



## Policy Wording

### 1 BACKGROUND

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- 1.1 Whereas the Principal Member named in the Policy Schedule has applied to the Insurer for the insurance as hereinafter set out, the Insurer hereby agrees to provide such insurance, subject:
- 1.1.1 to any proposal or other information supplied by or on behalf of the Insured Person:
    - 1.1.1.1 disclosing all facts and circumstances known to the Insured Person that are material to the assessment of the risks insured hereby, and
    - 1.1.1.2 forming the basis of this Policy, and
  - 1.1.2 to the condition of prior payment of the Premium by or on behalf of the Insured Person and the receipt thereof by or on behalf of the Insurer notwithstanding anything to the contrary set out in this Policy or any section thereof,
  - 1.1.3 and further subject to the terms, conditions, provisions and exceptions hereinafter set out or as contained in any endorsement that may be issued in regard thereto.

### 2 DEFINITIONS

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- 2.1 In this Policy, unless the context indicates a contrary intention, the following words and expressions shall bear the meanings assigned to them and cognate expressions bear corresponding meanings –

- 2.1.1 "Accident" means a sudden, unexpected, unusual, specific event which occurs at an identifiable time and place during the period of the Policy;
- 2.1.2 "Accidental death" means an unforeseen event, which could not reasonably have been expected to occur. The event must result in death caused directly and independently of all other causes by some external and visible means arising from this event, and excludes death by natural causes;
- 2.1.3 "Acute medicine" means medicine used for diseases or conditions that have a rapid onset and severe symptoms that require a short course of medicine treatment;
- 2.1.4 "Adult" means a member who is 18 years or older; excluding full-time students who are younger than 26 and Dependents who are permanently physically and/or mentally disabled;
- 2.1.5 "Admission" means admission into a Hospital as an Inpatient on the advice of and under the care and attendance of a qualified physician and is necessary for the medical care and/ or diagnosis and/or treatment of Bodily Injury or Illness covered by this Policy and which medical care and /or diagnosis and/or treatment could not reasonably have been obtained as an out-patient;
- 2.1.6 "Annual Overall Limit" refers to the total benefit amount payable per year;
- 2.1.7 "Application Form" means the form that the Principal Insured completes, that shall be the basis for the selection of cover. This may consist of electronic or recorded applications;
- 2.1.8 "ASISA" means the Association for Savings and Investments South Africa;
- 2.1.9 "Bodily Injury" means Bodily Injury by violent external and visible means caused by an Accident but shall include Bodily Injury caused by starvation, thirst and exposure to the elements as a result of a Road Accident;
- 2.1.10 "Beneficiary" means the person/s as nominated by the Principal Insured, to receive the Benefit, subject to the terms and conditions set out in this Policy and in the Policy Schedule. Such persons shall be nominated by the Principal Insured and nominations may be amended any time prior to the Principal Insured's demise;
- 2.1.11 "Benefit" means the Benefit amounts as set out in the Policy Schedule, provided by the Insurer in terms of this Policy;
- 2.1.12 "Benefit start date" means the date on which a member becomes entitled to benefits;
- 2.1.13 "Casualty/ Emergency Room" means the department of a Hospital providing treatment for out-patients or emergency cases for stabilization before admission to Hospital or transfer to an appropriate facility;
- 2.1.14 (Participation) Certificate is the document issued to the Principal Insured as proof of participation in the benefits of this Scheme;
- 2.1.15 "Cessation Age" The Principal Member's age as specified in clause 3 below at which age benefits would cease.

- 2.1.16 "Chronic" means any illness or disease that requires medication and treatment for an uninterrupted period of more than 3 (three) months;
- 2.1.17 "Chronic medicine" means medicine that meets all the following requirements:
- 2.1.17.1 Is within formulary and prescribed by a network medical practitioner for an uninterrupted period of at least 3 (three) months;
  - 2.1.17.2 Is for a condition appearing on the list of approved chronic conditions, as amended from time to time, the list being available on [www.essentialmed.co.za](http://www.essentialmed.co.za);
  - 2.1.17.3 Which has been applied for in the manner and at the frequency prescribed and which application has been approved and accepted by the Insurer;
  - 2.1.17.4 Maximum benefits per annum may be applicable to certain conditions;
- 2.1.18 "Commencement Date" means the date specified in the Policy Schedule;
- 2.1.19 "Compensation" means the amount payable to the Insured Person in the event of a Benefit claim;
- 2.1.20 "Cooling off period" A period of time after a sale of a policy is concluded during which the buyer can cancel the contract without incurring a penalty;
- 2.1.21 "Critical Illness" refer to Dread Disease;
- 2.1.22 "Day" means 24 (TWENTY FOUR) consecutive hours from time of Admission, or part thereof;
- 2.1.23 "Day Procedure" means surgical procedures that can be performed in a single day;
- 2.1.24 "Defined event" means the event which gives rise to the member having to seek medical treatment as set out in the Schedule hereto;
- 2.1.25 "Dependant" means a spouse, partner and children as described in 2.1.26 below;
- 2.1.26 "Dependant Child(ren)" means:
- 2.1.26.1 a child of a Principal Member under the age of 18 (eighteen) years, including a stepchild, an illegitimate child or legally adopted child, including a child adopted in terms of a customary adoption under a tradition practiced by the people of Southern Africa provided that the child's natural parents are both deceased, or an adoption under the tenets of any religion practiced by the people of Southern Africa provided that the child's natural parents are both deceased;
  - 2.1.26.2 a stillborn child of a Principal Member born after the 28th (twenty-eighth) week of pregnancy or posthumous child;
  - 2.1.26.3 a child of a Principal Member being permanently mentally or physically disabled and totally dependent upon the Principal Member;
  - 2.1.26.4 a child of a Principal Member under the age of 26 (twenty-six) years who is a full- time student at any learning institution registered in terms of legislation in the Republic of South Africa, and who is unmarried;

