HOW TO CLAIM FROM THE PROFESSIONAL PROVIDENT SOCIETY INSURANCE (PPS)

The Professional Provident Society Holdings Trust No IT 312/2011 (PPS) is a Registered South African Trust
Professional Provident Society Insurance Company Limited Reg. No 2001/017730/06 (PPS Insurance)
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BENEFITS AVAILABLE FROM PPS

Please refer to the PPS Policy Document for definitions and standard exclusions. The following information is a guide to claiming. All claims submitted are subject to the PPS Provider Policy terms and conditions.

SICKNESS AND PERMANENT INCAPACITY BENEFIT (S&PI)

When can I claim for the sickness cover under this benefit?
You can claim when you are sick and unable, due to the sickness, to perform your usual professional duties.

When does the benefit start paying?
The SPPI product has two waiting periods, namely, seven (7) days or thirty (3)0 days. Thus depending on which the waiting period you choose, the benefit will pay as follows:

- *7-day waiting period:* A Total Sick Pay Benefit will be considered if you are **totally** unable to perform your usual professional duties for at least seven consecutive days, due to sickness and will pay from day one. Once this initial requirement on a minimum period of seven consecutive days of total incapacity are met, ongoing claims can be submitted for continuing total, or partial claims.
- *30-day waiting period:* A Sick Pay Benefit will be considered if you are unable, either **totally or partially**, to carry out your usual professional duties for at least 30 consecutive days due to sickness. The Sick Pay Benefit will be paid on either a Total or a Partial basis, whichever is applicable, prospectively from day 31.

Please refer to your policy certificate to confirm if you have a 7 day or 30 day waiting period.

What if I can only do some of my duties after a period of being totally unable to work?
You may submit a claim for partial incapacity.

What is meant by 'total' incapacity?
You must be totally unable to perform any and all of your usual professional duties.

What is meant by 'partial' incapacity?
You may qualify for a Partial Sick Pay Benefit if you are not able to carry out your normal duties or normal work hours, due to the sickness, but you are able to attend to some of your usual professional duties. . 'Some of your usual professional duties' means that you have spent time during the working day attending to some of your duties and applying your knowledge and skill in relation to your nominated occupation. Should you

be able to attend to duties in relation to a different occupation, you must advise PPS of such change of occupation.

You may submit a claim for being able to work on a partial basis which will be considered and paid at 50% of your daily cover amount.

Hospital Benefits

Do I need to be sick and unable, due to the sickness, to perform my usual occupational duties for a total consecutive period of 7 days or more to claim hospital benefits?

No, to claim the hospital benefit you only have to be in hospital for ***four consecutive days*** (3 consecutive nights) or more.

Will I get paid if my child or spouse is hospitalised?

- If you elected to have the Family Hospital Benefit as a rider benefit, you will be paid a benefit if your spouse or child is hospitalised for four consecutive days (3 nights) or more. This will be a pro rata payment of the Family Hospital monthly benefit for the days in hospital.
- This benefit only covers your spouse and children.

What if more than one family member is hospitalised?

The benefit is designed to enable you to take time off work if a family member or members are hospitalised. If multiple family members are hospitalised for at least 4 consecutive days over the same or overlapping time periods, the benefit will pay once, for the longest duration of hospitalisation.

Is there a limit to the number of claims I can submit on the rider Family Hospital Benefit?

- No, there is no limit to the number of claims you can submit. However, the benefit will pay for a maximum of 182 days in a calendar year if your spouse or child hospitalised is a Profmed Medical Scheme member or dependent.
- A maximum of 91 days in a calendar year is payable for members and dependents on other medical aids.

When can I claim on this benefit?

There is a **six month waiting period** on this benefit, from policy inception. Claims can be submitted if hospitalisation occurs after the six months has expired.

What does pre-existing exclusion mean on the Family Hospital Benefit?

- No claim will be paid for any sickness, illness, disease, disability or impairment that existed prior to the commencement of the benefit.
- This applies to direct or indirect causes that aggravated the claim event and all symptoms that could have revealed the illness or condition.

What other benefits does the rider Family Hospital Benefit have?

- Child Terminal Illness benefit, and
- Child Death benefit.

How does the Child Terminal Illness benefit work?

