POLICY WORDING – TERMS AND CONDITIONS

This Policy Document sets out the terms and conditions which regulates our relationship and must be read as one document together with your policy Schedule and any other associated documentation. This Policy shall not be invalidated if any incorrect statement is made in good faith, unless the error of such a statement is likely to have materially affected the assessment of the risk under the Policy at the time the Policy was issued. Please contact our offices if you require any information regarding your Plan. A copy of your Policy Document can also be viewed on our website at www.legalandtax.co.za/compliance or requested from our Customer Service Department by calling 0860 587 587.

If you feel that your personal information has been processed by us without your consent or that your rights, in terms of the POPI (Protection of Personal Information) Act, have been violated, you may send a complaint through to our Information Officer at the following email address: popi@legalandtax.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 consecutive hours) in a facility that meets the definition of a hospital authorised by a Specialist; this does not include casualty wards.

1.3 **Child/Children:** Your biological, legally adopted, or step-child/children who are below the age of 18 (eighteen) years old. You can register up to 5 (five) unmarried children to be covered under your Policy. Certified proof of your relationships will be required. (Not applicable to Individual Plans).

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:** An insured person 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 period allowed for the payment of an outstanding Plan Fee. The Grace Period is 20 (twenty) days from the date you receive written notice that we have not received your payment. In the event of a claim during the Grace Period, the outstanding Plan Fee may be deducted from the cover amount payable.

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

1.10 **Insurer:** Centriq Life Insurance Company Limited ("Centriq Life"), a licensed life insurer and authorised financial services provider (FSP No. 7370).

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

1.12 **Insurance Premium:** The amount included in the Plan Fee and to be paid for the healthcare insurance cash benefit.

1.13 **Insured Person/s:** This is any person listed on the policy Schedule as being covered by the Policy, and which satisfies the definitions of a Policyholder, Spouse, and Child added to your Plan.

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.

1.15 **Plan:** The healthcare insurance cash benefit and if applicable VAS (Value-added Service) benefits.

1.16 **Plan Fee:** The total amount you are required to pay monthly in advance, in order to enjoy both the insurance and VAS benefits of the Policy.

1.17 **Policy:** This document, read together with the Schedule, which governs all aspects of our relationship.

1.18 **Policyholder:** The main insured person reflected in the Schedule. A legal entity cannot be the Policyholder. The Policyholder

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Legal and Tax Services (Pty) Ltd is an authorised Financial Services Provider, FSP No. 28566
Legal Expense Insurance products are underwritten by Centriq Insurance Company Limited ("Centriq"), a licensed non-life insurer and authorised financial services provider, FSP No. 3417
Funeral Insurance products are underwritten by Centriq Life Insurance Company Limited ("Centriq Life"), a licensed life insurer and authorised financial services provider, FSP No. 7370
HealthCare Plan Insurance products are underwritten by Centriq Life Insurance Company Limited ("Centriq Life"), a licensed life insurer and authorised financial services provider, FSP No. 7370

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.

1.19 **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.

1.20 **Professional Sport:** Participation in a sporting activity, from which income is earned.

1.21 **Schedule:** The document to which this Policy is attached that contains important information on the Insured Persons, Plan benefits, Plan Fees payable and the maximum cover amount.

1.22 **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 by the Policyholder. There may only be 1 (one) Spouse insured under this Plan at any point in time. Certified proof of such relationships will be required. (Not applicable to Individual Plans).

1.23 **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.

1.24 **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.

1.25 **Value-Added Services (VAS):** These are services and benefits that form part of your Plan over and above the insurance cash benefit underwritten by the Insurer. Any value-added service that forms part a Plan will be indicated next to the relevant heading by using the following format: **[VAS]**.

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

2 YOUR HEALTHCARE PLAN

2.1 Your Plan is a healthcare insurance product which pays a fixed cash amount in the event of hospital admission, subject to the terms and conditions of this Policy. Take note this insurance cash benefit is not a medical aid and under no circumstances must it be considered as a replacement for the benefits offered by a medical aid.

3 COVER AMOUNTS

3.1 The cover amount (i.e., the amount your Plan will pay in the event of the hospital admission of a person covered by the Policy).

