POLICY WORDING – TERMS AND CONDITIONS

The HealthCare Prestige Plan provides Non-medical expense cover as a result of hospitalisation, and is underwritten by Centriq Life Insurance Company limited, a licensed life insurer and authorised financial services provider (FSP No. 7370). This document sets out the terms and conditions which govern our relationship, and must be read as one document together with any other associated 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 offices should you require any information on any aspect of your plan. A copy of the policy wording can also be viewed on our website at legalandtax.co.za or you may contact our customer care department.

Your plan 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.

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 (Protection of Personal Information) Act have been violated in any way, you may send a complaint through to our POPI Officer at the following email address popi@legalandtax.co.za, or you may submit your complaint directly to the Information Regulator.

SECTION A – GENERAL PROVISIONS

In this policy all words and expressions signifying the singular shall include the plural and the plural shall include the singular. Words and expressions implying the masculine gender shall include the feminine. The following words and expressions shall have the following meanings:

1. DEFINITIONS

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; 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 on behalf of your child.

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. **Cover Amount:** The limited or fixed amount payable to the Insured by the Insurer as per the Welcome letter, Schedule or any other associated documentation.

1.7. **Day**: A 24-hour period.

1.8. **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.

1.9. **Exclusions**: The benefit does not cover everything because there are exclusions and limitations, all of which are set out below in section 10 (ten) and 11 (eleven).

1.10. **Grace Period**: The interval allowed for the payment of an outstanding premium. The grace period is 20 (twenty) days from the day after your premium was due.

1.11. **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.

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

1.13. **Inception Date**: The day that you receive confirmation that your policy has been activated.

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

1.15. **Insured**: A natural person, being the Policyholder, spouse or child*, who has been accepted by the Insurer under this policy and whose premium is paid and up to date. All members must be South African permanent residents or have permission by the relevant authority to reside and or work in the Republic of South Africa. We may ask for proof of such permission. (*Spouse and children are only covered on the Family Plan).

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

1.17. **Intermediary**: Legal and Tax Services (Pty) Ltd is an Authorised Financial Services Provider, FSP No. 28566. "We" or "Us" may be used interchangeably.

1.18. **Month**: One full calendar month commencing on the first day of each month.

1.19. **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 six-month period, it will be deemed to be part of the initial illness and associated claim.

1.20. **Plan**: The HealthCare Insurance cover as well as any value-added services included in your product, which is either the Individual Plan or Family Plan as set out in your Welcome Letter.

1.21. **Policy:** This Policy document, read together with the Welcome Letter or Schedule, is your Policy, which governs all aspects of our relationship.

1.22. **Policyholder:** The main member and person reflected 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. The minimum entry age for a Policyholder is 18 (eighteen) years. "You" or "Your" may be used with the same meaning.

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

1.24. **Premium**: The amount you are required to pay monthly in advance, in order to enjoy the benefits of the Plan. The premium amount is set out in the Schedule.

1.25. **Professional Sport**: The insured's participation in a sporting activity, from which most of the insured's income is earned.

1.26. **Schedule**: The document with your Welcome Pack to which this Policy is attached. In addition to other important information, the Schedule contains the Cover Amount.

1.27. **South African Borders**: The land within the registered and published national boundaries of the Republic of South Africa.

1.28. **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.

1.29. **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 months or more) and as nominated in writing by the Policyholder. There may only be one (1) spouse insured under this Plan at any point in time. Certified written proof of such relationships will be required.

1.30. **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.

1.31. **Value-Added Services (VAS):** These are services and benefits that form part of your Plan over and above the HealthCare 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]**. Value-added services are provided by ER24.

1.32. **Waiting Period**: The period during which no claims will be paid (see clause 5).