- If your child is diagnosed with a terminal illness and is given less than 12 months to live, you will receive a lump sum payment equal to 12 months Family Hospital Benefit, to a maximum of R50 000 a month.
- This benefit is subject to the terms of the policy document.

How does the Child Death benefit work?

- If your child is dies and no Child Terminal Illness benefit was paid, you will receive a lump sum payment equal to 1 month Family Hospital Benefit.
- This benefit is subject to the terms of the policy document and maximum payment limits stipulated in the policy document.

What is required for me to submit a claim?

For the respective benefits discussed above:

- A claim form completed by you (Declaration by Member Form);
- A claim form completed by your treating doctor (Declaration by Doctor Form);
- For hospital benefits we require proof of hospitalisation showing admission and discharge dates.
- For claims relating to your spouse or child, we require a marriage certificate and unabridged birth certificate of the child and proof of medical aid.
- For adopted children we require a copy of the official adoption court order and/or official proof of the registration of the adoption with the Registrar of Adoptions, a copy of the marriage certificate pertaining to the Spouse and proof of medical aid for the child.
- For the Child Terminal Illness and Death benefit, we require the respective benefit claim forms completed by the member and treating doctor, the unabridged birth certificate or proof of adoption papers, marriage certificate and a death certificate where applicable.

If my spouse and I are PPS Policyholders each with the rider Family Hospital Benefit, will we get paid on both policies if our child is in hospital?

Yes.

Where do I get these claim forms?

- You can send an email to memberservices@pps.co.za; to request claim forms;
- Ask your financial advisor to assist;
- From the PPS website, www.pps.co.za go to " PPS InTouch" on the right hand side of the screen:
    - If you have not registered you can register by clicking on the *self- register* button;
    - You need to have your member number, ID number/Passport number available when you register;
    - Once registered, login using your username and password and you will be taken to the PPS InTouch home page;
    - Click on the claims button at the top of the page and scroll to the bottom where you will find all the claim forms.

Who can complete the Declaration by Doctor Form?

- A Medical Practitioner registered with the Health Professions Council of SA (HPCSA) and approved by PPS.
- A Dental Practitioner registered with the Health Professions Council of SA (HPCSA) and approved by PPS for dental related claims.

Who are the approved Medical Practitioners?

- Approved Medical Practitioners must have a minimum qualification of the following:
  - BCh Bachelor of Surgery
  - BChir Bachelor of Surgery
  - BM Bachelor of Medicine
  - BS Bachelor of Surgery
  - ChB Bachelor of Surgery
  - DCh Doctor of Surgery
  - DS Doctor of Surgery
  - MBBCh Bachelor of Medicine and Bachelor of Surgery
  - MBBS Bachelor of Medicine and Bachelor of Surgery
  - MBChB Bachelor of Medicine and Bachelor of Surgery
  - MD Doctor of Medicine
  - BDS Bachelor of Dental Surgery
  - BChD Bachelor of Dental Surgery
  - DDS Doctor of Dental Surgery
  - DMD Doctor of Dental Medicine.

Would I be required to submit any additional information once the claim forms have been submitted?

Additional information may be requested from you or your (or spouse or child) treating doctor once assessed by a claims assessor, especially if the claim period exceeds the number of days the illness is expected to last or with particular conditions claimed.

What are average days?

To enable PPS to manage claims and to ensure that all valid claims are paid, average days provides a guideline to assessors of what is considered a reasonable period to recover from a specific illness or procedure. The concept of 'average days' considers current clinical practice and relevant medical literature in conjunction with PPS's claims experience. PPS will approve the sick pay period which is in line with this current clinical practice.

What happens if my claim period is more than the average days?

Should this period have been extended by the treating specialist/ doctor, the doctor will be asked to provide additional supportive information based on his/her medical examination of you. Based on this additional supportive information, PPS will be able to make an informed decision on the remainder of the claim period considering the member's nominated profession.

Why else would additional information be required?

The assessor may request additional information to determine when your illness started and to get a history of your illness. We may also require a general medical history. There may be other reasons why the assessor may call for additional information, for example, to determine the effect the condition has on your ability to attend to your activities of daily living and how the sickness affects your ability to do your work. This could include an Independent Medical Evaluation by a Specialist chosen by PPS or an Occupational Therapy Evaluation.

