PROSPERITY LIFE

hospicash 100
PRIVATE HOSPITAL FINANCE PLAN

HOSPICASH 50 AND HOSPICASH 100
EFFECTIVE 2026

The HospiCash benefit provides additional cash pay-out whilst hospitalised. The Insurance plan will pay a daily sum insured for every full 3 days hospitalized in a Private Hospital subject to the Insurance Plan selected and the Insurer's terms and conditions.

INSURER STANDARD TERMS AND CONDITIONS

Subject to the terms, conditions and provisions of the policy, the Insurer agree to pay the Policyholder for an insured incident occurring during the period of cover up to the limit of indemnity stated and based on 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" will be Namibia and South Africa. 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" mean 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 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.

"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, where the employer is the premium participant.

"Hospital" means a registered institution providing diagnostic and therapeutic facilities for surgical and medical diagnosis 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, and 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 one 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 beneficiary 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 procedure listed, 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.

"Policyholder" means a person who elects to insure under this policy provided that 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 monthly premium payable by the Policyholders to the Insurer before commencement of cover. Premiums are increased at the beginning of each benefit year, without the written consent of the premium payer.

"Prosperity Benchmark Tariff" refers to the scheme rates applied to claims made, strictly in accordance with the stipulates daily sum insured and subject to the event limit and overall annual limit of the selected Insured Plan.

"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. Increased premiums following risk rating will be done without written consent of the premium payer.

"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/or 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 keeping to the policy Terms and Conditions.

2. INSURED BENEFIT

The maximum annual insured benefit payable per benefit year as stated in the insured Benefit Schedule is:
HOSPICASH 50 – N$50 000.00 (fifty thousand Namibia Dollars) per person limited to N$15 000.00 (fifteen thousand Namibia Dollars) per event
HOSPICASH 100 – N$100 000.00 (one hundred thousand Namibia Dollars) per person limited to N$30 000.00 (thirty thousand Namibia Dollars) per event
FUNERAL COVER – N$10 000.00 (ten thousand Namibia Dollars) adult and N$5 000.00 (five thousand Namibia Dollars) Child

3. PRODUCT CONDITIONS

Only active members and active beneficiaries of PSEMAS (Public Service Medical Aid Scheme) and Oxygen medical plan may participate.

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

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

3.1. Maternity Benefit

- 12 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.

- 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 Child. On application to register the newborn Child, underwriting will apply, and any Pre-existing Condition will be excluded.

- In the event that 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 12 months and a general 3-month waiting period for the newborn Child will apply. On application to register the newborn Child, underwriting will apply, and any pre-existing conditions will be excluded.

6 month waiting period on Planned Hospital Admissions.

Only validated Private hospital (speciality 057 and 058) 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 hospitalisation.

4. PART (4) HOSPI CASH BENEFIT 50/100

- The benefit will pay a daily amount for every full day that an eligible insured life spends in a hospital, if hospitalised for three (3) or more days. A full day is defined as each day on which the Insured was still hospitalised at midnight of that day.

- The benefit is limited:
  - Hospicash 50 – N$50 000 per person with a maximum of N$15 000 per event
  - Hospicash 100 – N$30 000 per person with a maximum of N$30 000 per event

- The benefit is not payable to admission in any State hospital. Only valid Private hospital (speciality 057 and 058) events and claims will qualify for Hospicash payment.

- In the case of the death of the Policyholder, the cover of the registered beneficiaries will be terminated.

5. INCLUSIVE FUNERAL PLAN

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

Only legally or customary married spouse, common law partners, biological children and legally adopted children will qualify to be registered as beneficiary under the principal member.

Pre-existing Conditions, which could cause the death of any insured person, will be excluded for a period of 6 (six) months for members of Participating Employer Groups and 12 (twelve) months for individual members. 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 an insured person or beneficiary within the exclusion period.

Maximum entry age for principal member 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 for members of Participating Employer Groups
- 12 (Twelve) month exclusion period for death as a result of a pre-existing condition for individual members.
- 24 (Twenty-four) month exclusion period for death as a result of suicide.

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 a full discharge to the Insurer.

In the event that no beneficiary can be traced, or there are 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.

Should a claim arise within the first 12 (twelve) months from the date of inception, the Insurer reserves the right to request a medical certificate or medical history report. The Insurer also reserves the right to request any additional information that may be required to process a claim. The onus is on the beneficiary to obtain and provide information. A claim may be withheld if relevant documentation is not provided.

The benefit is subject to the benefits applicable to the benefit structure and the Funeral plan terms and conditions.

6. RESCUE ME

Only available to Policyholders of Hospicash 100.

The Rescue Me insurance plan is an inclusive insured benefit for Hospicash 100 Policyholders, offering cover to insured beneficiaries in the following events:

INSURED BENEFITS

- Medical Emergency Evacuation services by road within the borders of Namibia.

