject to registration at the Department of Home Affairs, or a life partner (someone whom you reside with for 6 (six) months or more) and as nominated in writing by the policyholder. There may be only one spouse insured under this plan at any point in time. Certified written proof of such relationships will be required.

1.22 **Specialist**: A doctor who has completed advanced education and clinical training in a specific field of medicine, for example a physician such as, but not limited to a neurologist, pulmonologist or surgeon including, but not limited to a general surgeon or orthopaedic surgeon.

1.23 **Symptom**: Any sensation or change in bodily function experienced by an individual that could be associated with a disease and is regarded as evidence of existence of a disease, injury or illness. This includes, but is not limited to, pain, nausea, recurrent infections or weakness.

1.24 **Value-Added Services (VAS):** These are services and benefits that form part of your plan over and above the insurance cover provided by the Insurer. Any value-added service that forms part of this plan will be indicated next to the relevant heading by using the following format: **[VAS]**

1.25 **Waiting period:** The period during which no claim will be paid (see Clause 8).

Unless the context requires otherwise, an expression in one gender includes the other gender, and the singular includes the plural, and *vice versa.*

2. YOUR HEALTHCARE PRESTIGE PLAN

2.1. Your Healthcare Prestige Plan is an insurance product that pays a fixed cash amount in the event of hospital admission, subject to the terms and conditions of this policy.

2.2. The plan provides non-medical expense cover as a result of hospitalisation and is designed to give you and your family peace of mind when in need of medical care and assistance. Take note this plan is not a medical aid and under no circumstances must it be considered as a replacement for the benefits offered by a medical aid.

2.3. The policy is underwritten by the Insurer.

2.4. We are authorised by the Insurer to market and administer all aspects of this policy. If you have any questions, contact one of our client service consultants by calling 0860 765 223, or emailing info@solacebenefits.co.za.

3. COVER AMOUNTS

3.1. The cover amount (i.e., the amount this policy will pay in the event of the hospital admission of a person covered by the plan).

4. WHO THE PLAN COVERS

4.1. You, and subject only to the Family or Couple plan, your spouse and a maximum of 5 (five) unmarried dependent children under 18 (eighteen) years of age and as listed on the policy schedule are covered.

5. BENEFIT

Your plan provides cover of up to R20 000 per year subject to:

5.1. If the life assured is admitted as an in-patient to a hospital for more than 48 (forty-eight) consecutive hours as a result of an accident, injury or illness, we shall, subject to the terms and conditions of this policy, pay a daily hospitalisation benefit of up to R1 000 per day starting from the first day of admission by a specialist, limited to a maximum period of 4 (four) days per hospitalisation event. This benefit is limited to 20 (twenty) hospitalisation days per year per policy.

5.2. A full day is deemed to have been spent in the hospital if a patient has been admitted before 00h00 as an in-patient and remains an in-patient for the next consecutive 24-hour period.

5.3. Payment shall be made once the in-patient has been discharged but subject to clause 9 (nine) herein and only into the bank account of the policyholder.

5.4. Costs incurred and arrangements made independently of the above will not be reimbursed.

6. MONTHLY PLAN, PAYMENT TERMS AND UNPAID DEBIT ORDERS

6.1. The policy will run for 1 (one) month at a time and is subject to payment of the premium when due.

6.2. If your premium date falls on a weekend or public holiday, we may process payment either shortly before or shortly after the weekend or public holiday.

6.3. If your premium is unpaid, you will have a 20 (twenty) day grace period to pay the premium, which period will run from the date you receive written notice of non-receipt of premium. If we do not receive outstanding premiums during the grace period, your policy may be cancelled, and you will receive written notice of cancellation of your policy.

7. CANCELLATION

7.1. You may cancel your policy within the first 31 (thirty-one) days of receipt of your policy documentation (cooling-off period) and we will refund any premium paid. You may need to submit supporting documentation before any refunds are granted.

7.2. You may cancel at any time by giving 31 (thirty-one) days' notice. You can either call us or send a written request.

7.3. The plan automatically cancels upon notification:

7.3.1. of your death;

7.3.2. when you cease to be an employee of your current participating employer; or

7.3.3. your participating employer withdraws.

7.4. We may cancel your policy by giving you 31 (thirty-one) days prior written notice.

8. WAITING PERIODS

8.1 In the event of hospitalisation as a result of an accident, it is a requirement that you need to be a customer for at least 1 (one) full day, calculated from inception date and time and further subjected to the conditions and exclusions under the policy.