- 2.1.27 "Dread Disease" means any of the following:
- 2.1.27.1 Heart Attack: being a heart attack as defined in the ASISA SCIDEP, set out in clause 2.4 of Annexure 1;
  - 2.1.27.2 Chronic Coronary Heart Disease: Open bypass surgery or surgical treatment of Coronary disease. This excludes angioplasty and / or any similar intra-arterial procedures;
  - 2.1.27.3 Stroke: being a stroke as defined in terms of the ASISA SCIDEP set out in clause 2.5 of Annexure 1;
  - 2.1.27.4 Cancer: being cancer as defined in ASISA SCIDEP set out in clause 2.3 of Annexure 1;
  - 2.1.27.5 Kidney Failure: means end stage renal failure presenting a chronic irreversible failure of both kidneys to function, as a result of which regular renal dialysis is required on a long-term basis;
  - 2.1.27.6 Major Organ Transplant: The human to human organ transplant from a donor to the Insured Person of one or more of the following organs:
    - 2.1.27.7 Kidney, Heart, Lung, Liver, Pancreas or Bone Marrow;
    - 2.1.27.8 The transplantation of all or other organs, parts of organs or any other tissue transplant is excluded;
    - 2.1.27.9 Paraplegia: The Insured Person suffers the total and irreversible loss of use of both legs or both arms as a result of an illness;
    - 2.1.27.10 Blindness: The Insured Person suffers the total and irrecoverable sudden loss of vision in both eyes as a result of an illness;
- 2.1.28 "Emergency Medical Services" means the emergency medical response unit available to the Insured Persons for urgent medical assistance;
- 2.1.29 "Family" means the Principal Member (being a natural person) in whose name this policy is effected and includes the Principal Member's Spouse and Dependent Children under the age of 18 (eighteen) years which form part of the Principal Member's household and who are resident in the Republic of South Africa;
- 2.1.30 "Family Funeral Benefit" means the amount paid upon the death of an Insured Member;
- 2.1.31 "Fertility Treatment" means any procedure done to result in a viable term pregnancy;
- 2.1.32 "Formulary" means the exhaustive list of procedures and services that are approved by Essential Med and which may be amended from time to time;
- 2.1.33 "High Care" which is in a hospital and to which a patient would be admitted by an attending medical professional as recommended;
- 2.1.34 "Hospital" means an establishment, which meets all the following requirements:
- 2.1.34.1 holds a license as a hospital or day clinic or nursing home (if licensing is required in the province or government jurisdiction);

- 2.1.34.2 operates primarily for the reception, care and treatment of sick, ailing or injured persons as inpatients;
- 2.1.34.3 provides organised facilities for diagnosis and surgical treatment;
- 2.1.34.4 is not primarily a rest or convalescent home or similar establishment and is not, other than incidentally, a place for alcoholics or drug addicts;
- 2.1.35 "Intensive Care Unit (ICU)" which is in a hospital and to which a patient would be admitted by an attending medical professional;
- 2.1.36 "Injury" means a sudden and unexpected bodily injury necessitating Primary Health Benefits, Emergency Benefits and/or Hospital Admission Benefits
- 2.1.37 "Illness" means the onset of any acute somatic, unforeseeable, unpredictable Illness (excluding mental Illness) which requires Admission to Hospital, and which was not a Pre-Existing Condition (unless otherwise provided for herein). A recurrence of any Illness will only be considered a separate Illness if 6 (SIX) months have elapsed from the date of onset of the preceding Illness;
- 2.1.38 "Inception date" means the date on which the application for this insurance, including any options regarded as benefits as selected by the Insured becomes active;
- 2.1.39 "Insured Persons" means the Principal Member as named on the Policy Schedule and their named Spouse and Dependent Children and any other person approved by the Insurer;
- 2.1.40 "Insurer" means African Unity Life Limited, an authorised financial services provider, registration number 2003/016142/06, FSP No. 15283, a long-term insurance company with limited liability, having its registered address Riesling House, The Vineyards Office Estate, 99 Jip de Jager Drive, Bellville;
- 2.1.41 "Insuring Section" means the Benefits payable and types of insurance cover granted to the Insured Person as more fully set out in clause 7;
- 2.1.42 "Junior Policy" means a specific policy intended for a minor, younger than 18 years of age;
- 2.1.43 "Main Member" means a person who has been registered as the Principal Insured;
- 2.1.44 "Medicine" means a substance registered under the Medicines and Related Substances Control Act, 1965, as amended or replaced from time to time and within the Essential Med formulary;
- 2.1.45 "Member" means each individual under cover, including a Dependant;
- 2.1.46 "Minor" means a Dependant who is not yet 18 years old;
- 2.1.47 "Network Medical Practitioner" means a Medical Practitioner who is a member of the Essential Med's service provider network and who appears on the list of Practitioners published on the Insurer's website at [www.essentialmed.co.za](http://www.essentialmed.co.za);
- 2.1.48 "Option" means a product registered under Essential Med, which offers a specific structure of benefits;

- 2.1.49 "Over the Counter Medication" also abbreviated to OTC, refers to medication that does not require a prescription from a medical doctor and is required to alleviate acute symptoms;
- 2.1.50 "Pandemic" means an epidemic of infectious disease that has spread through human populations across a large region, for instance across borders or even worldwide;
- 2.1.51 "Permanent Total Disability" means Permanent and total loss of or use of as a result of an accident while covered in Terms of the Policy:
- 2.1.51.1 Speech - 100%
  - 2.1.51.2 Hearing in both ears - 100%
  - 2.1.51.3 Any limb by physical separation at or above wrist or ankle of one or more limbs - 100%
  - 2.1.51.4 One or both eyes - 100%
  - 2.1.51.5 Sight in one or both eyes - 100%
- 2.1.52 "the / this Policy" means this insurance agreement concluded between the Insurer and the Principal Member in respect of the Benefits underwritten by the Insurer;
- 2.1.53 "Policy Schedule" means the long-term insurance policy schedule issued to the Principal Member in terms of section 48 of the Long-term Insurance Act 52 of 1998, as amended;
- 2.1.54 "Pre-authorization Services" refers to a telephonic call-center service in terms of which the Insurer or its subcontractor will pre-approve treatment for a member in terms of this agreement
- 2.1.55 "Pre-Existing Condition" means any Bodily Injury or Illness or Dread Disease for which the Insured Person received medical advice and/or treatment in the 10 (ten) years preceding the Commencement Date stated in the Policy Schedule (unless otherwise provided for herein) and signs and symptoms present prior to inception of the Policy but which were not yet made the subject of treatment or medical advice;
- 2.1.56 "Premium" means the premium payable to the Insurer on a monthly basis in terms of this Policy in order to secure the Benefits;
- 2.1.57 "Principal Member" means the person who applies for Insurance Cover under this Policy and includes a parent or person responsible for a minor that has applied for a Junior Policy on behalf of a minor;
- 2.1.58 "Professional Sport" means a sporting activity in which an Insured Person engages and from which such Insured Person derives the majority of their monthly income;
- 2.1.59 "Repatriation" the repatriation of the deceased within the borders of the defined Territory;
- 2.1.60 "SCIDEP" means the ASISA Standardized Critical Illness Definitions Project;

