PROSPERITY LIFE

3 in 1 COMBO

COMPLIMED COMPLETE COVER THREE-IN-ONE
EFFECTIVE 2026

The Complimed Complete Cover (3-in-1 Combo) combines GAP Cover, Funeral Cover, and Hospital Cash benefits at the rate insured, up to the limit of indemnity stated.

1. GAP Cover will pay the difference between NAMAF tariff covered by the medical aid fund and the costs charged by the service provider to a maximum of the insured rate whilst hospitalized.

2. The Hospi Cash Benefit provides financial assistance while hospitalized.

3. Funeral cover on the death of an insured Life a cash benefit in accordance with the policy schedule will be payable to assist in defraying funeral costs.

INSURER STANDARD TERMS AND CONDITIONS

Subject to the terms, conditions, and provisions of the policy, the Insurer agrees to pay the Principal Insured Person for an insured incident occurring during the period of cover up to the limit of indemnity stated and the benefit option selected for each section of the policy.

The application and relevant documentation form the basis of the policy agreement.

1. DEFINITIONS

The Policy and Schedule must be read as a summary document and forms the basis of the contract between the Insured and the Insurer.

"Accident" means an unintentional, violent, external, and visible bodily injury.

"Adult Beneficiary" means**,** for Premium purposes, a beneficiary over the age of 21 (twenty-one) including a spouse, an overaged child beneficiary older than 27 (twenty-seven) or special beneficiary for premium purposes.

"Area of Cover" includes Namibia, South-Africa, Lesotho, Eswatini, Mozambique, Botswana, Zimbabwe, Zambia, and Angola. Claims will be paid according to the Insurance Benefit structure.

"**Benefit Year"** means the Insurer's benefit year, being 1 January to 31 December.

"Claim" means compensation requested by the Insured for an insured incident according to the benefit schedule of the insurance policy selected.

"Date of Service" means the date on which a consultation, visit, treatment, procedure, or operation took place. In the event of hospitalisation, it shall mean the date of admission to a hospital.

"Eligible Child" means a biological child or legally adopted child or stepchild of the Policyholder who:

"Eligible child" means a biological child, or legally adopted child or stepchild of the Policyholder who:

(1) The Policyholder is liable for family care and support up to the age of twenty-seven (27) (including the children of common law spouses, a legally adopted child or stepchild).

(2) Is 27 years old on his/her next birthday; the child beneficiary will enjoy a full year benefit during the year he/she turns 28.

"Eligible Spouse" means the spouse of the Policyholder who has not attained the age of 60 (sixty) at commencement of insurance and shall include customary union according to Common Law Custom.

"Emergency Evacuation" means suffering acute illness or life-threatening bodily injury for which the Insured Person is recommended by a designated practitioner to be transported by air or road ambulance for treatment at a different location.

"Exclusions" means the conditions and / or services excluded under this policy.

"Family" means the Policyholders' Eligible Spouse and Eligible Children provided such "family" who elects to insure under the policy.

"FIA" means Financial Intelligent Act, 2007 (Act 3 of 2007) (FIA Act). The Insurer is regulated by the Long-term Insurance Act, 1998 (Act 5 of 1998) and must comply with the (FIA Act) which requires the Insurer to verify the identity of the policyholders and to keep proper supporting records thereof.

"Group" means any number of employees in relation to the employers who are the premium participant.

"Hospital" means a registered institution providing diagnostic and therapeutic facilities for surgical and medical diagnoses treatment and care under the supervision of registered staff and or medical practitioners.

"Inception Date" means the joining date of the Policyholder upon approval of the Insurer notwithstanding the date indicated on the application form, provided Premiums are received for such joining date.

"Illness" means any one somatic illness or disease, which manifests itself during the period of insurance.

"Incident" means any Accident or Illness, which causes an Insured Person to be confined to hospital and to undergo Medical or Surgical Procedures or where emergency evacuation is required due to that one accident or illness.