8.2 A waiting period of 3 (three) months together with 3 (three) consecutive premium payments from the date of first premium paid will apply in the event of a life assured being hospitalised due to natural causes (namely internal factors like an illness).

8.3 A waiting period of 12 (twelve) months together with 12 (twelve) consecutive premium payments from the date of first premium paid will apply in the event of a life assured being hospitalised for any medical condition, including but not limited to physical defect, illness, bodily injury or disability that existed prior to the inception date where admission is directly or indirectly as a result of or contributed to by such pre-existing condition.

8.4 In the event of a claim being repudiated due to either being in the waiting period or due to being a pre-existing condition, or in terms of an exclusion, it is the responsibility of the life assured to seek the necessary medical attention as recommended by their physician or medical practitioner.

8.5 Should the facts which are required to prove your claim take place over a period of time, it is a requirement that your premiums must be fully paid for the entire period of that time, failing which cover may be repudiated.

9. EXCLUSIONS

No claim will be paid if admission results from or is related to (whether directly or indirectly):

9.1 Participation in mass action or protest, contamination or damage from nuclear material, war, hostilities, rebellion, unlawful labour disturbances, public disorder, civil disobedience, resisting or impeding lawful authority, intimidation, conduct contrary to public policy or tainted with illegality or involving indecent or

unlawful sexual behaviour or based on malice or vexatious conduct on your part or undertaken to further ideological objectives (e.g. political, economic or environmental) or political activities, or which may harm the interests or wellbeing of any organ of state or municipality.

9.2 Any criminal act as defined by the laws governing the Republic of South Africa, this specifically includes but not limited to acting or driving under the influence of alcohol or drugs.

9.3 Medical treatment or rehabilitation for any drug or substance abuse.

9.4 Treatment for mental illnesses.

9.5 Hazardous professional or contact sports activities (except if such a sport is being played at school or club level).

9.6 Treatment consequential to refusing or delaying medical treatment or to remain under the care of a physician or medical practitioner.

9.7 Self-inflicted injuries including suicide.

9.8 Cosmetic and elective procedures including but not limited to, breast augmentation, breast reduction, gastroplasty, gender reversal operations, lipectomy, obesity treatments, epilation, otoplasty/reconstruction of the ear except in the case of bodily reconstruction as a direct result of an injury sustained in an accident.

9.9 Specialised dentistry, dental conditions and dental operations including, but not limited to, wisdom teeth removal, jaw surgery, orthodontic procedures and treatment of dental abscesses.

9.10 Routine physical or other examination where there are no real indications or decline in normal health, including costs, tests and examinations requested for immigration, emigration, visas, insurance policies, employment, admission to schools and universities, court medical reports, muscle-function tests, fitness examinations and test, adoption of children and retirement because of ill health.

9.11 Pain related conditions and treatment including bed rest, traction, physiotherapy, spinal blocks, medication or intravenous medication, observation without treatment, observation due to client not leaving despite being discharged by medical practitioner, or any prolonged stays caused directly or indirectly.

9.12 Investigations, routine physical or any other examinations including investigation of pain or pain-related conditions where a diagnosis cannot be confirmed by supporting test results, regardless of treatment received.

9.13 Pregnancy, childbirth and pregnancy related treatment where conception occurred prior or within the waiting period.

9.14 Infertility treatment or the artificial insemination of a person as defined in the Human Tissues Act, 1983 (Act 65 of 1983) or any amendment thereto or replacement thereof.

9.15 Congenital disorders, diseases or abnormalities.

9.16 Sexual transmitted diseases, unless as a direct result of rape or crime that has been officially reported to the South African Police Services.

9.17 All costs incurred during any waiting period and for conditions not disclosed.

9.18 Preventative hospitalisation, including quarantine.

9.19 Abortion not medically necessary.

9.20 All costs that exceed the stated and maximum allowed cover.

9.21 Any treatment relating to non-disclosure of a symptom or condition.

10. DISCLOSURES

10.1 You must disclose all material facts accurately and completely. All answers, statements and any other information you provide are your responsibility. Incorrect information, non-disclosure or misrepresentation of information may result in your claim being rejected or cancellation of this policy.