- 2.1.61 "Service Provider" means a medical practitioner, dentist, optometrist, pharmacist or similar;"
- 2.1.62 "Specialist" means a doctor who has completed advanced education and clinical training in a specified field of medicine, for example a physician such as, but not limited to a neurologist, pulmonologist etc. or surgeon such as, but not limited to a general surgeon, orthopedic surgeon and the like;
- 2.1.63 "Spouse" means the named Spouse of a Principal Member. Not more than one Spouse shall be covered in respect of each Principal Member;
- 2.1.64 "Suicide" the act or instance of taking one's own life;
- 2.1.65 "Temporary Total Disability" means the Insured Person being admitted to Hospital as an in- patient, the costs to be covered up to maximum stated benefit amounts;
- 2.1.66 "Territorial Limits" means the Republic of South Africa;
- 2.1.67 "This Policy" means this insurance agreement concluded between the Insurer and the Principal Member in respect of the Benefits underwritten by the Insurer;
- 2.1.68 "Unclaimed Benefits" A benefit which remains unclaimed for a period of 6 (six)months from date of notification of an insured event
- 2.1.69 "Waiting period" means the number months/ days any Member must wait from date of Inception before he/she can access his/her Benefits under the insurance;
- 2.1.70 "Writing" (or words of similar meaning) means legible writing and in one of the official languages of South Africa, and includes any form of electronic communication contemplated in the Electronic Communications and Transactions Act, 25 of 2002;
- 2.1.71 "Year" means a calendar year;
- 2.2 Any reference to the singular includes the plural and vice versa; and
- 2.3 Any reference to a gender includes the other gender;
- 2.4 The clause headings in this Policy have been inserted for convenience only and shall not be taken into account in its interpretation;
- 2.5 If any provision in a definition is a substantive provision conferring rights or imposing obligations on any party, effect shall be given to it as if it were a substantive clause in the body of the Policy, notwithstanding that it is only contained in the interpretation clause;
- 2.6 This Policy shall be governed by, construed and interpreted in accordance with the laws of the Republic of South Africa.

### 3 GENERAL PROVISIONS

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It is declared and agreed that:

- 3.1 Once any Insured Person has been Insured under this Policy for a period of 24 (TWENTY FOUR) consecutive months any Pre-Existing Condition shall no longer apply (subject to specific endorsements);
- 3.2 The age of the Principal Member cannot exceed 54 (FIFTY FOUR) years when first applying for Accident and Health Benefits or exceed 64 (SIXTY FOUR) when first applying for Primary Care Benefits (unless otherwise provided for herein);
- 3.3 Should a member reach the age of 65, the Insurer shall, by virtue of written notice to such a member, cancel his/her membership, subject to the following conditions applicable to Principal Members:
  - 3.3.1 The Insurer shall afford such a Member the option to nominate his/her spouse or other person approved by the Insurer, to substitute him/her as Principal member;
  - 3.3.2 Such nominated person shall be over the age of 18 (EIGHTEEN), but under the age of 54 (FIFTY FOUR) in the case of Accident and Health Benefits or 64 (SIXTY FOUR) in the case of Primary Care Benefits;
  - 3.3.3 The Insurer reserves the right to deny such substitution and/or impose any reasonable restriction the Insurer, in its sole discretion, deems appropriate;
- 3.4 All minor dependants will be covered up to the age of 21 (TWENTY ONE), unless otherwise provided for herein.
- 3.5 An Insured Person may not be covered under more than one Policy for this type of Insurance. In the event of this Policy not being the first Policy, then this Policy shall be invalidated and no claim shall be recognised by the Insurer. In the event that this Policy is the first Policy, then this Policy shall pay benefits only when it can be demonstrated to the satisfaction of the Insurer, that no other benefit is paid to the Insured Person by any other Financial Services Provider.

## 4 PAYMENT OF PREMIUM

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- 4.1 Premiums shall be payable monthly in advance on the payment day agreed upon between the parties. In the event of non-payment of the Premium on the due date, and subject to the provision of a 15 (FIFTEEN) day grace period to pay the Premium in arrears, insurance cover in respect of the Insured Person shall lapse after written notification of the non-payment to the Insured Person by the Insurer.
- 4.2 Premiums shall be payable by means of a debit order from a bank account nominated by the Principal Member. All costs associated in respect thereof shall be borne by the Principal Member.
- 4.3 If a Policy lapses due to non-payment a Member may, subject to the Insurer's approval first being had and obtained, re-instate the Policy within 2(TWO) months of the Policy lapsing by making written application for reinstatement;
- 4.4 Unless the missed Premium contributions are paid upon reinstatement, the Inception date will be changed to the date of reinstatement and standard waiting periods will be applicable from the duly amended Inception date.



- 4.5 Should the Insurer not receive the Policy Premiums timeously, all option benefits will be suspended until such time as the Premiums are received and paid in full.

## 5 GENERAL EXCLUSIONS AND LIMITATIONS

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- 5.1 The Insured Person shall only be covered within the Republic of South Africa. Should an Insured Person have an accident or fall ill in one of the neighboring countries of Lesotho, Swaziland, Botswana, Namibia, Mozambique or Zimbabwe, such Insured Person shall travel to the nearest South African border post at their own expense and request assistance;
- 5.2 The Insurer shall not be liable to pay Compensation for Bodily Injury or Illness or Dread Disease in respect of any Insured Person:
- 5.2.1 caused by suicide, or self-injury or intentional exposure to obvious risk of Injury (unless in an attempt to save human life);
  - 5.2.2 caused by a Pre-Existing Condition within the stipulated Waiting Period (unless otherwise provided for herein);
  - 5.2.3 over 65 (SIXTY FIVE) years of age (unless otherwise provided herein);
  - 5.2.4 caused by or as a result of the influence of alcohol, drugs or narcotics upon such Insured Person unless administered by or prescribed by and taken in accordance with the instructions of a member of the medical profession (other than him-or herself);
  - 5.2.5 caused by or arising from exposure to or contamination by atomic energy and/or nuclear fission or reaction;
  - 5.2.6 whilst travelling by air other than as a passenger and not as a member of the crew nor for the purpose of any trade or technical operation thereon or therein;
  - 5.2.7 whilst participating in any riot or civil commotion or public disorder or active involvement in war, acts of terrorism, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection or political risk of any kind;
  - 5.2.8 whilst participating in a hazardous or Professional Sport/ Activity;
  - 5.2.9 was caused by any mental illness, mental disability, mental impairment and psychopathic disorders, all forms of depression, major affective disorders, psychotic and neurotic conditions, as well as all stress and anxiety related disorders, other than those caused by Accident as defined in this Insurance
  - 5.2.10 was caused whilst engaging in combat duties, military exercises or any active service within any military, naval, air, police or correctional services body or the active duties of the provision of security or protection services to/for any organization/individual
  - 5.2.11 for any claims for mountaineering or rock climbing necessitating the use of ropes or guides, potholing, hang gliding, sky diving, riding or driving in a race or rally,