Special protocol for certain medical conditions:

Mental and Behavioural disorders, fibromyalgia, chronic fatigue syndrome, on-going chronic auto-immune and connective tissue disorders, back conditions,conditions that may have started prior to the business being granted, that could become chronic conditions or are already classified as chronic conditions.

Assessor may ask for:

1. Copies of clinical notes from treating doctor, or usual doctor or the doctor who completed the medical reports at application for the policy.
2. Mental and behavioural questionnaire(DBD doctor) – Psychiatric cases.
3. Medical Questionnaire (fibromyalgia/chronic Fatigue Syndrome/ME/Post Viral Fatigue) - Any chronic fatigue/myalgic encephalitis/connective tissue/auto immune cases.
4. General claims Questionnaire from you.
5. Your claim to be referred to Internal Control to verify medical aid records or any other information pertinent to the medical history.
   In order to assist the assessor to finalize the claim Internal Control may request further information from members.
6. You to consult a medical specialist for the claim period. The medical specialist is someone who is an expert in that particular field of medicine relating to your claim.

Will additional requirements be communicated to me?

Yes, you will be notified via email, phone or fax according to your preferred method of communication.

Who will be liable for the costs of additional information?

You will be required to pay for the completion of the Declaration by Doctor Form. Some practitioners may require payment for the completion of this form.PPS will pay for any additional reports requested by us from your doctor.

How long will it take for my claim to be assessed?

- The entire process should not take more than 8 working days to finalise.
- The process will take longer if additional information is required or if the standard forms have not been completed correctly.

Is there a limit to the number of claims I can submit?

No, there is no limit to the number of claims you can submit. However, claims for a condition that is regarded as the same or similar or as a result of an existing condition or related to an existing condition, will be limited to 728 days.

How much will I be paid?

Your benefit will depend on the sickness cover amount reflected on your Statement of Benefits and will be calculated based on the number of days of sickness.

What will be paid out if I am in hospital?

If you elected to have the Hospital Rider Benefit or the Family Hospital Rider Benefit, you will be paid an additional benefit, which is equal to the daily sickness cover amount reflected on your Statement of Benefits and will be calculated based on the number of days of in hospital.

Which hospitals are covered?

- District, regional and provincial hospitals
- Private hospitals
- Spinal rehab units
- Infectious Diseases hospitals
- Rehab Step down facilities (e.g. Life Rehab)
- Step Down Institutions

- Frail care facilities.

Which hospitals are not covered?
Alcohol and substance abuse rehab centres.

What is my 'usual professional duties'?
Usual Professional Duties are those occupational tasks which you carry out as part of your occupation prior to claim. This includes administrative duties such as sending emails and making telephone calls related to your business or occupation.

What is Gross Professional Income (GPI) and how does this affect my claim?
Gross Professional Income is personal income and actual expenses derived before tax. As per the terms of the Provider Policy, a member cannot receive sick pay benefits in excess of two-thirds of his gross professional income or total cost to company salary at time of claim. Thus, PPS can perform a financial review when a sick-pay benefit claim has been submitted to determine whether a member has the appropriate amount of cover.

What do I do if I have a query regarding my claim?
- You can send an email to memberservices@pps.co.za;
- Alternately contact PPS on 011 644 4300.

What happens if I need to claim for a number of months? What information will PPS require?
PPS will require:
- Monthly claim forms will be required, one from you and one from your doctor;
- You will be required to consult your doctor monthly;
- Telephonic consultations are not accepted by PPS;
- Fully completed and signed claim forms (Declaration by Member and Declaration by Doctor Forms) should be submitted to PPS at the end of the month you are claiming for;
- The Doctors Declaration form must be completed by your treating appropriate or relevant Specialist, that is, a doctor who has specialised in the field of medicine related to your condition.
- Additional requirements will be communicated to you and may include:
  - Progress reports/questionnaires from your attending specialist(at PPS's cost);
  - Questionnaires completed by you (to determine the effect the condition has on your daily activities of living and your ability to perform your usual professional duties);
  - You may be required to go for an independent assessment at PPS's cost.

Can I claim for public holidays and weekends?
Yes, your claim may include public holidays and weekends.