"Insured Person" means a Policyholder or an Eligible Spouse or an Eligible Child who elects to insure under the policy and who is not a member or a registered dependent of any other registered Medical Aid Fund or Medical Insurance plan.

"Insurer" means Prosperity Lifecare Insurance Limited (Reg. No. 03/LT/13)

"Medical and Surgical Procedures" means any listed procedure based on the Prosperity Rate Insured and further based on the terms and conditions of the insurance policy selected.

"MVA" means motor vehicle accident identified within a number of vehicle classes including cars, buses, motorcycles, off-road vehicles, light trucks, and regular trucks. Powered wheelchairs are specifically excluded from being considered motor vehicles.

"Medical Practitioner" means a legally qualified and registered medical practitioner.

"NAMFISA" means the Namibia Financial Institutions Supervisory Authority established by Act 3 of 2001 as statutory regulatory body.

"Nominated Beneficiary" means the nominated person entitled to be paid the benefits provided for in terms of this policy, upon the death of a Policyholder or the Policyholder in the event of the death of any of the additional insured persons. Such nominated beneficiary must be related by blood or marriage or by custom or tradition.

"Policyholder" means a person who elects to insure under this policy if he/she has not attained the age of 60 (sixty) at commencement of insurance.

"Participating Employer" means the employer named in the schedule employing the eligible employee under a contract of service or apprenticeship.

"Pre-Existing Condition" means any illness or physical infirmity for which the insured was diagnosed or received medical treatment or advice prior to membership.

"Premium" means the annual premium payable by the Policyholders to the Insurer before commencement of cover.

"Prosperity Benchmark Tariff" refers to the scheme rates applied to claims made by Namibian healthcare providers, based on the standard tariffs established by the Namibian Association of Medical Aid Funds (NAMAF) and adjusted by an additional percentage. This adjustment is set at 225% of NAMAF tariffs

"Prorated Benefits" means benefits that are allocated as per the Benefit Year and any Policyholder or his/her beneficiaries that join the Insurance plan during the course of the year will receive prorated benefits on all benefits, to be calculated on the number of months within a benefit year that the Policyholder or his/her beneficiaries is on the Insurance plan. Proration of benefits does not apply on the death of a Beneficiary or for new born Children, where the Policyholder has been a Policyholder for more than 12 months and no exclusions where applied.

"Rate Insured" means the tariff structure used by the Insurer based on the Prosperity Benchmark Tariff.

"Risk Rate" means a penalty placed on the premium of the Insured due to age or claims patterns.

"Self-Inflicted" means intentional injury caused by the person injured – where such person is aware of consequences that can happen e.g., drink and drive or suicide.

"Special Beneficiary" means a Child who is over the age of twenty-seven (27) years, unmarried and handicapped, either physically or mentally and not self-supporting, in which event an adult beneficiary rate shall apply.

"Sum Insured" means the maximum amount payable to any eligible person specified in the Schedule of benefits.

"Treatment" means any form of investigation or examination by means of a consultation or treatment by a medical practitioner for the purpose of treating or monitoring an Insured Person's medical condition arising out of an insured accident.

"Underwriting Protocols" means the guidelines, as amended from time to time, used to underwrite risk and to determine and impose the exclusion level of Pre-Existing Conditions on Individual or on group Member basis.

The Insurer's liability is conditional on the Policyholder claiming the benefit and abiding by the policy terms and conditions.

2. INSURED BENEFIT

2.1. COMPLIMED PLUS - GAP COVER

Only active members and active beneficiaries of registered medical aids under the Administration of Prosperity Health Namibia may participate.

The benefit is subject to the benefits applicable to the medical aid fund.

The benefit of the product only covers the difference between the tariffs charged by the medical practitioner and the tariffs paid by the medical aid fund but does not allow additional benefits to the benefits offered by the medical aid fund.

The "GAP COVER" benefit payable per insured incident is calculated on the difference between the NAMAF medical aid fund tariff and the maximum Rate insured of the Insurer (subject to annual Sum Insured and sub limits as defined).