- underwater activities involving the use of artificial breathing apparatus unless the Insured Person has an open water diving certificate or is diving with a qualified instructor to a depth no greater than 30 meters and/or similar activities, unless agreed to in writing by the Insurer;
- 5.2.12 for any claim arising whilst the Insured Person is perpetrating an intentional unlawful act in terms of South African Laws;
- 5.2.13 occurs during pregnancy, childbirth, Admission for complications or conditions arising whilst pregnant or during childbirth or for any congenital abnormalities during the first 12 (twelve) months from the Commencement Date or any Reinstatement Date;
- 5.2.14 for claims in respect of expenses arising out of regular medical treatments on an ongoing (chronic) basis;
- 5.2.15 for elective-, elective cosmetic surgery, corrective optical and laser surgery or treatment and costs resulting there from; except in the case of bodily reconstruction as a direct result of an injury sustained in an Accident while covered by this Policy
- 5.2.16 was caused by, directly or indirectly arising from, treatment of infertility or the artificial insemination of a person as defined in the Human Tissues Act (Act 65 of 1983) or any amendment thereto or replacement thereof;
- 5.2.17 for any newborn children where the Illness or Dread Disease was known by the Principal Insured Person prior to the birth of that Dependant;
- 5.2.18 for premature childbirth unless the expected date of birth is later than 12 (twelve) consecutive months after inception of insurance;
- 5.2.19 failure by the Insured Persons to take all reasonable precautions to prevent Accidents and failure to comply with all statutory requirements and regulations;
- 5.2.20 if injuries sustained whilst any person driving a vehicle or motorcycle is under the legal driving age, or is not authorized or qualified to drive such a vehicle or motorcycle;
- 5.2.21 for the costs incurred for the treatment of obesity;
- 5.2.22 for the treatment of any sexually transmitted diseases, unless as a result of a crime that has been reported to the South African Police Services;
- 5.2.23 for services rendered to an Insured Person by a person not registered with the South African Medical and Dental Council and/or the South African Health Professions Council;
- 5.2.24 for costs incurred as a result of failure to carry out the instructions or advise of a medical doctor, including deferring treatment in order to have costs covered once waiting periods and endorsements are no longer applicable;
- 5.2.25 for admissions for diagnostic procedures in order to diagnose a condition or illness, or in respect of expenses arising out of routine physical or other examinations where there is no objective indications or impairment in normal health;
- 5.2.26 for day admissions as described above in clause 5.2.25;

- 5.2.27 for a Pandemic as described in Definitions in the preamble hereof;
- 5.2.28 if the consequences of an Accident shall be aggravated by any condition or physical disability of the Insured Person which existed before the Accident occurred, the amount of any compensation payable under this Insurance in respect of the consequences of the Accident shall be the amount which it is reasonably considered would have been payable if such consequences had not been so aggravated;
- 5.2.29 in the case where the member is also covered by a Medical Aid as defined in the Medical Schemes Act 131 of 1998, a 3 (THREE) day franchise will be applied and thereafter the admission is covered up to a maximum of 21 (TWENTY ONE) days per illness event, paying a daily limit of R1500 per day whilst in hospital. In addition, Essential Med may apply the average length of stay to the relevant admission as approved by Essential Med based on the clinical guidelines as provided by the Department of Health;
- 5.2.30 was caused by any gradually operating cause of which the Insured Person is aware;
- 5.2.31 resulting from hospitalisation at the Insured Person's own choosing which has no connection with any Injury, Illness or Dread Disease;
- 5.2.32 resulting from, hospitalisation for the investigation of pain and pain related conditions and treatment in this context includes bed rest, traction, physiotherapy, spinal blocks, medication or intravenous medication;
- 5.3 Compensation under one Benefit pertaining to this Policy may not be in addition to another. The Insured may therefore not claim under the Specific Stated Conditions Benefit in addition to the Daily Illness Benefit or similarly Accident or Dread Disease Benefits;
- 5.4 Where an Insured Person is covered in terms of a statutory body such as the Compensation for Occupational Injuries and Diseases or the Road Accident Fund or their successors in title or assigns, in relation to an Accident, the Insurer will only be liable for amounts that the Insured may be liable for due to shortfalls incurred and up to the maximum Accident Benefit amount.

## 6 GENERAL CONDITIONS

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- 6.1 Insurance cover shall commence on the Commencement Date subject to receipt of the first Premium by the Insurer;
- 6.2 This Policy and the Policy Schedule shall be construed as one contract;
- 6.3 This Policy may be cancelled at any time by either of the parties giving the other 30 (THIRTY) days' notice in writing (or such other period as may be mutually agreed upon); The Insurer shall notify the Policyholder of any changes to the terms and conditions contained herein, including the premium of the Policy by giving the Policyholder 30 (THIRTY) days' written notice to the Policyholders last known address or electronic mail address;