4 BENEFIT

Your Policy provides the following cover per year:

4.1 If the insured person 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 capped daily insurance cash benefit per day starting from the first day of admission by a specialist, but limited to a maximum period of 4 (four) days per hospitalisation event. This insurance cash benefit is limited to 20 (twenty) hospitalisation days per year per Policy.

4.2 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.

4.3 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 WHO THE PLAN COVERS

5.1 You, and subject only to the Family Plan, your Spouse and a maximum of 5 (five) unmarried dependent Children under 18 (eighteen) years of age and as listed in the Schedule are covered.

6 MONTHLY PLAN AND PAYMENT TERMS

6.1 You must pay the Plan Fee (which is set out on your policy Schedule) monthly, in advance. The Policy automatically continues for 1 (one) month at a time, until cancelled.

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

6.3 If your Plan Fee is unpaid, you will have a 20 (twenty) day Grace Period to pay the Plan Fee, which period will run from the date we notify you of non-payment. We will debit your account again to collect the next monthly Plan Fee. If the debit order is met, your insurance benefit starts again from that payment, and you may be subject to a new Waiting Period if not previously satisfied.

6.4 If your Plan Fee is unpaid on 2 (two) successive due dates your Plan will be cancelled.

6.5 If you wish to reinstate your Policy, you may do so within 2 (two) months of it being cancelled, but you may be subject to new Waiting Periods if not previously satisfied.

6.6 Should a claim related to an event occur during an unpaid period, any Plan Fees missed may be deducted from the applicable cover amount.

7 HOW TO CANCEL YOUR PLAN

7.1 You may cancel your Plan within the first 31 (thirty-one) days of receipt of your Policy Document (cooling-off period) and we may refund any Plan Fee paid. You may need to submit supporting documentation before any refunds are processed.

7.2 You may cancel at any time after the cooling-off period, and you can either call us or send a written request. The Policy will automatically be cancelled if your debit order is returned unpaid by your bank with an unpaid code that requires us to stop debiting your account. We do not refund Plan Fees outside of the cooling-off period unless there was no consent to debit your account.

7.3 We are also entitled to cancel the Policy at any time with 31 (thirty-one) days written notice, without reasons.

7.4 The Policy is automatically cancelled upon notification of the Policyholders death.

8 WAITING PERIODS

8.1 There is no waiting period for admission due to an accident.

8.2 A waiting period of 3 (three) months together with 3 (three) consecutive Plan Fee payments from the date of first payment will apply in the event of an insured person 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 Plan Fee payments from the date of first payment will apply in the event of an insured person being hospitalised for any pre-existing medical condition, including but not limited to physical defect, illness, bodily injury or disability that existed prior to the inception date and 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 insured person to seek the necessary medical attention as recommended by their specialist 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 Plan Fees 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 is 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 specialist 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 or a diagnosis, including observation due to the patient not leaving despite being discharged, 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 Preventative hospitalisation, including quarantine.

9.18 Abortion not medically necessary.

9.19 Any treatment relating to non-disclosure of a symptom, illness 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 a claim being repudiated or the cancellation of this Policy.

11 HOW TO REPORT CLAIMS

11.1 We must be notified within 30 (thirty) days of the discharge of any insured person, failing which we may elect to repudiate a claim.

11.2 When there is a potential claim, you must contact our Customer Service Department on 0860 587 587 to assist you with a claim sheet as well as the list of supporting documentation you will need to provide to submit a claim.

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

11.4 With the exception of accidents, claims may 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 your completed claim sheet, we may still request further information should we feel this information will be required or necessary to prove a claim. Failure to provide further information within a reasonable period, normally 30 (thirty) days, may result in the closure of your claim until such time as you comply. If at a later stage, the further information is received, a claim may be repudiated if Policy conditions are not satisfied.

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 shall at all times have the right to inspect all documents relating to a claim and will communicate with you, a claimant or specialist regarding any information.

11.9 Cover of a claim cannot be approved orally or over the phone, and must be authorised in writing.

11.10 Provided we have received the claim sheet (fully completed with all supporting information), claims may be paid within 24 (twenty four) hours of being approved, excluding weekends and public holidays.

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 We are entitled to submit your medical records to a medical expert to obtain a medical opinion and we reserve the right to determine the amount of days which are reasonable to be hospitalised based on a medical opinion received, and we shall accordingly determine whether or not a claim meets the criteria of an admission exceeding 48 (forty-eight) hours.