Benefits are allocated as per the Insurer's Benefit Year and any Policyholder or his/her beneficiaries that join the Insurance plan during the course of the year will receive pro-rated benefits on all insured benefits, calculated on the number of months within an insured benefit year that the Policyholder or his/her beneficiaries are on the insurance plan. Pro-ration of benefits does not apply on the death of a Beneficiary or for newborn Children, where the Policyholder has been a Policyholder for more than 12 months and no exclusions were applied.

The Insurer may impose a waiting period depending on the level of risk ranging from 3 (three) months to a lifelong waiting period on new applications.

The Insurer may decline a new application depending on the level of risk.

The maximum entry age of this policy for principal members and his/her spouse is (60) sixty years.

Specific benefit waiting period will apply to all members, unless otherwise agreed to with the Insurer:

2.1.1. Maternity Benefit

a) 9 month waiting period for individual members and groups with less than 10 principal Insured Lives. This waiting period includes the cost of birth, birth complications, and any medical complication of the newborn Child.

b) Should the Insurer establish a non-disclosure on pregnancy, the Insurer might declare the policy void or alternatively load an additional 3-month general waiting period for the newborn baby. On applications to register the newborn baby, underwriting will apply, and any pre-existing condition will be excluded.

c) If a female person had already been pregnant on application, and declare the same, any cost pertaining to maternity benefits for joining date will be excluded for 9 months and a general 3 month waiting period for the newborn baby will apply. On application to register the newborn baby, underwriting will apply, and any pre-existing conditions will be excluded.

2.1.2. Eye Surgery – 12 months waiting period

2.1.3. Excimer Laser and Radial Keratotomy – only after 2 years' continuous membership.

2.1.4. Medical Reconstructive Surgery – only after 2 years' continuous membership

Should the maximum agreed tariff not adequately define a procedure then the payment for such treatment pertaining to any other defined incident shall constitute a separate Claim.

In-hospital treatment must be validated with the Insurer at least 48 (forty-eight) hours prior to the procedure being done. Emergency cases must be validated within 24 (twenty-four) hours after the incident occurred.

Only validated Private Hospital events and claims may be considered for payment in accordance with the insured benefits of the Policy selected.

A risk rating of 15% may be imposed on the monthly premium once the accumulated claim ratio (claims incurred vs. contributions) exceeds 80% where such claims calculation will exclude acute hospitalization.

Terms and conditions of the Insurer apply.

3. HOSPI CASH

The Policyholder or his/her beneficiaries will receive an amount, subject to the benefit, for every full day spent in Hospital after the third day of hospitalization. The eligible Insured will not qualify for this benefit if hospitalization is 3 days or less. A full day is defined as each day on which the Insured was still hospitalized at midnight on that day.

In the event of hospitalization of maternity cases with twins are born, it is defined as one event.

Only Private Hospital (speciality 57 and 58) events and claims will qualify for Hospicash.

The benefit is not payable to admission in any provincial hospital since case management is not a possibility from the service providers' side.

4. FUNERAL PLAN

A maximum of six (6) beneficiaries, including the Policyholder, will be covered for the duration of the policy.

On the death of the Policyholder the cover of the Eligible Spouse under this policy may be continued.

Only legally or customary married spouses, Common Law Partners, own children, and legally adopted children will qualify to be registered as dependents under the principal member.

Nomination of a beneficiary is essential. The nominated person is entitled to be paid the benefits provided for in terms of this policy upon the death of an insured person or the Policyholder in the event of the death of any of the additional insured persons.

In the absence of a nominated beneficiary, the parent of a Child or the legal spouse will be deemed the nominated beneficiary.

All benefits payable shall be paid to the Nominated beneficiary. In the absence of a nominated beneficiary, the parent of a child or the legal spouse will be deemed the nominated beneficiary, failing which the benefit will be payable to the diseased Estate, Funeral home, or the participating employer whose receipt shall in every case be full discharge to the Insurer.