- 6.4 No Premium will be refunded in instances where benefits are not utilised by a Member;
- 6.5 This Policy is not assignable. Compensation shall be payable only to the Insured Person or his/her estate whose receipt shall irrevocably discharge the Insurer from all its obligations in terms of this agreement;
- 6.6 This Policy shall be terminated with immediate effect in the event of the Insured Person:
- 6.6.1 Providing false information or failing to disclose pre-existing conditions when making application for any Policy
  - 6.6.2 providing or attempting to provide false information upon submission if a claim;
  - 6.6.3 allowing a third party the use of a membership card;
- 6.7 Notice must be given to the Insurer in writing as soon as practicable of any occurrence which may give rise to a claim under this Insurance, but in any event within 3 (THREE) months of such occurrence, failing which the claim will be repudiated;
- 6.8 Claims for payment of costs shall be submitted to the Insurer within 120 (ONE HUNDRED AND TWENTY) days of service. In the event of claims being submitted after this period, it will be deemed stale and the Insurer will not be liable to cover the costs thereof;
- 6.9 In the event that the Insurer repudiates liability for any claim under the Policy, the claimant shall have 90 (NINETY) days from the date of notice of the repudiation within which to make representations to the Insurer disputing the repudiation of the claim, whereafter the matter will be deemed to have been resolved to the satisfaction of the parties;
- 6.10 If any amount payable in terms of this Policy is not claimed in accordance with the provisions of this Policy within 6 (SIX) months from the date on which it became due for payment, all rights and claims in respect thereof shall deemed to be forfeited and no further claim whatsoever shall be valid against the Insurer pursuant to this Policy;
- 6.11 All certificates, information and evidence required by the Insurer shall be furnished in the form prescribed and without expense to the Insurer. Upon written request and at the expense of the Insurer the Insured Person shall submit to any and all medical examinations required by the Insurer;
- 6.12 Qualified medical advice shall be sought and followed promptly on the occurrence of any Bodily Injury, Dread Disease or Illness and the Insurer shall not be liable for any part of any claim which in the opinion of the medical adviser arises from the unreasonable or willful neglect or failure of an Insured Person to seek and remain under the care of a qualified member of the medical profession.
- 6.13 The Insured Person shall notify Essential Med Pre Authorisations Department at least 48 (forty-eight) hours prior to being hospitalised and give full particulars of the hospitalisation at the contact number as provided on the membership card. Failure to do so will result in the non-payment of claims. In the event of the incapacity of the Insured Person due to an emergency this condition shall not apply, subject thereto that the Insured person notify the Insurer of said hospitalisation as soon as he/she is physically able to do so.

- 6.14 Should any claim under this agreement of Insurance be in any respect fraudulent or intentionally exaggerated or if any fraudulent means or devices are used by the Insured Person or anyone acting on his/her behalf to obtain any benefit under this Insurance all benefits hereunder shall be forfeited and no Premiums shall be refunded.
- 6.15 It is a condition precedent to Insurer's liability to pay Benefits on behalf of an Insured Person that all medical records, notes and correspondence referring to the subject of a claim or a related Pre Existing Condition shall be made available to any medical or other advisor appointed by Insurer and such advisor or advisors shall, for the purpose of reviewing the claim, be allowed so often as may be deemed necessary to make examination of the Insured Person or any other record pertaining to the claim. The conditions listed are:
- 6.15.1 Kaposi's Sarcoma;
  - 6.15.2 Pneumocystis carinii;
  - 6.15.3 Tuberculosis;
  - 6.15.4 CMV;
  - 6.15.5 Cryptococcal meningitis;
  - 6.15.6 Cryptosporidium;
  - 6.15.7 Disseminated Herpes/Shingles;
- 6.16 The Insurer reserves the right to permanently exclude certain Benefits based on preexisting conditions and prior conditions. The relevant Endorsement will be placed on the Policy and reflect on the Policy Schedule.

## 7 INSURING SECTION

The following Insurance Cover is provided under the conditions of this agreement:

Name	Waiting Period	Benefits		
GP Visits	1 month	Unlimited primary healthcare benefits with GP Network Providers. Non-Network Provider will be reimbursed up to R250 for the consultation a maximum of 3 times per year per policy		
Specialist Visits	3 months	If your network doctor requires you to be seen by a specialist, an annual benefit amount is available to help cover these costs		
		<b>Level 1</b>	<b>Level 2</b>	<b>Level 3</b>
		R1000 Benefit Per Policy Per Annum	R1500 Benefit Per Policy Per Annum	R2000 Benefit Per Policy Per Annum
Dentistry	6 months	Managed unlimited dentist consultations and procedures as per formulary from a Network Registered Provider		
		<b>Level 1</b>	<b>Level 2</b>	<b>Level 3</b>
		Cleaning, pain control, amalgam fillings and normal extractions.	Level 1 benefits plus: • 1 Root Canal Treatment up to R2000 per event per beneficiary within a	Level 1 benefits plus: • 2 Root Canal Treatments up to R2000 per event per

Name	Waiting Period	Benefits		
			12 month period. <ul style="list-style-type: none"> <li>1 Crown per beneficiary to the value of R4500 per event within a 24 month period.</li> <li>Resin fillings included.</li> </ul>	beneficiary within a 12 month period. <ul style="list-style-type: none"> <li>2 Crowns per beneficiary to the value of R4500 per event within a 24 month period.</li> <li>Resin fillings included.</li> <li>R2000 AOL to be applied in event of shortfall.</li> </ul>
Radiology and Pathology	1 month	Should your network doctor require you to have blood tests or X-rays done, an extensive list of covered items is available.		
Optometry	12 months	Your Optometry benefit includes an eye test per beneficiary per annum through Spec Savers		
		<b>Level 1</b>	<b>Level 2</b>	<b>Level 3</b>
		Free single vision lenses and frames every 24 months	Level 1 or free bi-focal vision lenses and frames every 24 months	Level 2 or contact lenses – 4 packages in a 24 month cycle to the value of R350 each
Acute Medication	1 month	Unlimited acute medication on the formulary when prescribed by a network doctor.		
Chronic Medication	6 months	Unlimited chronic medication on the formulary when prescribed by a network doctor.		
OTC Medication	1 month	Single Policies: Limited to R350 per annum and R100 per event Family Policies: Limited to R750 per annum and R100 per event		
Funeral	3 months for natural causes None for accidents	Can be added to any combination plan that included primary care or accident or hospital benefits. Benefit will be paid out within 48 hours upon receipt of all required documentation.		
		<b>Level 1</b>	<b>Level 2</b>	<b>Level 3</b>
		R10000	R20000	R30000
Accident Hospitalisation	None	Includes emergency services		
		<b>Level 1</b>	<b>Level 2</b>	<b>Level 3</b>
		<ul style="list-style-type: none"> <li>Singles: Up to R75,000 per event with an AOL of R150,000</li> <li>Families: Up to R150,000 per event with an AOL of R300,000</li> </ul>	<ul style="list-style-type: none"> <li>Singles: Up to R125,000 per event with an AOL of R250,000</li> <li>Families: Up to R250,000 per event with an AOL of R500,000</li> </ul>	<ul style="list-style-type: none"> <li>Singles: Up to R200,000 per event with an AOL of R400,000</li> <li>Families: Up to R400,000 per event with an AOL of R800,000</li> </ul>
Illness Hospitalisation	3 months 12 months for stated conditions on level 3 24 months for hysterectomy on level 3	Amounts available for hospital expenses in the event of an insured member requiring admission		
		<b>Level 1</b>	<b>Level 2</b>	<b>Level 3</b>
		<ul style="list-style-type: none"> <li>1<sup>st</sup> 24 hours: up to R6,500</li> <li>Day 2: up to R4,500</li> <li>Day 3: up to R4,500</li> <li>Day 4 to 21: up to R1,500 per day</li> </ul>	<ul style="list-style-type: none"> <li>1<sup>st</sup> 24 hours: up to R10,000</li> <li>Day 2: up to R6,500</li> <li>Day 3: up to R5,000</li> <li>Day 4 to 21: up to R1,500 per day</li> </ul>	<ul style="list-style-type: none"> <li>1<sup>st</sup> 24 hours: up to R10,000</li> <li>Day 2: up to R6,500</li> <li>Day 3: up to R5,000</li> <li>Day 4 to 21: up to R1,500 per day</li> </ul> Stated conditions have amounts paid regardless of but not in addition to admission days. <ul style="list-style-type: none"> <li>Hernia: R20,000</li> <li>Appendectomy: R35,000</li> <li>Gallbladder/Kidney stones: R35,000</li> <li>Miscarriage: R10,000</li> <li>Hysterectomy: R24,000</li> </ul>
Maternity	12 months	This benefit is not in addition to the Daily Illness Benefit. R30,000 available to cover the birth of your child regardless of delivery method.		
ICU	3 months	<b>Level 1</b>	<b>Level 2</b>	
		Up to R12,500 per day for a maximum of 5 days	Up to R20,000 per day for a maximum of 5 days	