11.13 In the event of the death of an insured person we shall be entitled to have a post-mortem examination done where it is not prohibited by law.

11.14 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 Policy 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 Only hospitalisation within the South African borders will be considered.

12.3 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).

12.4 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.

12.5 Should an illness, symptom or treatment to the same injury reoccur within a 6 (six) month period of your last admission, it will be deemed to be part of the initial illness or treatment and associated claim.

12.6 This Policy is intended as a risk cover. If the insured person entered into this Policy with prior knowledge of a foreseeable or predicted medical event or condition that wouldn't 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.

12.7 It is the duty of the insured person to disclose all medical and health information prior to the inception date. It remains the duty of the insured person 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.

12.8 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.

12.9 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.

12.10 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 insured person, 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.

12.11 If you submit a claim and there is both a basis for exclusion and a basis for cover, then if the basis for exclusion is either the dominant or the initiating cause of the facts, we may repudiate your claim.

12.12 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.

12.13 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 cover is not approved and a claim is repudiated, you, or a claimant will be notified in writing, and you will be provided with detailed reasons for such a decision.

13.2 If you, or a claimant do not agree with the repudiation, you have 90 (ninety) days to make written representations to us. Complaints may also be lodged directly with the Insurer (complaints@centriq.co.za), the FAIS Ombud, the Long-Term Insurance Ombudsman or the Financial Sector Conduct Authority.

13.3 You, or a claimant 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, the claim will lapse.

14 ANNUAL INCREASE

14.1 We may increase the Plan fee each year by an amount not exceeding 10% based on product review performance or additions. The maximum cover amount may increase by an approximate corresponding percentage provided that it does not exceed that allowed by legislation. You will have 31 (thirty-one) days' notice before the increase takes effect.

14.2 If you are dissatisfied with the increase, you may select a more affordable Plan (if applicable), or you may cancel, failing which the increase will come into effect.

14.3 If your claim has been approved the maximum cover amount may not increase due to the annual increase in your Plan Fee, but will remain at the amount applicable when the claim was approved.

15 NOTICES AND COMMUNICATIONS

15.1 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 such 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 amendments.

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 ADDITIONAL BENEFIT [VAS PROVIDED BY ER24]

17.1 Your Policy includes Trauma Assist [VAS] which offers face-to-face or telephonic trauma counselling from a qualified Trauma Counsellor and access to unlimited private ambulance service to the nearest private or public hospital should you or someone covered under your policy have been involved in an emergency and requires ambulance assistance. Unlimited access to a telephonic nurse on call 24 hours a day, 7 days a week.

18 TREATING CUSTOMERS FAIRLY (TCF)

18.1 TCF was implemented by 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.

18.2 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 believe.
- **Outcome 6:** Customers do not face unreasonable post-sale barriers to change products, switch providers, submit a claim or make a complaint.

19 COMPLAINTS

19.1 The purpose of our Complaint Resolution Policy is to ensure compliance with the Short-Term and 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

19.2 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@legalandtax.co.za. The complaint should contain sufficient detail regarding:

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

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

19.2.3 Full details of the Policy or policy number, where applicable;

19.2.4 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

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

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

19.3.2 It will be assessed and logged into our central complaints register. The complaint will be allocated to our trained and skilled Complaints Officer.

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

19.3.4 We will provide a response in writing or verbally with full reasons for our decision.

19.3.5 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:

19.3.5.1 Refer the matter to the Insurer being Centriq by emailing complaints@centriq.co.za.

19.3.5.2 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 0860 663 247.

19.3.5.3 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.

19.3.5.4 Alternatively refer the matter to the Financial Sector Conduct Authority by contacting them on +27 (12) 428 8000 or visit their website www.fsca.co.za.

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

19.3.5.6 Refer the matter for conciliation.

20 PERSONAL INFORMATION AND COMMUNICATIONS

20.1 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.

20.2 Your information shall be kept confidential. However, we may disclose it to certain third parties (as required in the normal course of our business), 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.

20.3 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 the personal information that we process to ensure that your privacy and confidentiality is upheld.

20.4 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.

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

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

This document is to be read together with our Privacy and PAIA Policy 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 Privacy Policy, 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 Customer Service Department to info@legalandtax.co.za, our Information Officer to popi@legalandtax.co.za or contact us on 0860 587 587.