11. CLAIMS

11.1 We must be notified within 30 (thirty) days of a life assured being discharged, failing which we may elect to repudiate a claim.

11.2 When there is a potential claim, you must contact our Customer Care department on 0860 765 223 and they will assist and provide you with a claim sheet as well as the list of supporting documentation they will need to provide to submit a claim.

11.3 Claims may be repudiated if at the date of admission, premiums are in arrears.

11.4 Claims may also be repudiated if a waiting period applies.

11.5 You must complete a claim sheet in full in the manner requested by us. We will also require all supporting information and evidence required to prove the claim. We may require documents to be certified by a Commissioner of Oaths.

11.6 After receipt of the claim sheet, we may still request further information if we feel this information will be required or necessary to prove the claim.
11.7 We are entitled to investigate the claim, and you grant us full authority and power of attorney to freely contact any person and or institution to take statements, and conduct whatever investigations we consider necessary.
11.8 We are entitled to submit your medical records to a medical practitioner to obtain a medical opinion.
11.9 We reserve the right to determine the amount of days which are reasonable to be hospitalised based on a medical opinion received as per clause 16.2, and we shall accordingly determine whether or not a claim meets the criteria of an admission exceeding 48 (forty-eight) hours.
11.10 Cover of a claim cannot be approved orally or over the phone, and must be authorised in writing.
11.11 Provided we have received the claim sheet (fully completed with all supporting information), we will advise within 7 (seven) business days in writing whether a claim has been approved or repudiated.
11.12 Claims may be approved and paid within 24 (twenty-four) hours, excluding weekends and public holidays, provided that we are in receipt of all claim documents.
11.13 We shall be entitled to access any medical and hospital records in relation to a life assured's health and copies of such records.
11.14 All certificates, information and evidence required by us shall be furnished in the form prescribed.
11.15 In the event of the death of a life assured we shall be entitled to have a post-mortem examination done where it is not prohibited by law.
11.16 Any receipt or discharge which the life assured may give to us for any benefit paid under this policy shall be deemed as final and complete discharge of all liability in respect of any and every contingency resulting to the life assured whether resulting before or after the date of such receipt or discharge.
11.17 In the event of the death of the policyholder during admission for an accident or illness, and subject to approval by us, payment may be made to the *spouse, alternatively a beneficiary in accordance with the Administration of Estate Act and or the Intestates Succession Act.

12. CONDITIONS FOR COVER

12.1 The benefit does not cover everything because there are exclusions and limitations. The following are conditions which have to be met before a claim can be approved. Even after approval, we may withdraw cover if any one of these conditions are not completely met.
12.2 You may not have more than one Healthcare plan entered into through the intermediary. Where you have entered into other related policies, this policy shall only pay the shortfall amount not paid by the other related policies and the total shortfall amount payable in terms of this policy shall not exceed our daily benefit of R1 000 per day and limited to a maximum period of 4 (four) days per hospitalisation event, and also subject to 20 (twenty) hospitalisation days per year per policy as per clause 5.1 above.
12.3 Only hospitalisation within the South African borders will be considered.
12.4 We will only consider claims where you have been admitted into hospital by a specialist practitioner as defined by the Health Professions Council of South Africa (HPCSA).
12.5 Your admission to hospital must be immediate or within 48 (forty-eight) hours of accident and/or injury occurring or recommendation made by a specialist medical practitioner that the symptoms of your illness require admission to hospital.
12.6 Should an illness, symptom or treatment to the same injury reoccur within a 6 (six) month period, it will be deemed to be part of the initial illness or treatment and associated claim.
12.7 This policy is intended as a risk cover. If the life assured entered into this policy with prior knowledge of a foreseeable or predicted medical event or condition that would ordinarily be covered under this policy, but failed to disclose such a medical event or condition, then we may not be liable to indemnify you in terms of this policy.
12.8 It is the duty of the life assured to disclose all medical and health information prior to the inception date. It remains the duty of the life assured to inform us of any material changes which may affect the terms and conditions of the policy, such as a change in medical condition or personal details.
12.9 You must be truthful and not withhold any information related to your claim. You must tell us all important or relevant information or facts, even if we don't ask for it.
12.10 Should any benefit have been paid out on the basis of false and or incorrect information provided, we shall have the right to take such steps to put it in the same position as it would have been in if the correct information had been provided in the first instance.
12.11 If for any reason, we fail to enforce any provision of this policy strictly or at all, whether such leniency be offered in the processing of a claim or extension of cover to the life assured, such leniency should not be interpreted as

a waiver of any of our rights under the policy, nor will that prevent us from enforcing the Policy strictly thereafter. The terms of the policy remain in full force and effect at all times.