2. EASE OF USE

We have a variety of ways for you to use our services:

- Phone us on 0860 587 587
- Email info@legalandtax.co.za. We will be in touch
- SMS the word "Health" to the short code 31690. We will call you
- WhatsApp + (27) 71 526 8527
- Visit our website: www.legalandtax.co.za

3. ONE PLAN PROTECTS THE WHOLE FAMILY (NOT APPLICABLE TO INDIVIDUAL PLAN)

3.1 Not just you, but also your Spouse and up to 5 (five) Children are covered. A legal entity (e.g. a company, trust, partnership) cannot be a member of the Plan, and all insured persons must be a South African permanent resident or be in possession of a valid work permit. If your spouse or child wishes to make use of the Insurance benefit, you will need to show that both the date of your marriage, union or life partnership and or date of adoption, and the date of the facts giving rise to the claim all took place after the expiry of the Waiting Period (see 5 below). Cover for mentally or physically incapacitated children over the age of 18 may be added as beneficiaries subject to approval by us and provided the children are financially dependent on the principal insured for support and maintenance. Necessary documentation in support of this will be required by us prior to considering any application.

3.2 Third generation dependents will not be covered.

3.3 Only one policy may be issued to any one insured person.

SECTION B – YOUR HEALTHCARE INSURANCE BENEFIT

4. BENEFIT

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

4.1. If the Insured is admitted as an in-patient to a hospital for more than 48 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, 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.

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 13 herein and only into the bank account of the Policyholder and or nominated premium payer.

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

4.5. Partners and benefits may change from time to time.

ADDITIONAL BENEFITS

- **Trauma Assist** [VAS] – one call connects you to vital assistance (emergency ambulance service, rape and assault counselling, HIV counselling, traumatic event advice and more). This service is provided by ER24.
- Our Trauma Assist line operates 24/7 (call 0860 587 587) or dial *120*15570# from your cell phone.

5. WAITING PERIODS

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

5.2 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 member being hospitalised due to natural causes (namely internal factors like an illness).

5.3 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 member 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.

5.4 In the event of a claim being declined 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 to seek the necessary medical attention as recommended by their physician or medical practitioner.

5.5 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 will be rejected.

6. HOW TO CANCEL YOUR PLAN

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

6.2 Should your policy be cancelled in writing within the first 31 (thirty-one) days of the date of receipt of the policy application (cooling off period), the premium will be refundable if it has been deducted from your bank account. You may need to submit supporting documentation before any refunds are granted.

6.3 The plan will automatically be cancelled if your debit order is returned unpaid by the bank with an unpaid code that requires us to stop debiting.

6.4 The plan automatically cancels upon notification of the Policyholder's death.

6.5 We do not refund premiums unless there was no authority to debit your account.

6.6 We reserve the right to cancel your policy by giving you 31 (thirty-one) days written notice prior to cancellation.

7. MONTHLY PLAN, PAYMENT TERMS AND UNPAID DEBIT ORDERS

7.1 You must pay the amount due (which is set out in your Schedule) monthly in advance ("the Premium"). The Plan will automatically continue for 1 (one) month at a time, until you stop paying the premium.

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

7.3 The cover in this policy has no surrender/cancellation/maturity values.

7.4 If the premium is not paid within the grace period, you will lose all insurance benefits of the Plan going forward, until we receive another payment. We will continue to debit your account in an attempt to collect the next monthly premium. If the debit order is met, your insurance benefit starts again from that payment, and you may be subject to a new Waiting Period.

7.5 If your debit order is unpaid on 2 (two) successive due dates, we will automatically apply the Protector Benefit to your Plan, which is designed to offer you Value Added Services at a lower premium. This means that you will not have any insurance cover, however, you will still be able to get emergency assistance and ambulance transportation, unlimited access to a nurse via the call centre and trauma counselling. All these details will be set out in a new Welcome Pack which will be sent to you. If your first Protector debit order is returned unpaid, your Plan will be cancelled and we will not debit you again without you requesting us to do so.

7.6 Should you request us to reactivate your policy, your policy will start afresh from the payment of the next premium and may be subject to new waiting periods.

8. ANNUAL INCREASE

8.1 We may increase the premium each year by an amount not exceeding 10%. The Maximum Cover Amount may increase by a corresponding percentage. You will be informed of any increase to the premium.

8.2 The liability of the Insurer shall be limited to the cover as stated in this policy.

9. GENERAL TERMS

9.1 We can amend these terms and conditions on 1 (one) month's written notice. If you are unhappy with the amendment, you may cancel within 1 (one) month of receiving notification, failing which the amendment will come into effect.

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

9.3 If we need to send you a written 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) days if sent by letter.

9.4 If we fail to enforce any provision strictly or at all, this does not mean that we waive any of our rights thereto, nor does it mean that we will not enforce it thereafter.