Where do I send my claim forms to?
Fully completed claim forms may be sent to claims@pps.co.za.

How confidential is my claim information?
All documents, irrespective of the content, are handled as confidential. You can however advise PPS on your claim form to keep your accredited PPS financial advisor informed. This does require your specific consent. If no consent is received, your financial advisor will not be informed regarding the progress of your claim.

How long do I have after my sickness to submit my claim form?
Claims for benefits in terms of the PPS Provider Policy should be submitted as soon as possible after the occurrence of the event that gave rise to the claim in order to ensure efficient claims processing.

If I claim, will this affect my premiums or my Profit Share Account?
No, it will not affect either.

If I'm not happy with the outcome of the assessment of my claim what can I do?
You may submit a *written appeal* to claims@pps.co.za, stating the reasons why you feel that the decision taken is not correct. Should you be unhappy once you have received a written response from the Claims Department you may submit a further appeal to claims@pps.co.zawho will refer your appeal to Senior Management at PPS. Should you still be dissatisfied with the response you may submit a final appeal, this time to the Internal Arbitrator at PPS at arbitrator2@pps.co.za. In all instances the Ombudsman for Long Term Insurance can be contacted regarding an appeal. The details are as follows:

Telephone: **0860 OMBUDS (0860 662 837)**
Fax: **(021) 674 0951**
Email: **info@ombud.co.za**
Web: **www.ombud.co.za**

Postal Address: **The Ombudsman for Long-Term Insurance**
Private Bag X45
Claremont
Cape Town
7735

Before submitting a complaint to the Ombudsman, you must endeavour to resolve the complaint with the PPS internally.

Which bank account will my payment be paid into and when will this be paid?
- The benefit will be paid to your premium paying account, unless you request PPS to pay to a different account. If you want the payment to be made into a different account, you will be required to provide PPS with proof of the account which can be a letter from the bank confirming that the account belongs to you or a cancelled cheque.
- The benefit will be paid once assessed and the claim is accepted as valid.

Can I still apply for additional cover after a claim?
Yes you may. Your application will be subject to the standard PPS underwriting policy and PPS will consider the information relating to the claim submitted. In some instances such an application may be deferred for a period of time depending on the medical condition you are claiming for. This will be communicated to you by the PPS Underwriting Department.

DISABILITY BENEFIT

THE PPS PROFESSIONAL DISABILITY PROVIDER™ PRODUCT (PDP)

When can I claim this benefit?

When you suffer from a condition (illness/injury) that significantly prevents you from using your professional training and knowledge to carry out your own occupation or any other occupation that could be carried out by someone with similar qualifications.

What is required from me to submit a claim?

- Professional Disability Provider claim form (member);
- Professional Disability Provider claim form (doctor);
- Occupational Questionnaire (completed by you);
- Quality of Life Questionnaire (completed by you);
- Comprehensive medical report from your treating specialist/doctor.

Where do I get these claim forms?

- You can send an email to memberservices@pps.co.za; to request claim forms;
- Ask your financial advisor to assist;
- From the PPS website, www.pps.co.za go to " PPS InTouch" on the right hand side of the screen:
  - If you have not registered you can register by clicking on the *self-register* button;
  - You need to have your member number, ID number/Passport number available when you register;
  - Once registered, login using your username and password and you will be taken to the PPS InTouch home page;
  - Click on the claims button at the top of the page and scroll to the bottom where you will find all the claim forms.

Would I be required to submit any additional information once the claim forms have been submitted?

Yes, you may be required to submit a report from an Independent specialist (someone that does not treat you). This may include the following:

- Occupational Health Therapist;
- Independent second opinion/report (We will advise the specifics if it is a requirement as this is dependent on information already submitted).

Who will pay for these reports?

Independent Specialist reports will be paid by PPS if we request such reports.

Why would additional information be required?

This will assist us in ensuring that we make a fair and informed decision regarding your claim.

Will additional requirements be communicated to me?

Yes, you will be advised via email, phone or fax.

How long will it take for my claim to be assessed?

- The entire process should not take more than 15 working days to finalise;

- The assessment process is longer as this type of claim requires a thorough review of the medical information, a panel discussion of the claim and careful consideration of the permanency of medical conditions.
- The process will take longer if additional information is required or if the standard forms have not been completed correctly.