Name	Waiting Period	Benefits		
Emergency Casualty Ward	1 month	For after hours emergencies when your GP is not available and no hospital admission is required		
		<b>Level 1</b>	<b>Level 2</b>	<b>Level 3</b>
		R2,000 per annum	R4,000 per annum	R6,000 per annum
Dread Disease	12 months	Heart attacks, Coronary Heart Disease, Stroke, Cancer & Kidney Failure are a few conditions that are covered with cash benefits that pay out according to SCIDEP staging		
		<b>Level 1</b>	<b>Level 2</b>	<b>Level 3</b>
		R9,000 a day while admitted for a dread disease up to a maximum benefit limit of R185,000	R9,000 a day while admitted for a dread disease up to a maximum benefit limit of R250,000	R9,000 a day while admitted for a dread disease up to a maximum benefit limit of R350,000
Permanent Disability	6 months for spouse	An amount will be paid out less costs incurred in the event of an accident that results in Permanent Disability		
		<b>Level 1</b>	<b>Level 2</b>	<b>Level 3</b>
		R200,000 – Main Member only	R250,000 – Main Member only	R250,000 – Main Member and Spouse

- 7.1 General Medical Practitioner visits including Radiology, Pathology and Medication: benefits are subject to a 1 (ONE) month waiting period calculated from the inception date, unless otherwise stated herein; Chronic Medication benefits have a 6 (SIX) month waiting period calculated from the inception date unless otherwise stated herein;
- 7.2 Dental benefits shall have a 6(SIX) month waiting period calculated from the inception date;
- 7.3 Specialist benefits are subject to a 90 (NINETY)day waiting period calculated from the inception date, unless otherwise stated herein;
- 7.4 Optometry benefits are subject to a 12 (TWELVE) month waiting period calculated from the inception date, with one set of frames per 24-month period, unless otherwise stated herein;
- 7.5 Accident Permanent Disability Cover:
- 7.5.1 If during the period of the Policy the Principal Member Only or Principal Member and Spouse if Benefit Level 3 is selected, within the Territorial Limits, sustains Bodily Injury which directly and independently of all other causes results within 24 (TWENTY FOUR) calendar months of the Accident, in Permanent Disability as specified in the circumstances set out in the Insuring Section to this Policy, the Insurer agrees to pay to the Principal Member or his/her estate the Compensation stated in the Insuring Section;
- 7.5.2 The following percentage shall be payable in the event of Bodily Injury resulting in:
- 7.5.2.1 Permanent Total Disability - 100%
- 7.5.2.2 Permanent and total loss of or use of:
- 7.5.2.2.1 Speech: 100%
- 7.5.2.2.2 Hearing in both ears: 100%

7.5.2.2.3 Any limb by physical separation at or above wrist or ankle of one or more limbs: 100%

7.5.2.2.4 One or both eyes: 100%

7.5.3 For Permanent Disability, the compensation shall be limited to:

7.5.3.1 Benefit Level 1: R200 000 only for principal;

7.5.3.2 Benefit Level 2: R250 000 only for principal;

7.5.3.3 Benefit Level 3: R250 000 for principal and spouse/ partner;

7.5.3.4 There is no Permanent Disability Cover available on a Junior Policy;

7.6 Accident Stated Benefit for Hospital Stay Cover:

7.6.1 For an Accident resulting in Hospitalisation, the compensation shall be limited to:

7.6.1.1 Benefit Level 1: for single member, an amount of up to R75 000 per incident and an AOL of R150 000 for family, an amount of up to R150 000 per incident and an AOL of R300 000

7.6.1.2 Benefit Level 2: for single members, an amount of up to R125 000 per Insured Person per Accident and up to R250 000 AOL; For family, an amount of up to R250 000 per incident with an AOL of R500 000

7.6.1.3 Benefit Level 3: for single members, an amount of up to R200 000 per Insured Person per Accident and up to R400 000 AOL; For family, an amount of up to R400 000 per incident with an AOL of R800 000

7.6.1.4 Benefit Level 4: for single members, an amount of up to R300 000 per Insured Person per Accident and up to R600 000 AOL; For family, an amount of up to R600 000 per incident with an AOL of R1 200 000 AOL

7.6.1.5 Benefit Level 5: an amount of up to R500 000 per Insured Person per Accident and up to R1 000 000 AOL; For family, an amount of up to R1 000 000 per incident with an AOL of R2 000 000

7.7 Temporary Total Disability (Illness) in Hospital Cover:

7.7.1 The Insurance Cover afforded any Insured Person for Temporary Total Disability will only come into effect 3 (THREE) months after the Commencement Date;

7.7.2 If during the period of the Policy any Insured Person, within the Territorial Limits, sustains an Illness which first manifests itself after 3 (THREE) months from the Commencement Date stated in the Policy Schedule which directly and independently of all other causes results within fourteen days of the onset of such Illness, as defined, in Hospitalisation, the Insurer agrees to pay to the Insured Person the compensation stated in the Insuring Section;

7.7.3 The Compensation specified for Temporary Total Disability shall cease as soon as the Insured Person has been discharged from Hospital;

