PROSPERITY LIFE

COMPLIMED GAP

PRIVATE HOSPITAL GAP PLAN FOR
PSEMAS HIGHER OPTION &
PSEMAS STANDARD OPTION

COMPLIMED GAP (PSEMAS)
STANDARD OPTION AND HIGH OPTION
EFFECTIVE 2026

The Complimed GAP (PSEMAS) will pay the difference between the PSEMAS approved tariff covered by PSEMAS and the applicable Rate Insured.

INSURER STANDARD TERMS AND CONDITIONS

Subject to the terms, conditions, and provisions of the policy, the Insurer agrees 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 25 (twenty-five) or special beneficiary for Premium purposes.

"Area of Cover" will include 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.

"Continuation Membership" means 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 two (2) years, with a break in membership of less than 3 (three) months after termination from the previous medical aid fund or medical insurer. The Insurer may impose waiting periods depending on the level of risk, ranging from a three (3) month waiting period to a lifelong exclusion on new applications. A general waiting period of twelve (12) months will be applied for confinements (including birth, birth complications and any medical complication of the newborn baby). The Insurer may decline a new application depending on the level of risk.

"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 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-five (25) (including the children of common law spouses, a legally adopted child or stepchild).

(2) Turns 25 year old on his/her next birthday; the child beneficiary will enjoy a full year benefit during the year he/she turns 26.

"Eligible Spouse" means the spouse of the Policyholder who has not attained the age of 65 (sixty-five) 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, in relation to employers who are Premium participants.

"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.

"Hospital Benchmark Tariff" (HBT) (applicable to all hospital claims) means the tariff set by the Ministry of Finance for services rendered to PSEMAS members, as amended from time to time in the Government Gazette.

"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 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.

"Policyholder" means a person who elects to insure under this policy provided that he/she has not attained the age of 65 (sixty-five) 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 commencement of cover.

"Premium" means the annual 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.

"Pro-Rated 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 newborn Children, where the Policyholder has been a Policyholder for more than 12 months and no exclusions where applied.

"Prosperity Benchmark Tariff" means the insured rate applicable to claims submitted by healthcare providers, determined with reference to the standard tariffs published by the Namibian Association of Medical Aid Funds (NAMAF), as adjusted by an additional percentage, currently set at 200% of the NAMAF tariff.

"Rate Insured" means the tariff structure used by the Insurer based on the Hospital Benchmark Tariff and/or 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.

"Adult Beneficiary" means a Child who is over the age of twenty-five (25) 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 event.

"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 policyholder basis.

The Insurer's liability is conditional on the Policyholder claiming the benefit and abiding by 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 N$1 250 000 (one million two hundred and fifty thousand Namibia Dollars) per person and N$2 500 000 (two million five hundred thousand Namibia Dollars) per family.

3. PRODUCT CONDITIONS

Only active members and active beneficiaries of PSEMAS may participate.

The insured 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 do not allow additional benefits to what is offered by the medical aid fund.

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

The PSEMAS Higher Option provides benefits per member (N$ 350 000.00) for hospitalisation, subject to an overall family limit per annum (N$ 700 000.00), payable at 100% of the applicable PSEMAS agreed tariff.

GAP Cover shall become applicable only once the relevant PSEMAS benefit limits have been fully exhausted. Thereafter, the excess per insured event shall be calculated as the difference between the applicable PSEMAS State tariff and the Hospital Benchmark Tariff (HBT), subject to the terms, conditions, and limits of the policy.

Benefits are allocated as per the Insurer's Benefit Year and any Principal Insured or Insured Person who joins the insurance plan during the course of the year will receive pro-rated benefits on all insured benefits, to be 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.

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 policyholder and his/her spouse is 65 (sixty)-five.

Insurer may impose waiting periods depending on the level of risk, ranging from a three (3) month waiting period to a lifelong exclusion on new applications. A general waiting period of twelve (12) months will be applied for confinements (including birth, birth complications and any medical complication of the newborn baby). The Insurer may decline a new application depending on the level of risk.

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

3.1. Maternity Benefit

- 12 month waiting period for individual policyholders 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 may 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.

3.2. **Cataract Surgery** – 12 months waiting period.

3.3. **Excimer Laser and Radial Keratotomy** – only after 2 years' continuous insured cover.

3.4. **Medical Reconstructive Surgery** – only after 2 years' continuous insured cover.

If the agreed tariff does 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.

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.

3.5. INTERNATIONAL TRAVEL COVER

The Rescue Me Policy covers insured beneficiaries in accordance with the benefits of the insurance plan selected, and in the following events:

3.5.1. INSURED BENEFITS

- Medical Emergency Evacuation
- Repatriation
- International Travel Insurance
- 24/7 Access to call-centre dispatch

3.5.2. COVER

- The cover amounts to N$10 000 000 (ten million Namibia Dollars) per life per annum
- 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

3.5.3. EMERGENCY EVACUATION

- The benefit will pay the actual amount of the bill received from 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

3.5.4. REPATRIATION

The benefit will cover the cost of repatriation in case of:

- Within the Policy definition "Area of Cover", emergency transportation done under benefit 3.5.3, whether by means of either Road transport or commercial flight in case of patient still being alive after the emergency treatment.
- Within the Policy definition "Area of Cover", emergency transport done under benefit 3.5.3, where the patient (covered life under the policy) passed away and the mortal remains be repatriated to the town of residence in Namibia.
- The benefit payment is subject to provision of the following documentation:
    - Valid Claim form of the Insurer and certified copy of the death certificate

3.5.5. ACCESS AGREEMENT

Call Centre Access for dispatch

- The benefit is subject to the benefits applicable to the benefit structure and the Terms and Conditions of the Rescue Me Policy.

4. CLAIMS

4.1. CLAIMS PROCEDURE

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

- Family name, initials and signature of the Policyholder or Eligible 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.
- Proof of PSEMAS authorisation including any Deviation matters
- PSEMAS payment statement

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.

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

4.2. 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.
- 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 and/or Healthcare Professional in accordance with the standard terms and conditions of the Insurer and in terms of the Policy selected.

4.3. 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.

5. PRODUCT SCHEDULE

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

5.1. 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.

5.2. 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, the policy is suspended. If premium payments are not received after 90 days, then the policy is terminated.

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. 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 the aforesaid 48-hour period.

Maximum contribution charge is for 6 beneficiaries, thus 1 Policyholder with 5 beneficiaries. Child beneficiaries over the age of 25 (twenty-five) 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.

6. POLICYHOLDER COVER

6.1. 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.

6.2. INSURANCE AMENDMENTS

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

6.3. CANCELLATIONS OR AMENDMENTS

Either party may give 30 (thirty) days' notice of amendments or cancellation subject to the terms and conditions of the insurance policy selected. For policies paid on a monthly basis, 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 commence 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.

6.4. 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 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 or a decline of the newborn Child application, 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.

6.5. 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.

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 an application depending on the level of risk.

6.6. 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.

6.7. 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.

6.8. 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.

7. GENERAL

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

The table of benefits and rates insured 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.

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.

8. INDEMNITY TO THE INSURER

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

9. 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.
- Dentistry (specialised 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 air, 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, 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, unless otherwise approved by the Insurer.

- 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.

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

- Any cost pertaining to maternity benefits for individual policyholders 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.

- 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, 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.