Who will determine if the claim will be paid?
A medical assessment committee (Medical Officers' Committee or MOC) comprising of medical specialists and other professionals will assess your claim.

Is there a limit to the number of claims I can submit?
Yes, once the full sum assured has been paid the benefit ends.

How much will I be paid?
The benefit amount is reflected on you PPS Policy Certificate. You can also ask your financial advisor for this information.

DREAD DISEASE BENEFIT

THE PPS PROFESSIONAL HEALTH PROVIDER™, PROFESSIONAL HEALTH PRESERVER (PHP) AND BUSINESS PROVIDER PRODUCT (BHP)

When can I claim this benefit?
When you are diagnosed with any of the conditions listed in your policy document.

What is required for me to submit a claim?
- Professional Health Provider, Health Preserver, Business Provider Claim form – Doctor;
- Professional Health Provider, Health Preserver, Business Provider Claim form – Member;
- **Comprehensive** report and **copies** of any tests done to confirm the diagnosis.

Who will pay for these reports?
In the even that we request independent specialist reports then PPS will pay for these reports.

Where do I get these claim forms?
- You can send an email to memberservices@pps.co.za; to request claim forms;
- Ask your financial advisor to assist;
- From the PPS website, www.pps.co.za go to " PPS InTouch" on the right hand side of the screen:
  - If you have not registered you can register by clicking on the *self-register* button;
  - You need to have your member number, ID number/Passport number available when you register;
  - Once registered, login using your username and password and you will be taken to the PPS InTouch home page;
  - Click on the claims button at the top of the page and scroll to the bottom where you will find all the claim forms.

Would I be required to submit any additional information once the claim forms have been submitted?
Yes, additional information may be requested from you or your treating doctor. This information will only be requested if sufficient information is not available to assess your claim.

Why would additional information be required?
The assessor may request additional information to determine when your illness started (dependant on the condition claimed for) to determine the chronological history of your illness.

Will additional requirements be communicated to me?
Yes you will be advised via email, phone or fax.

How long will it take for my claim to be assessed?
- The entire process should not take more than 8 working days to finalise;
- The process will take longer if additional information is required or if the standard forms have not been completed correctly.

Is there a limit to the number of claims I can submit?
Yes, you can only be paid 100% (100% in total for the accelerated PHP) of the insured amount for each condition covered under your policy. The stand-alone cover remains in force for unrelated conditions for which you can continue to claim should an unrelated event occur. The event paid for will be excluded from future claims if paid at 100% of the benefit.

How much will I be paid?
If you are awarded 100% it will be the full sum assured of the policy for that condition. If you are awarded less than 100% it will be a percentage of the sum assured, depending on the award given.

What are the different awards?
- *A - 100% of the Sum Assured;*
- *B – 75% of the Sum Assured;*
- *C – 50% of the Sum Assured;*
- *D – 25% of the Sum Assured.*

If you have selected the 'Core 100%' benefit under the PPS Health Provider then the award will be for 100% for the following conditions as long as the claim meets the requirements of at least a severity D:
- *Heart Attack (Cardiovascular);*
- *Cardiac Surgery and Procedures (Cardiovascular);*
- *Stroke (neurological);*
- *Cancer.*

How will the different awards be determined?
The award will depend entirely on the information submitted with your claim and the stage of the disease that you are suffering from. If you are awarded a 25% benefit and your condition worsens you may submit a new claim and additional reports which PPS will consider and may then pay a benefit based on a higher severity level based on the additional information available.

What is a severity level?
It is the degree of illness or how severe an illness is. The criteria for determining how severe an illness is, is set out in the PPS Provider Policy or you can refer to you Policy Certificate and Policy document for this criteria.

How will the severity level that I qualify for be determined?
This will be based on the assessment of the medical information submitted by your doctor against the definitions/degree of each level as defined in your policy document.

What does survival period mean?
A survival period will be applied to the dread disease and impairment condition you are claiming for. You have to be alive at the end of the survival period in order to receive a benefit payment. If the claimant dies during the survival period no benefit payment will be made, since the claimant would not have incurred the lifestyle adjustment costs, resulting from the dread disease or impairment condition, which the product is designed to cover.