If no beneficiary can be traced, or there is no participating employer, and payment of the Funeral Home is made by a Family member, payment can be made to the Family member with sufficient proof to be provided that the cost of the Funeral was paid by the Family member this proof should be in the form of an invoice and receipt from the Funeral home in the name of the Family member.

Claims documents required:

- Completed funeral claim form.
- Certified copy of the Death certificate.
- Certified copy of the deceased's ID document.
- Proof of membership.
- Proof of paid-up premiums.
- Proof as nominated beneficiary.

Pre-Existing Conditions, which could cause the death of any insured person will be excluded for a period of 6 (six) or 12 (twelve) months. A pre-existing condition is any medical condition, physical defect, illness, or bodily injury that existed before the start date of a funeral policy, and that causes the death of a Policyholder or beneficiary within 6 months from joining the policy.

Maximum entry age for Policyholder and his/her spouse is 60 (sixty).

- 3 (three) month general exclusion period for death as a result of natural causes, unless the death is the direct result of an accident.

- 6 (six) month exclusion period for death as a result of a pre-existing condition applicable to Policyholders of Participating Employer groups as defined in the terms and conditions.

- 12 (twelve) month exclusion period for death as a result of a pre-existing condition applicable to individual policyholders.

- 12 (twelve) month exclusion period for death as a result of HIV/Aids, applicable to both policyholders of Participating Employer groups and individual policyholder.

- 24 (twenty-four) month exclusion period for death as a result of suicide applicable to both Groups and individual members.

In addition to the product conditions, the Terms and Conditions of the Insurer
Only active members and active beneficiaries of a registered medical aid fund may participate.

5. CLAIMS

5.1. CLAIMS PROCEDURE

Every Claim submitted to the Insurer in terms of the medical insurance plan in respect of service rendered as contemplated in this Policy, must contain the following particulars:

- Family name, initials and signature of the Policyholder or Spouse.
- The first name of the patient as per the membership card.
- The name of the medical insurance plan.
- The Policy number.
- The practice code/name of the supplier of the service, where applicable.
- The practice code/number/name and specialty of the supplier of the service where the service provider is in the employ or consulting on behalf of a preferred service provider.
- The date of service.
- The nature and costs, according to the agreed tariff, of each service diagnosis or diagnostic code, where applicable.
- Copy of approved validation when applicable.
- The name of the referring medical practitioner.

To qualify for insured benefits, a Claim shall be submitted to the Insurer not later than the last day of the sixth (6) month from commencement of the first occurrence or hospital treatment for such incident.

No benefit payable shall carry interest.

The Insurer will not be liable to pay any benefits if the Insured or any Eligible Spouse of Eligible Children fail(s) to comply with any Policy obligation.

5.2. CLAIMS SETTLEMENT

In the event of an Insured Person suffering an insured event the Insured Person is required to:

- Obtain any necessary day-to-day medical services from a registered Health Professional where the Insured Person's insurance plan allows for Day-to-Day medical treatment benefits.
- Undergoing medical or surgical procedures or treatment as an in-patient in a hospital or similar registered medical facility.
- Required emergency medical evacuation.

The Insurer shall compensate the Policyholder and/or Healthcare Professional in accordance with the standard terms and conditions of the Insurer and in terms of the Policy selected.

5.3. POLICYHOLDER VALIDATION AND BENEFIT REGISTRATION

The in-Hospital benefits of insurance policies will be payable provided treatment, or medical services were validated through the Insurer.

6. PRODUCT SCHEDULE

The Sum Insured and premiums of each insurance policy as annexures hereto.

6.1. BENEFITS

Benefits are subject to the Terms and Conditions of the Insurer as well as any special Terms and Conditions specific to each insurance policy.

6.2. PREMIUMS

The premium is due monthly or annually in advance and if it is not received by the Insurer on/or before the 7th (seventh) day of the month of cover, then this policy shall be deemed to have been cancelled at midnight on the last day of the preceding period of insurance.