10. CONDITIONS FOR COVER

10.1 The benefit does not cover everything because there are exclusions and limitations, all of which are set out below. The following are conditions which have to be met before a claim will be approved. Even after approval, we will withdraw cover if any one of these conditions are not completely met.

10.2 You may not have more than one HealthCare Plan entered into through the intermediary (Legal and Tax Services Pty Ltd). 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 4.1.

10.3 Only hospitalisation within the South African borders will be considered.

10.4 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).
10.5 Your admission to hospital must be immediate or within 48 hours of accident and/or injury occurring or recommendation made by a specialist medical practitioner that the symptoms of your illness requires admission to hospital.
10.6 Should an illness, symptom or treatment to the same injury reoccur within a six-month period, it will be deemed to be part of the initial illness or treatment and associated claim.
10.7 This policy is intended as a risk cover. If the insured entered into this policy with prior knowledge of a foreseeable or predicted medical event that would ordinarily be covered under this policy, but failed to disclose such a medical event then we will not be liable to indemnify you in terms of this policy.
10.8 It is the duty of the insured to disclose all medical and health information prior to the inception date. It remains the duty of the Insured 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.
10.9 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.
10.10 Should any benefit have been paid out on the basis of false and or incorrect information provided by the Insured, 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.
10.11 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 insured, 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.
10.12 If you submit a claim and there is both a basis for exclusion and a basis for cover, we will reject the claim where the main cause of the action falls under the exclusions for this policy.
10.13 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.
10.14 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 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 hours, you need to report the crime as soon as reasonably possible.

11. EXCLUSIONS

We will not be liable to pay if any admission to hospital arises directly or indirectly from:

11.1 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.
11.2 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.
11.3 Medical treatment or rehabilitation for any drug or substance abuse.
11.4 Treatment for mental illnesses.
11.5 Hazardous professional or contact sports activities (except if such a sport is being played at school or club level).
11.6 Treatment consequential to refusing or delaying medical treatment or to remain under the care of a physician or medical practitioner.
11.7 Self-inflicted injuries including suicide.
11.8 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.
11.9 Specialised dentistry, dental conditions and dental operations including, but not limited to, wisdom teeth removal, jaw surgery, orthodontic procedures and treatment of dental abscesses.
11.10 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.
11.11 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.

11.12 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.
11.13 Pregnancy, childbirth and pregnancy related treatment where conception occurred prior or within the waiting period.
11.14 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.
11.15 Congenital disorders, diseases or abnormalities.
11.16 Sexual transmitted diseases, unless as a direct result of rape or crime that has been officially reported to the South African Police Services.
11.17 All costs incurred during any waiting period and for conditions not disclosed.
11.18 Preventative hospitalisation, including quarantine.
11.19 Abortion not medically necessary.
11.20 All costs that exceed the stated and maximum allowed cover.
11.21 Any treatment relating to non-disclosure of a condition.

12. CLAIMS

12.1 If you have a claim, you will have to submit a claim, by calling 0860 587 587 or emailing claims@legalandtax.co.za. Our service consultants will provide a claim form for you to complete and will require supporting information and documents. You must comply with the requests of our Claims Department. Failure to provide further information within a reasonable period, normally 30 (thirty) days, will result in the closure of your file. If at a later stage, the further information is received, the claim may be rejected if we have been prejudiced.
12.2 You must notify us within 30 (thirty) days of being discharged. We will not accept late notification.
12.3 After receipt of your claim form, we may still request further information if we feel this information will be required to approve your claim.
12.4 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 any nominated beneficiary, alternatively in terms of intestate Succession and or the Executor/trix of the deceased's estate subject to a letter of authority or power of attorney being provided.

13. CLAIM APPROVAL

13.1 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.
13.2 We are entitled to submit your medical records to a medical practitioner to obtain a medical opinion.
13.3 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 13.2, and we shall accordingly determine whether or not your claim meets the criteria of an admission exceeding 48 hours as per clause 4.1 above.
13.4 Cover of a claim cannot be approved orally or over the phone, and must be authorised in writing by the Claims Manager.
13.5 Provided we have received the claim form (fully completed with all supporting information), we will advise you within 7 (seven) working days in writing whether the claim has been approved or rejected.
13.6 Payments will be effected within 24 (twenty-four) hours of being approved.
13.7 We shall be entitled to access any medical and hospital records in relation to an insured's health and copies of such records.
13.8 All certificates, information and evidence required by us shall be furnished in the form prescribed.
13.9 In the event of the death of an Insured we shall be entitled to have a post-mortem examination done where it is not prohibited by law.
13.10 Any receipt or discharge which the insured 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 Insured whether resulting before or after the date of such receipt or discharge.