Important
- A 14 day general survival period is applied;
- For a valid Core 100% claim you must survive for 14 days after the event occurred or the condition is diagnosed**:**
- Certain conditions have longer survival periods, to determine the permanence or severity of the condition, built into the definitions:
  - Heart attack has a 30 day survival period;
  - Stroke, has a 3 month survival period.

Important note: Please note that the Professional Health Preserver is a different product and different conditions and survival periods may apply.

What is the CatchAll benefit and how is it assessed?

Claims will only be paid under the CATCHALL COVER BENEFIT if the life insured suffers a dread disease, trauma or physical impairment that is not covered in terms of the BASIC BENEFIT or MATERNITY. The CATCHALL COVER BENEFIT claim criteria for a serious medical or physical condition must

- Result in a Whole Person Impairment (WPI) severity of at least 35%; or
- Results in confinement to a bed or wheelchair, for lives assured older than 75; or
- Is permanent and unlikely to change in spite of further medical or surgical treatment.

DEATH BENEFIT

THE PPS PROFESSIONAL LIFE PROVIDER™ PRODUCT (PLP)
THE PPS ACCIDENTAL DEATH PRODUCT
LIFE ASSURANCE (LA)
BUSINESS LIFE PROVIDER

May I claim against this benefit when I am still alive?
Yes, if *you* are diagnosed with a terminal illness and have a life expectancy of 12 months or less, you can claim the Terminal Illness Benefit. Half of the life cover sum assured will be paid to you, once approved by PPS. The remainder of the benefit will be paid to your beneficiaries when you pass away. Your premiums will be reduced accordingly.

When will the Death benefit be paid?
If the life insured dies during the benefit term, PPS Insurance will pay the sum assured due in respect of the benefit to the nominated beneficiary(ies).

To whom will the benefit be paid if there is no beneficiary nominated?
The benefit will be paid to the deceased's Estate.

What happens if the beneficiary is a minor child?
The benefit will be paid to the minor child's legal guardian.

What is required of my executor or beneficiary to submit a claim?

Natural Death	*Unnatural Death*
Death Certificate	Death Certificate
Detailed death certificate (BI 1663), if death certificate does not indicate the exact cause of death	Detailed death certificate (BI 1663), if death certificate does not indicate the exact cause of death
Banking details of Estate or nominated beneficiary/s	Banking details of Estate or nominated beneficiary/s
If paying to Estate PPS requires a letter of executorship	If paying to Estate PPS requires a letter of executorship
Copy of ID documents of beneficiaries	Copy of ID documents of beneficiaries
If the deceased was divorced copy of divorce order and settlement agreement	If the deceased was divorced copy of divorce order and settlement agreement
Medical report from treating doctor	Police Report (post mortem)
	Medical report from treating doctor
If a Trust is nominated PPS requires Copy of Trust deed and Letter of authority of trustees	If a Trust is nominated PPS requires Copy of Trust deed and Letter of authority of trustees

Where does one get a letter of executorship?
From the Master of the High Court.

Where will my executor/ beneficiary get these claim forms?
Notification of death should be sent to claims@pps.co.za with a copy of the death certificate and exact cause of death. The relevant documentation will be forwarded to the person submitting the claim.

What happens if a family member needs cash for the funeral or any other urgent costs incurred by the death of the member?
A request for "Immediate needs" (R50 000) may be submitted to PPS at claims@pps.co.za with a copy of the death certificate and banking details and proof (bank letter/cancelled cheque) of the beneficiaries.

Would any additional information be required once the requirements have been submitted?
The assessor may request additional information to determine when the illness leading to the death started (dependant on the condition claimed for).

Will additional requirements be communicated to the person that submitted the claim?
Yes, you will be advised via email, phone, fax.

How long will it take for my claim to be assessed?
The claim should be paid within 4 working days from the receipt of all the requested information.

How much will be paid?
The full life cover insured amount as at date of death will be paid based on the beneficiary nomination form unless the policy was ceded (security for a loan). In these instances the cessionary will be paid and the remainder, if any, will be paid to the beneficiaries based on the nomination form.

What is required for the Profit Share Account to be paid out?
The exact same process as above will apply. No immediate needs can however be paid from the Profit Share Account. The Profit Share Account can also not be ceded.