Where a Policyholder request a debit order deduction on a selected date, and the payment day falls on a Saturday, Sunday or recognized Namibian public holiday, the payment day will automatically be the next ordinary business day. Furthermore, if there are insufficient funds in the nominated account to meet the obligation, the Insurer is entitled to track the account for a period of 48 hours and re-present the instruction for payment during this 48-hour period.

Maximum contribution charge is for 6 (six) Beneficiaries, thus 1 Policyholder with 5 (five) Beneficiaries. Child beneficiaries over the age of 25 (twenty-five) and Special Beneficiaries as defined, will pay an additional adult beneficiary premium.

The Insurer shall not be obliged to accept any premium tendered to it after the Inception Date or renewal date, but may do so upon such terms as it, at its sole discretion, may determine.

The Insurer, in its sole discretion, may allow a freeze of premiums for employer groups in industries directly or indirectly impacted by national and international pandemics. A freeze of contributions may in such instances be allowed for a maximum period of 6 months during which period Insured Persons will not have access to any insured benefits and no claims will be paid for medical services with service dates incurred during this period. Pro-ration of benefits will be effective from the first (1st) day of the month in which the premium freeze is effective up to the end of the month of the premium freeze period. The premiums and benefit freeze period will be lifted on the first (1st) day of the month, in which full premiums have been paid. Policyholders will be reactivated on the first (1st) day of the month in which premiums have been received, without any new underwriting restrictions.

The premium schedule of each insurance policy forms part of the Benefit Schedules as Annexures hereto and may change from time-to-day at the Insurer's discretion.

No claims will be payable if the monthly premium is not paid up to date on/or before the 7th day of each month.

7. POLICYHOLDER COVER

7.1. COMMENCEMENT OF COVER

Cover in terms of this policy commences on acceptance of the contract as approved by the Insurer, on the 1st day of the month following receipt of payment. Claims originating prior to the date of commencement of cover will not be covered by the Insurer.

7.2. INSURANCE AMENDMENTS

The terms and conditions of the Insurer may be amended at the sole discretion of the Insurer.

7.3. CANCELLATIONS OR AMENDMENTS

Either party may give 30 (thirty) calendar days' notice of amendments or cancellation subject to the Terms and Conditions of the insurance policy selected. For monthly paid policies, there will be no premium refund for the remainder of the month in which the policy is cancelled.

Claims received upon cancellation of the insured policy will only be considered if such claiming incident commences no later than the last day of the 6th (sixth) month from the commencement of the first occurrence or Hospital treatment or Medical Services, before the date of cancellation, with due consideration to available insured limits, which may be pro-rated upon cancellation.

7.4. BIRTH NOTIFICATION AND REGISTRATION

Registration of a newborn Child is required on the first (1st) day of the month following the month of birth with a maximum allowable registration period of 30 (thirty) days after the date of birth or adoption of the child. Such a child shall thereupon be registered by the Insurer as a beneficiary.

Increased premiums shall be due for newborn Children as from the first day of the month following the month of birth; Benefits for newborn babies will accrue as from the first (1st) day of the month following the month of birth.

Unless otherwise determined by the Insurer, the registration of a newborn baby where the mother belongs to another Medical Aid Fund or Medical Insurance Plan, or where the mother does not belong

to any Medical Aid Fund or Insurance Plan, will be the first (1st) day of the month following the month of registration. Benefits for the newborn Child where the mother belongs to another Medical Aid Fund or Medical Insurance plan, or to no Medical Aid Fund or Insurance Plan, will accrue from the first (1st) day of the month following the month of registration on a pro-rated basis, provided that no such Child shall qualify for benefits until such time as the Policyholder qualifies for benefits, unless an exclusion or waiting period is imposed, then the exclusion or waiting period will prevail and no benefits will be paid.

The Insurer will not be liable for any incurred costs associated with maternity, confinement, birth, or birth complication costs, which relates to the birth of the newborn on another registered Medical Aid Fund or Medical Insurance Plan. Contributions will be due from the first (1st) day of the month following the month of registration.