COVER:

- Cover: Part of the sum insured of the Insurance Plan selected
- The policy does not constitute an exclusive service provider agreement, and the policy covers all duly registered Paramedical Service Providers, within the area of cover and within the agreed Rate insured of the Insurer.

7. EMERGENCY EVACUATION

The benefit will pay the Agreed insured rate for services rendered by a registered organisation providing emergency transportation, provided the transportation was absolutely necessary as a result of:

- serious accident or injury; or
- an acute life-threatening condition

8. CLAIMS

8.1. CLAIMS PROCEDURE

Every Claim submitted to the Insurer in terms of the Hospicash Insurance Plan, and in respect of Service rendered as contemplated in this Policy, a fully completed claim form, which includes the Hospital Claim containing the following particulars:

- Family name, initials and signature of the Policyholder or Spouse.
- The first name of the patient as per the Policyholder card.
- The name of the Medical Insurance Plan.
- The Policyholder 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 cost, according to the Agreed tariff, of each Service Diagnosis or diagnostic code, where applicable.
- Copy of approved Policyholder validation when applicable.
- The name of the referring Medical Practitioner.

To qualify for insured benefits, a claim shall be submitted to the Insurer no 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.

Hospicash claims for admissions to State Facilities are excluded from this insurance cover.

The Insurer will not be liable to pay any benefits if the Insured or any Eligible Persons fails to comply with any Policy obligation.

8.2. CLAIMS SETTLEMENT

In the event of an Insured Person suffering an insured event, as defined, this necessitates the Insured Person to:

- Undergo 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 in accordance with the standard Terms and Conditions of the Insurer and in terms of the Policy selected.

8.3. POLICYHOLDER VALIDATION AND BENEFIT REGISTRATION

The In-Hospital benefits of insurance policies will be payable provided that the treatment or medical service was validated through the Insurer.

9. PRODUCT SCHEDULE

The insured benefits and premiums of each insurance policy as set out in the Policy brochure.

9.1. 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.

9.2. PREMIUMS

The Premium is due monthly or annually in advance and if it is not received by the Insurer on or before the seventh (7^{th}) 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 in the event that the payment day falls on a Saturday, Sunday or recognized Namibian Public holiday, the payment day will automatically be the next ordinary business day. Further, 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 beneficiaries, thus 1 Policyholder with 5 beneficiaries. Child beneficiaries over the age of 27 (twenty-seven) and special beneficiaries as defined, will pay an additional adult beneficiary premium.

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 re-activated on the first (1st) day of the month in which premiums have been received, without any new underwriting restrictions.

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

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.

10. POLICYHOLDER COVER

10.1. 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 originated prior to date of commencement of cover will not be covered by the Insurer.

10.2. INSURANCE AMENDMENTS

The Terms and Conditions of the Insurer may be amended at the sole discretion of the Insurer.

10.3. 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 six (6) months 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.

10.4. 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 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 Child 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, in the event of the mother belonging 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 Child 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 new born 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.

10.5. NOTIFICATION AND REGISTRATION OF ADDITIONAL FAMILY MEMBERS

A Policyholder who (re)marries or wishes to register a partner or Child subsequent to 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 1st (first) day of the month, following the month of registration.

Additional family members will be subject to the standard waiting period.
The Insurer may decline an application depending on the level of risk.

10.6. 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 Premium were not paid on or before the 7th day or the month of cover.

10.7. RISK RATE

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

10.8. MISREPRESENTATION, MISDESCRIPTION OR NON-DISCLOSURE

Misrepresentation, misdescription or non-disclosure of any material fact or circumstances in connection with this policy, a claim or the application for this policy may result in this policy being cancelled, a claim rejected, or the policy voided from inception and all premiums forfeited.

In the event that a benefit has been paid as a result of any misrepresentation, non-disclosure, misdescription or fraudulent action by an Insured Person or by any person claiming any benefit under this policy, such person will be required to repay or return the benefit paid. The Insurer shall be entitled to take legal action to recover the benefit and any costs involved.

11. GENERAL

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

The table of benefits and tariffs applies in 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 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 the NAMFISA.

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.

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.

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.

12. INDEMNITY

Neither the Insurer nor any employee, broker/agent or Consultant shall be liable for any damage caused by any act, advice, negligence or otherwise.

13. 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 insured medical benefit other than prescribed in the benefit schedule.
- Cost related to preventative surgery where no firm diagnosis has been made including Prophylactic mastectomy.
- Any cost of insured 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.
- Hospital admission for Depression, insanity, mental or mental stress-related conditions.
- 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, unless otherwise approved by the Insurer.
- Any illness or event caused by the abuse of alcohol, unless otherwise approved by the Insurer.
- Hospital or Psychiatric facility for Drug addiction, negligence whether gross negligence or otherwise, wrongful acts or breach of any prohibition related to drug abuse.

- Any cost pertaining to maternity benefits for individual members as well as for 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 baby, unless otherwise agreed to by the Insurer (refer to policy conditions).
- More than one pregnancy per family per annum.
- 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, unless 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.