7.8 ICU and High Care Benefit: A maximum of 5 (FIVE) days benefit at daily rates limited to an amount per Benefit Level selected for ICU or High Care Benefit. The same waiting periods pertaining to Hospitalisation benefits and Pre- Existing conditions shall be applied;



- 7.9 Specific Stated Conditions Benefits: A 12 (TWELVE) month waiting period and in the case of the Hysterectomy benefit, a 24 (TWENTY FOUR) month waiting period is applicable to the Benefit amounts applicable up to the maximum benefit as stated in section 7 or costs, whichever is the lesser. This Benefit cannot be used in combination with the Daily Illness Benefit amounts
- 7.10 Dread Disease:
- 7.10.1 If during the Period of Insurance any Insured Person is diagnosed as suffering from a Dread Disease, symptoms of which were not present in the 24 months prior to the Inception of the Policy and which symptoms manifested itself after 12 (TWELVE) months from the Inception Date stated in the Policy Schedule, the Insurer agrees to pay the Insured as Compensation the sum stated in the Schedule of Compensation;
- 7.10.2 Upon discharge from the Hospital and after the Insured Person has survived for a period of 30 (thirty) days from the date of discharge the amount of Compensation that will be paid shall be costs incurred, up to selected Benefit Level and in accordance with Graded Compensation as per SCIDEP;
- 7.10.3 It is declared that upon payment of 100% of the Compensation for any one claim under Dread Disease in respect of any Insured Person, all cover provided to the Insured shall be terminated with immediate effect and cannot be reinstated in respect of the Dread Disease Benefit that has been paid for that Insured Person;
- 7.10.4 Compensation under Dread Disease shall not be in addition to benefit received from Temporary Total Disability Illness in Hospital.
- 7.11 Funeral Benefit: Waiting period of 90 days applicable to Natural Causes. In the event of the death of an Insured Member, the following amounts are payable:
- 7.11.1 Benefit Level 1: R10 000,
- 7.11.2 Benefit Level 2: R20 000,
- 7.11.3 Benefit Level 3: R30 000
- 7.11.4 Principal Member: 100% of Benefit amount
- 7.11.5 Spouse and Children over the age of 14: 75% of Benefit amount
- 7.11.6 Children over the age of 6: 50% of the Benefit amount
- 7.11.7 Children over 28 weeks' gestation and under the age of 6: 25% of the Benefit amount
- 7.11.8 Stillborn to 28 weeks: R1250
- 7.11.9 There are no Funeral Benefits applicable to the Junior Policy;
- 7.12 Casualty Room Benefit: Benefit amounts are according to Benefit Level Selected, namely
- 7.12.1 Level 1: R2000 per annum,
- 7.12.2 Level 2: R4000 per annum and
- 7.12.3 Level 3: R6000 per annum;

7.12.4 The Casualty Room Benefit is only available after hours and must be pre-authorized by Essential Med

## 8 DISPUTE RESOLUTION

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- 8.1 Should any dispute, disagreement or claim arise between the parties concerning this Policy agreement ("the Dispute"), the parties shall endeavor to resolve the Dispute by referring the Dispute to the Arbitration Foundation of Southern Africa ("AFSA") for final resolution by way of arbitration in accordance with the rules of AFSA by an arbitrator or arbitrators appointed by AFSA.
- 8.2 The Arbitrator shall, if the matter is of a financial nature, be a Chartered Accountant, registered as such at the South African Institute of Chartered Accountants, and have in excess of 10 (TEN) years financial accounting experience; and if the matter is of a civil nature, be an Attorney registered with the Law Society of South Africa, and have in excess of 10 (TEN) years civil and insurance related practical experience;
- 8.3 Unless otherwise agreed in writing by the parties, any such arbitration shall be held at the nearest metropolis where Insured Person resides;
- 8.4 Each Party to this Policy irrevocably:
- 8.4.1 consents to any arbitration in terms of the aforesaid rules being conducted as a matter of urgency; and
  - 8.4.2 authorises the others to apply, on behalf of the parties to such Dispute, in writing to the secretariat of AFSA in terms of the aforesaid rules for any such arbitration to be conducted as a matter of urgency, provided that the party, which, intends so applying first notifies the other parties in writing of its intention to do so;
- 8.5 The provisions of this clause 8 shall not preclude a party from seeking urgent interim relief from the appropriate Court of law;
- 8.6 For the purposes of clause 8 and for the purposes of having any award made by the arbitrator(s) being made an order of court, each of the parties hereby submits itself to the High Court of South Africa or its successor in title or assigns;
- 8.7 This clause 8 constitutes an irrevocable consent by each of the parties to any proceedings in terms hereof, is severable from the rest of the Policy agreement and shall, notwithstanding the termination hereof, remain in full force and effect.

## 9 DOMICILIUM

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- 9.1 The *domicilium citandi et executandi* address of a Principal Member shall be the address set out in the application form or such later address as notified in writing.

- 9.2 For purposes of this Policy, the Insurer's addresses shall be address at Riesling House, The Vineyards Office Estate,99 Jip de Jager Drive, Bellville; +27 86 1234 556 (facsimile), for the attention of the Company Secretary.
- 9.3 Any notice given in terms of this Policy shall be in writing and shall
- 9.3.1 if delivered by hand be deemed to have been duly received by the addressee on the date of delivery;
  - 9.3.2 if posted by prepaid registered post be deemed to have been received by the addressee on the 8th (EIGHTH) day following the date of such posting;
  - 9.3.3 if transmitted by facsimile, e-mail or Short Message System (SMS), be deemed to have been received by the addressee on the day following the date of dispatch, unless the contrary is proved;
- 9.4 Notwithstanding anything to the contrary contained or implied in the Policy Agreement, a written notice or communication actually received by the Insurer or a member from the other as the case may be, including by way of facsimile transmission shall be adequate written notice or communication to such party.