Unless otherwise determined by the Insurer, on admission of a newborn Child born within another Medical Aid Fund or Medical Insured Plan, or where the mother does not belong to any Medical Aid Fund or Insurance Plan on the first (1st) day of the month following the month of registration, the Insurer may impose waiting periods depending on the level of risk ranging from 3 months to a lifelong condition specific exclusion on the newborn Child, during which periods no benefit shall accrue to the newborn Child, but contributions by the Policyholder for the beneficiary shall be payable to the Insurer.

The Insurer may decline a newborn Child application depending on the level of risk.

7.5. NOTIFICATION AND REGISTRATION OF ADDITIONAL FAMILY MEMBERS

A Policyholder who marries or wishes to register a partner or Child after joining the insurance policy, should apply within 30 (thirty) days from the date of marriage or adoption to register the spouse, common law spouse or child as a Beneficiary. Registration will be the first (1st) day of the month, following the month of registration.

If a Policyholder or member and/or his/her dependents who has been a policyholder(s) or member(s) of another registered medical aid fund or medical insurer in Namibia for a minimum period of at least 2 (two) years, with a break in membership of less than 3 (three) months after termination from the previous Medical Aid Fund or Medical Insurer, then the Insurer may impose waiting periods depending on the level of risk, ranging from a 3 (three) month waiting period to a lifelong exclusion

on new applications. A general waiting period of twelve (12) months will be applied for confinements. The Insurer may decline a new application depending on the level of risk.

The Insurer may decline an application depending on the level of risk.

7.6. WITHDRAWAL OF COVER

The Insurer may declare a policy or any part of it invalid in the event of any essential facts affecting the insurance not being disclosed or being misrepresented by the Insured, or in the event where premiums were not paid on or before the 7th (seventh) day or the month of cover.

7.7. RISK RATE

The Insurer may amend the policy, premiums, and benefits of a Policyholder when the risk of such Policyholder increases, without the written consent of the premium payer.

7.8. FRAUDULENT OR DELIBERATE ACTS

The Insurer will terminate the contract and reject the claim if:

- Any claim under this policy is in any respect fraudulent.
- It is found that fraudulent means or false information was used to benefit from the cover granted.

- The insured person allows anyone acting on his behalf to provide false information to obtain a benefit. or
- The insured person deliberately and wilfully conspires to cause, aggravate or accelerate the illness or accident that gave rise to a claim.
- The Insurer will make no refunds for premiums already paid and may initiate legal proceedings against the defrauding party.

8. GENERAL

The policy does not acquire any paid-up value or surrender value.

The table of benefits and rates insured applies within the area of cover.

The Policyholder shall submit claims to the Insurer within 6 (six) months of occurrence of Incident. Failing to submit claims within the prescribed period will result in forfeiting benefits under this Policy in respect of such claim.

The Insurer reserves the right to alter the terms and conditions of this policy if it is necessary to do so to comply with any changes in legislation of NAMFISA.

The Insurer reserves the right to cancel the cover and declare all premiums paid as forfeited, should there be evidence of, or an attempted submission of a fictional claim, fraud, or misrepresentation.

Pre-Existing Conditions will be excluded for a period as determined by the Insurer.

The Insurers' liability is conditional on the Policyholder claiming the benefit and keeping to the policy terms and conditions.

Annual benefit- and premium reviews are done at the end of each Benefit Year and premiums increased at the beginning of each Benefit Year, without the written consent of the premium payer. These reviews exclude the risk rating.

The Insurer shall not be liable for the failure of a broker or agent to adequately explain the terms and conditions of the policy and the terms and conditions of the Insurer, and each policy schedule will serve as guidelines for payment of benefits and collection of premiums.

9. INDEMNITY OF THE INSURED

In consideration of the Insured having paid the agreed premium to the Insurer and subject to the terms, conditions, and exclusions herein, the Insurer hereby undertakes to pay upon the death of the Insured, to the Beneficiary or the estate of the Insured, the funeral benefit of the Insured.