12.12 If you submit a claim and there is both a basis for exclusion and a basis for cover, we may repudiate the claim where the main cause of the action falls under the exclusions for this policy.

12.13 You must, where possible, take all reasonable steps to look after your safety and wellbeing so as to prevent a claim from happening, and to avoid being a direct cause of any injury or illness sustained or a contributory factor to a prolonged stay in hospital or aggravating symptoms.

12.14 In the event that you have been hospitalised as a result of being a victim of a crime, it must be reported to the SAPS within 48 (forty-eight) hours of the crime occurring and you will be required to provide us with the certified police report. In the event that you are hospitalised and not in a position to report the matter within 48 (forty-eight) hours, you need to report the crime as soon as reasonably possible.

13. CLAIM REPUDIATION

13.1 If your claim is repudiated, you will be notified in writing, and we will give reasons for the decision.

13.2 If you do not agree with the repudiation, you will have 90 (ninety) days from date of repudiation to make written representations to us. We will respond in writing within 14 (fourteen) days thereof. Complaints may also be lodged directly with the Insurer (complaints@centriq.co.za), the FAIS Ombud (Tel: +27 (12) 470 9080) or with the Long-term Insurance Ombudsman (Tel: 0860 103 236).

13.3 You have 180 (one hundred and eighty) days from the expiry of the above 90 (ninety) day period to institute legal action to dispute a decision and if you do not, your claim will lapse.

13.4 Failure to provide the claim sheet or further information within a reasonable period (normally 30 (thirty) days) may result in the claim being closed or repudiated.

14. ANNUAL INCREASE

15.1 We may increase the premium yearly. The cover amount may increase by an approximate corresponding percentage, provided that the cover amount may not exceed that allowed by legislation. We will send you 31 (thirty-one) days written notice before the increase takes effect. If you are unhappy with the increase, you may select a more affordable plan (if available), or you may cancel within 1 (one) month of receiving notification thereof, failing which the increase will come into effect.

15. NOTICES AND COMMUNICATIONS

16.1 If we need to send you a written notice or communication, we may send it to either your last known email address or SMS number. If you have no email or SMS number, we will send it by letter to your last known postal address. The communication will be deemed to have been received within 24 (twenty-four) hours of email or SMS, and within 3 (three) business days if sent by post.

16. GENERAL TERMS

16.1. We can amend these terms and conditions by giving you 31 (thirty-one) days' written notice. You may cancel if you are not pleased with the amendment.

16.2. No amendments or variations of these terms and conditions will be accepted, and no representations made contrary hereto can be relied on, unless approved in writing by the Insurer.

16.3. This policy acquires no surrender, paid up or loan value and it cannot be assigned. The policy may also not be pledged as security for a loan or debt.

17. TREATING CUSTOMERS FAIRLY (TCF)

17.1. TCF was implemented by the Financial Services Board (now the Financial Services Conduct Authority (FSCA)) to ensure that the fair treatment of customers is embedded within the culture of all financial services providers to ensure customer confidence and offer appropriate products and services with due diligence.

17.2. We subscribe to all 6 (six) outcomes of TCF which are as follows:

- Outcome 1: Customers are confident that they are dealing with providers where the fair treatment of customers is central to the provider's culture.
- Outcome 2: Products and services marketed and sold in the retail market are designed to meet the needs of identified customer groups and are targeted accordingly.

- Outcome 3: Customers are given clear information and are kept appropriately informed before, during and after the time of contracting.
- Outcome 4: Where customers receive advice, the advice is suitable and takes account of their circumstances.
- Outcome 5: Customers are provided with products that perform as providers have led them to expect, and the associated service is both of an acceptable standard and what they have been led to expect.
- Outcome 6: Customers do not face unreasonable post-sale barriers to change products, switch providers, submit a claim or make a complaint.

18. COMPLAINTS

18.1. The purpose of the Complaint Resolution Policy which is available upon request is to ensure compliance with the Long-Term Insurance Act, Insurance Act, Financial Advisory and Intermediary Services (FAIS) Act, the Policyholder Protection Rules and any other applicable legislation.