## 10 GENERAL

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- 10.1 This agreement constitutes the entire insurance policy and that no other conditions, stipulations, warranties and representations whatsoever, have been made by any party or that party's agent, other than as specifically included herein.
- 10.2 No latitude, extension of time or other indulgence which may be given or allowed by either party to the other in respect of any payment provided for in the Policy or the performance of any other obligation shall under any circumstances be construed to be an implied consent by such party or operate as a waiver or a novation of or otherwise affect any of the affording party's rights in terms of or arising from the Policy, or prevent such party from demanding, at any time and without notice, strict and punctual compliance with each and every provision or term hereof.
- 10.3 No amendment or cancellation of the Policy shall be of any force and effect unless such amendment or cancellation is in writing and signed by the Insurer.
- 10.4 This Policy does not accumulate cash or surrender value and may not be converted into a paid-up policy. The Insurer specifically determines that no loans will be allowed in terms of the Policy.
- 10.5 Statements made by the Insured Person relating to the Policy will be deemed to be true and incontestable.
- 10.6 The parties consent to the jurisdiction of the High Court of South Africa, to hear and determine any action or proceeding, which may result from or arises from the Policy, but nothing prohibits the Insurer to institute action in any competent Court having jurisdiction over the matter thus contested.

**INSURER:** **AFRICAN UNITY LIFE PROPRIETARY LIMITED**, an authorised financial services provider; Registration number 1911/0038181/06. FSP No. 8447

**INTERMEDIARY:** **ESSENTIAL MEDICAL PROPRIETARY LIMITED** Registration number: 2011/116999/07. FSP No. 42980

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## ANNEXURE 1

### DEFINITIONS OF HEART ATTACK, STROKE AND CANCER

#### 1 BACKGROUND

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- 1.1 The Policy together with this Annexure 1 constitutes an indivisible agreement between the parties.
- 1.2 All words and expressions defined in the Policy shall have a similar meaning in this Annexure 1 unless expressly stipulated otherwise or inconsistent with, or otherwise indicated by the context.

#### 2 SCIDEP DEFINITIONS

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- 2.1 For purposes of this Policy, the Dread Diseases shall bear the meanings as assigned to it in the Policy or this Annexure 1, which ever applicable, which definitions are prescribed in terms of the SCIDEP definitions.
- 2.2 For the sake of convenience, a layman's definition is included herein due to the complexity of the medical definitions of Dread Diseases.
- 2.3 CANCER
  - 2.3.1 Cancer is an uncontrolled growth that spreads into the normal tissue surrounding the organ where the cancer originates. The diagnosis must be supported by tests where a pathologist confirms the presence of cancer using a microscope. Some cancers have been specifically excluded because the long-term outcome is good and the effect on quality of life is minimal; and treatment is neither expensive nor extensive.
  - 2.3.2 there are specific exclusions to this definition that include:
    - 2.3.2.1 Cancerous cells that have not invaded the surrounding or underlying tissue;
    - 2.3.2.2 Early cancer of the prostate gland and breast; and
    - 2.3.2.3 All cancers of the skin except cancerous moles that have invaded underlying tissue.
  - 2.3.3 Staging of cancer:
    - 2.3.3.1 As a general rule there are four stages of cancer.
      - 2.3.3.1.1 Stage 1 cancer is defined by an invasive cancer confined to the tissue or organ of origin.

2.3.3.1.2 Stage 2 cancer is defined by the involvement of adjacent structures or organs.

2.3.3.1.3 Stage 3 cancer involves spreading to regional lymph nodes.

2.3.3.1.4 Stage 4 cancer is characterized by distant metastasis.

2.3.3.2 However, each type of cancer is staged specifically by the American Joint Committee for Cancer (AJCC). This staging is based on the outcome of the specific cancer and does not always follow the general rule as stated above.

2.4 HEART ATTACK: Four levels of severity of heart attacks are defined:

2.4.1 Level D is the mildest and Level A the most severe;

2.4.2 In both Levels C and D the patient recovers fully and the heart function returns to normal;

2.4.3 In Levels A and B, more permanent damage has resulted, which means the heart function is less than 100% after recovery;

2.4.4 The effect of the heart attack on heart function should be measured weeks after the heart attack;

2.4.5 Level A: Heart attack severe impairment in function:

2.4.5.1 These are heart attacks where a significant proportion of the heart muscle was damaged. The same tests are used to measure the damage as under Level B but the results would show a more serious level of impaired function;

2.4.5.2 This person will have difficulty coping with normal activities of daily living, and will most likely not be able to work.

2.4.6 Level B: Heart attack with mild permanent impairment in function:

2.4.6.1 This is usually a heart attack that does not recover 100% of normal function. The degree of permanent damage can be measured by heart sonar, an exercise tolerance test or a measurement of physical abilities. These measurements should be performed 6 weeks after the heart attack;

2.4.6.2 A person with this level of heart damage should still be able to manage normal daily activities and even his/her occupation, if the occupation does not involve strenuous physical work. However, this person's insurability will be adversely affected, and the future risk for a repeat cardiac event is high. Significant life-style adaptation and risk factor modification are indicated.

2.4.7 Level C: Moderate heart attack of specified severity:

2.4.7.1 In this case damage to the heart muscle is more than in Level D. In some cases a cardiologist will intervene early and reverse the potential damage. This intervention may include administration of drugs to dissolve the blood clot in the coronary artery(ies), balloon stretching of the coronary artery, with or without a stent.

2.4.7.2 Because the clinical methods of diagnosing this level of heart attack are unambiguous, only two of the three criteria are required:

2.4.7.2.1 Typical chest pain or other symptoms typically associated with a heart attack;

2.4.7.2.2 Certain defined ECG changes. At this level the changes are more marked and more specific to a heart attack;

2.4.7.2.3 Elevated blood test results greater than required for Level D.

2.4.8 Level D: Mild heart attack with full recovery: This is a heart attack where the ECG changes and blood test results are mildly abnormal. Therefore, all three criteria are required, e.g. typical chest pain or other symptoms associated with a heart attack; and certain defined ECG changes; and an elevation in certain blood test results.

## 2.5 STROKE

2.5.1 A stroke occurs when the blood supply to a portion of the brain is obstructed and this part of the brain tissue dies. It can also happen when there is bleeding into the brain tissue due to a weakening or abnormality of the blood vessel wall. A common cause of the rupture of a brain blood vessel is longstanding uncontrolled high blood pressure.

2.5.2 The result of a stroke is usually paralysis of an arm and leg, sometimes with one half of the face affected as well. In some cases people also lose their ability to speak. The paralysis can recover to varying degrees. Some recover fully, whereas others may retain permanent weakness of a limb(s).

2.5.3 A Transient Ischaemic Attack (TIA) occurs when the blood supply is momentarily interrupted, but restored before any permanent damage can occur. It usually results in one or more of the following symptoms:

2.5.3.1 A loss of sensation;

2.5.3.2 Dizziness;

2.5.3.3 Lameness of a limb;

2.5.3.4 Loss of speech, which only occurs for a few minutes to hours and recovery is quick and spontaneous.

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