10. GENERAL EXCLUSIONS

The Insurer shall not be liable for paying any benefits due to bodily injury, sickness, disease, death, or medical evacuation directly or indirectly caused by related or in consequence of.

- War, invasion, hostilities, civil war, rebellion, revolution.
- Any condition for which an Insured Person received treatment or advice prior to becoming an Insured Person under the applicable sections of the policy unless otherwise agreed to by the Insurer.
- Misrepresentation, misdescription or non-disclosure of any material fact shall render this Policy voidable.
- The cost of any medical benefit other than prescribed in the benefit schedule.
- Any cost of medical benefits specifically excluded by the Insurer.
- Any cosmetic related procedures unless specifically provided for in the benefit schedule of the Policy selected.
- Orthogenetic surgery.
- Surgical treatment for obesity or its sequel.
- Dentistry (specialized and conservative), orthodontic or similar treatment unless specifically provided for in the Insured plan selected.
- Artificial insemination or hormone treatment for infertility.
- Routine physical or any procedure of purely diagnostic nature unless specifically provided for in the Insured plan selected.
- Investigator treatment.
- Transportation by, road or aid, for reasons other than urgent live support necessity, or transport to a hospital, which could simply have occurred via own transport, is specifically excluded.

- Depression, insanity, mental or mental stress-related conditions unless specifically provided for in the Insured plan selected.

- Costs, which directly or indirectly arise from or can be ascribed to suicide, attempted suicide, or intentional self-inflicted injury, do not qualify for benefits whether the Insured Person concerned is of sound mind or not.

- Any illness or event caused by the abuse of alcohol, unless otherwise approved by the Insurer.

- The cost of harvesting and/or preserving human tissue, including, but not limited to, stem cells, for future use thereof to treat a medical condition which has not yet been diagnosed in a beneficiary.

- Drug addiction, negligence, whether gross negligence or otherwise, wrongful acts or breach of any prohibition related to drug abuse, unless specifically provided for in the Insured plan selected.

- Voluntary Abortions, unless otherwise approved by the Insurer

- Infertility Treatment

- Sterilization and Vasectomies, unless pre-authorized by the Insurer, such procedure will be allowed once per lifetime.

- Surgical procedures relating to the reversal of Sterilizations and Vasectomies.

- Any cost pertaining to maternity benefits for individual members as well as to employer groups with less than 10 principal insured lives will be excluded for a period of 12 (twelve) months from date of joining, including the cost of birth, birth complications and any medical complication of the newborn Child, unless otherwise agreed to by the Insurer (refer to policy conditions).

- More than one pregnancy per family per annum.

- Surrogate pregnancies.

- There is no cover, at the time of the accident, death, or injury, when the Insured Person participated in:
    - Any activity that involves the use of firearms, specifically approved by the Insurer.

No claims will be payable if the monthly premium is not paid up to date on or before the 7th day of each month.

11. EXCLUSIONS – FUNERAL PLAN

The Insurer shall not be liable for paying any benefits due to death directly or indirectly caused by related or in consequence of.

- War, invasion, hostilities, civil war, rebellion, revolution, or terrorism
- Any condition for which an Insured Person received treatment or advice prior to becoming an insured person under the applicable sections of the policy, unless otherwise stipulated under this policy.
- The use of nuclear, biological, or chemical weapons, or any radioactive contamination.
- Attacks on, or sabotage of facilities (for example, nuclear power plants, reprocessing plants, final repository sites and research reactors) and storage depots that lead to the release of radioactivity of nuclear biological.
- Directly or indirectly, because of Acquired Immune Deficiency Syndrome (A.I.D.S) or any AIDS related or HIV infection during the first 12 (Twelve) months from the date of

  commencement of cover.
- Directly because of suicide during the first 24 (Twenty-Four) months from the date of commencement of cover.
- Misrepresentation, misdescription, or non-disclosure of any material fact shall render this Policy voidable.

No claims will be payable if the monthly premium is not paid up to date on or before the 7th day of each month.