HOW TO SUBMIT A COMPLAINT

18.2. We request that your complaint be submitted to us in writing within a reasonable time (normally 30 (thirty) days) of a complaint arising. Please address your written complaints to the Complaints Officer: complaints@solacebenefits.co.za. It can also be submitted either by hand, post, or fax to the contact details that appear at the bottom of this page. The complaint should contain sufficient detail regarding:

18.2.1. The full names, ID/ passport number and contact details of the complainant;

18.2.2. The full names, ID/passport number and contact details of the client (if different from the complainant);

18.2.3. Full details of the policy or policy number, where applicable;

18.2.4. Specific details about the nature of the complaint, which would include sufficient facts, dates and supporting documentation to enable us to deal with the complaint quickly and fairly.

WHAT WILL HAPPEN ONCE A COMPLAINT IS MADE

18.3. The following is a step-by-step guideline of how a complaint will be dealt with, once received by us:

18.3.1. The complaint will be acknowledged within 24 (twenty-four) hours of receipt.

18.3.2. It will be assessed and, if a valid complaint, will be logged into our central complaints register. The complaint will be allocated to our trained and skilled Complaints Officer.

18.3.3. The Officer will investigate and revert to you with our findings within 5 (five) to 10 (ten) business days. You may be requested to provide additional information before we provide you with a final resolution. If we require further time to investigate the complaint, this will be communicated to you in writing.

18.3.4. You will receive a response in writing or verbally with full reasons.

18.3.5. Legislation requires us to advise the complainant in writing within 6 (six) weeks of receiving the complaint if the complaint cannot be resolved and the reasons why the complaint could not be resolved. In the event that the complaint cannot be resolved, you may have recourse to the following, whichever is applicable:

18.3.5.1. Refer the matter to the Insurer being Centriq Life Insurance Company Limited, for attention Complaints Department on claimscomplaints@centriq.co.za.

18.3.5.2. Refer the matter to the FAIS Ombud within 6 (six) months of notification that the complaint cannot be resolved or within 6 (six) months of our failure to deal with a complaint. You may file the Complaint on their website www.faisombud.co.za or you may contact them on +27 (12) 470 9080.

18.3.5.3. Refer the matter to the Ombudsman for Long Term Insurance. You may file the Complaint on their website www.ombud.co.za or you may contact them on 0860 103 236.

18.3.5.4. Seek legal advice from an attorney regarding any legal action that may be taken.

18.3.5.5. Refer the matter for conciliation.

19. PERSONAL INFORMATION AND COMMUNICATIONS

19.1. We are bound by the terms and provisions of both Section 51 of the Electronic Communications and Transactions Act, 2002 (“ECT Act”) as well as the Protection of Personal Information Act 4 of 2013 (“POPI Act”) regarding the processing of your personal information. We may use any necessary legal means to check and validate the information you provide to us.

19.2. Your information shall be kept confidential. However, we may disclose it to certain third parties (as required in the normal course of our business), to other Insurers for the specific purpose of insurance and to reduce and prevent any form of fraudulent activity, and otherwise as may be legally required by us.

19.3. Where your personal information is shared with third parties, we endeavour to ensure that they understand and adhere to the provisions of the POPI Act in so far as it relates to the processing of your personal information and we endeavour to have privacy agreements in place to ensure adherence to this. We have implemented reasonable security measures to protect your personal information that we process to ensure that your privacy and confidentiality is upheld.

19.4. In taking out this policy you have provided us with your personal information and have further consented to us processing your personal information in accordance with the provisions of the POPI Act and you further confirm that the information you have provided us is accurate and correct. We will destroy your personal information that you have provided to us upon your request.

19.5. All our case records are kept for a minimum period of 5 (five) years, which is a statutory requirement in terms of FAIS.

19.6. The information submitted by you will be made available to and processed by our staff where required, as well as our external compliance officer for audit purposes, the Regulator (FSCA) and any Ombud who has jurisdiction.

19.7. This document is to be read together with our Privacy and POPI Policy and PAIA Policy which is available upon request and which you are deemed to have agreed to by taking out this policy. Should you have any queries or concerns relating to any terms contained in our policies, or should you wish to withdraw your consent to allow us to process your personal information, you may, at any time, send a request in writing to our Information Officer to popi@solacebenefits.co.za.