14. CLAIM REJECTION

14.1 If we reject your claim, you will be notified in writing, and we will give you the reasons for the decision.
14.2 If you wish to contest the rejection, you will have 90 (ninety) days to make written representations to us, to be marked for the attention of the Claims Manager. We will respond in writing within 14 (fourteen) days.
14.3 You may also lodge a complaint under the Financial Services Ombuds Schemes Act or with the Long-term Insurance Ombudsman.
14.4 You have 180 (one hundred and eighty) calendar days from the expiry of the above 90 (ninety) calendar days' period to institute legal action to dispute our decision and if you do not, failing which any claim against us will lapse.

14.5 Failure to provide the claim form (fully completed with all supporting information and evidence), within 30 (thirty) calendar days of first submitting a claim, will result in cover being declined. All costs and expenses incurred in providing us with information or evidence are for your own account.

15. CESSION

No rights or benefits payable under this policy may be ceded or transferred to any third party. You may exercise all rights provided for by this policy without the consent of any of the beneficiaries.

16. TCF (TREATING CUSTOMERS FAIRLY)

16.1 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.

16.2 We subscribe to all 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 product, switch provider, submit a claim or make a complaint.

17. COMPLAINTS RESOLUTION POLICY

17.1 The purpose of the Complaint Resolution Policy is to ensure compliance with the Long-Term Insurance Act, Financial Advisory and Intermediary Services Act (FAIS), the Policyholder Protection Rules and any other applicable legislation. We have embedded the principals of TCF into our culture and it forms the foundation of our commitment to our policyholders.

17.2 All our records are kept for a minimum period of 5 (five) years and this is a statutory requirement in terms of FAIS.

17.3 All of your personal information as per the Protection of Personal Information Act (POPI) will be held for this period.

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

18. COMPLAINT MUST BE IN WRITING

We request that your complaint be submitted to us in writing. Please address your written complaints to the Complaints Officer: complaints@legalandtax.co.za.

19. COMPLAINTS PROCEDURE

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

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

19.2 It will be assessed and, will be logged into our central complaints register.

19.3 The complaint will be allocated to our trained and skilled Complaints Officer.

19.4 The officer will investigate and revert to you with our findings within 5 (five) to 10 (ten) working 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.

19.5 You will receive a response in writing with full reasons.

19.6 In the event that the complaint cannot be resolved, the complainant may have recourse to the following, whichever is applicable:

- Refer the matter to the insurer.
- Refer the matter to the FAIS Ombud within 6 (six) months of notification that the claim cannot be resolved or within 6 (six) months of the FSP's failure to deal with the claim.
- Refer the matter to the Ombudsman for Long-Term Insurance, if appropriate and within their jurisdiction.
- Seek legal advice from an attorney regarding any legal action that may be taken.
- Refer the matter to arbitration or mediation.

19.7 Details of our Complaints Resolution Policy can be found on our website legalandtax.co.za or refer to your welcome pack and associated documents. You may also contact our call centre on 0860 587 587.

20. CONFIDENTIALITY, SHARING AND PROTECTION OF PERSONAL INFORMATION

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) regarding the processing of your personal information. We may use necessary legal means to check and validate the information you provide to us.

20.2 Your information shall be kept confidential, however, we shall 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 as may be otherwise legally required by us.

20.3 Where your personal information is shared with third parties, we 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 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.

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 with is accurate and correct. We will retain your personal information only for as long as we are legally required to and will destroy the personal information you have provided to us upon your request.

20.5 This document is to be read together with our Privacy and PAIA Policy which are available on our website and which you are deemed to have read, accepted and agreed to by taking out this policy with us. 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 care department at the following email address info@legalandtax.co.za.

20.6 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 POPI Officer at the following email address popi@legalandtax.co.za or you may submit your complaint directly to the Information Regulator.